Adding New Provider
Checklist

______ Conduct Preapproval Visit and on-site training

______ Complete the Provider Status Change Form

______ Submit Provider Status Change Form along with the following documentation to OSDE within ***TEN days*** of the preapproval visit:

- ______ Preapproval Visit Form
- ______ DHS Permit or License
- ______ NDL Search
- ______ Tier Documentation

Note: Once OSDE staff has entered the provider into Site Maintenance, you will be notified

______ Complete and submit the online Provider Application and Agreement

Note: The agreement date entered on the Provider Agreement must match the effective date listed on the Preapproval Form

______ Notify OSDE that the online Provider Application and Agreement is ready for approval

Note: OSDE will notify you when the provider has been approved

Note: Providers cannot claim meals prior to the approved effective date. The 28-day timeline for the first review begins on the effective date.

Failure to submit new providers timely may result in loss of reimbursement.

Provider Status Change Form

Agreement #: ________________ Sponsor Name: ____

Provider Site #: _______________ Provider Name: ____

Type of Change (select one):

☐ Update information ☐ New Add ☐ Inactive ☐ Drop/Close

Address: ____

Phone Number: _________________________________

Primary Caregiver Name (if different than provider): ____

Primary Caregiver Date of Birth: ___________________________________

<u>If adding new, complete this section:</u> ☐ N/A

Provider Date of Birth: ___________________________________

License/Permit #: __________________________________ Capacity: ______________

If license is a temporary permit or any other type of license with an expiration, please supply expiration date: _______________________

NDL search has been conducted and proper identification is on file? ☐ Yes ☐ No

Was the preapproval visit conducted *prior* to the provider participating? ☐ Yes ☐ No

Effective Date (this date must match the date listed on the preapproval form and agreement: _________________________

<u>If making site inactive, complete this section:</u> ☐ N/A

Date provider wishes to become inactive: __________________________

Will the provider be inactive beyond the current fiscal year? ☐ Yes ☐ No

If yes, the provider may be required to drop and re-apply later.

Date provider plans to become active again: _________________________

Reason for inactive status: ____

<u>If dropping the program or closing, complete this section:</u> ☐ N/A

Reason for drop/closure: ____

Will you be submitting any additional claims for this provider? ☐ Yes ☐ No

If yes, do not submit this form at this time, please wait until last claim has been paid

Last Claim Month: _______________________________

Last Operating Day (must be within last claim month): _______________________

<u>If updating any other information, complete this section:</u> ☐ N/A

Meal time changes must use the meal time change form, NOT this form

Requested change: ____

____

____

____

Did you approve this change prior to implementation? ☐ Yes ☐ No

If no, please explain: ____

Effective Date of Change: ______________________________