APPENDIX G: Provider Qualification Determination Template

Provider Name: Provider Name

Dear: Provider Qualification Primary Contact Name,

Attached is your DP 1059, which verifies your qualification for specific services through the Consolidated, Community Living, and Person/Family Directed Support (P/FDS) Waivers.

Upload this form to the online electronic provider enrollment application along with all other required supporting documentation.

If you have any questions regarding the ODP Provider Qualification process, please do not hesitate to contact me at PQ AE Lead Contact Information.

If the DP 1059 indicates, you are not qualified to provide specific services through the Consolidated, Community Living and Person/Family Directed Support (P/FDS) Waivers, you may appeal this decision by filing a request for hearing in writing within thirty-three (33) days of this letter to:

Department of Human Services
Bureau of Hearings and Appeals
2330 Vartan Way, Second Floor
Harrisburg, PA 17110-9721

A copy of your appeal must be sent to:

Department of Human Services
Office of Developmental Programs, Division of Program Management

Room 411, Health and Welfare Building

625 Forster Street

Harrisburg, Pennsylvania 17105

Please refer to 55 Pa. Code Chapter 41 (relating to Medical Assistance Provider Appeal Procedures) for more information about your appeal rights and responsibilities. You may view Chapter 41 in its entirety at: **MA Provider Appeal Procedures**

If you have any questions, please do not hesitate to contact me at **PQ AE Lead Contact Information**.

Thank you.

Name of PQ AE Lead

cc: Regional PQ Lead