

New Jersey Department of Human Services
Division of Aging Services
Provider Application Section III: Services

SPECIALIZED MEDICAL EQUIPMENT & SUPPLIES (SME)

*Read carefully the description of services and requirements.
If you do not qualify, please do not apply.*

Definition:

Specialized medical equipment and supplies to include devices, controls, or appliances, specified in the plan of care, which enable individuals to increase their abilities to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live.

This service also includes items necessary for life support, ancillary supplies and equipment necessary to the proper functioning of such items, and durable and non-durable medical equipment. All items shall meet applicable standards of manufacture, design and installation.

Service Limitations/Exclusions Include:

- Services must be for the direct medical or remedial benefit of the client.
- Prior Authorize costs at or above \$500.
- All products shall be provided in accordance with applicable State or local codes.
- Evidence of permits and approval for installations must be available as required.

Billing Codes:

<u>JACC</u>	<u>Service/Unit</u>
J9836	1 item

SME PROVIDER QUALIFICATIONS

The applicant must submit evidence that it meets **all** items in Section 1 **or** Section 2 below.*

Section 1

- 1.a Valid Medicaid and/or Medicare provider number
- 1.b Fee Schedule
- 1.c Business product/service literature
- 1.d Evidence of Liability Insurance and Worker's Compensation Coverage

Section 2

- 2.a Business entity with evidence of authority to conduct such business in NJ, i.e. NJ Tax Certificate, Trade Name Registration and/or Ownership proof
- 2.b Any license required
- 2.c Evidence of Liability Insurance and Worker's Compensation Coverage
- 2.d Fee schedule
- 2.e Business product/service literature
- 2.f Possesses any license/registration/approval to vend product brands

*Submit photocopy as evidence.

**Check all evidence submitted with application.
Incomplete applications and / or applications submitted without required
documentation and evidence will be returned.**

CERTIFICATION

FOR THE PURPOSE OF ESTABLISHING ELIGIBILITY TO RECEIVE DIRECT PAYMENT FOR SERVICES TO RECIPIENTS UNDER THE NEW JERSEY JACC PROGRAM, I CERTIFY THAT THE INFORMATION FURNISHED ON THIS APPLICATION IS TRUE, ACCURATE, AND COMPLETE. I AM AWARE THAT IF ANY OF THE STATEMENTS MADE BY ME IN THIS APPLICATION ARE WILLFULLY FALSE, I AM SUBJECT TO PUNISHMENT, INCLUDING BUT NOT LIMITED TO DISQUALIFICATION FROM THE NEW JERSEY JACC PROGRAM. I AGREE TO NOTIFY THE NEW JERSEY DEPARTMENT OF HUMAN SERVICES, DIVISION OF AGING SERVICES OF ANY CHANGES IN THE INFORMATION CONTAINED IN THIS APPLICATION.

Name and Title of Applicant

Representative _____

Signature _____ Date _____