Reset Form

SCHEDULE A – MEDICAID HOME AND COMMUNITY-BASED SERVICES WAIVER PROVIDER AGREEMENT

State Form 53870 (2-09)
FAMILY AND SOCIAL SERVICES ADMINISTRATION / DIVISION OF DISABILITY AND REHABILITATIVE SERVICES
BUREAU OF DEVELOPMENTAL DISABILITIES SERVICES (BDDS)

Provider agrees to provide only those Medicaid Home and Community-Based Services which meet the following criteria:

1. Services which the Provider is licensed or certified to provide (if applicable);
2. Services for which the Provider has received formal Medicaid Waiver certification;
3. Services which have been authorized by the recipient's waiver case manager or targeted case manager (as appropriate) as set out in the recipient's Plan of Care; and
4. If applicable, in accordance with any addendum to this Agreement.

Provider Name: _____

Doing Business As *(if legal name is different from provider name stated above)*. If DBA name is different from provider name, provide documentation:

_____

Home Office address *(number and street, city, state, and ZIP code)*: _____

Mailing address *(number and street, city, state, and ZIP code)*: _____

Pay To address *(number and street, city, state, and ZIP code)*:_____

Service Location(s) *(if different from above)*:_____

_____

Telephone Number: _____

E-mail address:_____

Social Security Number or Federal Identification number *(not both)*: _____

Check one of the following: ☐ Individual, ☐ Partnership, ☐ Corporation, ☐ Not-For-Profit

List current Medicaid Provider Number, if any: _____

List current Medicaid Waiver Provider number, if known: _____

List current Medicare Provider Number, if any, **and specify type (*i.e., home health agency, AAA, etc.)***:

_____

Typed or Printed Name of
Authorized Representative: _____

Title: _____ Date *(month, day, year)*: _____

By execution of this Agreement, the undersigned entity ("Provider") requests enrollment as a provider of services or supplies to recipients of Home and Community-Based Services authorized under the Medicaid Home and Community-Based Services Waiver Programs (hereinafter, "Medicaid Waiver"), and as a condition of enrollment, Provider agrees:

1. To comply, on a continuing basis, with all enrollment requirements established under rules adopted by the State of Indiana Family and Social Services Administration (IFSSA).

2. To comply with all federal and state statutes and regulations pertaining to the Medicaid Program including the Medicaid Waiver Program, as they may be amended from time to time.

3. To meet, on a continuing basis, the state and federal licensure, certification or other regulatory requirements for Provider's specialty including all provisions of the State of Indiana Medical Assistance law, State of Indiana's Medicaid Waiver program, or any rule or regulation promulgated pursuant thereto.

4. To notify IFSSA or its agent within then (10) days of any change in the status of Provider's license, certification or permit to provide its services to the public in the State of Indiana.

5. To provide Medicaid and/or Medicaid Waiver-covered services and/or supplies for which federal financial participation is available for Medicaid Waiver recipients pursuant to all applicable federal and state statutes and regulations.

6. To safeguard information about Medicaid recipients, including at least:

    a. recipient's name, address, and social and economic circumstances;
    b. medical services provided to recipients;
    c. recipient's medical data, including diagnosis and past history of disease or disability;
    d. any information received for verifying recipient's income eligibility and amount of medical assistance payments;
    e. any information received in connection with the identification of legally liable third party resources.

7. To release information about Medicaid recipients only to the IFSSA, its agent, or a Medicaid Wavier recipient's case manager or targeted case manager and only when in connection with:

    a. Providing services for recipients; and
    b. Conducting or assisting an investigation, prosecution, or civil or criminal proceeding related to the provision of Medicaid covered services.

8. To maintain a written contract with all subcontractors which fulfills the requirements that are appropriate to the service or activity delegated under the subcontract. No subcontract, however, terminates the legal responsibility of the provider to the agency to assure that all activities under the contract are carried out.

9. To abide by the Indiana Health Coverage Programs Provider Manual, as amended from time to time, the Medicaid Waiver Programs Provider Manual, as amended from time to time, as well as all provider bulletins and notices. Any amendments to the Indiana Health Coverage Programs Provider Manual, the Medicaid Waiver Program, as well as provider bulletins and notices communicated to Provider shall be binding upon receipt. Receipt of amendments, bulletins and notices by Provider shall be presumed when mailed to the billing Provider's current "mail to" on file with IFSSA or its fiscal agent.

10. To submit timely billing on Medicaid approved claim forms, as outlined in the Medicaid Programs Provider Manual, in an amount specified in the written contract.

11. To be individually responsible and accountable for the completion, accuracy, and validity of all claims filed under the provider number issued, including claims filed by the Provider, the Provider's employees, or the Provider's agents. Provider understands that the submission of false claims, statements, and documents or the concealment of material fact may be prosecuted under the applicable Federal and/or State law.

12. To submit claim(s) for Medicaid reimbursement only after first exhausting all other sources of reimbursement as required by the Indiana Health Coverage Programs Provider Manual, bulletins, and banner pages.

13. To submit claim(s) for Medicaid reimbursement utilizing the appropriate claims forms and codes as specified in the Medicaid Programs Provider Manual, bulletins, and notices.

14. To submit claims that can be documented by Provider as being strictly for:

    a. those services and/or supplies specified in the written contract.
    b. those services and/or supplies actually provided to the recipient in whose name the claim is being made.

15. To accept payment as payment in full the amounts determined by IFSSA or its fiscal agent in accordance with federal and state statutes and regulations as the appropriate payment for Medicaid covered services provided to Medicaid Waiver recipients. Provider agrees not to bill recipients or any member of a recipient's family, for any additional charge for Medicaid and/or Medicaid Waiver covered services, excluding any co-payment permitted by law.

16. To refund within fifteen (15) days of receipt, to IFSSA or its fiscal agent any duplicate or erroneous payment received.

17. To make repayments to IFSSA or its fiscal agent, or arrange to have future payments from the Medicaid program withheld, within sixty (60) days of receipt of notice from IFSSA or its fiscal agent that an investigation or audit has determined that an overpayment to Provider has been made, unless an appeal of the determination is pending.

18. To pay interest on overpayments in accordance with IC 12-15-13-3, IC 12-15-21-3, IC 12-15-23-2.

19. To make full reimbursement to IFSSA or its fiscal agent of any federal disallowance incurred by IFSSA when such disallowance relates to payments previously made to Provider under the Medicaid Program.

20. To fully cooperate with federal and state officials and their agents as they conduct periodic inspections, reviews and audits.

21. To make available upon demand by federal and state officials and their agents all records and information necessary to assure the appropriateness of Medicaid payments made to Provider, to assure the proper administration of the Medicaid and Medicaid Waiver programs and to assure Provider's compliance with all applicable statutes and regulations. Such records and information are specified in the "Provider Requirements" Section of the Waiver Provider Manual and shall include, without being limited to, the following*: (405 IAC 1-5)*

    a. Medical records as specified by Section 1902(a)(27) of Title XIX of the Social Security Act and any amendments thereto;
    b. records of all treatments, drugs, services and/or supplies for which vendor payments have been made, or are to be made under the Title XIX Program, including the authority for and the date of administration of such treatment, drug, services and/or supplies;
    c. any records determined by IFSSA or its representative to be necessary to fully disclose and document the extent of services provided to individuals receiving assistance under the provisions of the Indiana Medicaid program;

d. documentation in each recipient's record that will enable the IFSSA or its agent to verify that each charge is due and proper;
e. financial records maintained in the standard, specified form;
f. all other records as may be found necessary by the IFSSA or its agent in determining compliance with any Federal or State law, rule, or regulation promulgated by the United States Department of Health and Human Services or by the IFSSA.

22. To cease any conduct that IFSSA or its representative deems to be abusive of the Medicaid or Medicaid Waiver programs.

23. To promptly correct deficiencies in Provider's operations upon request of IFSSA or its fiscal agent.

24. To file all appeal requests within the time limits listed below. Appeal requests must state facts demonstrating that:

a. the petitioner is a person to whom the order is specifically directed;
b. the petitioner is aggrieved or adversely affected by the order; and
c. the petitioner is entitled to review under the law.

25. Provider must file a statement of issues within the time limits listed below, setting out in detail:

a. specific findings, actions, or determinations of IFSSA from which Provider is appealing;
b. with respect to each finding, action or determination, all statutes or rules supporting Provider's contentions of error.

26. Time limits for filing an appeal and the statement of issues are as follows:

a. The provider must file an appeal of determination that an overpayment has occurred within sixty (60) days of receipt of IFSSA's determination. The statement of issues must be filed within 60 days of receipt of IFSSA's determination.
b. All appeals of actions not described in (a) must be filed within fifteen (15) days of receipt of IFSSA's determination. The statement of issues must be filed within forty-five (45) days of receipt of IFSSA's determination.

27. To cooperate with IFSSA or its agent in the application of utilization controls as provided in federal and state statutes and regulations as they may be amended from time to time.

28. To comply with civil rights requirements as mandated by federal and state statutes and regulations by ensuring that no person shall on the basis of race, color, national origin, ancestry, disability, age, sex, or religion be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination in the provision of a Medicaid service.

29. To comply with *42 Code of Federal Regulations, part 455, subpart B* pertaining to the disclosure of information concerning the ownership and control of the provider, certain business transactions, and information concerning persons convicted of crimes. Said compliance will include, but is not limited to, giving written notice to IFSSA/DDRS and its fiscal agent, at least sixty (60) days before making a change in any of the following: Name (legal name, DBA name, or name as registered with the Secretary of State), address (service location, "pay to," "mail to,", or home office), federal tax identification number(s), or change in the provider's direct or indirect ownership interest or controlling interest. Pursuant to *42 Code of Federal Regulations, part 455.104(c),* IFSSA must terminate an existing provider agreement if a provider fails to disclose ownership or control information as required by federal law.

30. To furnish to IFSSA or its agent, as a prerequisite to the effectiveness of this Agreement, the information and documents set out in Schedule A t to this Agreement, which is incorporated here by reference, and to update this information as it may be necessary.

31. That subject to item 32, this Agreement shall be effective as of the date set out in the provider notification letter.

32. If there is a change in case manager, the Provider shall assure that the current case manager participates in an Interdisciplinary Team meeting, at which the recipient's new case manager is present. The purpose of the Interdisciplinary meeting will be to coordinate the transfer of case management services to the new case manager.

33. To report any incidents (including suspected abuse, neglect or exploitation) to Adult Protective Services or Child Protective Services, and to the Bureau of Developmental Disabilities Services.

34. To comply with Provider and Case Management Standards issued by the Division of Disability and Rehabilitative Services, as applicable, and as amended from time to time. These standards are binding upon receipt unless otherwise stated. Receipt will be presumed when the standards or any amendments are mailed to the Provider's current address on file with IFSSA or its fiscal agent.

35. That this Agreement may be terminated as follows:

    a. By IFSSA or its fiscal agent for Provider's breach of any provision of this Agreement;
    b. By IFSSA or its fiscal agent, or by Provider, upon 60 days written notice.

36. That this Agreement, upon execution, supersedes and replaces any provider agreement previously executed by the Provider.

THE UNDERSIGNED, BEING THE PROVIDER OR HAVING THE SPECIFIC AUTHORITY TO BIND THE PROVIDER TO THE TERMS OF THIS AGREEMENT, AND HAVING READ THIS AGREEMENT AND UNDERSTANDING IT IN ITS ENTIRETY, DOES HEREBY AGREE, ON BEHALF OF THE PROVIDER AS A BUSINESS ENTITY, TO ABIDE BY AND COMPLY WITH ALL OF THE STIPULATIONS, CONDITIONS AND TERMS SET FORTH HEREIN.

THE UNDERSIGNED ACKNOWLEDGES THAT THE COMMISSION OF ANY MEDICAID RELATED OFFENSE AS SET OUT IN 42 USC 1320a-7b MAY BE PUNISHABLE BY A FINE OF UP TO $25,000 OR IMPRISONMENT OF NOT MORE THAN FIVE YEARS OR BOTH.

Provider-Authorized Signature – All Schedules
The owner or an authorized officer of the business entity must complete this section.
I certify, under penalty of law, that the information stated in Schedule A is correct and complete to the best of my knowledge. I am aware that, should an investigation at any time indicated that the information has been falsified; I may be considered for suspension from the program and/or prosecution for Medicaid Fraud. I hereby authorize the Indiana Family and Social Services Administration to make any necessary verifications of the information provided herein, and further authorize and request each education institution, medical/license board or organization to provide all information that may be required in connection with my application for participation in the Indiana Medicaid Waiver Program. All providers are required to adhere to the Indiana Administrative Code (IAC) 460 in addition to all policies and procedures released by IFSSA, DDRS and BDDS.

Provider DBA Name_____

Tax identification number _____

Officer Name _____ Title_____

Signature_____ Date (month, day, year) _____

Telephone Number_____

Note: Failure to complete this section will result in an automatic denial of agreement.