COMMONWEALTH OF PENNSYLVANIA DEPARTMENT OF HUMAN SERVICES

OLTL - HCBS WAIVER AGREEMENT *
Home and Community Based Services

This AGREEMENT and Rider A, made this the _____ day of _____, __between the Commonwealth of Pennsylvania, Department of Human Services, herein referred to as the "Department" and _____ herein referred to as the "Provider" sets forth the terms of participation in the approved Medicaid Waiver Program, herein referred to as the "Program".

1. The Provider agrees to participate in the Program and to know and to comply with all applicable Federal and State laws and regulations, which include the Commonwealth's Contract Compliance Regulations as set forth at 16 Pa. Code §§ 49.101 *et seq*.

2. The Provider is responsible for determining that the individual to be served has a current valid Medicaid Services Eligibility card.

3. The Provider shall certify that the services or items for which payment is claimed were actually provided to the person identified as the recipient; that the claim does not exceed the Provider's customary charge for the same or equivalent services or items provided to persons who are not Medicaid recipients; that the claim is correctly coded in accordance with billing instructions prescribed by the Department; and, that all information submitted in support of the claim is true, accurate and complete.

4. The Provider agrees to keep records necessary to disclose the nature and extent of services provided to recipients.

5. The Provider agrees to provide all records, including, but not limited to, any information needed regarding payments the Provider has claimed under the Medicaid State Plan or any applicable Waiver Program, to the Department, its Medicaid Fraud Control Unit, and the United States Department of Health and Human Services, upon request.

6. The Provider will be reimbursed in accordance with the rates established by the Department for services provided in compliance with the requirements of the approved Medicaid State Plan or applicable Waiver Program.

7. The effective date of this Agreement shall be the date that the Department enters the Provider's name into the Medical Assistance Management Information System (MMIS). This Agreement will continue from the effective date until it is terminated by either party.

8. The Provider may terminate this Agreement without cause by providing 60 calendar days written notice to the Department.

*Under the terms of this Provider Agreement, all full-time and part-time employees of the provider agency, or individuals delivering services through individual service agreements with a qualified provider agency, must also meet the Department of Human Services, Office of Long-Term Living (OLTL) Standards for Provider Participation and all other policies to safeguard the health and welfare of waiver recipients. Individuals who meet the Standards for Provider Participation, but do not have individual service agreements with qualified provider agencies, must have Provider Agreements directly with the Office of Medical Assistance Programs and the Office of Long-Term Living.

The Provider represents and warrants that the person signing this agreement is a duly authorized representative of the Provider and has the authority to enter into a legal, valid, and binding obligation on behalf of the Provider.

RIDER A TO THE OLTL – HCBS WAIVER PROVIDER AGREEMENT

Provider compliance with the following Minimum Protection Assurances is an integral part of maintaining the Provider's Medical Assistance Provider Agreement.

Minimum Protection Assurances

1. The Provider, _____, assures that he/she has never been convicted of a felony involving physical harm to a person, which includes, but is not limited to, homicide, rape, aggravated assault, robbery, and arson.

2. The Provider, _____, assures that he/she has not, within the five years immediately preceding the date of his/her enrollment in the Waiver Program, been convicted of a felony not involving physical harm to a person, which includes, but is not limited to, grand theft, distribution of controlled substances, extortion, embezzlement, fraud or burglary.

3. The Provider, _____, has not, within five years immediately preceding the date of his/her enrollment in the Waiver Program, been named on any central registry as a perpetrator of a founded or indicated report of child abuse.

4. The Provider, _____, assures that he/she will not be unjustly enriched as a result of any financial arrangement (such as owner-lease kickbacks) with the recipient receiving supports. This includes, but is not limited to, the Provider receiving gifts from the recipient or being named as the beneficiary on the recipient's life insurance policies. The recipient's life insurance policy assurance does not apply to the recipient's spouse, children, or other relatives.

5. The Provider, _____, assures that it will not restrict an individual's freedom of choice to be served by any qualified Provider under the Waiver and will freely provide each individual with information on other providers upon request.

6. The Provider, _____, assures that he/she will make every reasonable effort to provide Waiver services of satisfactory quality, under recipient's direction and in accordance with his/her Personal Support Plan.

7. The Provider, _____, assures that it will complete the training requirements and all other obligations specified in the Department's Standards for Provider Participation.

The Provider represents and warrants that the person signing this application is a duly authorized representative of the Provider and has the authority to enter into a legal, valid, and binding obligation on behalf of the Provider that is seeking to enroll in Pennsylvania Medical Assistance (PA MA).

I have reviewed the information in this enrollment application and affirm on behalf of the Provider seeking to enroll in Pennsylvania Medical Assistance (PA MA) that the information submitted in or with this application is true, accurate, and complete.

I understand that the Provider is responsible for notifying the Department of Human Services if any information included in this enrollment application changes or if the Provider becomes aware that any of the information is not true, inaccurate or incomplete.

I understand that any false statements or omissions may be subject to prosecution under applicable state or federal law, including, but not limited to, 18 Pa. C.S. § 4904, relating to any unsworn falsifications to authorities.

I understand that knowingly and willfully providing incomplete or false information in this application may result in the denial of enrollment or termination of the Provider from Pennsylvania Medical Assistance (PA MA).

_____ _____

(Provider – Original Signature) **(Date)**