

Mike McCormick

**Authorized Signature**

**Number: APD-AR-14-009**

**Issue Date: 2/13/2014**

**Topic:** Other

**Due Date:**

**Subject:** State Plan K - Provider Enrollment Agreements

**Applies to (check all that apply):**

- |  |   |
|--|---|
| <input type="checkbox"/> All DHS employees                             | <input type="checkbox"/> County Mental Health Directors |
| <input checked="" type="checkbox"/> Area Agencies on Aging             | <input type="checkbox"/> Health Services                |
| <input checked="" type="checkbox"/> Aging and People with Disabilities | <input type="checkbox"/> Office of Developmental        |
| <input type="checkbox"/> Children, Adults and Families                 | Disabilities Services(ODDS)                             |
| <input type="checkbox"/> County DD Program Managers                    | <input type="checkbox"/> Other (please specify):        |

**Action Required:**

In order for providers to be authorized and paid for State Plan K Option Services, they must be enrolled providers.

For the following services, providers will need to fill out and sign a Provider Enrollment Agreement (PEA) prior to being authorized to provide services. These services include:

- Environmental (Home) Modifications
- Chore Services
- Specialized Equipment
- Transition Services

Local APD/AAA staff should give the attached PEA to potential providers proposing to provide either of the services in this transmittal and request they fill it out and return it to the local APD/AAA office.

Completed PEAs should be submitted with the request packets (bids) to Central Office at [KPlan.Requests@state.or.us](mailto:KPlan.Requests@state.or.us).

**Reason for Action:** Under 42 CFR 455 subpart E providers are required to enroll as a Medicaid Provider to receive payment for services authorized under a State Plan, etc. This action provides the agreement necessary to comply with that federal statute. The Patient Protect and Affordable Care Act (ACA), specifically 42 CFR 455.104, requires disclosure of the name, address, date of birth, social security number (SSN), and employer identification number (EIN) of any person or corporation with an ownership or control interest in the provider. The name and EIN of any subcontractor

in which the provider has a 5 percent or more interest. These individuals must indicate if they are related to another person with an ownership or control interest in the provider or subcontractor as a spouse, parent, child, or sibling. In addition, any managing employees of the provider must disclose their name, address, date of birth, and SSN. Corporate entities will include their primary business address, every business location, and their P.O. Box address, as applicable.

**Field/Stakeholder review:**     Yes     No

**If yes, reviewed by:    APD Field OPS**

*If you have any questions about this action request, contact:*

<b>Contact(s):</b>	Margaret May Debbie Satterfield		
<b>Phone:</b>	503-945-6418 503-945-6453	<b>Fax:</b>	
<b>E-mail:</b>	<a href="mailto:margaret.may@state.or.us">margaret.may@state.or.us</a> <a href="mailto:debra.satterfield@state.or.us">debra.satterfield@state.or.us</a>		

## Centrally Approved State Plan Medicaid Provider Enrollment Agreement

Applicant has applied for the following provider type(s):

- Chore Services (74-729)**
- Home Modifications (77-760)**
- Specialized Equipment (74-742)**
- Transition Services ( )**

### Section A – Provider information

Disclosure of Social Security numbers is required pursuant to [42 USC 405\(c\)\(2\)\(C\)\(i\)](#) for the purpose of establishing identification, [42 CFR 455.104](#) for the purpose of exclusion verification, and [26 CFR 301.6109-1](#) for the purpose of reporting tax information.

#### Provider information

Business or  Individual      The Department of Human Services (DHS) may report information to the Internal Revenue Service (IRS) and the Oregon Department of Revenue under the provider's social security number (SSN) or under the Employer Identification Number (EIN).

#### ► Business information *(if applicable)*

Official business name (as known by IRS and registered with Secretary of State):

Street address:	City:	State:	Zip code + 4:
Mailing address:	City:	State:	Zip code + 4:
Employee Identification Number (EIN):	Phone Number:		

Type of business as filed with the IRS:

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Sole proprietor           | <input type="checkbox"/> Partnership           | <input type="checkbox"/> Limited partnership                 |
| <input type="checkbox"/> Corporation (corp., inc.) | <input type="checkbox"/> S corporation (SCORP) | <input type="checkbox"/> Limited Liability Corporation (LLC) |

#### ► Individual or Individual Contractor information *(if applicable)*

Last name (as known by IRS):	First name (as known by IRS):	MI:	Title: choose one
Street address:	City:	State:	Zip code + 4
Social Security Number (SSN):	Date of birth:	Home phone number:	
Percentage of ownership:      %	Officer title:		

Are you related to any other owner?  Yes  No

If yes, how are you related (spouse, parent, child, sibling)?

Have you been convicted of a criminal offense that excludes you from working with individuals being served under Medicare, Medicaid, or Child Welfare?  Yes  No

## Section B – Information for other persons with ownership or controlling interest

Provide the following information for all **managing employees**, all **corporate officers** and all persons (individual or corporation) who have **ownership or controlling interest in the business**. Attach a separate paper for additional persons as necessary. **Do not include the applicant**. This information is required by

[42 CFR 455.104 and 42 CFR 455.106](#).

1.	Name:	Percentage of ownership and officer title:	Date of birth:	
	Street address:	City:	State:	ZIP code + 4:
	Phone number:	Social Security number:		

Is this person related to any other owner?  Yes  No

If yes, how are they related (*spouse, parent, child, sibling*)? \_\_\_\_\_

Has this person been convicted of a criminal offense related to the person's involvement in any program under Medicare, Medicaid or Child Welfare?  Yes  No

2.	Name:	Percentage of ownership and officer title:	Date of birth:	
	Street address:	City:	State:	ZIP code + 4:
	Phone number:	Social Security number:		

Is this person related to any other owner?  Yes  No

If yes, how are they related (*spouse, parent, child, sibling*)? \_\_\_\_\_

Has this person been convicted of a criminal offense related to the person's involvement in any program under Medicare, Medicaid or Child Welfare?  Yes  No

## Section C – Information on ownership or controlling interest related to outside entities

Provide the following information for all **other businesses** in which the persons or entities listed in Section A and B also have five percent (5%) or more ownership or controlling interest in any subcontractor of the business. Attach a separate paper for additional entities as necessary. This information is required by [42 CFR 455.104](#).

Business name:				
Business street address:	City:	State:	ZIP code + 4:	
Phone number:	TIN/EIN:		Percentage of ownership:	

## Agreement

The Provider Enrollment Agreement, hereinafter referred to as Agreement, sets forth the conditions for being enrolled as a Medicaid Provider for the above selected services and Provider Type with the State of Oregon Department of Human Services (DHS) and for receiving Medicaid payment for services provided as prior authorized by DHS. This Agreement is valid for the term of 2 years and shall remain in effect during the term of 2 years unless terminated earlier in writing in accordance with the terms of this Agreement.

1. Provider understands and agrees that all information submitted in the Agreement is true and accurate. Information disclosed by the provider is subject to verification. Any deliberate omission, misrepresentation or falsification of any information contained in this Agreement or contained in any communication supplying information to DHS, may be punished by administrative law, criminal law or both.
2. Provider must notify DHS of any changes to the information contained in this Agreement within thirty (30) days of the date of the change. Provider understands and agrees DHS may terminate this Agreement if it determines that the provider did not fully and accurately make any disclosure required in this Agreement or if the provider fails to notify DHS of any changes within thirty (30) days.
3. Provider agrees to comply with all applicable licensing, certification and regulatory requirements as set forth by federal and state statutes, regulations, and rules, and agrees to fully comply with all Oregon statutes and regulation applicable to the provider's scope of service.
4. Provider understands and agrees that prior authorization is required before services are delivered for any client and that payment will not be issued if prior authorization was not granted.
5. Payment for services shall be processed after the service has been completed and appropriate documentation and invoice has been received for the service which was provided. Provider understands and agrees payment cannot be made to any individual or entity that has been excluded from participation in federal or state programs, or that employs or is managed by excluded individuals or entities ([ORS 443.004](#)). As a condition of payment, provider must meet and maintain compliance with the Provider Rules, [OAR 407-120-0300 through 407-120-0380 and 407-120-1505](#).
6. Provider may terminate this Agreement at any time by submitting a written notice in person or by certified mail with the specific date on which termination will take place. Notification must be submitted a minimum of sixty (60) days prior to the termination date.
7. Department of Human Services (DHS) may terminate this Agreement at any time by submitting a Notice in person or by certified mail with the specific date on which termination will take place.
8. Provider understands and agrees provider is not employed by any division of DHS or any Area Agency on Aging (AAA), or any Community Developmental Disability Program (CDDP) and shall not for any purposes be deemed an employee of the State of Oregon or any AAA. Provider is responsible for its employees and for providing employment-related benefits and deductions that are required by law. Provider is solely responsible for its acts or omissions, including the acts or omissions of its own officers, employees or agents.

9. Provider shall indemnify and defend the State of Oregon, any Oregon county, Area Agency on Aging, Community Developmental Disability Program, their respective agencies and their officers, employees and agents from and against all claims, suits, actions, losses, damages, liabilities, costs and expenses of any nature whatsoever arising out of, or relating to the acts or omissions of provider or its officers, employees, subcontractors or agents under this Agreement.
10. Provider has fully read, understands and agrees to comply with the terms and conditions set forth in this Agreement. Payment of claims will be from federal and state funds. Any falsification in connection with the receipt of payment for services may be prosecuted under federal and state law.

By signing below, provider declares that he or she understands and agrees that violation of any of the terms and conditions of this Agreement constitute grounds for termination of this Agreement and may be grounds for administrative sanction as provided by Oregon statute or rule.

\_\_\_\_\_  
 Provider (Authorized Representative) signature

\_\_\_\_\_  
 Date

**DHS use only**

OIG verified                       GSA verified                       SoS Verified                       Approved  Denied  
 Effective date: \_\_\_\_\_                      Expiration date: \_\_\_\_\_  
 DHS staff or designee: \_\_\_\_\_                      Date: \_\_\_\_\_

Questions on this form please contact the Provider Relations and Payment Support Unit at:  
 1-800-241-3013.