INSTRUCTIONS:

Please submit this completed form and the required attachments. Incomplete forms will be returned for completion prior to processing. Please return this form and all attachments to MHWIProviderNetworkManagement@MolinaHealthCare.Com.

The following facility types can submit one form to cover all locations and a roster of all locations must be included:

- Atypical Providers
- Durable Medical Equipment Suppliers
- Indian Health Clinics
- Laboratories
- Radiology
- Transportation Services

Facilities with multiple locations that share one license only need to complete one form.

All other facility types must complete a separate form for each location.

The information listed below should accompany the completed form:

- ✓ *Copies of current organizational or facility licenses/certifications/registrations*
- ✓ *A copy of your current (not expired) professional liability insurance face sheet*
- ✓ *A copy of the letter verifying approval of CMS participation (if applicable)*
- ✓ *If your organization is not accredited by a body listed in Section 4 of this form and your organization is required to be certified by CMS or the State, we also request a copy of the most recent CMS or State on-site survey results.*
- ✓ *W9 form(s) showing all federal Tax Identification Numbers (TINs) used by the organization/facility (Only Page 1 of this form is needed: http://www.irs.gov/pub/irs-pdf/fw9.pdf)*

Facilities that offer Long-Term Care Services (LTSS) must complete pages 5-7 of the application and include attachments 1 and 2. If you do not offer LTSS services, you may stop at page 4.

1. ORGANIZATION INFORMATION: *(Provide physical location information on the following page)*	
Legal Name of Organization (Legal name listed with the IRS)	
DBA Name of Organization (if applicable)	
Historic Name(s) of Organization (if under same ownership)	
Organization Medicare # *(primary)*:	Organization Medicaid # *(primary)*:
Organization TIN *(primary)*:	Organization NPI *(primary)*:
Credentialing Contact Street Address: _____ Address Line 2: _____ City: State: Zip: Contact Name: _____ Email: _____ Phone: _____ Fax: _____	**Billing Address** *(if different than Credentialing)* Street Address: _____ Address Line 2: _____ City: State: Zip: Contact Name: _____ Email: _____ Phone: _____ Fax: _____

2. CURRENT INSURANCE COVERAGE:
(Please attach a copy of your current facility professional/general liability insurance face-sheet)

☐ *Please check here if your facility is not required to carry liability insurance.*

Professional Liability Insurance Information *(if available)*

Current Carrier Name:		Policy Number:
Policy Start Date:	Policy End Date:	Policy Type (malpractice, general, etc.):
Coverage amount per occurrence:		Coverage amount aggregate:

General Liability Insurance Information *(if no professional liability available)*

Current Carrier Name:		Policy Number:
Policy Start Date:	Policy End Date:	Policy Type (malpractice, general, etc.):
Coverage amount per occurrence:		Coverage amount aggregate:

COMPLETE THE BELOW INFORMATION FOR EACH PRACTICE LOCATION

Only include information for locations that you wish to be listed with Molina Healthcare.
Complete a copy of sections 3-4 of this application for every location where information differs between locations

3. PHYSICAL LOCATION INFORMATION: *(Include any additional information relevant to this location on a separate sheet)*	
Location DBA (if different than the Organization DBA)	
Other DBAs Previously Used (if under same ownership)	
Is this location Medicare Certified? ☐ **Yes** ☐ **No**	Is this the primary address? ☐ **Yes** ☐ **No**
Site-specific Medicare #:	Site-specific Medicaid #:
Site-specific TIN:	Site-specific NPI:
Physical Practice Location Street Address**:** Address Line 2**:** _____ City: _____ State: _____ Zip: _____ Phone: _____ Fax: _____	State provider # *(if applicable, LTC, etc.)*: Is this location handicap accessible? ☐ **Yes** ☐ **No**
Please list any languages spoken by office personnel:	
Practice Limitations (e.g., age, gender, etc.):	

Location State License(s) and/or State Registration(s) – *(Attach a copy of all)*

☐ *Please check here if this location is not required to be licensed, certified, or registered by a State agency.*

Type of Credential	State	Number	Expiration Date	Most Recent Survey Date
State License				
State Registration				
State Certification				
Other:				

Additional Location Credentials – *(Attach a copy of all)*

☐ *Please check here if this location holds no additional licenses, certificates, registrations, etc.*

Type of Credential	State	Number	Expiration Date	Additional Notes/Info
DEA				
CLIA				
State CSR/CDS/DPS				
Other:				

Specialty & Federal Taxonomy Code	Specialty & Federal Taxonomy Code

4. ACCREDITATION / CERTIFICATION *(check all that apply)*:		
☐	*Please check here if the State conducts routine surveys of your organization for license, registration, or clinical oversight.*	
☐	*Please check here if your organization is NOT accredited and NOT required to be surveyed by ANY organization.*	
Accreditation Organization		**Date of Last Survey**
☐ (CMS)	Medicare Certification *(attach most recent survey and acceptance letter)*	
☐ (AAAHC)	Accreditation Association for Ambulatory Health Care	
☐ (ACHC)	Accreditation Commission for Health Care	
☐ (AAAASF)	American Association for Accreditation of Ambulatory Surgery Facilities	
☐ (AADE)	American Association of Diabetes Educators	
☐ (AAHHS)	American Association for Hospitals & Health Systems (AOA)	
☐ (ACR)	American College of Radiology	
☐ (CABC)	Commission for the Accreditation of Birth Centers	
☐ (CARF)	Commission on Accreditation of Rehabilitation Facilities	
☐ (CCAC)	Continuing Care Accreditation Co	
☐ (CHAP)	Community Health Accreditation Program	
☐ (CIHQ)	Center for Improvement in Healthcare Quality	
☐ (CLIA)	Clinical Laboratory Accreditation	
☐ (COA)	Council on Accreditation	
☐ (COLA)	Committee of Laboratory Accreditation	
☐ (DNV)	Det Norske Veritas	
☐ (IAC)	The Intersocietal Accreditation Commission	
☐ (IHS)	Indian Health Services	
☐ (NABP)	National Association of Boards of Pharmacy	
☐ (NDAC)	National Dialysis Accreditation Commission	
☐ (OSHA)	Occupational Safety and Health Administration	
☐ (PHAB)	Public Health Agency Board	
☐ (SAMHSA)	Substance Abuse and Mental Health Services Administration	
☐ (TCT)	The Compliance Team	
☐ (TJC)	The Joint Commission	
☐ (URAC)	Utilization Review Accreditation Commission	

Please review the services below and if you offer any services listed, complete pages 5-7.
If you do not offer Long-Term Care Services (LTSS) you may STOP here.

The information listed below should accompany the completed form for LTSS Services in addition to the forms listed on page 1.

- ✓ *MCW Attestation Form (Attachment 1)*
- ✓ *Wisconsin Medicaid Agreement Form (Attachment 2)*

5. SERVICES

***Indicate which Benefit Package services you are applying to provide:**

- ☐ Adaptive Aids (general, vehicle, service dog)
- ☐ Adult Day Care (licensed)
- ☐ Adult Family Home (AFH) 1-2 Bed
- ☐ Adult Family Home (AFH) 3-4 Bed
- ☐ Alcohol & Other Drug Abuse Services (AODA)
- ☐ Assistive Technology/Communication Aids (includes interpreter services)
- ☐ Community-Based Residential Facility (CBRF)
- ☐ Community Support Program (CSP) (licensed)
- ☐ Community Supported Living
- ☐ Consultative Clinical & Therapeutic Services for Caregivers (CCTS) (training for paid and unpaid caregivers)
- ☐ Consumer Education and Training (including mental health peer specialists)
- ☐ Counseling & Therapeutic Resources (licensed, non-Medicaid-certified therapies)
- ☐ Daily Living Skills Training
- ☐ Day Habilitation Services
- ☐ Day Treatment Services – AODA
- ☐ Day Treatment Services – Medical/Behavioral
- ☐ Disposable Medical Supplies (including OTC)
- ☐ Durable Medical Equipment (except hearing aids or prosthetics)
- ☐ Environmental Accessibility Adaptations (home modifications)
- ☐ Financial Management Services (fiscal intermediary for SDS)
- ☐ Financial Management Services (organizational rep payee)
- ☐ Home Delivered Meals
- ☐ Home Health Agency (licensed and Medicaid certified; Medicare may also be required depending on service)
- ☐ Housing Counseling
- ☐ Mental Health Services
- ☐ Nursing Facility (licensed)
- ☐ Nursing Services (independent/private)
- ☐ Occupational and Physical Therapy Services (outpatient)
- ☐ Personal Care Agency (Wisconsin Medicaid certified)
- ☐ Personal Emergency Response Service (PERS)
- ☐ Prevocational Services
- ☐ Residential Care Apartment Complexes (RCAC)
- ☐ Respite Care (in member's home)
- ☐ Respite Care (in substitute living facility)
- ☐ Speech & Language Pathology Services (outpatient)
- ☐ Supported Employment
- ☐ Supportive Home Care (chore services)
- ☐ Supportive Home Care (general; including non-medical personal care)
- ☐ Transportation Services
- ☐ Vocational Futures Planning & Support
- ☐ Other (list):

Please indicate if your agency has a nurse on staff. ☐ Yes ☐ No
Professional Degree(s) ☐ RN ☐ LPN ☐ Other (please explain) _____
NPI Number _____ Medicaid Number _____ Medicare Number _____
Owner Occupied ☐ Yes ☐ No

REQUIRED DISCLOSURES

Please provide a complete explanation of any "Yes" answers. If necessary, attach additional sheets with the detailed explanation.

1. Has Provider licensure or certification (if applicable) ever been terminated, stipulated, restricted, limited, conditioned, suspended, revoke, refused, voluntarily relinquished, or not renewed by any licensing/certification agency or board or any agency or organization, or is there a review pending?

   ☐ Yes ☐ No

2. Has Provider participation (if applicable) in any professional organization ever been voluntarily or involuntarily denied, terminated, restricted, limited, suspended, or revoked?

   ☐ Yes ☐ No

3. Has Provider licensure or certification (if applicable) in any private, federal, (i.e., Medicare or Medicaid), or state health insurance program ever been revoked or otherwise limited or restricted, or is any investigation or proceeding with respect to any such action presently underway?

   ☐ Yes ☐ No

4. Within the past five (5) years, has your company or any representative, owner, partner, or officer, collectively, "your company" ever been a party to any court or administrative proceedings where the violation of any local, state or federal statute, ordinance rule or regulation by your Company was alleged?

   ☐ Yes ☐ No

5. Within the past five (5) years, has your organization had any reported findings on an annual independent audit?

   ☐ Yes ☐ No

6. Within the past five (5) years, has Provider or any representative, owner, partner, or officer (collectively, "your business") been investigated, reprimanded, censored, or otherwise disciplined by, or have ever been required to submit, a corrective action plan by virtue of review or audit by an independent auditor, licensing board, or any governmental agency or purchaser of services?

   ☐ Yes ☐ No

7. Has Provider, any principals, owners, partners, shareholders, directors, members, or officers of your business entity ever been convicted of, or plead guilty or no contest to, a felony, serious or gross misdemeanor, or any crime or municipal violation involving dishonesty, assault, sexual misconduct or abuse, or abuse of controlled substances or alcohol, or are charges pending against you or any of the above persons for any such crimes by information, indictment or otherwise?

   ☐ Yes ☐ No

8. Has Provider ever had any liability claims or lawsuits brought against their person, including pending claims or lawsuits?

   ☐ Yes ☐ No

PROVIDER ASSURANCES AND CERTIFICATIONS

☐ I agree that all information included in this application is true and correct and that the Provider understands and agrees to the application information and requirements. Provider further acknowledges that the information in this application is subject to periodic verification without notice and that any misrepresentation on this form may result in disqualification from receiving public (MCO) funds and legal action or fiscal sanctions may be taken as determined appropriate by My Choice Family Care or its designated representative(s). Provider understands that completion of provider application does not guarantee network admission and/or subsequent contract with the MCO.

☐ I agree to allow authorized representatives of My Choice Family Care and its funding sources, to have access to all records necessary to confirm the provision of services by the Provider. Failure on the part of the Provider to comply with program requirements, or not have sufficient documentation to verify provision of the services billed, may result in withholding or forfeiture of any payments. Providers must have client records as outlined in the MCO contract, that minimally include names and address, the service type and dates of service provided, the number of units of service provided, and documentation that service was provided.

☐ I acknowledge that the Provider is required to consistently complete criminal background checks; and verify that all staff, including the proprietor/licensee, providing services that result in direct contact with MCFC members in compliance with Wisconsin Administrative Codes DHS 12 and DHS 13, do not appear on the list of excluded individuals on the State of Wisconsin's Department of Health Services (DHS) Caregiver Registry. In addition, prior to employing any individual, whether that individual has direct contact with members, the provider must verify that the employee does not appear on the list of excluded individuals maintained by the United States Office of Inspector General (OIG). OIG maintains an online database at: http://exclusions.oig.hhs.gov/.

☐ Provider Applicant certifies to the best of their knowledge and belief that the Provider is not an "ineligible Organization". The Provider Applicant further certifies to the best of their knowledge and belief that the agency and its principals: (1) are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any Federal department or agency; (2) have not, within a three-year period preceding this application, been convicted of or had a civil judgement rendered against it for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (Federal, State or local) transaction or contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property; (3) are not presently indicted for or otherwise criminally charged by a governmental entity (Federal, State or local) with commission of any of these offenses enumerated in #(2) of this certification; and (4) have not, within a three-year period preceding this application, had one or more public transactions (Federal, State or local) terminated for cause or default.

☐ I acknowledge that the Wisconsin Department of Health Services (DHS) requires Electronic Visit Verification (EVV) for Medicaid-covered personal care and supportive home care services: procedure codes T1019, T1020, S5125, and S5126. I attest that (if applicable) our organization participates and is compliant as required in the EVV program.

Authorized Signature _____ **Date** _____

Title _____ **Email** _____

MY CHOICE WISCONSIN (MCW) ATTESTATION FORM

(CONTRACT, TRAINING, CAREGIVER BACKGROUND CHECKS, POLICY & PROCEDURES)

Provider Legal Name: _____

EIN _____ **Certification or License #** _____

By signing this attestation Provider is accepting acknowledgment of My Choice Wisconsin contract requirements and confirming the organization and/or facility is operating in accordance with Wisconsin Department of Health Services requirements and regulations.

Contract/Credentialing/Caregiver Background Check (CBC) – All Services

1. Provider agrees that upon request of the Health Plan and/or MCO, Provider shall submit all required documents to maintain participation in the provider network. Credentialing documents may be required for annual renewals, every 3 years for re-credentialing, and every 4 years for CBC documents per Wis. Stat. § 50.065 and Wis. Admin. Code § DHS 12 ☐ **Yes** ☐ **No**
2. Provider agrees to verify individual credentials of health professionals and other service workers employed or subcontracted by Provider and notify MCW of any changes in licensure (VIII.D.16). Health professions certified by Medicaid agree to provide information regarding education, board certification, and recertification upon request of MCW. (VIII.D.16). ☐ **Yes** ☐ **No** ☐ **N/A**
3. Provider is completing the necessary criminal background checks required by Wis. Stat. § 50.065, Wis. Admin. Code § DHS 12 via the WI Administrative Code (https://recordcheck.doj.wi.gov/), and is in compliance with the governing reporting, hiring, and contracting requirements per Chapters DHS 12 and 13. ☐ **Yes** ☐ **No** ☐ **N/A**
4. Provider runs a driver abstract and CBC on all staff who transport individuals. ☐ **Yes** ☐ **No** ☐ **N/A**
5. Provider agrees to submit proof of compliance of CBCs and driver abstract (when applicable) via the BID form and the CBC upon request for audit or quality concerns via secure e-mail to MCW Credentialing and/or Provider Quality staff. All information obtained is treated as confidential**.** ☐ **Yes** ☐ **No** ☐ **N/A**
6. Provider agrees that the workers CBC will be made available to the member, guardian, POA, and/or entity that is the employer upon request. ☐ **Yes** ☐ **No** ☐ **N/A**
7. Provider has policies/procedures for hiring practices that include running caregiver background checks and review of the CBC for exclusions prior to employment, every four (4) years, and to address the actions necessary should an exclusion or concerning background history be identified. ☐ **Yes** ☐ **No** ☐ **N/A**
8. Provider transports individuals and has a communication system in all transport vehicles to allow for communication with My Choice Wisconsin staff. ☐ **Yes** ☐ **No** ☐ **N/A**
9. All transport vehicles undergo safety inspections to ensure that the vehicle is safe, accessible, and equipped appropriately to meet members' needs. This includes vehicles owned by the organization, leased, subcontracted, or personal employee vehicles if used to transport individuals. ☐ **Yes** ☐ **No** ☐ **N/A**

10. Provider agrees to notify My Choice Wisconsin if transporting individuals of any accidents, license suspension or revocations. Employee misconduct directly related to My Choice Wisconsin individuals must be reported immediately. ☐ **Yes** ☐ **No** ☐ **N/A**
11. Provider has policies/procedures for review of the Nurse Aid Registry for any staff who have/had experience as a nursing assistant, home health aide or hospice aide, as defined in Wis. Admin. Code § DHS 12 to ensure there has not been a substantial finding of abuse, neglect, or misappropriation of funds or property of a client. ☐ **Yes** ☐ **No** ☐ **N/A**
12. Provider has policies/procedures to notify DQA of caregiver misconduct. ☐ **Yes** ☐ **No** ☐ **N/A**

Any item not checked above please provide a brief explanation: _____

_____

_____

General Training Requirements – All Services

1. Provider attests that policies, procedures and training for staff are in place and are distributed to all applicable staff. Trainings are completed annually at minimum for the following:
   - ☐ Equity & Inclusion (Cultural Competency, Cultural Humility, etc.)
   - ☐ Fraud, Waste & Abuse
   - ☐ Ethics, Confidentiality, Member Rights
   - ☐ HIPPA Training
2. Healthcare Program **(DSNP, Partnership)** provider attests that policies, procedures and training for staff are in place and distributed to all applicable staff annually at minimum **(Does not pertain to Long-Term Care Providers)**
   - ☐ Model of Care Training is distributed and completed by staff - MCW Model of Care Training
   - ☐ Provider acknowledges that My Choice Wisconsin offers Practice Guidelines on the MCW website as a resource for training and education purposes for staff - MCW Practice Guidelines
3. ☐ Provider documents required training logs for all applicable employees, maintains employee records, and staff rosters and will provide them to MCW upon request
4. ☐ All new employees who have regular and direct contact with members receive the required minimum hours of orientation training that include required training topics based on the services rendered.
5. ☐ All employees who have regular and direct contact with members receive the required minimum hours of annual training that include required training topics based on the services rendered.

Any item not checked above please provide a brief explanation: _____

_____

_____

Service Regulatory Attestations – All Services

1. **Adult Day Services, Adult Daycare (Licensed), Daily Living Skills Training** ☐ **Yes** ☐ **N/A**
    a. Provider attests that the organization follows all operational and administrative requirements including, but not limited to, certification or licensure, policy & procedures, training, member rights, and quality assurance for Day Services, Daily Living Skills Training and Adult Day Care regulations as stated in Wisconsin Legislature: DHS 105.14
    b. Provider attests that the organization will follow the MCW Adult Day Services, Adult Daycare (Licensed), Daily Living Skills Training Exhibit
2. **Behavioral Health OR Alternative Therapies** ☐ **Yes** ☐ **N/A**
    a. Provider attests that the organization follows all operational and administrative requirements including, but not limited to, certification or licensure, policy & procedures, training, member rights, and quality assurance for Behavioral Health OR Alternative Therapy Services
    b. Provider attests that service(s) and treatment must be provided by a WI Medicaid Certified Licensed Treatment Professional, Certified Substance Abuse counselor, licensed therapist, or be a qualified treatment trainee
    c. Provider attests that the organization will follow the MCW Behavioral Health OR Alternative Therapies Exhibit
3. **Personal Care, Supportive Home Care, Home Health, In-Home Respite, Self-Directed Support, Supportive Visit Services** ☐ **Yes** ☐ **N/A**
    a. Provider attests that the organization follows all operational and administrative requirements including, but not limited to, certification or licensure, policy & procedures, training, member rights, and quality assurance for Personal Cares, Supportive Home Care, In-Home Care Respite Services or Self-Directed Supports
    b. Provider offers Personal Cares, Supportive Home Care, In-Home Care Respite Services or Self-Directed Supports and attests compliance with the Managed Care Organization Training and Documentation Standards for Supportive Home Care found at https://www.dhs.wisconsin.gov/publications/p01602.pdf.
    c. Provider attests that the organization will follow the MCW Personal Care, Supportive Home Care, Home Health, In-Home Respite, Self-Directed Support, or Supportive Visit Services Exhibit
4. **Pre-Vocational/Supported Employment/Vocational Futures Planning** ☐ **Yes** ☐ **N/A**
    a. Provider attests that the organization follows all operational and administrative requirements including, but not limited to, certification or licensure, policy & procedures, training, member rights, and quality assurance for Pre-Vocational/Supported Employment/Vocational Futures Planning Services
    b. Provider attests that the organization will follow the MCW Pre-Vocational/Supported Employment/Vocational Futures Planning Exhibit
5. **Residential Services (1-2 AFH, 3-4 AFH, CBRF, RCAC)** ☐ **Yes** ☐ **N/A**
    a. Provider attests that the organization follows all operational and administrative requirements including, but not limited to, certification or licensure, policy & procedures, training, member rights, and quality assurance per DQA Licensure and/or AFH Certification regulations and requirements
    b. Provider attests that the organization will follow the MCW Residential Exhibit

6. **Skilled Nursing Facilities (SNF)** ☐ **Yes** ☐ **N/A**
    a. Provider attests that the facility follows all operational and administrative requirements including, but not limited to, certification or licensure, policy & procedures, training, member rights, and quality assurance as stated in the Nursing Home regulations per Wisconsin Legislature: Chapter DHS 132
    b. Provider attests that the facility will follow the MCW SNF Exhibit
7. **Transportation** ☐ **Yes** ☐ **N/A**
    c. Provider attests that the organization follows all operational and administrative requirements including, but not limited to, certification or licensure, policy & procedures, training, member rights, and quality assurance for Transportation Services
    d. Provider attests that the organization will follow the MCW Transportation Exhibit
8. **All Other Services Not Listed Above** ☐ **Yes** ☐ **N/A**
    e. Provider attests that the organization follows all operational and administrative requirements including, but not limited to, certification or licensure (when applicable), policy & procedures, training, member rights, and quality assurance for the service being rendered per CMS/DHS requirements, State licensing regulations, Board Certifications or Industry Standard requirements.
    f. Provider attests that the organization will follow the MCW Exhibit for the service being rendered, contracted and credentialing with MCW.

Any item not checked above please provide a brief explanation: _____

_____

_____

By signing, I attest I am authorized to sign on the provider's behalf and the information in this document is true and accurate.

Print Name: _____

Title: _____

***Signature:** _____

Date: _____

E-mail: _____

Phone number: _____

*** Electronic signature is considered valid only when document is submitted by e-mail from the signer's e-mail address or via DocuSign. If mailing or faxing, signature must be handwritten.**

DEPARTMENT OF HEALTH SERVICES
Division of Medicaid Services
F-00180C (07/2017)

STATE OF WISCONSIN
42 CFR 431.107 & 42 CFR 438.602(b)

WISCONSIN MEDICAID PROGRAM PROVIDER AGREEMENT AND ACKNOWLEDGEMENT OF TERMS OF PARTICIPATION

FOR WAIVER SERVICE PROVIDER AGENCIES OR INDIVIDUALS

Completion of this form is required under Federal Law by the Centers for Medicare & Medicaid Services, Department of Health and Human Services, under the Code of Federal Regulations 42 CFR 431.107.

Name of Provider (Typed or Printed—Must exactly match name used on all other documents)		Phone Number	
Address – Street	City	State	Zip Code

The above-referenced provider of home and community-based waiver services under Wisconsin's Medicaid program, hereinafter referred to as the provider, hereby agrees and acknowledges as follows:

1. To provide only the items or services authorized by the managed care organization or IRIS program.
2. To accept the payment issued by the managed care organization or IRIS program as payment in full for provided items or services.
3. To make no additional claims or charges for provided items or services.
4. To refund any overpayment to the managed care organization or IRIS program.
5. To keep any records necessary to disclose the extent of services provided consistent with the provider's business type.
6. To provide, upon request by the managed care organization, the IRIS program, or the Department of Health Services (DHS) or its designee, information regarding the items or services provided.
7. To comply with all other applicable federal and state laws, regulations, and policies relating to providing home and community-based waiver services under Wisconsin's Medicaid program including the caregiver background check law.
8. Medicaid Confidentiality Policies and Procedures: To maintain the confidentiality of all records or other information relating to each participant's status as a waiver participant and items or services the participant receives from the Provider.
9. To respect and comply with the waiver participant's right to refuse medication and treatment and other rights granted the participant under federal and state law.
10. Medicaid Fraud Prevention Policies and Procedures (including records retention): To keep records necessary to disclose the extent of services provided to waiver participants **for a period of ten (10) years** and to furnish upon request to the DHS, the federal Department of Health and Human Services, or the state Medicaid Fraud Control Unit, any information regarding services provided and payments claimed by the Provider for furnishing services under the Wisconsin Medicaid Program. This requirement includes retaining all records and documents according to the terms provided by Wis. Admin. Code § DHS 106.02(a)-(d); (f)-(g).
11. The provider agrees to comply with the disclosure requirements of 42 CFR Part 455, Subpart B, as now in effect or as may be amended. To meet those requirements and address real or potential conflict of interest that may influence service provision, among other things the provider shall furnish to the managed care organization and upon request, to the Department in writing:
    a) The names and addresses of all vendors of drugs, medical supplies or transportation, or other providers in which it has a controlling interest or ownership;

b) The names and addresses of all persons who have a controlling interest in the provider;

c) Whether any of the persons named in compliance with (a) and (b) above are related to any owner or to a person with a controlling interest as spouse, parent, child or sibling;

d) The names and addresses of any subcontractors who have had business transactions with the provider;

e) The identity of any person named in compliance with (a) and (b) above, who has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or Title XX services programs since the inception of those programs.

12. To provide to the DHS identifying information, including name, specialty, date of birth, Social Security number, national provider identifier, (NPI) (if eligible for an NPI), Federal taxpayer identification number, and State license or certification for purposes of enrollment with the State Medicaid program.
13. To include its NPI (if eligible for an NPI) on all claims submitted under the Medicaid program.
14. To comply with the advance directives requirements specified in 42 CFR Part 489, Subpart I.

Modifications to this agreement cannot and will not be agreed to. Altering this agreement in any way voids the Department of Health Services' signature. This agreement is not transferable or assignable.

Name – Provider (Typed or Printed)

SIGNATURE – Provider	Date Signed

FOR DMS USE ONLY (DO NOT WRITE BELOW THIS LINE)	
SIGNATURE – Department of Health Services 	Date Signed 8/14/17