DEPARTMENT OF HEALTH SERVICES
Division of Long Term Care
F-00180B (02/2014)

STATE OF WISCONSIN
42 CFR 431.107

WISCONSIN MEDICAID PROGRAM PROVIDER AGREEMENT AND ACKNOWLEDGEMENT OF TERMS OF PARTICIPATION

FOR WAIVER SERVICE PROVIDER AGENCIES OR INDIVIDUALS – SELF-DIRECTED SUPPORTS[1]

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)		Telephone Number	
Address – Street	City	State	Zip Code

The above-referenced agency or individual 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 services or items authorized by the local waiver administrative agency as directed by the waiver participant in amounts not to exceed the authorization.
2. To accept the payment issued by the local waiver administrative agency or its fiscal agent as payment in full for provided services or items.
3. To make no additional claims or charges for provided services or items.
4. To refund any overpayment to the waiver administrative agency or its fiscal agent.
5. To keep records of the services or items provided.
6. To provide, upon request by the local waiver administrative agency or the Department of Health Services (DHS) or its designee, information regarding the services or items 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.
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 7 years** and to furnish upon request to the Department, 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. (For state policy related to record retention see DHS 106.02, Wis. Administrative Code or the DLTC numbered memo addressing record retention available at http://dhs.wisconsin.gov/dsl_info/NumberedMemos/DSL/CY_2001/NMemo2001-07.htm .)
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 waiver agency and upon request, to the Department in writing:

[1] Note: This agreement is intended to be used for providers who are individuals employed by the waiver participant under a self-directed supports plan and paid by a fiscal agent and who are not employees of an agency that otherwise provides services to waiver clients.

(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 XIX services programs since the inception of those programs.

Pursuant to 42 CFR § 447.10(e), I hereby voluntarily reassign my right to direct payment from the State to each local waiver administrative agency that has authorized me to provide waiver services to an individual waiver participant.

If you check yes, it means that you will receive payment from the local waiver administrative agency that is responsible for the participants to whom you are authorized to provide waiver services rather than directly from the State Medicaid Agency.

☐ Yes ☐ No

MODIFICATIONS TO THIS AGREEMENT CANNOT AND WILL NOT BE AGREED TO. THIS AGREEMENT IS NOT TRANSFERABLE OR ASSIGNABLE.

NAME – Provider (Typed or Printed)	
SIGNATURE – Provider	Date Signed
SIGNATURE – Waiver Agency Representative	Date Signed
Print Name – Waiver Agency Representative	