



North Carolina Department of Health and Human Services
Division of Medical Assistance - Provider Services
2501 Mail Services Center
Raleigh NC 27699-2501

801 Ruggles Drive
Raleigh NC 27603

Thank you for your interest in becoming a direct enrolled Community Alternatives Program Provider with the NC Medicaid Program. In order for us to complete the enrollment process, you must receive endorsement prior to submitting the following:

Group Applicant

- Community Alternatives Program Provider Enrollment Application
- North Carolina Division of Medical Assistance Medicaid Participation Agreement – All applicants must indicate they have read, understood and agreed to the rules and regulations governing Medicaid by signing and dating the NC Medicaid Participation Agreement. Original Signature Required. Agreement can not be altered.
- National Provider Identifier (NPI) is required.
- A copy of your National Plan and Provider Enumeration System (NPPES) letter must accompany the application.
- CAP MR/DD Providers only - Copy of Notification of Endorsement Action by LME.
- W-9. Individual applications for enrollment require the social security number of the provider except as permitted by the Internal Revenue Service (IRS). For sole proprietorship or single-owner LLC, please attach appropriate documentation from the IRS referencing the assigned Employer Identification Number (EIN). Please reference complete instruction which have been supplied by the IRS.
- Attachment A - Provider Certification for Signature on File (if desired)
- Attachment B - Electronic Claims Submission (ECS) Agreement – all applicants who wish to submit claims electronically must read, sign and date the ECS agreement.
- Attachment C - Letter of Attestation for False Claims Act Education (required)

Providers are requested to include on their application the name, e-mail address, and fax number of the individual at their site that is responsible for receiving Medicaid information.

Providers are assigned a provider number and are notified by mail once the enrollment process has been completed. Please do not submit claims for any services until you have received notification of your provider number, and its effective date. Billing information and medical coverage policies are available on DMA's website at <http://www.ncdhhs.gov/dma/prov.htm>.

Thank you again for your interest, if you have any questions or need additional information, please feel free to contact your CAP Provider Enrollment Specialist at 1-919-855-4050.

NC Division of Medical Assistance Home Page - <http://www.ncdhhs.gov/dma/>

Instructions for Medicaid Direct Enrollment of Community Alternatives Program Services Provider

A prospective provider must apply for and be enrolled as a Medicaid provider with the NC Division of Medical Assistance (DMA) to qualify for reimbursement for CAP services. The enrollment process includes the following steps:

1. Provider completes and signs the enrollment packet and returns along with the required credentials to:
DMA Provider Services
Attn: CAP Provider Enrollment Specialist
2501 Mail Services Center
Raleigh, NC 27699-2501
2. If the packet is not completed properly, DMA will return the packet for correction or for additional information.
3. If the provider meets all qualifications, DMA assigns a provider number. Once the provider number has been assigned, the provider will receive written notification.
4. The provider may begin billing upon receipt of the provider number.

Important Points to Remember

- All sites are required to have separate provider numbers.
- All parts of the CAP Provider Enrollment packet must be completed. Signature must be original.
- White out and alterations are not accepted.
- Please do not highlight any information on the enrollment packet.
- CAP MR/DD Providers only - Each site and service must obtain endorsement from the Local Management Entity (LME).
- Please review the attached documents for provider qualifications, licensure, and certification requirements applicable to your provider type prior to completing your enrollment packet. (These documents do not need to be returned to DMA with your enrollment packet.)
- Copies of the applicable credentialing documentation must accompany the application. If these documents are missing, the application will be returned to the provider.
- Name on application must exactly match name on Medicaid Participation Agreement.
- Make a copy of all submitted documentation.

COMMUNITY ALTERNATIVES PROGRAM FOR CHILDREN (CAP/C)

<u>TYPE OF SERVICES</u>	<u>PROVIDER QUALIFICATIONS</u>	<u>DOCUMENTATION/PROOF</u>
Case Management	Agency designated by DMA	NA
Home Mobility Aids	Agency designated by DMA to provide case management	NA
Hourly Nursing	Agency licensed by Division of Health Service Regulation (DHSR) to provide nursing services	Copy of current license from DHSR
Medical Supplies	Agency designated by DMA to provide case management	NA
Personal Care	Agency licensed by Division of Health Service Regulation (DHSR) to provide In-Home Aide services	Copy of current license from DHSR
Respite Care - In-Home (Aide)	Agency licensed by Division of Health Service Regulation (DHSR) to provide In-Home Aide services	Copy of current license from DHSR
Respite Care - In-Home (Nursing)	Agency licensed by Division of Health Service Regulation (DHSR) to provide In-Home Nursing services	Copy of current license from DHSR
Respite Care - Institutional	Nursing facility or hospital enrolled with DMA to provide Medicaid services	Copy of Copy of most recent Division of Medical Assistance notice of approval as a Medicaid provider
Waiver Supplies	Agency designated by DMA to provide case management	NA

Note: The Division of Health Service Regulation (DHSR) was formerly known as the Division of Facility Services (DFS).

NA = Not Applicable DMA has necessary documentation/proof on file
 Required documentation/proof should be attached to the application/provider agreement when submitted to DMA
 Revised 07/07

COMMUNITY ALTERNATIVES PROGRAM FOR DISABLED ADULTS (CAP/DA)

TYPE OF SERVICES	PROVIDER QUALIFICATIONS	DOCUMENTATION/PROOF
Adult Day Health Care	Agency certified by Division of Aging (DOA) as an Adult Day Health Care Facility	Copy of current certification issued by DOA
Case Management	Lead Administrative Agency +	NA
Home Delivered Meals	Lead Administrative Agency + OR agency approved by Division of Aging	Lead Agency: NA Other Agency: Copy of letter of approval or copy of most recent review by DOA
Home Mobility Aids	Lead Administrative Agency +	NA
In-Home Aide Level II	Agency licensed by Division of Health Service Regulation (DHSR) to provide In-Home Aide services	Copy of current license from DHSR
In-Home Aide Level III Personal Care	Agency licensed by Division of Health Service Regulation (DHSR) to provide In-Home Aide services	Copy of current license from DHSR
Medical Supplies	Lead Administrative Agency +	NA
Personal Emergency Response System (PERS)	Agency that operates or accepts responsibility for providing 24 hrs per day, 7 days per week monitoring service	Copies of: agency marketing materials; blank contract describing services; AND contract between operating provider and monitoring station if provider agency does not directly provide the monitoring service; AND contract The recipient signs.
Respite Care - In-Home	Agency licensed by Division of Health Service Regulation (DHSR) to provider In-Home Aide services	Copy of current license
Respite Care - Institutional	Nursing facility or hospital with swing bed enrolled with DMA to provider Medicaid Services	Copy of most recent Division of Medical Assistance notice of approval as a Medicaid provider
Waiver Supplies	Lead Administrative Agency +	NA

NA = Not Applicable DMA has necessary documentation/proof on file

+ = Lead Agency designated by County Commissioners

Required documentation/proof should be attached to the application/provider agreement when submitted to DMA

Note: The Division of Health Service Regulation (DHSR) was formerly known as the Division of Facility Services (DFS).

**COMMUNITY ALTERNATIVES PROGRAM FOR PERSONS WITH MENTAL RETARDATION AND
OTHER/DEVELOPMENTAL DISABILITIES (CAP-MR/DD)**

TYPE OF SERVICE PROVIDER QUALIFICATIONS -LICENSE / CERTIFICATION OTHER STANDARDS Effective 9-1-2005

Adult Day Health	Adult Day Health Care Facility		Certified by the NC Division of Aging	Adult Day Health Care Programs- general and certification requirements only
Augmentative Communication	Local Management Entity (LME)		LMEs are approved by DMH	Purchasing follows LME business procedures. Augmentative Communication Devices must be recommended by speech/language pathologist licensed to practice in NC. Augmentative Communication Technology Professionals are individuals with hands on knowledge and expertise with augmentative communication devices.
Crisis Services	Provider Agency/ Organization OR Local Management Entity (LME)		Certified by LME <u>and</u> approved by DMH LMEs are approved by DMH	Worker Qualifications: must meet requirements for paraprofessional in 10A NCAC 27G .0100-.0200. Client specific competencies to be met identified by the individual's person centered planning team and documented in the plan of care. Direct care staff must have a criminal record check. A healthcare registry check is required in accordance with 10A NCAC 27G.0200. Driving record must be checked if providing transportation.

*****Note:** Waiver services cannot be provided to recipients by legally responsible relatives, i.e., spouse or parents/step-parents. **These individuals cannot own or operate the provider agency providing services to their minor children/step-children or spouse.** Services may be provided by relatives or friends (except for legally responsible relatives as noted above). Direct Care Staff must have expertise, as appropriate, in the field in which the service is being provided. Services provided by relatives and friends may be covered if relatives or friends meet the qualifications for providers of care. There are strict controls to assure that payment is made to the relative or friends in return for specific services rendered, and there is justification as to why the relative or friend is the provider of care, e.g., lack of other qualified provider in remote areas. Medicaid payment may be made to qualified parents of minor children or to spouses for extraordinary services requiring specialized skills (e.g., skilled nursing, physical therapy) which such people are not legally obligated to provide. Legal guardians of the person may provide waiver services to participants since they are not financially responsible for the participant.

*****Note:** For the purposes of this waiver, a qualified professional refers to a qualified professional in the field of developmental disabilities.

**COMMUNITY ALTERNATIVES PROGRAM FOR PERSONS WITH MENTAL RETARDATION AND
OTHER/DEVELOPMENTAL DISABILITIES (CAP-MR/DD)**

TYPE OF SERVICE PROVIDER QUALIFICATIONS -LICENSE / CERTIFICATION OTHER STANDARDS Effective 9-1-2005

Day Supports (continued)	Licensed Day Care Programs	Licensed Day Care Programs-GS 110 Article 7	Licensed Day Care Programs- Private Providers are certified by LME and approved by DMH	Licensed Day Care Programs- general and license requirements only
	OR			
	Adult Day Care Programs	Adult Day Care Programs	Adult Day Care and Adult Day Health Programs- Certified as Adult Day Care or Adult Day Health Facility by Division of Aging	Adult Day Health and Adult Day Care Programs- general and certification requirements only
	OR			
	Before and After School Day Care Programs operated by NC Public School System		Before and After School Day Care Programs operated by NC Public School System and qualified by LMEs Certified by the LME and approved by DMH	Before and After School Day Care Programs operated by NC Public School System-qualified by the LME- general and license requirements only

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OTHER/DEVELOPMENTAL DISABILITIES (CAP-MR/DD)**

TYPE OF SERVICE PROVIDER QUALIFICATIONS -LICENSE / CERTIFICATION OTHER STANDARDS Effective 9-1-2005

Home and Community Support (HCS) ___ Individual ___ Groups	Provider Agency/Organization OR Management Entity (LME)		Certified by LME and approved by DMH LMEs are approved by DMH	Worker Qualifications: must meet requirements for paraprofessional in 10A NCAC 27G .0100-.0200. Client specific competencies to be met as identified by the individual's person centered planning team and documented in the plan of care. Direct care staff must have a criminal record check. A healthcare registry check is required in accordance with 10A NCAC 27G.0200. Driving record must be checked if providing transportation.
Home Modifications	Local Management Entity (LME)		LMEs are approved by DHHS	Must meet applicable state and local building codes. Purchasing follows LME business procedures.
Individual/ Caregiver Training and Education	Provider Agency/Organization OR Local Management Entity (LME)		Certified by LME and approved by DMH LMEs are approved by DMH	Worker Qualifications: Must have expertise as appropriate, in the field in which the training is being provided. Driving record must be checked if providing transportation.

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**COMMUNITY ALTERNATIVES PROGRAM FOR PERSONS WITH MENTAL RETARDATION AND
OTHER/DEVELOPMENTAL DISABILITIES (CAP-MR/DD)**

TYPE OF SERVICE PROVIDER QUALIFICATIONS -LICENSE / CERTIFICATION OTHER STANDARDS Effective 9-1-2005

<p>Personal Care</p> <p>Enhanced Personal Care Services</p>	<p>Provider Agency/ Organization</p> <p>OR</p> <p>Local Management Entity (LME)</p> <p>OR</p> <p>Home Care Agency</p>	<p>Licensed by the Division of Facility Services (DFS) as a Home Care Agency</p>	<p>Certified by LME and approved by DMH</p> <p>LMEs are approved by DMH</p> <p>Approved by DFS</p> <p>Certified by LME and approved by DMH</p>	<p>Worker Qualifications: must meet requirements for paraprofessional in 10A NCAC 27G .0100-.0200. Client specific competencies to be met as identified by the individual's person centered planning team and documented in the plan of care. Direct care staff must have a criminal record check. A healthcare registry check is required in accordance with 10A NCAC 27G.0200. Driving record must be checked if providing transportation.</p> <p><u>Staff providing enhanced personal care have additional training/instruction specific to the medical and/or behavioral needs of the consumer.</u></p>
<p>Personal Emergency Response System</p>	<p>Agency operating or accepting responsibility for providing 24 hrs per day, 7 days per week monitoring service</p>	<p>Business license</p> <p>(Not all enrolled provider has a business license) no state requirements for this service</p>		<p>Copies of: agency marketing materials; blank contract describing services; and contract between the provider agency and the monitoring station if the provider agency does not operate the monitoring station.</p> <p>Must be able to provide 24-hour service.</p>

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OTHER/DEVELOPMENTAL DISABILITIES (CAP-MR/DD)**

TYPE OF SERVICE PROVIDER QUALIFICATIONS -LICENSE / CERTIFICATION OTHER STANDARDS Effective 9-1-2005

Residential Supports	Provider Agency/ Organization OR Local Management Entity (LME)		Certified by LME/ Area Authorities/County Programs and approved by DMH LMEs are approved by DMH	Worker Qualifications: must meet requirements for paraprofessional in 10A NCAC 27G .0100-.0200. Client specific competencies to be met as identified by the individual's person centered planning team and documented in the plan of care. Direct care staff must have a criminal record check. A healthcare registry check is required in accordance with 10A NCAC 27G.0200. Driving record must be checked if providing transportation.
Respite-Care Institutional	State regional MR facility		Copy of most recent DMA notice of approval as a Medicaid provider Certified by DFS as an ICF-MR in accordance with federal conditions of participation	State MRCs have deemed status for all training and documentation requirements. This type of respite must be provided in a Medicaid ICF-MR bed in a State regional mental retardation facility.

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OTHER/DEVELOPMENTAL DISABILITIES (CAP-MR/DD)**

TYPE OF SERVICE PROVIDER QUALIFICATIONS -LICENSE / CERTIFICATION OTHER STANDARDS Effective 9-1-2005

Respite Care Non-Institutional Community and facility based	Local Management Entity (LME)	As applicable, licensed by DFS as a respite care facility in accordance with G.S. 122C	Providers Agencies/ Organizations are Certified by LME <u>and</u> approved by DMH	Worker Qualifications: must meet requirements for paraprofessional in 10A NCAC 27G .0100-.0200. Client specific competencies to be met as identified by the individual's person centered planning team and documented in the plan of care. Direct care staff must have a criminal record check. A healthcare registry check is required in accordance with 10A NCAC 27G.0200. Driving record must be checked if providing transportation. <u>Staff providing enhanced respite care have additional training/instruction specific to the medical and/or behavioral needs of the consumer.</u>
Enhanced Respite (Non-Institutional)	Provider Agency/Organization		LMEs are approved by DMH	
Respite Nursing	Provider Agency/ Organization (Home Care Agency or Home Health Agency) OR Local Management Entity (LME)		Agency licensed by DFS as a Home Care Agency or Home Health Agency and Certified by LME <u>and</u> approved by DMH LMEs are approved by DMH	Worker Qualifications: RN or LPN Service providers must have a criminal record check and healthcare registry check. Driving record must be checked if providing transportation.

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OTHER/DEVELOPMENTAL DISABILITIES (CAP-MR/DD)**

TYPE OF SERVICE PROVIDER QUALIFICATIONS -LICENSE / CERTIFICATION OTHER STANDARDS Effective 9-1-2005

Specialized Consultative Services	Provider Agency/ Organization OR Local Management Entity (LME)		Certified by LME and approved by DMH LMEs are approved by DMH	Worker Qualifications: Must hold appropriate NC license for PT, OT, ST, psychology, nutrition; or state certification for Recreation Therapy.
Specialized Equipment and Supplies	Local Management Entity (LME)		LMEs are approved by DMH	Purchasing follows LME business procedures.
Supported Employment	Provider Agency/ Organization OR Local Management Entity (LME)		Certified by LME/ Area Authorities/County Programs and approved by DMH LMEs are approved by DMH	Worker Qualifications: must meet requirements for paraprofessional in NCAC 27G .0100-.0200. Client specific competencies to be met as identified by the individual's person centered planning team and documented in the plan of care. Direct care staff must have a criminal record check. A healthcare registry check is required in accordance with 10A NCAC 27G.0200. Driving record must be checked if providing transportation.

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OTHER/DEVELOPMENTAL DISABILITIES (CAP-MR/DD)**

TYPE OF SERVICE PROVIDER QUALIFICATIONS -LICENSE / CERTIFICATION OTHER STANDARDS Effective 9-1-2005

Transportation	Local Management Entity (LME)		LMEs are approved by DMH	Insurance coverage as required by NC law, driving record check and criminal background checks
Vehicle Adaptation	Local Management Entity (LME)		LMEs are approved by DMH	Must meet safety codes if applicable to the modification being provided

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PERSONAL EMERGENCY RESPONSE SYSTEM (PERS)

PROVIDER QUALIFICATIONS:

Brochure - agency marketing materials
Copy of the blank contract describing services

Copy of the contract between the provider agency and the monitoring station if the provider agency does not operate the monitoring service

On letterhead provide the following information:

Who does the 24 hour monitoring and where are they located

Who completes the medical and responder information and gets the information to the monitoring staff

If you do not have a contract that the subscriber (recipient) signs will need a letter on letter or statement stating that subscriber (recipient) does not sign any contract

Please have the person supplying the information sign the letter at the bottom and print their name and title.

Will need an addendum to the subscribers agreement if the agreement states the subscriber is responsible for monthly charges and/or agreement states subscriber will be liable and responsible for the payment of any expenses or costs incurred by any person responding to a call from the monitoring center.

INSTRUCTIONS FOR APPLICATION ACKNOWLEDGEMENT CARD

Please fill in the information below.
This is our method of acknowledging receipt of your application.

PLACE A STAMP ON THE ACKNOWLEDGEMENT CARD TO ENSURE DELIVERY BY THE POST OFFICE.

**Provider Services
DHHS/DMA
2501 Mail Services Center
Raleigh NC 27699-2501**

PLACE STAMP
HERE. POST
OFFICE WILL
NOT DELIVER
WITHOUT
PROPER
POSTAGE.

Name

Address

City State Zip Code

APPLICATION ACKNOWLEDGEMENT CARD

Dear Prospective Provider:

We have received your application for enrollment in the NC Medicaid Program.

DMA will notify you of your status via mail once the enrollment process has been completed, or in the event additional information is needed.

Thank you again for your interest in the NC Medicaid Program.

Sincerely,

DMA Provider Services



**North Carolina Department of Health and Human Services
Division of Medical Assistance - Provider Services - 919-855-4050
Community Alternatives Program (CAP) Provider Enrollment Application**

STATE USE ONLY
[] Initial Enrollment
[] Re-enrollment
[] CHOW
[] Other Change

Type of Application:

- Initial Request
- Change of Ownership. Medicaid Provider Number: _____
- Re-enrollment. Medicaid Provider Number: _____
- Amendment. Medicaid Provider Number: _____
- Add New Service Delete Service
- Add New Site Delete Site

Effective Date Requested: _____

Type or Print All Information in Blue or Black Ink

Name of Provider (must exactly match the name on Medicaid Participation Agreement):

Telephone Number: (_____) _____ - _____

Fax Number: (_____) _____ - _____

Email Address: _____

Site Address: _____

Street

City & State

Zip Code + Four (Last 4 digits required)

County: _____

Payment/Mailing Address: _____

Street or Post Office Box

City & State

Zip Code + Four (Last 4 digits required)

Contact Person's Name: _____

Contact Person's Telephone Number: (_____) _____

COMMUNITY ALTERNATIVES PROGRAM SERVICES

For initial enrollment or reapplication/re-enrollment, use "X" to indicate services the provider agency will provide under each CAP Program; use "A" to add new service(s); use "D" to delete services.

1. CAP/DA (Disabled Adult) Services

- | | |
|---|--|
| <input type="checkbox"/> Adult Day Health Care | <input type="checkbox"/> Medical Supplies |
| <input type="checkbox"/> Case Management | <input type="checkbox"/> Personal Emergency Response System (PERS) |
| <input type="checkbox"/> Home Delivered Meals | <input type="checkbox"/> Respite Care – In-Home |
| <input type="checkbox"/> Home Mobility Aids | <input type="checkbox"/> Respite Care – Institutional |
| <input type="checkbox"/> In-Home Aide Level II | <input type="checkbox"/> Waiver Supplies |
| <input type="checkbox"/> In-Home Aide Level III Personal Care | |

2. CAP/C (Disabled Children/Katie Beckett) Services

- | | |
|---|---|
| <input type="checkbox"/> Case Management | <input type="checkbox"/> Respite Care – In –Home (Aide) |
| <input type="checkbox"/> Home Mobility Aids | <input type="checkbox"/> Respite Care – In-Home (Nursing) |
| <input type="checkbox"/> Hourly Nursing | <input type="checkbox"/> Respite Care – Institutional |
| <input type="checkbox"/> Medical Supplies | <input type="checkbox"/> Waiver Supplies |
| <input type="checkbox"/> Personal Care | |

3. CAP-MR/DD (Mentally Retarded/Developmentally Disabled) Services

- | | |
|---|---|
| <input type="checkbox"/> Adult Day Health Care | <input type="checkbox"/> Residential Supports |
| <input type="checkbox"/> Augmentative Communication Devices | <input type="checkbox"/> Respite Care- Facility Based with 24 hrs awake staff |
| <input type="checkbox"/> Crisis Services | <input type="checkbox"/> Specialized Consultative Services |
| <input type="checkbox"/> Day Supports | <input type="checkbox"/> Respite Care – Noninstitutional Community Based |
| <input type="checkbox"/> Home and Community Supports | <input type="checkbox"/> Respite Care – Noninstitutional Nursing-Based |
| <input type="checkbox"/> Home Modifications | <input type="checkbox"/> Respite Care – Institutional |
| <input type="checkbox"/> Individual/Caregiver Training & Education | <input type="checkbox"/> Specialized Equipment and Supplies |
| <input type="checkbox"/> Personal Care Services | <input type="checkbox"/> Supported Employment |
| <input type="checkbox"/> Personal Emergency Response System (PERS)* | <input type="checkbox"/> Transportation |
| *PERS does not require endorsement. | <input type="checkbox"/> Vehicle Adaptations |

REQUIRED EFFECTIVE 1-1-07

*National Provider Identifier (NPI):

***YOU MUST ATTACH A COPY OF YOUR NATIONAL PLAN AND PROVIDER ENUMERATION SYSTEM (NPPES) CERTIFICATION LETTER**

A. If you are enrolling as a group provider, list all shareholders/partners (including self) who have 5% or more ownership AND all individual officers, directors, managers, and Electronic Funds Transfer (EFT) authorized individuals and information requested on each. If you are an individual, enter name, address, title, and social security information for yourself only.

Name and Address	Title	SSN	License #	% Owner
Check business relationship that applies:				
<input type="checkbox"/> Owner <input type="checkbox"/> Shareholder <input type="checkbox"/> Partner				
Check relationship to enrolling provider: <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> Child <input type="checkbox"/> Sibling				

Name and Address	Title	SSN	License #	% Owner
Check business relationship that applies:				
<input type="checkbox"/> Owner <input type="checkbox"/> Shareholder <input type="checkbox"/> Partner				
Check relationship to enrolling provider: <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> Child <input type="checkbox"/> Sibling				

Name and Address	Title	SSN	License #	% Owner
Check business relationship that applies:				
<input type="checkbox"/> Owner <input type="checkbox"/> Shareholder <input type="checkbox"/> Partner				
Check relationship to enrolling provider: <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> Child <input type="checkbox"/> Sibling				

Name and Address	Title	SSN	License #	% Owner
Check business relationship that applies:				
<input type="checkbox"/> Owner <input type="checkbox"/> Shareholder <input type="checkbox"/> Partner				
Check relationship to enrolling provider: <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> Child <input type="checkbox"/> Sibling				

B. Have you, or individuals or organizations having a direct or indirect ownership or control interest of five percent (5%) or more in this business been convicted of a criminal offense related to the involvement of such persons or organization in the programs of Medicaid (Title XIX) or Social Services Block Grant (XX)?
 Yes No (If you answered 'Yes', attach explanation)

- C. Have any of your directors, officers, agents or managing employees of your group been convicted of a criminal offense related to their involvement in the program of Medicaid, Medicare or Social Services Block Grant?
 Yes No (If you answered 'Yes', attach explanation)
- D. Have civil monetary penalties ever been levied against this agency by Medicare, Medicaid or other State or Federal Agency or Program?
 Yes No (If you answered 'Yes', attach explanation)
- E. Have you or any of the individuals listed in Item 'A' ever:
- a. Been convicted of a felony, had adjudication withheld on a felony, pled no contest to a felony or entered into a pre-trial agreement for a felony?
 Yes No

If yes, list the name(s) of the individual(s) and provide a copy of the administrative complaint and final disposition:

- b. Had any disciplinary action taken against any business or professional license held in this or any other state? Or had your license to practice restricted, reduced or revoked in this or any other state?
 Yes No

If 'Yes' to 'E b', complete below and attach a copy of the final disposition. Attach documentation from the proper authorities that approve the reinstatement of the license:

Against Whom?	Action Taken?	Who took Action?	Date of Action?

- c. Been denied enrollment, been suspended or excluded from Medicare or Medicaid in any state, or been employed by a corporation, business, or professional association that has ever been suspended or excluded from Medicare or Medicaid in any state?
 Yes **No**

If 'Yes', list the name(s) and provider number(s) of the individual(s) and provide a copy of the documentation:

Name	Provider Number

- d. Had suspended payments from Medicare or Medicaid in any state, or been employed by a corporation, business, or professional association that had suspended payments from Medicare or Medicaid in any state?
 Yes **No**

- e. Owes money to Medicaid or Medicare that has not been paid?
 Yes **No**

- F. Is the organization/agency incorporated?
 Yes **No**

If yes, please attach a copy of Application for Incorporation, copy of Certified Articles of Incorporation and any subsequent changes to the Application/Articles of Incorporation.

Signature Authorizations and Related Information Required

**** All Information Must Be Entered for the Application to be Processed****

I certify that the above information is true and correct. I further understand that any false or misleading information may be cause for denial or termination of participation as a Medicaid Provider. Individual applications must have the provider's original signature. Authorized agents can only sign for a group application.

Signature of Application or Authorized Agent

Date

Printed Name and Title

Medicaid Participation Agreement

B. PROVIDER FURTHER UNDERSTANDS AND AGREES:

1. Payment of claims is from State, Federal and County funds and any false claims, false statements or documents, or misrepresentation or concealment of material fact may be prosecuted by applicable State and/or Federal law.
2. DMA may withhold payment because of irregularity from whatever cause until such irregularity or difference can be resolved or may recover overpayments, penalties or invalid payments due to error of the provider and/or DMA and its agents.
3. If any part of this agreement is found to be in conflict with any Federal or State laws or regulations having equal weight of law, or if any part is placed in conflict by amendment of such laws, this agreement is so amended except that if the fulfillment of this agreement on the part of either party is rendered unfeasible or impossible, both the provider and DMA shall be discharged from further obligation under the terms of this agreement, except for equitable settlement of the respective debts up to the date of termination.
4. Neither providers nor employees thereof shall use or disclose information concerning Medicaid patients, including name and address, social and economic conditions or circumstances, medical data and medical services provided, except for purposes of rendering necessary medical care, arranging for medical care or services not available from the provider, establishing eligibility of the patient, and billing for services of the provider. Neither patient records nor portions thereof may be transferred except by written consent of the patient or as otherwise provided by law.
5. That federal and/or State officials and their contractual agents may make certification and compliance surveys, inspections, medical and professional reviews, and audit of costs and data relating to services to Medicaid patients as may be necessary under Federal and State statutes, rules and regulations. Such visits must be allowed at any time during hours of operation, including unannounced visits. All such surveys, inspections, reviews and audits will be in keeping with both legal and ethical practice governing patient confidentiality.
6. That billings and reports related to services to Medicaid patients and the cost of that care must be submitted in the format and frequency specified by DMA and/or its fiscal agent.
7. That payment will be made in accordance with the approved Medicaid State Plan.
8. Neither this agreement nor the assigned provider number shall be transferable or assignable except as provided by Federal regulations.
9. This agreement may be terminated by the Provider upon giving thirty (30) days prior written notice to all parties to the agreement.
10. DMA may terminate this agreement upon giving written notice or refuse to enter into an agreement when:
 - a. The provider fails to meet conditions for participation, including licensure, certification or other terms and conditions stated in the provider agreement, or
 - b. The provider is determined to have violated Medicaid rules or regulations, or
 - c. Any person with ownership or control interest in the provider agency or an agent or managing employee of the provider has been convicted of a criminal offense related to services provided under titles XVIII, XIX, or XX of the Social Security Act, or
 - d. The provider fails to provide medically appropriate health care services, or
 - e. The State determines it to be in the best interests of the State and Medicaid recipients to do so.
11. Claims may not be reassigned to an individual or organization that advances money to the provider of services for accounts receivable that the provider has assigned, sold or transferred to the individual or organization for an added fee or deduction of a portion of the accounts receivable.

C. AS A PROVIDER OF COMMUNITY ALTERNATIVES PROGRAM(S) (CAP) SERVICES, THE PROVIDER AGENCY AGREES:

1. To render only those CAP services authorized by the CAP case manager under a CAP recipient's plan of care.
2. To render only those services for which the provider has requested enrollment for and received approval from DMA to provide.
3. To render only those services it is qualified to provide according to state or federal law, regulations, and Medicaid policies (including but not limited to policies published in the Medicaid Provider Manuals and/or Medicaid Bulletins) at the time the service is rendered, including being licensed, certified or accredited if required by law, regulation, rule or program policies.
4. To notify DMA within fifteen (15) working days of the need to delete services approved by DMA for which the agency is no longer qualified to provide under law, regulations, rules or program policies.
5. That it meets all requirements of the Patient Self Determination Act including: (i) having written policies and procedures for informing adults before they come under the agency's care for personal care services about their rights under law to make decisions about their medical care, including the right to accept or refuse medical or surgical treatment and the right to complete an advance directive; (ii) providing written information to all adults of the agency's policy for advance directives; (iii) documenting in the patient's medical record whether or not he has executed an advance directive; (iv) not conditioning the provision of care or discriminating against the patient based on his decision; and (v) providing for education individually or with others, of staff and the community on issues concerning advance directives.
6. To report any change in ownership or name to DMA within 5 days after such change and hold DMA harmless for payment of claims to the enrolled provider prior to execution of the required changes in the provider name or ownership.
7. To meet provider agency/organization standards established by the Division of Mental Health/Developmental Disability/Substance Abuse Services.

Signature of Authorization Required:

****All Information Must Be Entered For The Agreement To Be Processed****

I certify that the above information is true and correct. I further understand that any false or misleading information may be cause for denial or termination of participation as a Medicaid Provider. Individual agreements must have the provider's original signature. Authorized agents can only sign for group agreements.

_____	_____
Signature of Applicant or Authorized Agent	Date
_____	_____
Printed Name and Title	Month of Fiscal Year End Date

INTERNAL USE BY THE DIVISION OF MEDICAL ASSISTANCE

EFFECTIVE DATE:

This agreement is executed and shall become effective on the _____ day of _____ in the year of _____.

The agreement shall remain subject to renewal on a periodic basis. A new agreement may be required as DMA necessitates, by operation of law, Medicaid regulations, polices or other material circumstances, or termination upon substitution of a new agreement, or by act of the parties as herein provided. You are herein authorized to provider services of which are in accordance with the approved services definitions.

DMA APPROVAL:

Accepted on _____ by _____

NORTH CAROLINA DIVISION OF MEDICAL ASSISTANCE

PROVIDER CERTIFICATION

FOR

SIGNATURE ON FILE

By signature below, I understand and agree that non-electronic Medicaid claims may be submitted without signature and this certification is binding upon me for my actions as a Medicaid provider, my employees, or agents who provide services to Medicaid recipients under my direction or who file claims under my provider name and identification number.

I certify that all claims made for Medicaid payment shall be true, accurate, and complete and that services billed to the Medicaid Program shall be personally furnished by me, my employees, or persons with whom I have contracted to render services, under my personal direction.

I understand that payment of claims will be from federal, state and local tax funds and any false claims, statements, or documents or concealment of a material fact may be prosecuted under applicable Federal and State laws and I may be fined or imprisoned as provided by law.

I have read and agree to abide by all provisions within the NC Medicaid provider participation agreement and/or on the back of the claim form.

Group or attending provider number to which this certification applies: _____

(Leave blank if submitting with new enrollment packet. A provider number will be assigned once enrollment is complete. This certification is only applicable to the provider number listed above. When the attending number is required on a claim form, each attending provider is required to fill out a separate certification in addition to the group certification.)

Provider Name (must exactly match name on application)

Signature of Provider Listed Above or Authorized Agent
(Authorized Agent only applicable for group provider numbers)

Date

Mail completed form to:
(Must be original, faxes not accepted)

DMA-Provider Services
2501 Mail Service Center
Raleigh, NC 27699-2501

**NORTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF MEDICAL ASSISTANCE
INSTRUCTIONS FOR COMPLETING THE
ELECTRONIC CLAIMS SUBMISSION (ECS) AGREEMENT**

Carefully read the ECS Agreement in its entirety. The signature of the provider constitutes acceptance of the conditions for electronic submission of claims. The ECS Agreement is not transferable from one group practice to another, from one owner of a practice/facility to another or for members of a group moving to another group or solo practice. The Agreement may not be altered or marked in any way. Photo or fax copies are not accepted. **If you are already filing electronically, it is not necessary to complete this Agreement if you are only changing your clearinghouse or billing agent.**

1. Type or print in black ink and **return all copies** to the **Division of Medical Assistance**. Do not separate the copies.
2. Upon DMA approval, a signed copy will be returned to the provider. **Claims should not be submitted electronically until there is an approved ECS Agreement and transmission has been tested with EDS (DMA's fiscal agent).**
3. Provider Business Name
 - a. Enter the name of the business/practice/facility or the name of the practitioner if the business is a solo practice.
 - b. If you are currently enrolled in the N.C. Medicaid program, the provider name entered on the Agreement must match the name on the Remittance and Status Report.
 - c. If the name of the business/practice/facility has changed since enrollment, attach an explanation or call the DMA Provider Services Unit at 919-855-4050.
4. Mailing Address – Enter the address for receipt of mail if different from the site address. If either address has changed and DMA has not been notified, please attach an explanation. If the addresses on the Agreement do not match those in DMA's provider files, the ECS Agreement will be returned.
5. Signature – Original signatures are required. Signature stamps are not acceptable.
 - a. The signature of the provider is required for solo practitioners and partnerships.
 - b. The owner, business officer or an individual who has authority to enter into contracts on behalf of the provider organization must sign the Agreement.
 - c. An authorized agent such as the medical director, owner, vice president, business officer, etc., who has the authority to enter into contracts on behalf of the group must sign for the group.
 - d. When new members join a group that **already has an ECS Agreement**, simply complete page three and **add the new providers' signatures only**. Current providers do not have to sign the Agreement again.
6. Provider Number – List the number to which Medicaid payment is to be made.
7. Completion of the bottom section on page three is required if filing under a group provider number, even if there is only one practitioner in the group.
8. Before submitting electronic claims, contact the ECS unit at EDS, 1-800-688-6696 or 919-851-8888 (option "1" on the voice response menu.) Electronic claims will not process until EDS activates authorization for ECS billing. The ECS Unit must assign an authorization/logon number and verify that testing has been successfully completed.

Return the completed ECS Agreement to:

**Provider Services
Division of Medical Assistance
2501 Mail Service Center
Raleigh, NC 27699-2501**

**NORTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF MEDICAL ASSISTANCE
ELECTRONIC CLAIMS SUBMISSION (ECS) AGREEMENT**

DMA Provider Enrollment, 2501 Mail Service Center Raleigh, NC 27699-2501

The Provider of Medical Care ("Provider") under the Medicaid Program in consideration of the right to submit claims by paperless means rather than by, or in addition to, the submission of paper claims agrees that it will abide by the following terms and conditions:

1. The Provider shall abide by all Federal and State statutes, rules, regulations and policies (including, but not limited to: the Medicaid State Plan, Medicaid Manuals, and Medicaid bulletins published by the Division of Medical Assistance (DMA) and/or its fiscal agent) of the Medicaid Program, and the conditions set out in any Provider Participation Agreement entered into by and between the Provider and DMA.
2. Provider's signature electing electronic filing shall be binding as certification of Provider's intent to file electronically and its compliance with all applicable statutes, rules, regulations and policies governing electronic claims submission. The Provider agrees to be responsible for research and correction of all billing discrepancies. Any false statement, claim or concealment of or failure to disclose a material fact may be prosecuted under applicable federal and/or state law (P.L. 95-142 and N.C.G.S. 108A-63), and such violations are punishable by fine, imprisonment and/or civil penalties as provided by law.
3. Claims submitted on electronic media for processing shall fully comply with applicable technical specifications of the State of NC, its fiscal agent and/or the federal government for the submission of paperless claims. DMA or its agents may reject an entire claims submission at any time due to provider's failure to comply with the specifications or the terms of this Agreement.
4. The Provider shall furnish, upon request by DMA or its agents, documentation to ensure that all technical requirements are being met, including but not limited to requirements for program listings, tape dumps, flow charts, file descriptions, accounting procedures, and record retention.
5. The Provider shall notify DMA in writing of the name, address, and phone number of any entity acting on its behalf for electronic submission of the Provider's claims. The Provider shall execute an agreement with any such entity, which includes all of the provisions of this agreement, and Provider shall provide a copy of said agreement to DMA prior to the submission of any paperless claims by the entity. Prior written notice of any changes regarding the Provider's use of entities acting on its behalf for electronic submission of the Provider's claims shall be provided to DMA. For purposes of compliance with this agreement and the laws, rules, regulations and policies applicable to Medicaid providers, the acts and/or omissions of Provider's staff or any entity acting on its behalf for electronic submission of the Provider's claims shall be deemed those of the Provider, including any acts and/or omissions in violation of Federal and State criminal and civil false claims statutes.
6. The Provider shall have on file at the time of a claim's submission and for five years thereafter, all original source documents and medical records relating to that claim, (including but not limited to the provider's signature and all electronic media and electronic submissions), and shall ensure the claim can be associated with and identified by said source documents. Provider will keep for each recipient and furnish upon request to authorized representatives of the Department of Health and

Human Services, DMA, the State Auditor or the State Attorney General's Office, a file of such records and information as may be necessary to fully substantiate the nature and extent of all services claimed to have been provided to Medicaid recipients. The failure of Provider to keep and/or furnish such information shall constitute grounds for the disallowance of all applicable charges or payments.

7. The Provider and any entity acting on behalf of the provider shall not disclose any information concerning a Medicaid recipient to any other person or organization, except DMA and/or its contractors and as provided in paragraph 6 above, without the express written permission of the recipient, his parent or legal guardian, or where required for the care and treatment of a recipient who is unable to provide written consent, or to bill other insurance carriers or Medicare, or as required by State or Federal law.
8. To the extent permitted by applicable law, the Provider will hold harmless DMA and its agents from all claims, actions, damages, liabilities, costs and expenses, which arise out of or in consequence of the submission of Medicaid billings through paperless means. The provider will reimburse DMA processing fees for erroneous paperless billings when erroneous claims constitute fifty percent or more of paperless claims processed during any month. The amount of reimbursement will be the product of the per-claims processing fee paid to the fiscal agent by the State in effect at the time of submission and the number of erroneous claims in each submission. Erroneously submitted claims include duplicates and other claims resubmitted due to provider error.
9. Sufficient security procedures must be in place to ensure that all transmissions of documents are authorized and protect recipient specific data from improper access.
10. Provider must identify and bill third party insurance and/or Medicare coverage prior to billing Medicaid.
11. Either the Provider or DMA has the right to terminate this agreement by submitting a (30) day written notice to the other party; that violation by Provider or Provider's billing agent(s) of the terms of this agreement shall make the billing privilege established herein subject to immediate revocation by DMA; that termination does not affect provider's obligation to retain and allow access to and audit of data concerning claims. This agreement is canceled if the provider ceases to participate in the Medicaid Program or if state and federal funds cease to be available.
12. No substitutions for or alterations to this agreement are permitted. In the event of change in the Provider billing number, this agreement is terminated. Election of electronic billing may be made with execution of a new provider participation agreement or completion of a separate electronic agreement.
13. Any member of a group practice that leaves the group and establishes a solo practice must make a new election for electronic billing under his solo practice provider number.
14. The cashing of checks or the acceptance of funds via electronic transfer is certification that the Provider presented the bill for the services shown on the Remittance Advice and that the services were rendered by or under the direction of the Provider.

- 15. Provider is responsible for assuring that electronic billing software purchased from any vendor or used by a billing agent complies with billing requirements of the Medicaid Program and shall be responsible for modifications necessary to meet electronic billing standards.
- 16. Electronic claims may not be reassigned to an individual or organization that advances money to the Provider for accounts receivable that the provider has assigned, sold or transferred to the individual or organization for an added fee or deduction of a portion of the accounts receivable.

The undersigned having read this Agreement for billing Medicaid claims electronically and understanding it in its entirety, hereby agree(s) to all of the stipulations, conditions, and terms stated herein.

Medicaid Provider Name: _____

Medicaid Provider Number (if currently enrolled): _____

Business Site/Physical Address:

_____ **Street**

_____ **City & State** **Zip Code + Four (Last 4 digits required)**

_____ **Signature of Provider or Authorized Agent** **Date**

_____ **Typed or Printed Name and Title of Provider or Authorized Agent**

_____ **Contact Person's Name and Telephone Number**

DMA/FISCAL AGENT APPROVAL:

Acceptance Date: _____ **by** _____

LETTER OF ATTESTATION

The Deficit Reduction Act (DRA) of 2005, which went into effect January 1, 2007, required specific changes to states' Medicaid programs. One of the changes is the requirement for employee education about false claims recovery. Section 6032 of the DRA amended the Social Security Act, Title 42, United States Code, Section 1396(a) by inserting an additional relevant paragraph (68). This paragraph is cited below; in summary it requires any entities that receive or make annual payment under the Medicaid State Plan of at least five million dollars to have detailed, specific written policies established about the Federal and State False Claims Acts for their employees, agents and contractors.

Specifically, §1396(a)(68) of the Social Security Act requires that any entity that receives or makes annual payments under the State plan of at least \$5,000,000, as a condition of receiving such payments, shall –

- (A) establish written policies for all employees of the entity (including management), and of any contractor or agent of the entity, that provide detailed information about the False Claims Act established under section 3729 through 3733 of title 31, United States Code [31 USCS §3729-3733], administrative remedies for false claims and statements established under chapter 38 of title 31, United States Code [31 USCS §. 3801 et seq.], any State laws pertaining to civil or criminal penalties for false claims and statements, and whistleblower protections under such laws, with respect to the role of such laws in preventing and detecting fraud, waste, and abuse in Federal health care programs (as defined in section 1128B(f)[42 USCS § 1320-7b(f)]);
- (B) include as part of such written policies, detailed provisions regarding the entity's policies and procedures for detecting and preventing fraud, waste, and abuse; and
- (C) include in any employee handbook for the entity, a specific discussion of the laws described in subparagraph (A), the rights of the employees to be protected as whistleblowers, and the entity's policies and procedures for detecting and preventing fraud, waste, and abuse;

Effective January 1, 2007, all providers who meet the above conditions are required to certify that they are in compliance with §1396(a)(68) of the Social Security Act as a condition of enrollment in the North Carolina Medicaid Program.

As a North Carolina Medicaid provider, or the owner/ operator/ manager of a North Carolina Medicaid provider entity, I certify that our entity has read and understands the above requirements. I also certify that if our entity receives or makes annual payments under the State plan of at least \$5,000,000 we have complied with and established written policies and procedures that provide detailed information concerning the Federal False Claims Act, 31 USC 3729 *et seq.*, administrative remedies for false claims and statements established under 31 USCS §. 3801 *et seq.*, and any North Carolina State laws pertaining to civil or criminal penalties for false claims and statements, and whistleblower protections under such laws, with respect to the role of such laws in preventing and detecting fraud, waste, and abuse in Federal health care programs.

I further certify, when the above conditions apply, that our entity's written policies include detailed provisions regarding our policies and procedures for detecting and preventing fraud, waste, and abuse; and that our employee handbook contains a specific discussion of the Federal and State False Claims Acts, the rights of the employees to be protected as whistleblowers, and our policies and procedures for detecting and preventing fraud, waste, and abuse.

Copies of any and all training manuals, written policies and procedures for detecting and preventing fraud, waste, and abuse, and employee handbooks will be maintained on-site for a minimum of five (5) years for inspection and auditing by the Division of Medical Assistance

Signed _____ Date

Printed Name

Relationship to entity (owner, operator, manager, CFO, self, etc)

STATE USE ONLY Medicaid Provider Number: _____
--

Request for Taxpayer Identification Number and Certification

**Give form to the
requester. Do not
send to the IRS.**

Print or type See Specific Instructions on page 2.	Name (as shown on your income tax return)	
	Business name, if different from above	
	Check appropriate box: <input type="checkbox"/> Individual/Sole proprietor <input type="checkbox"/> Corporation <input type="checkbox"/> Partnership <input type="checkbox"/> Limited liability company. Enter the tax classification (D=disregarded entity, C=corporation, P=partnership) ▶ <input type="checkbox"/> Exempt payee <input type="checkbox"/> Other (see instructions) ▶	
	Address (number, street, and apt. or suite no.)	Requester's name and address (optional)
	City, state, and ZIP code	
	List account number(s) here (optional)	

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on Line 1 to avoid backup withholding. For individuals, this is your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the Part I instructions on page 3. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN* on page 3.

Social security number
or
Employer identification number

Note. If the account is in more than one name, see the chart on page 4 for guidelines on whose number to enter.

Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding, and
3. I am a U.S. citizen or other U.S. person (defined below).

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the Certification, but you must provide your correct TIN. See the instructions on page 4.

Sign Here	Signature of U.S. person ▶	Date ▶
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General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

Purpose of Form

A person who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) to report, for example, income paid to you, real estate transactions, mortgage interest you paid, acquisition or abandonment of secured property, cancellation of debt, or contributions you made to an IRA.

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN to the person requesting it (the requester) and, when applicable, to:

1. Certify that the TIN you are giving is correct (or you are waiting for a number to be issued),
2. Certify that you are not subject to backup withholding, or
3. Claim exemption from backup withholding if you are a U.S. exempt payee. If applicable, you are also certifying that as a U.S. person, your allocable share of any partnership income from a U.S. trade or business is not subject to the withholding tax on foreign partners' share of effectively connected income.

Note. If a requester gives you a form other than Form W-9 to request your TIN, you must use the requester's form if it is substantially similar to this Form W-9.

Definition of a U.S. person. For federal tax purposes, you are considered a U.S. person if you are:

- An individual who is a U.S. citizen or U.S. resident alien,
- A partnership, corporation, company, or association created or organized in the United States or under the laws of the United States,
- An estate (other than a foreign estate), or
- A domestic trust (as defined in Regulations section 301.7701-7).

Special rules for partnerships. Partnerships that conduct a trade or business in the United States are generally required to pay a withholding tax on any foreign partners' share of income from such business. Further, in certain cases where a Form W-9 has not been received, a partnership is required to presume that a partner is a foreign person, and pay the withholding tax. Therefore, if you are a U.S. person that is a partner in a partnership conducting a trade or business in the United States, provide Form W-9 to the partnership to establish your U.S. status and avoid withholding on your share of partnership income.

The person who gives Form W-9 to the partnership for purposes of establishing its U.S. status and avoiding withholding on its allocable share of net income from the partnership conducting a trade or business in the United States is in the following cases:

- The U.S. owner of a disregarded entity and not the entity,

- The U.S. grantor or other owner of a grantor trust and not the trust, and
- The U.S. trust (other than a grantor trust) and not the beneficiaries of the trust.

Foreign person. If you are a foreign person, do not use Form W-9. Instead, use the appropriate Form W-8 (see Publication 515, Withholding of Tax on Nonresident Aliens and Foreign Entities).

Nonresident alien who becomes a resident alien. Generally, only a nonresident alien individual may use the terms of a tax treaty to reduce or eliminate U.S. tax on certain types of income. However, most tax treaties contain a provision known as a “saving clause.” Exceptions specified in the saving clause may permit an exemption from tax to continue for certain types of income even after the payee has otherwise become a U.S. resident alien for tax purposes.

If you are a U.S. resident alien who is relying on an exception contained in the saving clause of a tax treaty to claim an exemption from U.S. tax on certain types of income, you must attach a statement to Form W-9 that specifies the following five items:

1. The treaty country. Generally, this must be the same treaty under which you claimed exemption from tax as a nonresident alien.
2. The treaty article addressing the income.
3. The article number (or location) in the tax treaty that contains the saving clause and its exceptions.
4. The type and amount of income that qualifies for the exemption from tax.
5. Sufficient facts to justify the exemption from tax under the terms of the treaty article.

Example. Article 20 of the U.S.-China income tax treaty allows an exemption from tax for scholarship income received by a Chinese student temporarily present in the United States. Under U.S. law, this student will become a resident alien for tax purposes if his or her stay in the United States exceeds 5 calendar years. However, paragraph 2 of the first Protocol to the U.S.-China treaty (dated April 30, 1984) allows the provisions of Article 20 to continue to apply even after the Chinese student becomes a resident alien of the United States. A Chinese student who qualifies for this exception (under paragraph 2 of the first protocol) and is relying on this exception to claim an exemption from tax on his or her scholarship or fellowship income would attach to Form W-9 a statement that includes the information described above to support that exemption.

If you are a nonresident alien or a foreign entity not subject to backup withholding, give the requester the appropriate completed Form W-8.

What is backup withholding? Persons making certain payments to you must under certain conditions withhold and pay to the IRS 28% of such payments. This is called “backup withholding.” Payments that may be subject to backup withholding include interest, tax-exempt interest, dividends, broker and barter exchange transactions, rents, royalties, nonemployee pay, and certain payments from fishing boat operators. Real estate transactions are not subject to backup withholding.

You will not be subject to backup withholding on payments you receive if you give the requester your correct TIN, make the proper certifications, and report all your taxable interest and dividends on your tax return.

Payments you receive will be subject to backup withholding if:

1. You do not furnish your TIN to the requester,
2. You do not certify your TIN when required (see the Part II instructions on page 3 for details),
3. The IRS tells the requester that you furnished an incorrect TIN,

4. The IRS tells you that you are subject to backup withholding because you did not report all your interest and dividends on your tax return (for reportable interest and dividends only), or

5. You do not certify to the requester that you are not subject to backup withholding under 4 above (for reportable interest and dividend accounts opened after 1983 only).

Certain payees and payments are exempt from backup withholding. See the instructions below and the separate Instructions for the Requester of Form W-9.

Also see *Special rules for partnerships* on page 1.

Penalties

Failure to furnish TIN. If you fail to furnish your correct TIN to a requester, you are subject to a penalty of \$50 for each such failure unless your failure is due to reasonable cause and not to willful neglect.

Civil penalty for false information with respect to withholding. If you make a false statement with no reasonable basis that results in no backup withholding, you are subject to a \$500 penalty.

Criminal penalty for falsifying information. Willfully falsifying certifications or affirmations may subject you to criminal penalties including fines and/or imprisonment.

Misuse of TINs. If the requester discloses or uses TINs in violation of federal law, the requester may be subject to civil and criminal penalties.

Specific Instructions

Name

If you are an individual, you must generally enter the name shown on your income tax return. However, if you have changed your last name, for instance, due to marriage without informing the Social Security Administration of the name change, enter your first name, the last name shown on your social security card, and your new last name.

If the account is in joint names, list first, and then circle, the name of the person or entity whose number you entered in Part I of the form.

Sole proprietor. Enter your individual name as shown on your income tax return on the “Name” line. You may enter your business, trade, or “doing business as (DBA)” name on the “Business name” line.

Limited liability company (LLC). Check the “Limited liability company” box only and enter the appropriate code for the tax classification (“D” for disregarded entity, “C” for corporation, “P” for partnership) in the space provided.

For a single-member LLC (including a foreign LLC with a domestic owner) that is disregarded as an entity separate from its owner under Regulations section 301.7701-3, enter the owner’s name on the “Name” line. Enter the LLC’s name on the “Business name” line.

For an LLC classified as a partnership or a corporation, enter the LLC’s name on the “Name” line and any business, trade, or DBA name on the “Business name” line.

Other entities. Enter your business name as shown on required federal tax documents on the “Name” line. This name should match the name shown on the charter or other legal document creating the entity. You may enter any business, trade, or DBA name on the “Business name” line.

Note. You are requested to check the appropriate box for your status (individual/sole proprietor, corporation, etc.).

Exempt Payee

If you are exempt from backup withholding, enter your name as described above and check the appropriate box for your status, then check the “Exempt payee” box in the line following the business name, sign and date the form.

Generally, individuals (including sole proprietors) are not exempt from backup withholding. Corporations are exempt from backup withholding for certain payments, such as interest and dividends.

Note. If you are exempt from backup withholding, you should still complete this form to avoid possible erroneous backup withholding.

The following payees are exempt from backup withholding:

1. An organization exempt from tax under section 501(a), any IRA, or a custodial account under section 403(b)(7) if the account satisfies the requirements of section 401(f)(2),
2. The United States or any of its agencies or instrumentalities,
3. A state, the District of Columbia, a possession of the United States, or any of their political subdivisions or instrumentalities,
4. A foreign government or any of its political subdivisions, agencies, or instrumentalities, or
5. An international organization or any of its agencies or instrumentalities.

Other payees that may be exempt from backup withholding include:

6. A corporation,
7. A foreign central bank of issue,
8. A dealer in securities or commodities required to register in the United States, the District of Columbia, or a possession of the United States,
9. A futures commission merchant registered with the Commodity Futures Trading Commission,
10. A real estate investment trust,
11. An entity registered at all times during the tax year under the Investment Company Act of 1940,
12. A common trust fund operated by a bank under section 584(a),
13. A financial institution,
14. A middleman known in the investment community as a nominee or custodian, or
15. A trust exempt from tax under section 664 or described in section 4947.

The chart below shows types of payments that may be exempt from backup withholding. The chart applies to the exempt payees listed above, 1 through 15.

IF the payment is for . . .	THEN the payment is exempt for . . .
Interest and dividend payments	All exempt payees except for 9
Broker transactions	Exempt payees 1 through 13. Also, a person registered under the Investment Advisers Act of 1940 who regularly acts as a broker
Barter exchange transactions and patronage dividends	Exempt payees 1 through 5
Payments over \$600 required to be reported and direct sales over \$5,000 ¹	Generally, exempt payees 1 through 7

¹ See Form 1099-MISC, Miscellaneous Income, and its instructions.

² However, the following payments made to a corporation (including gross proceeds paid to an attorney under section 6045(f), even if the attorney is a corporation) and reportable on Form 1099-MISC are not exempt from backup withholding: medical and health care payments, attorneys' fees, and payments for services paid by a federal executive agency.

Part I. Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. If you are a resident alien and you do not have and are not eligible to get an SSN, your TIN is your IRS individual taxpayer identification number (ITIN). Enter it in the social security number box. If you do not have an ITIN, see *How to get a TIN* below.

If you are a sole proprietor and you have an EIN, you may enter either your SSN or EIN. However, the IRS prefers that you use your SSN.

If you are a single-member LLC that is disregarded as an entity separate from its owner (see *Limited liability company (LLC)* on page 2), enter the owner's SSN (or EIN, if the owner has one). Do not enter the disregarded entity's EIN. If the LLC is classified as a corporation or partnership, enter the entity's EIN.

Note. See the chart on page 4 for further clarification of name and TIN combinations.

How to get a TIN. If you do not have a TIN, apply for one immediately. To apply for an SSN, get Form SS-5, Application for a Social Security Card, from your local Social Security Administration office or get this form online at www.ssa.gov. You may also get this form by calling 1-800-772-1213. Use Form W-7, Application for IRS Individual Taxpayer Identification Number, to apply for an ITIN, or Form SS-4, Application for Employer Identification Number, to apply for an EIN. You can apply for an EIN online by accessing the IRS website at www.irs.gov/businesses and clicking on Employer Identification Number (EIN) under Starting a Business. You can get Forms W-7 and SS-4 from the IRS by visiting www.irs.gov or by calling 1-800-TAX-FORM (1-800-829-3676).

If you are asked to complete Form W-9 but do not have a TIN, write "Applied For" in the space for the TIN, sign and date the form, and give it to the requester. For interest and dividend payments, and certain payments made with respect to readily tradable instruments, generally you will have 60 days to get a TIN and give it to the requester before you are subject to backup withholding on payments. The 60-day rule does not apply to other types of payments. You will be subject to backup withholding on all such payments until you provide your TIN to the requester.

Note. Entering "Applied For" means that you have already applied for a TIN or that you intend to apply for one soon.

Caution: A disregarded domestic entity that has a foreign owner must use the appropriate Form W-8.

Part II. Certification

To establish to the withholding agent that you are a U.S. person, or resident alien, sign Form W-9. You may be requested to sign by the withholding agent even if items 1, 4, and 5 below indicate otherwise.

For a joint account, only the person whose TIN is shown in Part I should sign (when required). Exempt payees, see *Exempt Payee* on page 2.

Signature requirements. Complete the certification as indicated in 1 through 5 below.

1. Interest, dividend, and barter exchange accounts opened before 1984 and broker accounts considered active during 1983. You must give your correct TIN, but you do not have to sign the certification.

2. Interest, dividend, broker, and barter exchange accounts opened after 1983 and broker accounts considered inactive during 1983. You must sign the certification or backup withholding will apply. If you are subject to backup withholding and you are merely providing your correct TIN to the requester, you must cross out item 2 in the certification before signing the form.

3. Real estate transactions. You must sign the certification. You may cross out item 2 of the certification.

4. Other payments. You must give your correct TIN, but you do not have to sign the certification unless you have been notified that you have previously given an incorrect TIN. "Other payments" include payments made in the course of the requester's trade or business for rents, royalties, goods (other than bills for merchandise), medical and health care services (including payments to corporations), payments to a nonemployee for services, payments to certain fishing boat crew members and fishermen, and gross proceeds paid to attorneys (including payments to corporations).

5. Mortgage interest paid by you, acquisition or abandonment of secured property, cancellation of debt, qualified tuition program payments (under section 529), IRA, Coverdell ESA, Archer MSA or HSA contributions or distributions, and pension distributions. You must give your correct TIN, but you do not have to sign the certification.

What Name and Number To Give the Requester

For this type of account:	Give name and SSN of:
1. Individual	The individual
2. Two or more individuals (joint account)	The actual owner of the account or, if combined funds, the first individual on the account ¹
3. Custodian account of a minor (Uniform Gift to Minors Act)	The minor ²
4. a. The usual revocable savings trust (grantor is also trustee)	The grantor-trustee ¹
b. So-called trust account that is not a legal or valid trust under state law	The actual owner ¹
5. Sole proprietorship or disregarded entity owned by an individual	The owner ³
For this type of account:	Give name and EIN of:
6. Disregarded entity not owned by an individual	The owner
7. A valid trust, estate, or pension trust	Legal entity ⁴
8. Corporate or LLC electing corporate status on Form 8832	The corporation
9. Association, club, religious, charitable, educational, or other tax-exempt organization	The organization
10. Partnership or multi-member LLC	The partnership
11. A broker or registered nominee	The broker or nominee
12. Account with the Department of Agriculture in the name of a public entity (such as a state or local government, school district, or prison) that receives agricultural program payments	The public entity

¹ List first and circle the name of the person whose number you furnish. If only one person on a joint account has an SSN, that person's number must be furnished.

² Circle the minor's name and furnish the minor's SSN.

³ You must show your individual name and you may also enter your business or "DBA" name on the second name line. You may use either your SSN or EIN (if you have one), but the IRS encourages you to use your SSN.

⁴ List first and circle the name of the trust, estate, or pension trust. (Do not furnish the TIN of the personal representative or trustee unless the legal entity itself is not designated in the account title.) Also see *Special rules for partnerships* on page 1.

Note. If no name is circled when more than one name is listed, the number will be considered to be that of the first name listed.

Secure Your Tax Records from Identity Theft

Identity theft occurs when someone uses your personal information such as your name, social security number (SSN), or other identifying information, without your permission, to commit fraud or other crimes. An identity thief may use your SSN to get a job or may file a tax return using your SSN to receive a refund.

To reduce your risk:

- Protect your SSN,
- Ensure your employer is protecting your SSN, and
- Be careful when choosing a tax preparer.

Call the IRS at 1-800-829-1040 if you think your identity has been used inappropriately for tax purposes.

Victims of identity theft who are experiencing economic harm or a system problem, or are seeking help in resolving tax problems that have not been resolved through normal channels, may be eligible for Taxpayer Advocate Service (TAS) assistance. You can reach TAS by calling the TAS toll-free case intake line at 1-877-777-4778 or TTY/TDD 1-800-829-4059.

Protect yourself from suspicious emails or phishing schemes.

Phishing is the creation and use of email and websites designed to mimic legitimate business emails and websites. The most common act is sending an email to a user falsely claiming to be an established legitimate enterprise in an attempt to scam the user into surrendering private information that will be used for identity theft.

The IRS does not initiate contacts with taxpayers via emails. Also, the IRS does not request personal detailed information through email or ask taxpayers for the PIN numbers, passwords, or similar secret access information for their credit card, bank, or other financial accounts.

If you receive an unsolicited email claiming to be from the IRS, forward this message to phishing@irs.gov. You may also report misuse of the IRS name, logo, or other IRS personal property to the Treasury Inspector General for Tax Administration at 1-800-366-4484. You can forward suspicious emails to the Federal Trade Commission at: spam@uce.gov or contact them at www.consumer.gov/idtheft or 1-877-IDTHEFT(438-4338).

Visit the IRS website at www.irs.gov to learn more about identity theft and how to reduce your risk.

Privacy Act Notice

Section 6109 of the Internal Revenue Code requires you to provide your correct TIN to persons who must file information returns with the IRS to report interest, dividends, and certain other income paid to you, mortgage interest you paid, the acquisition or abandonment of secured property, cancellation of debt, or contributions you made to an IRA, or Archer MSA or HSA. The IRS uses the numbers for identification purposes and to help verify the accuracy of your tax return. The IRS may also provide this information to the Department of Justice for civil and criminal litigation, and to cities, states, the District of Columbia, and U.S. possessions to carry out their tax laws. We may also disclose this information to other countries under a tax treaty, to federal and state agencies to enforce federal nontax criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism.

You must provide your TIN whether or not you are required to file a tax return. Payers must generally withhold 28% of taxable interest, dividend, and certain other payments to a payee who does not give a TIN to a payer. Certain penalties may also apply.