

WISCONSIN MEDICAID SELF-DIRECTED SUPPORTS PROVIDER AGREEMENT AND ACKNOWLEDGEMENT OF TERMS OF PARTICIPATION

(For Waiver Service Provider Agencies)

INDIVIDUAL OR NON-TRADITIONAL PROVIDER AGREEMENT¹

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 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 county waiver administrative agency.
2. To accept the payment issued by the county waiver administrative agency 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 county waiver administrative agency.
5. To keep records of the items or services provided.
6. To provide, upon request by the county waiver administrative agency or DHFS 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.
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** (http://dhfs.wisconsin.gov/dcms_info/num_memos/2001/2001-07.HTM) and to furnish upon request to the Department, the Secretary of 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..
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, among other things the provider shall furnish 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 another as spouse, parent, child, or sibling;

¹ Note: This agreement is intended to be used for providers who are individuals, or by a company that provides services that are not typically provided to waiver clients.

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- d) The names, addresses, and any significant business transactions between the provider and any subcontractor;
 - e) The identity of any person 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 county 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 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

SIGNATURE – Provider	Date Signed
SIGNATURE – Waiver Participant	Date Signed
