Developmental Disabilities Independent Provider Enrollment Application and Agreement

(Revised 10/13/2016)

This Provider Enrollment Application and Agreement (the Agreement) sets forth the conditions and agreements for being enrolled as a Medicaid Independent Provider (non-PSW; hereinafter referred to as Provider) with the Department of Human Services (DHS). Under the terms of this Agreement, the Provider will receive a Provider number, as required in order to receive an authorization for services, submit payment claims, and to receive payment for Community Service Payments. Community Service Program services are provided to persons with intellectual or developmental disabilities (hereinafter referred to as Recipients). Payments for services are made using federal Medicaid or State of Oregon funds or a combination of both state and federal funds.

As a condition for participation as a Medicaid independent provider with DHS for Community Service Programs, Provider agrees to comply with all provisions of Oregon Administrative Rules (OAR) chapter 411, divisions, 317, 318, 345, 375, and 411-435-0050(9) and chapter 407, division 025, as applicable to the specific services provided and the individual being served, and which rules may be amended from time to time and which are hereby incorporated into this Agreement by reference. Provider also agrees to comply with the conditions outlined in this Agreement.

Provider must complete all sections of this Agreement. If the answer is 'none' or 'n/a' indicate that in the section.

Type of action requested

- ☐ New enrollment
- ☐ Provider name change, provider #:
- ☐ Renewal or re-enrollment, provider #:
- ☐ Revalidation (only when requested by DHS), provider #:

Provider Type (Services you intend to provide)

- ☐ Behavior Consultation OAR 411-435-0050(9) (83-710)
- ☐ Discovery OAR chapter 411, division 345 (74-749)
- ☐ Job Development OAR chapter 411, division 345 (74-749)

Provider information

Provider Legal Name (First, middle, last as shown on SS Card)

Business Name/DBA (if applicable, exactly as filed with the Oregon Secretary of State Corporation Division):

___ Initial here to confirm that, if operating as a business, the applicant is the sole owner of the business.

Indicate the type of business, if applicable:

- ☐ For profit corporation
- ☐ Sole proprietorship
- ☐ Limited liability company
- ☐ Partnership** (requires the use of a Developmental Disabilities Agency Medicaid Provider Enrollment Application and Agreement)

Provider DOB	Provider SSN
Provider Physical Address	City, State, Zip+4
County	Provider Phone Number
Provider Mailing Address	City, State, Zip+4
County	Provider Fax Number
Provider Email Address	Provider Website
EIN (If EIN rather than SSN used for tax purposes)	Legal Name Associated to EIN

Criminal Offenses (Exclusion and Suspension)

A.	Do you now have or have you ever had an ownership in, controlling interest in or been an agent or managing employee of an entity that has been convicted of a criminal offense related to that person's or entity's involvement in any program under Medicare, Medicaid, or title XXI services program since the inception of those programs? ☐ Yes ☐ No
B.	Are you now or have you ever been terminated, suspended or excluded from participation as a provider in Medicare or any state Medicaid or CHIP program? ☐ Yes ☐ No
C.	Have you ever been convicted of fraud or financial improprieties? ☐ Yes ☐ No

1. Provider understands and agrees that all information submitted herein or in support of this Agreement is true and accurate. Information disclosed by the Provider may be subject to verification. Provider must notify DHS of any changes to the information contained in this Agreement within 30 days of the date of the change. Provider understands DHS may terminate this Agreement if it determines that the Provider did not fully and accurately make any disclosure required in this Agreement or if the Provider fails to notify DHS of any changes within 30 days. Any deliberate omission, misrepresentation or falsification of any information contained in this Agreement or contained in any communication supplying information to DHS may be punished by administrative or criminal law or both, including but not limited to revocation of the Provider's Agreement that is required to deliver Community Service Program services to persons with intellectual and developmental disabilities and receive payment for Medicaid services.

2. Provider certifies it complies with the qualifications listed in the Exhibit associated with the Provider Type(s) indicated above, and attached hereto, and agrees to comply with all applicable training, licensing, certification and regulatory requirements as set forth by federal and state statutes, regulations, and rules necessary to provide services to Recipients.

3. Provider understands and agrees that prior authorization by the Department or its designee is required before providing services to any Recipient and that payment will not be valid if prior authorization was not granted. Verification of the authorization is the responsibility of the Provider.

4. Provider agrees to provide services as documented in the service agreement or ISP as necessary to ensure the health, safety and well-being of Recipients and to promote their independence, community integration and productivity. Provider agrees payment may be denied or subject to recovery if care, services or supports were not authorized or not provided in accordance with the program-specific rules and this Agreement.

5. Provider agrees to accept the rate authorized by DHS as payment in full and will not charge the Recipient, or any person responsible for the Recipient, any additional amounts for Provider's services, other than the permissible charges authorized or required by administrative rule. Provider understands and further agrees that payment cannot be made to any individual or entity that has been excluded from participation in federal or state programs. As a condition of payment, **Provider must meet and maintain compliance with the Provider Rules, OAR 407-120-0300 through 407-120-0380 and 407-120-1505. Any changes to the provider information included above must be provided to DHS within 30 days of the change.**

6. Provider agrees to participate in and cooperate with the approaches used by the DHS, OHA and its representatives to promote the integrity and quality of the Community Services Program. Provider agrees to respond to the actions or improvements required as a result of program integrity and quality assurance activities.

7. Provider agrees that by signature of the Provider, including electronic signature on an invoice form, on a claim in eXPRS, or transmittal document, that the services claimed were actually provided and appropriate; were documented; and were provided in accordance with the highest industry standards and applicable administrative rules governing the specific services. In the event of a conflict between the highest industry standards and the applicable administrative rules, Provider shall comply with the stricter standard. The Provider is solely responsible for the accuracy of claims submitted, and the use of a billing entity does not alter the Provider's responsibility for the claims submitted on Provider's behalf. Any overpayment made to Provider by DHS may be recouped by DHS including, but not limited to, withholding of future payments or other process as authorized by law. Services shall be billed and payments will be made in accordance with OAR chapter 411, division 375. DHS is not liable for any claim billed after one calendar year from the date of service.

8. Provider may terminate this Agreement at any time by submitting a written notice in person or by certified mail to DHS with the specific date on which termination will take place. Notification must be submitted a minimum of 90 days prior to the termination date unless otherwise provided by OAR chapter 411, division 375, program-specific or other DHS rule, or with the agreement of DHS.

9. DHS may terminate this Agreement at any time by submitting a written notice in person or by certified mail with the specific date on which termination will take place.

10. Provider understands and agrees Provider is not employed by the State of Oregon or any division of DHS or any Community Services Program (including any Community Developmental Disabilities Program (CDDP) or Brokerage) and shall not for any purpose be deemed an employee of the State of Oregon, any CDDP or Brokerage. Provider is responsible for maintaining current criminal history check and any applicable training required to deliver service. Provider is solely responsible for its acts or omissions. Provider agrees it is responsible for maintaining and submitting updated/new Criminal History Checks and, as applicable, OIS Certification to ODDS.ProviderEnrollment@state.or.us.

11. **PROVIDER SHALL INDEMNIFY AND DEFEND THE STATE OF OREGON, CDDPS, BROKERAGES OR THEIR FISCAL INTERMEDIARIES, THEIR RESPECTIVE AGENCIES AND THEIR OFFICERS, EMPLOYEES AND AGENTS FROM AND AGAINST ALL CLAIMS, SUITS, ACTIONS, LOSSES, DAMAGES, LIABILITIES, COSTS AND EXPENSES OF ANY NATURE WHATSOEVER ARISING OUT OF, OR RELATING TO THE PROVIDER'S ACTS OR OMISSIONS UNDER THIS AGREEMENT.**

12. Provider shall obtain the insurance and in the amounts set forth in the insurance requirements in Exhibit A and provide proof of such insurance to DHS upon request.

14. Provider agrees it will make itself available to more than one Recipient.

15. Provider agrees it has fully read and understands this Agreement. This Agreement becomes effective upon the date Provider signs the Agreement and will terminate two years from that date or immediately upon the expiration date of any required certification or license as identified in the Exhibit associated with the Provider Type(s) indicated above, whichever date is sooner, unless terminated earlier in accordance with this Agreement.

16. Provider cannot subcontract, delegate, or otherwise assign work to any other owner, employee, partner, person, or entity that is not independently eligible and enrolled to provide the service. Provider agrees that they have no co-owners, employees or subcontractors and agrees it will be required to become certified as an agency prior to hiring any staff.

You may choose to enroll as a provider through the Oregon Health Authority. If you are interested in enrolling with the Oregon Health Authority, please visit this website: www.oregon.gov/OHA/healthplan/pages/providerenroll.aspx.

Provider signature

Knowingly and willfully failing to fully and accurately disclose the information requested may result in denial of a request to enroll or contract, or if the licensee/owner already is enrolled, a termination of its Medicaid provider agreement or contract.

By signing, I hereby certify and swear under penalty of perjury that (a) I have knowledge concerning the information above, and (b) the information above is true and accurate. I agree to inform DHS or its designee, in writing, within 30 days of any changes or if additional information becomes available.

Name of Provider	Title
Signature of Provider	Date

The Department limits its request for and use of taxpayer identification numbers, including SSNs, to those purposes authorized by law and as described in this notice. The Oregon Consumer Identity Theft Protection Act permits DHS to collect and use SSN's to the extent authorized by federal or state law.

For the purpose of reporting on IRS Form 1099, providers must submit the employee identification number (EIN) or if none, then the provider's SSN. Taxpayer identification numbers for the provider, including SSN for the provider, individuals or entities other than the provider, are subject to mandatory disclosure for purposes of the Disclosure of Ownership and Control Interest Statement, as authorized by OAR 407-120-0320(5)(c) and OAR 410-141-0120.

Failure to submit the requested taxpayer identification number(s) may result in a denial of enrollment as a provider and issuance of the provider number, or denial of continued enrollment as a provider and deactivation of all provider numbers used by the provider to obtain reimbursement from DHS or for encounter purposes.

Upon completion of this Agreement, print, sign and submit the entirety of this Agreement along with all required supporting documentation to:
ODDS.ProviderEnrollment@state.or.us
OR
Fax 503-947-5357, Attention: Provider Relations Unit, Independent Provider Enrollment PEAA

EXHIBIT A

PROVIDER INSURANCE REQUIREMENTS

Required Insurance: Provider shall obtain at Provider's expense the insurance specified in this Exhibit A, prior to performing any services under this Agreement and maintain the required insurance in full force and at its own expense throughout the duration of this Agreement and all warranty periods. Provider shall obtain the following insurance from insurance companies or entities that are authorized to transact the business of insurance and issue coverage in Oregon and that are acceptable to DHS.

1) **Professional Liability:**

☒ **Required by DHS** ☐ **Not required by DHS**

Professional Liability Insurance covering any damages caused by an error, omission or any negligent acts related to the services to be provided under this Agreement. Provider shall provide proof of insurance of not less than the following amounts as determined by the DHS:

☒ Per occurrence limit for any single claimant: $1,000,000.

☒ Annual aggregate limit for multiple occurrences and multiple claimants: $3,000,000.

2) **Commercial General Liability:**

☒ **Required by DHS** ☐ **Not required by DHS**

Commercial General Liability Insurance covering bodily injury, death and property damage in a form and with coverage satisfactory to the State. This insurance shall include personal injury liability, products and completed operations. Coverage shall be written on an occurrence basis. Provider shall provide proof of insurance of not less than the following amounts as determined by the DHS:

☒ Per occurrence limit for any single claimant: $1,000,000.

☒ Annual aggregate limit for multiple occurrences and multiple claimants: $2,000,000.

AND

Property Damage:

☒ Per occurrence limit for any single claimant: $200,000.

☒ Per occurrence limit for multiple claimants: $600,000.

☐ **EXEMPT:** Provider may be waived from the listed General Liability Insurance requirements if Provider attests that services will not be provided in the provider's office or business location.

______ (Initial) By *checking the EXEMPT box* *and* *initialing, provider is attesting that they will not be providing services in the provider's office or business location.*

3) **Automobile Liability Insurance:**

☒ **Required by DHS** ☐ **Not required by DHS**

Automobile Liability Insurance covering all owned, non-owned, or hired vehicles. This coverage may be written in combination with the Commercial General Liability Insurance (with separate limits for "Commercial General Liability" and "Automobile Liability"). Provider shall provide proof of insurance of not less than the following amounts as determined by the DHS:

Bodily Injury/Death:

☒ Per occurrence limit for any single claimant: $2,000,000.

☒ Per occurrence limit for multiple claimants: $4,000,000.

AND

Property Damage:

☒ Per occurrence limit for any single claimant: $200,000.

☒ Per occurrence limit for multiple claimants: $600,000.

☐ **EXEMPT:** Provider may be waived from the listed Automobile Liability Insurance requirements if Provider will not be providing transportation in the course of service delivery as a consultant.

______ (Initial) By *checking the EXEMPT box* *and* *initialing, provider is attesting that they will not be providing transportation as part of performing consultation services to Recipients.*

4) **ADDITIONAL INSURED.** The Commercial General Liability insurance and Automobile Liability insurance must include the State of Oregon, its officers, employees and agents as Additional Insureds but only with respect to the Provider's activities to be performed under the agreement. Coverage must be primary and non-contributory with any other insurance and self-insurance.

"TAIL" COVERAGE. If any of the required insurance policies is on a "claims made" basis, such as professional liability insurance, the Provider shall maintain either “tail" coverage or continuous "claims made" liability coverage, provided the effective date of the continuous “claims made” coverage is on or before the effective date of the Agreement, for a minimum of 24 months following the later of : (i) the Provider’s completion and DHS ’s acceptance of all Services required under the Agreement or, (ii) the expiration of all warranty periods provided under the Agreement. Notwithstanding the foregoing 24-month requirement, if the Provider elects to maintain “tail” coverage and if the maximum time period “tail” coverage reasonably available in the marketplace is less than the 24-month period described above, then the Provider may request and DHS may grant approval of the maximum “tail” coverage period reasonably available in the marketplace. If DHS approval is granted, the Provider shall maintain “tail” coverage for the maximum time period that “tail” coverage is reasonably available in the marketplace.

5) **NOTICE OF CANCELLATION OR CHANGE.** The Provider or its insurer must provide 30 days’ written notice to DHS before cancellation of, material change to, potential exhaustion of aggregate limits of, or non-renewal of the required insurance coverage(s).

6) **CERTIFICATE(S) OF INSURANCE.** DHS shall receive from the Provider a certificate(s) of insurance for all required insurance from upon request from DHS. The certificate(s) or an attached endorsement must specify: i) all entities and individuals who are endorsed on the policy as Additional Insured and ii) for insurance on a “claims made” basis, the extended reporting period applicable to “tail” or continuous “claims made” coverage.

EXHIBIT B
Qualification & Documentation Requirements for a Behavior Consultant

1. Education/Experience.

a. At minimum, a Bachelor's degree in one or more of the following fields: Special Education, Psychology, Speech Therapy, Occupational Therapy, Recreation, Art or Music Therapy, Child Development, Human Development and Family Sciences, General Human Services AND at least one year of experience with individuals who present with difficult or dangerous behaviors;
OR

b. Three years of experience with individuals who present difficult or dangerous behaviors AND at least one year of that experience must include providing the services of a Behavior Consultant.

2. Behavior Consultant Requirements

a. Have the skills and abilities necessary to provide Behavior Consultation services, including knowledge and experience in developing Behavior Support Plans based on Positive Behavior Theory and Practice;

b. Must have a current OIS certificate with a minimum of a G level training. This is a minimum of two days training in the Oregon Intervention System (OIS) and have a current OIS certificate.

c. Any Behavior Consultant including physical intervention, physical maneuvers, or emergency intervention strategies in a plan must be certified as an Oregon Intervention System (OIS) instructor.

d. Submit with the Provider Enrollment Agreement a copy of the current OIS certificate(s) and a resume demonstrating how the Behavior Consultant meets the requirements in Section 1 of this Exhibit C.

e. Complete the background check process under the position title of a 'Behavioral Consultant' as described in OAR 407-007-0200 to 407-007-0370. Applicant must have an outcome of approved or approved with restrictions and submit a copy of the approval letter.

f. Provider must maintain an approved PEAA, OIS Certification and criminal history check. Providers who allow any of these to lapse, irrespective of approved Provider Enrollment Agreement or provider number, will result in a denial or overpayment for the service.[1]

g. As licenses or certifications are updated Provider must submit a copy of the updated documentation to DHS.

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[1] ***NOTE:*** *The term of the Provider Enrollment Agreement will be limited to the date of expiration of any required certification or license. Provider will need to reapply to renew their provider number and submit a current certificate or license to continue to bill, and receive payment, for Medicaid services.*

EXHIBIT C
Qualification & Documentation Requirements for Job Development

a. Complete the background check process described in OAR 407-007-0200 to 407-007-0370. Applicant must have an outcome of approved or approved with restrictions and submit a copy of the approval letter.
b. Submit with this Provider Enrollment all other current provider enrollment agreements (i.e. if Job Coaching services are provided as a Personal Support Worker).
c. Meet or exceed the requirements in OAR chapter 411, division 345.
d. Submit a copy of the current contract held to provide Vocational Rehabilitation services, including the certificate for completing the EOP II training program. If not submitted prior to the activation of the provider number, this must be submitted within 365 days of the activation of the provider number or this agreement will be automatically terminated.
e. Submit documentation to demonstrate the Provider initial 90 day training requirement has been met as outlined under OAR chapter 411, division 345. If not submitted prior to the activation of the provider number, this must be submitted within 90 days of the activation of the provider number or this Agreement will be automatically terminated.
f. Submit documentation to demonstrate the Provider annual training requirement has been met. This must be submitted every two years, upon re-enrollment, or this Agreement will not be renewed.
g. Submit documentation to demonstrate the Provider credentialing requirements have been met (i.e., the independent contractor holds the APSE CESP certificate or a Department-approved substantial equivalent).

†**NOTE:** *The term of the Provider Enrollment Agreement will be limited to the date of expiration of any required certification or license. The Provider will need to reapply to renew a provider agreement and provider number and submit a current certificate or license to continue to bill, and receive payment, for Medicaid services.*

EXHIBIT D
Qualification & Documentation Requirements for
Job Discovery

a. Complete the background check process described in OAR 407-007-0200 to 407-007-0370. Applicant must have an outcome of approved or approved with restrictions and submit a copy of the approval letter.
b. Submit with this Provider Enrollment all other current provider enrollment agreements (i.e. if Job Coaching services are provided as a Personal Support Worker).
c. Meet or exceed requirements in OAR chapter 411, division 345.
d. Submit a copy of the current contract held to provide Vocational Rehabilitation services, including the certificate for completing the EOP II training program. If not submitted prior to the activation of the provider number, this must be submitted within 365 days of activation of the provider number or this agreement will be automatically terminated.
e. Submit documentation to demonstrate the provider initial training requirement has been met as outlined under OAR chapter 411, division 345.
f. Submit documentation to demonstrate the provider annual training requirement has been met. This must be submitted every two years, upon re-enrollment, or this agreement will not be renewed.
g. Submit documentation to demonstrate the provider credentialing requirements have been met (i.e. the independent contractor holds the APSE CESP certificate or a Department-approved substantial equivalent).
h. Submit a copy of the Discovery Profile you intend to use (this may be done electronically through the Discovery provider survey).
i. Submit all other qualification information requested in the online Discovery provider survey.

†**NOTE:** *The term of the Provider Enrollment Agreement will be limited to the date of expiration of any required certification or license. The Provider will need to reapply to renew a provider agreement and provider number and submit a current certificate or license to continue to bill, and receive payment, for Medicaid services.*