MISSOURI DEPARTMENT OF SOCIAL SERVICES
MISSOURI MEDICAID AUDIT AND COMPLIANCE

PARTICIPATION AGREEMENT FOR ADULT DAY CARE SERVICES

BY MY SIGNATURE BELOW, I, THE APPLYING PROVIDER, READ AND AGREE THAT, upon the acceptance of my enrollment, I will participate in the Vendor Payment plan for Adult Day Care Services. I am responsible for all services provided and all billing done under my provider number regardless to whom the reimbursement is paid. It is my legal responsibility to ensure that the proper billing code is used and indicate the length of time I actually spend providing a service regardless to whom the reimbursement is paid. I agree to be financially responsible for all services which are not documented. I agree the Provider Manual, bulletins, rules, regulations and amendments thereto shall govern and control my delivery of service, and further agree to the following terms:

1. I (the provider) agree that it is my responsibility to access manual materials that are available from the MO HealthNet Division over the internet. I will comply with the Medicaid manual, bulletins, rules and regulations as required by the Missouri Medicaid Audit and Compliance Unit (MMAC) and the United States Department of Health and Human Services in the delivery of services and merchandise and in submitting claims for payment. I understand that in my field of participation I am not entitled to Medicaid reimbursement if I fail to so comply, and that I can be terminated from the program for failure to comply;
2. The rate of reimbursement for services will be made in accordance with a fixed fee per unit of service, as defined and determined by the MO HealthNet Division to be based on an efficient and economical provider of these services, and that charges will not exceed those to the general public for identical services. An associated provider as defined in Sec. (1)(G) of 13 CSR 40-81.126 will receive the fixed fee less and offset for expenses as defined in subsection (4)(B) of 13 CSR 40-81.126;
3. Signing this agreement will allow the provider to use either a paper or electronic claim processing method. Providers who choose to use electronic claim processing must have their electronic claim processing program tested by the fiscal agent before electronic processing can be approved.
   The provider agrees that the selection of an electronic claim processing method in no way modifies any requirements of the Missouri Medicaid program policies or procedures except those dealing with claim submission. All data elements required by DSS for paper claims are required for claims submitted electronically. Those claims not meeting required specification will not be processed.
   In the event that the provider is placed on prepayment review by DSS, as authorized by State Regulation 13 CSR 70-3.030, the provider agrees to submit all claims on paper until notified by DSS that electronic billing can resume;
4. No collection for Title XIX covered services will be made from the recipient-patient, his or her spouse, parent, guardian, relative or anyone else receiving public assistance, and if any payment is received or assured from any other source on the recipient-patient's account, that amount will be deducted from the claim filed with Title XIX Medicaid. Any payment so received after provider payment is made by Title XIX shall be reported to the MO HealthNet Division for appropriate adjustment action;
5. All parties agree to comply with the 1964 Civil Rights Act, as amended; Section 504 of the Rehabilitation Act of 1973; the Age Discrimination Act of 1975; the Omnibus Reconciliation Act of 1981 and the Americans with Disabilities Act of 1990 and all other applicable State and Federal Laws which prohibit discrimination in the delivery of services on the basis of race, color, national origin, age, sex, handicap/disability or religious beliefs. Further, all parties agree to comply with Title VII of the Civil Rights Act of 1964 which prohibits discrimination in employment on the basis of race, color, national origin, age, sex, handicap/disability or religious beliefs;
6. All providers are required to maintain fiscal and medical records to fully disclose services rendered to Title XIX Medicaid participants. These records shall be retained for five (5) years, and shall be made available on request by an authorized representative of the DSS, Department of Health and Senior Services or the U.S. Department of Health and Human Services. Documents retained must include all records and documents required by applicable regulation and Medicaid manual and bulletin provisions. All services billed through the Medicaid Program are subject to post-payment review. This may include unannounced on-site review of records. Failure to submit or failure to retain documentation for all services billed to the Medicaid Program may result in recovery of payments for Medicaid services and may result in sanctions to the provider's Medicaid participation;
7. Medicaid participation under this agreement may be terminated by either party upon written notice mailed to either the provider's most recent address recorded in the Medicaid enrollment files or MMAC. The written notice shall state the reason(s) for the termination. Such reason(s) could include the provider being in violation of (a) this agreement, (b) Medicaid claim certification statement, (c) rules, regulations, policies or procedures of the MO HealthNet Division, or (d) State or Local Regulations or Laws which also apply, i.e., fire codes and health codes. All corporations must be registered with the Secretary of State, Corporate Division, and be certified in good standing. The provider must be in compliance with all other applicable state or federal laws or regulations. Violation of any law or regulation may result in this agreement being terminated immediately upon mailing of the written notice from the MMAC;
8. If at any time state or federally appropriated funds available to the MO HealthNet Division for payment to the provider for covered services under this agreement are insufficient to pay the full amount due, the provider agrees to accept payments reduced in proportion to the funding deficiency.

SIGNATURE OF AUTHORIZED SIGNER: The authorized signer of this document verifies that he/she is an individual or the representative of the Provider and is the duly authorized agent to execute the agreement on behalf of the Provider under authority granted by said Provider.

⇨ DATE SIGNED:

TYPE OR PRINT NAME OF PERSON SIGNING	TYPE OR PRINT NAME OF ADULT DAY CARE

GEOGRAPHIC AREA(S) SERVED (by county)