MISSOURI DEPARTMENT OF SOCIAL SERVICES
MISSOURI MEDICAID AUDIT AND COMPLIANCE
PROVIDER CONTRACTS

IN-HOME SERVICES ASSURANCES

Questions #1, #2 and #3 must be answered. Disclose all associations with any currently enrolled provider(s) under #1and previous enrolled provider(s) under #2. If the question does not apply, write N/A; if disclosing - include individuals name(s), provider(s) name and type of service

LEGAL PROVIDER NAME AS FILED WITH THE IRS AND SECRETARY OF STATE, INCLUDING DBA NAME (SOLE PROPRIETORS, INCLUDE NAME AND DBA NAME)
1. Disclose all persons, individuals or business entities identified within the proposal or involved with the applying provider that **are currently contracted/enrolled** with the Missouri Medicaid Audit and Compliance Unit (MMAC) or Department of Department of Health and Senior Services, Division of Senior and Disability Services (DSDS) or its designee (hereafter state agencies) to provide any other service. List the type of service and the name of the company. If revalidating - disclose current enrollment here
2. Disclose all persons, individuals or business entities identified within the proposal or involved with the business entity that **have been previously (no longer) contracted** with the state agencies. List the name of the company and the position held.
3. Disclose all persons, individuals or business entities identified within the proposal or involved with the business entity that have been sanctioned, suspended, terminated from participation, or denied enrollment in Medicaid, Medicare, SSBG/GR, or any other government public assistance program.
4. Applying provider understands and agrees to respond to messages received after business hours from participants and the state agencies within two hours of receipt.
5. Applying provider understands and agrees to maintain a working computer at its main office location with access to the internet in order to retrieve information posted on the website by the state agencies and to transmit information to and from the state agencies.
6. Applying provider understands and agrees to maintain an e-mail account that is known to MMAC in order to communicate with the state agencies. Applying provider further understands and agrees to check the e-mail account periodically throughout each business day.
7. Applying provider understands and agrees to maintain subscription to DSDS E-News (http://health.mo.gov/seniors/hcbs/).
8. Applying provider understands and agrees to maintain subscription MO HealthNet News (http://dss.mo.gov/mhd/providers/index.htm).
9. Applying provider understands and agrees to notify MMAC via the Change Request form (https://mmac.mo.gov/providers/provider-enrollment/home-and-community-based-services/provider-contracts-forms/) of changes in office location, business hours, telephone number, e-mail address, service area, key personnel, ownership, etc. in compliance with the Program Requirements.
10. Applying provider understands and agrees to maintain service delivery on holidays, weekends, and in the event of inclement weather, worker absence, vacation, or labor shortage in compliance with 19 CSR 15-7.021.
11. Applying provider understands and agrees to develop policies and procedures and ensure service delivery to participants during times of natural or man-made disasters. The policies/procedures must include working with the DHSS/DSDS, prioritizing/assisting participants and working with the local emergency operation centers.
12. Applying provider understands and agrees to post the Elder Abuse & Neglect Hotline number (800/392-0210) in each of its office locations.
13. Applying provider understands and agrees to maintain employment of a Registered Nurse (RN) who will be available during hours of operation to address nursing issues. In addition to all screening requirements, the RN must meet the hiring requirements and perform duties in compliance with 19 CSR 15-7.021; 19 CSR 15-7.021; 13 CSR 70-91.010 and 13 CSR 70-91.010.
14. Applying provider understands and agrees to perform reference checks for all applicants in compliance with 19 CSR 15-7.021.

15. Applying provider understands and agrees to verify certifications, licenses and degrees of all personnel and agrees to perform ongoing verification in compliance with 19 CSR 15-7.021; the Program Requirements and the MO HealthNet Division Personal Care Provider Manual and the Program Requirements.

16. Applying provider understands and agrees to maintain the proper insurance coverage at all times in compliance with 19 CSR 15-7.021 and the Program Requirements.

17. Applying provider understands and agrees to authorize its insurance carrier, broker, agent and/or premium finance company to release information regarding required insurance coverage to MMAC.

18. Applying provider understands and agrees to comply with requirements of the Drug Free Workplace Act of 1990.

19. Applying provider understands and agrees to comply with requirements of the E-Verify federal work authorization program. Information regarding E-Verify is available at http://www.dhs.gov/files/programs/gc_1185221678150.shtm.

20. Applying provider understands and agrees to comply with all applicable rules and laws administered by the Occupational Safety and Health Administration (OSHA), including the provision of medical supplies to ensure universal precautions, including, but not limited to, gloves.

21. Applying provider understands and agrees to comply with all applicable Health Insurance Portability and Accountability Act of 1996 (HIPAA) regulations and all amendments thereafter.

22. Applying provider understands and agrees to comply with all applicable federal and state laws, regulations and executive orders regarding employment practices including, but not limited to:
    - Fair Labor Standards Act, as amended
    - Title VII of the Civil Rights Act of 1991, as amended
    - Americans with Disabilities Act of 1990, as amended

23. The applying provider understands and agrees that a site visit will be conducted prior to a final decision regarding the award of a contract. Site visits will include a question and answer session with the applying provider's director, designated manager and RN supervisor. Staff must be knowledgeable of the requirements of the program.

24. The applying provider understands and agrees that the submission of a proposal does not guarantee MMAC's acceptance or approval of the proposal or that a contract or Medicaid enrollment to provide services will be awarded.

25. The applying provider understands and agrees that denial of a contract and/or subsequent Medicaid enrollment is the sole and final decision of MMAC. Decisions are made based on a variety of information including the proposal, site visit, past contractual performance, etc. and are not appealable to the Administrative Hearing Commission.

Affirmation

On behalf of the applying provider, I affirm all statutory and regulatory requirements are incorporated into applying provider's policies and procedures and documentation supporting compliance with such requirements will be maintained.

I further affirm that the policies and procedures submitted with applying provider's proposal are only a portion of the policies and procedures required to be developed and adhered to by the applying provider and its employees. All documents and a policy manual will be available for review upon request.

I further affirm the applying provider will comply with all requirements outlined in this document, In-Home Services Assurances.

I further affirm that all documents and information submitted pursuant to applying provider's proposal are true and correct to the best of my knowledge and belief and that all required documents are included with this proposal.

I further affirm I am an individual or the representative of the applying provider and am the duly authorized agent to execute this document on behalf of the applying provider under authority granted by said applying provider.

LEGAL PROVIDER NAME AS FILED WITH THE IRS AND SECRETARY OF STATE, INCLUDING DBA NAME (SOLE PROPRIETORS, INCLUDE NAME AND DBA NAME)	
FEDERAL EMPLOYER IDENTIFICATION NUMBER (FEIN)	TELEPHONE NUMBER
SIGNATURE OF AUTHORIZED REPRESENTATIVE	TITLE OF AUTHORIZED REPRESENTATIVE
TYPED OR PRINTED NAME OF AUTHORIZED REPRESENTATIVE	DATE