MMAC - FORMS

- CHANGE REQUEST
- EFT - banking
- BOS (Business Organization Structure)
- VENDOR PROFILE
- SAC (Service Area Commitment)
- CDS ASSURANCES

https://**mmac.mo.gov**/providers/provider-enrollment/home-and-community-based-services/provider-contracts-forms/

Changing Banking Accounts

Must submit EFT form
and a Change Request form

DO NOT close the current account until a deposit has been made into the new account or your payments will be delayed

Sometimes banking changes are kicked back for one reason or another; that is why we ask that you NOT close the old account until a deposit has been made into the new one.

CHANGE REQUEST FORM

As a HCBS provider you are required to submit a Change Request form along with any requested documents/forms listed when you request a change.

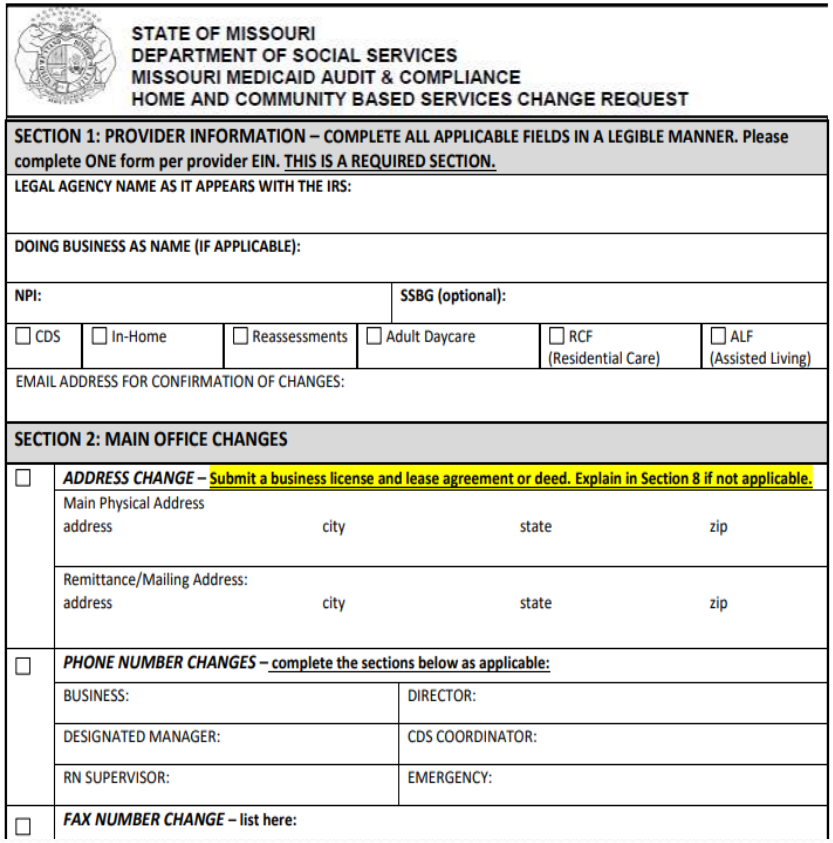
(address, telephone, fax, email, days/hours, etc.)

Per 13 CSR 65-2.020(B) - **REQUIRES** MO HealthNet providers to notify MMAC Provider Enrollment Unit (PEU) of any changes to enrollment within 30 days of the effective date, including changes in ownership (CHOW) which must be reported within 30 days of the effective date.

HCBS Change Request VS Provider Update

HCBS Change Request

https://mmac.mo.gov/wp-content/uploads/sites/11/2022/05/Change-Request-22.pdf



STATE OF MISSOURI
DEPARTMENT OF SOCIAL SERVICES
MISSOURI MEDICAID AUDIT & COMPLIANCE
HOME AND COMMUNITY BASED SERVICES CHANGE REQUEST

SECTION 1: PROVIDER INFORMATION – COMPLETE ALL APPLICABLE FIELDS IN A LEGIBLE MANNER. Please complete ONE form per provider EIN. THIS IS A REQUIRED SECTION.

LEGAL AGENCY NAME AS IT APPEARS WITH THE IRS:

DOING BUSINESS AS NAME (IF APPLICABLE):

NPI: | SSBG (optional):

☐ CDS | ☐ In-Home | ☐ Reassessments | ☐ Adult Daycare | ☐ RCF (Residential Care) | ☐ ALF (Assisted Living)

EMAIL ADDRESS FOR CONFIRMATION OF CHANGES:

SECTION 2: MAIN OFFICE CHANGES

☐ ***ADDRESS CHANGE*** – Submit a business license and lease agreement or deed. Explain in Section 8 if not applicable.

Main Physical Address
address | city | state | zip

Remittance/Mailing Address:
address | city | state | zip

☐ ***PHONE NUMBER CHANGES*** – complete the sections below as applicable:

BUSINESS: | DIRECTOR:

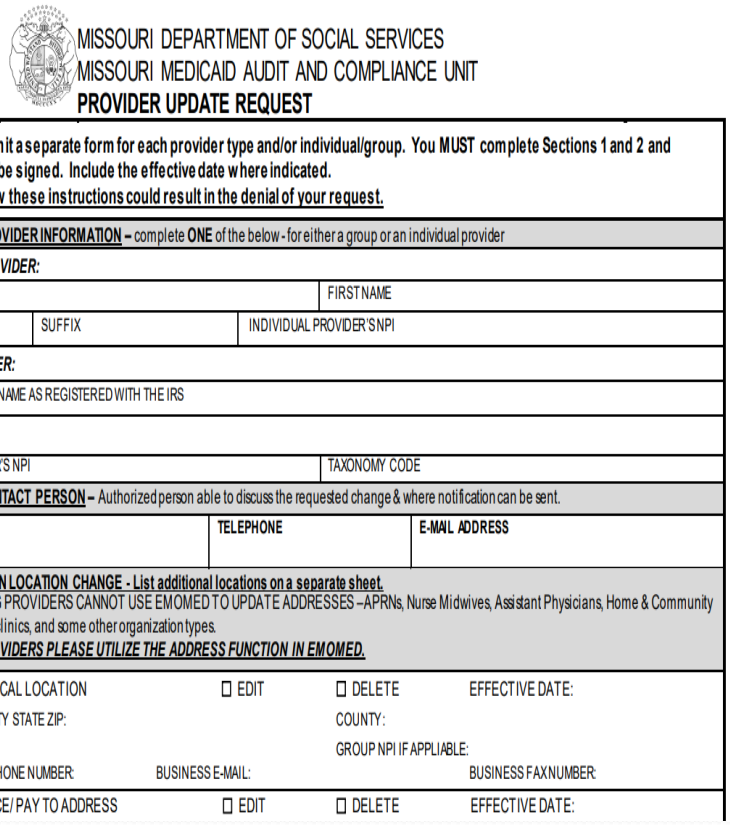
DESIGNATED MANAGER: | CDS COORDINATOR:

RN SUPERVISOR: | EMERGENCY:

☐ ***FAX NUMBER CHANGE*** – list here:

Provider Update Form

https://mmac.mo.gov/wp-content/uploads/sites/11/2021/04/Provider-Update-Request.pdf



MISSOURI DEPARTMENT OF SOCIAL SERVICES
MISSOURI MEDICAID AUDIT AND COMPLIANCE UNIT
PROVIDER UPDATE REQUEST

You must submit a separate form for each provider type and/or individual/group. You MUST complete Sections 1 and 2 and the form must be signed. Include the effective date where indicated.
Failure to follow these instructions could result in the denial of your request.

SECTION 1: PROVIDER INFORMATION – complete **ONE** of the below - for either a group or an individual provider

INDIVIDUAL PROVIDER:

LAST NAME | FIRST NAME

MIDDLE INITIAL | SUFFIX | INDIVIDUAL PROVIDER'S NPI

GROUP PROVIDER:

LEGAL BUSINESS NAME AS REGISTERED WITH THE IRS

DBA (if applicable)

GROUP PROVIDER'S NPI | TAXONOMY CODE

SECTION 2: CONTACT PERSON – Authorized person able to discuss the requested change & where notification can be sent.

NAME | **TELEPHONE** | **E-MAIL ADDRESS**

SECTION 3: MAIN LOCATION CHANGE - List additional locations on a separate sheet.
THE FOLLOWING PROVIDERS CANNOT USE EMOMED TO UPDATE ADDRESSES – APRNs, Nurse Midwives, Assistant Physicians, Home & Community Based providers, clinics, and some other organization types.
ALL OTHER PROVIDERS PLEASE UTILIZE THE ADDRESS FUNCTION IN EMOMED.

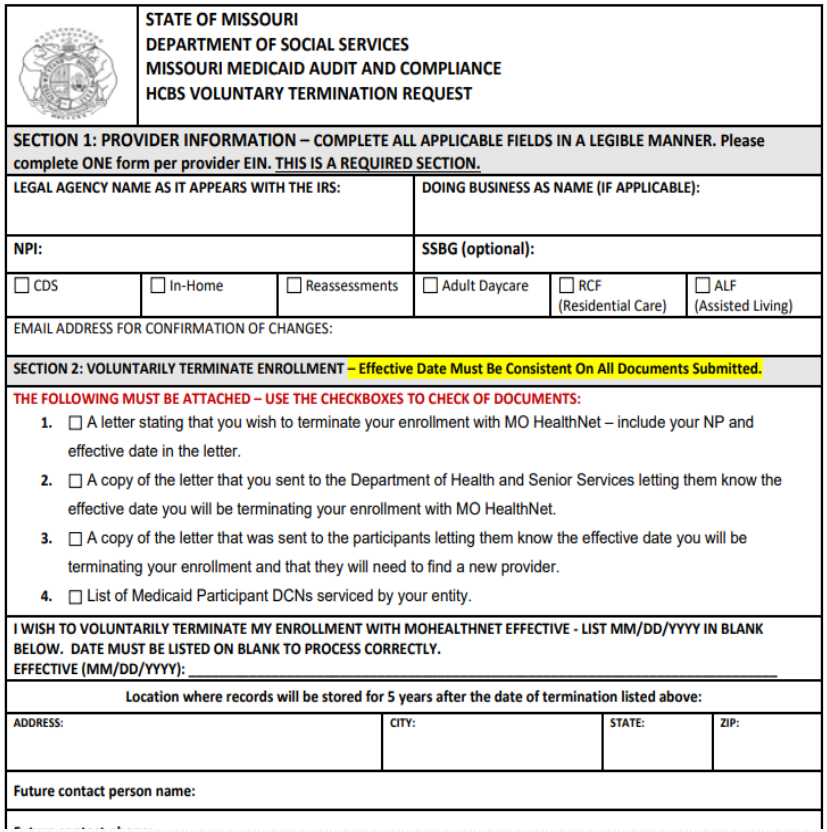
☐ MAIN PHYSICAL LOCATION ☐ EDIT ☐ DELETE EFFECTIVE DATE:
ADDRESS CITY STATE ZIP: COUNTY:
GROUP NPI IF APPLIABLE:
BUSINESS PHONE NUMBER: BUSINESS E-MAIL: BUSINESS FAX NUMBER:

☐ REMITTANCE/ PAY TO ADDRESS ☐ EDIT ☐ DELETE EFFECTIVE DATE:

HCBS Voluntary Term form VS Provider Termination

HCBS Voluntarily Termination

https://mmac.mo.gov/wp-content/uploads/sites/11/2022/05/HCBS-Voluntary-Termination-Form-22.pdf



STATE OF MISSOURI
DEPARTMENT OF SOCIAL SERVICES
MISSOURI MEDICAID AUDIT AND COMPLIANCE
HCBS VOLUNTARY TERMINATION REQUEST

SECTION 1: PROVIDER INFORMATION – COMPLETE ALL APPLICABLE FIELDS IN A LEGIBLE MANNER. Please complete ONE form per provider EIN. THIS IS A REQUIRED SECTION.

LEGAL AGENCY NAME AS IT APPEARS WITH THE IRS:	DOING BUSINESS AS NAME (IF APPLICABLE):
NPI:	SSBG (optional):

☐ CDS ☐ In-Home ☐ Reassessments ☐ Adult Daycare ☐ RCF (Residential Care) ☐ ALF (Assisted Living)

EMAIL ADDRESS FOR CONFIRMATION OF CHANGES:

SECTION 2: VOLUNTARILY TERMINATE ENROLLMENT – Effective Date Must Be Consistent On All Documents Submitted.

THE FOLLOWING MUST BE ATTACHED – USE THE CHECKBOXES TO CHECK OF DOCUMENTS:

1. ☐ A letter stating that you wish to terminate your enrollment with MO HealthNet – include your NP and effective date in the letter.
2. ☐ A copy of the letter that you sent to the Department of Health and Senior Services letting them know the effective date you will be terminating your enrollment with MO HealthNet.
3. ☐ A copy of the letter that was sent to the participants letting them know the effective date you will be terminating your enrollment and that they will need to find a new provider.
4. ☐ List of Medicaid Participant DCNs serviced by your entity.

I WISH TO VOLUNTARILY TERMINATE MY ENROLLMENT WITH MOHEALTHNET EFFECTIVE - LIST MM/DD/YYYY IN BLANK BELOW. DATE MUST BE LISTED ON BLANK TO PROCESS CORRECTLY.
EFFECTIVE (MM/DD/YYYY): _____

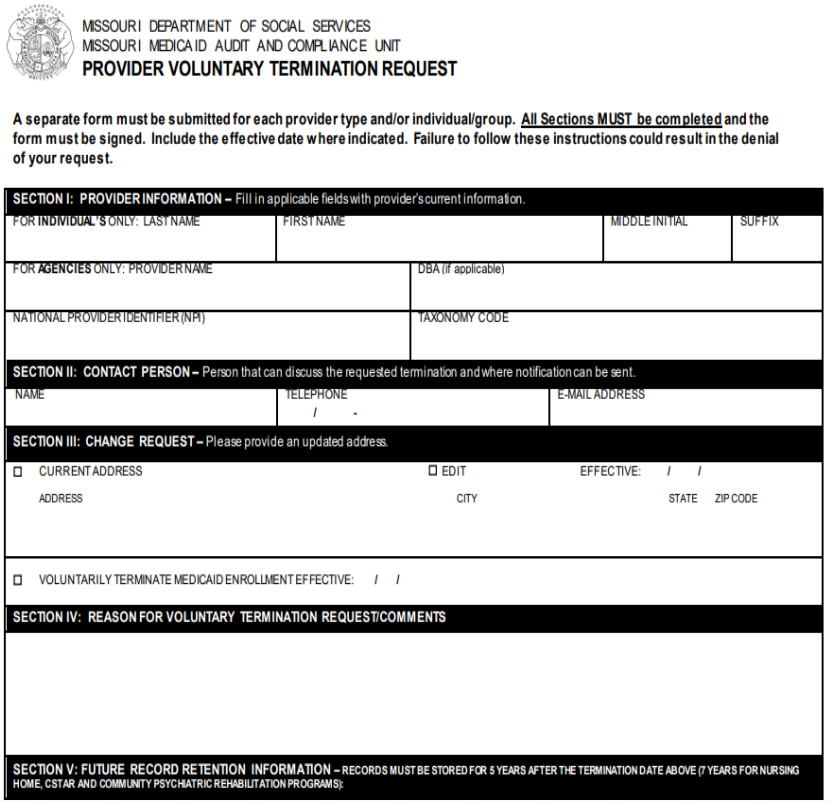
Location where records will be stored for 5 years after the date of termination listed above:

ADDRESS:	CITY:	STATE:	ZIP:

Future contact person name:

Voluntary Termination Request

https://mmac.mo.gov/wp-content/uploads/sites/11/2021/04/Provider-Voluntary-Termination-Request-form-3.2022.pdf



MISSOURI DEPARTMENT OF SOCIAL SERVICES
MISSOURI MEDICAID AUDIT AND COMPLIANCE UNIT
PROVIDER VOLUNTARY TERMINATION REQUEST

A separate form must be submitted for each provider type and/or individual/group. All Sections MUST be completed and the form must be signed. Include the effective date where indicated. Failure to follow these instructions could result in the denial of your request.

SECTION I: PROVIDER INFORMATION – Fill in applicable fields with provider's current information.

FOR **INDIVIDUALS** ONLY: LAST NAME	FIRST NAME	MIDDLE INITIAL	SUFFIX
FOR **AGENCIES** ONLY: PROVIDER NAME		DBA (if applicable)	
NATIONAL PROVIDER IDENTIFIER (NPI)		TAXONOMY CODE	

SECTION II: CONTACT PERSON – Person that can discuss the requested termination and where notification can be sent.

NAME	TELEPHONE / -	E-MAIL ADDRESS

SECTION III: CHANGE REQUEST – Please provide an updated address.

☐ CURRENT ADDRESS ☐ EDIT EFFECTIVE: / /

ADDRESS CITY STATE ZIP CODE

☐ VOLUNTARILY TERMINATE MEDICAID ENROLLMENT EFFECTIVE: / /

SECTION IV: REASON FOR VOLUNTARY TERMINATION REQUEST/COMMENTS

SECTION V: FUTURE RECORD RETENTION INFORMATION – RECORDS MUST BE STORED FOR 5 YEARS AFTER THE TERMINATION DATE ABOVE (7 YEARS FOR NURSING HOME, CSTAR AND COMMUNITY PSYCHIATRIC REHABILITATION PROGRAMS):

Personnel Change

SECTION 4: STAFF CHANGES – A CURRENT FCSR MUST BE SUBMITTED

☐ **Update contact person for a satellite office - a current FCSR is required**

Name:

Date of birth: | SSN: | Date of hire:

☐ **DIRECTOR NAME:**

Date of birth: | SSN:

Office address:

Date of Hire:

☐ **CDS COORDINATOR NAME:**

Date of birth: | SSN:

Office address:

Date of Hire:

☐ **IHS DESIGNATED MANAGER NAME:**

Date of birth: | SSN:

Office address:

Date of Hire:

THE FOLLOWING MUST BE ATTACHED:
- Copy of licensure or degree
- Copy of Provider Certification Training
- Copy of Resume

☐ **IHS RN SUPERVISOR NAME:**

Date of birth: | SSN:

Office address:

Date of Hire:

THE FOLLOWING MUST BE ATTACHED:
- Copy of licensure
- Copy of employment application

- If adding a new staff member – please notify MMAC on the change request if to prior person is leaving
- Include updated email and phone if different
- MMAC only makes the changes indicated

Updating Contact Numbers

☐	***PHONE NUMBER CHANGES*** – complete the sections below as applicable:	
	BUSINESS:	DIRECTOR:
	DESIGNATED MANAGER:	CDS COORDINATOR:
	RN SUPERVISOR:	EMERGENCY:
☐	***FAX NUMBER CHANGE*** – list here:	
☐	***EMAIL ADDRESS CHANGE*** – list below. Use section 6 or another sheet to report more than 1 e-mail change:	

When updating phone numbers – please put the phone number you want updated in the appropriate box (not the name of the person)

Electronic Health Records

More and more providers are transitioning to a paperless work environment. In keeping up with the times MMAC has an attestation

This is NOT for EVV-this is in reference to employee records, tax, payroll, screenings, etc.

If you are one of those providers who is paperless or transitioning you will be required to submit this disclosure to MMAC.

The form is a simple 1 page form with Yes/No answers

Electronic Health Records

The questions are very straight forward regarding your system

Please remember that HIPAA also applies to the electronic records as they do to paper records.

BAA or Business Associate Agreement – between the Provider and their Vendor regarding HIPAA

MISSOURI DEPARTMENT OF SOCIAL SERVICES
MISSOURI MEDICAID AUDIT AND COMPLIANCE
Electronic Health Records Disclosure

LEGAL PROVIDER NAME AS FILED WITH THE IRS AND SECRETARY OF STATE, INCLUDING DBA NAME (SOLE PROPRIETORS, INCLUDE NAME AND DBA NAME)
1. What system/application/software are you using for Electronic Health Records? This may include an electronic medical records system, electronic health records system, or an electronic case management system.
2. What is the name of the software or the application being used for Electronic Health Records? List all if using multiple applications.
3. How many locations is this same software or application being used for? Do all locations have the same accessibility?
4. Do you have a backup plan in case of security compromise or in case of an outage?
5. What procedures do you use to ensure no data is missed when migrating from either a paper or a different electronic system to a new electronic record keeping system?
6. Do you have a Security Risk Assessment on file? For more information, please visit Security Risk Assessment Tool | HealthIT.gov
7. Do you have a disaster recovery plan in place?
8. Do you have a training plan to ensure new and existing staff know about proper electronic record keeping?
9. Will you have the capability to retrieve and access the Electronic Health Records for at least 6 years as required by state Medicaid regulations, in case you switch applications?
Affirmation
On behalf of the applying provider, I affirm all statutory and regulatory requirements are incorporated into the provider's policies

HCBS Settings Requirement

Purpose of the Final Rule – HCBS Settings

- To ensure that individuals receive Medicaid HCBS in settings that have access to benefits of community living and are able to receive services in the most integrated setting

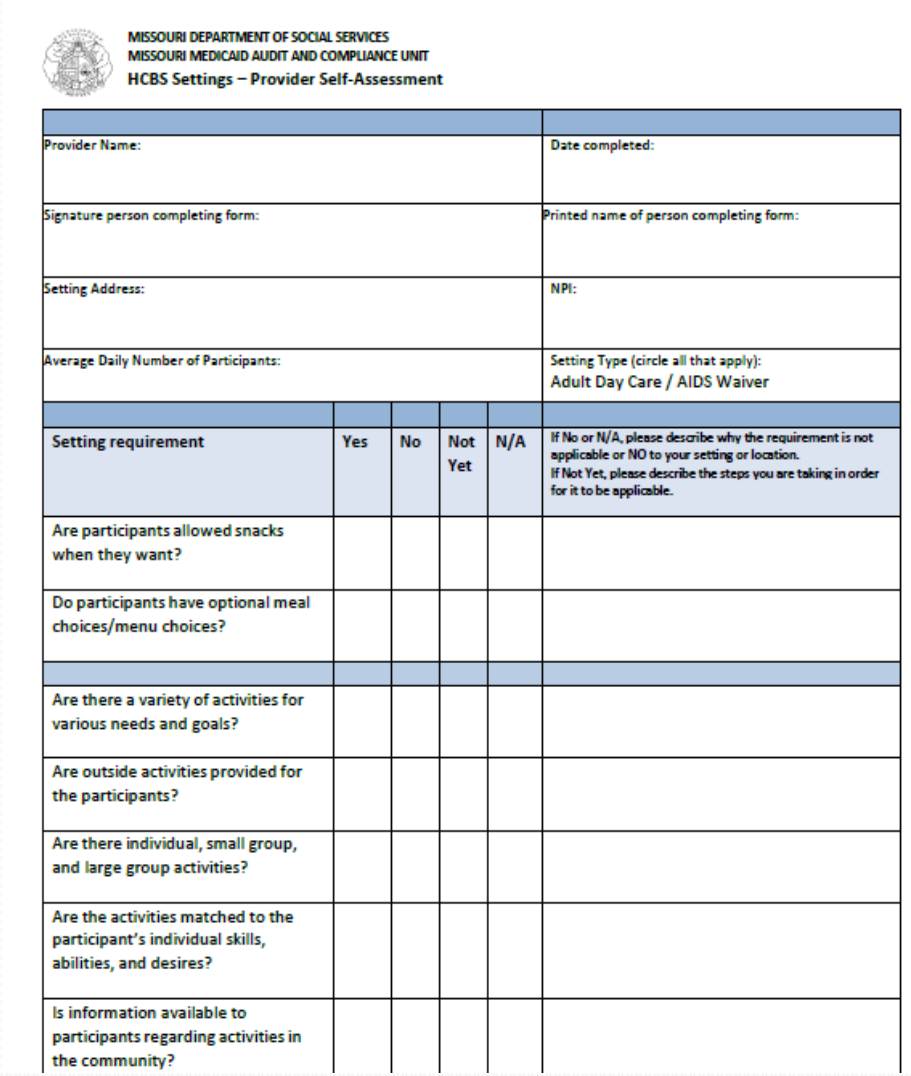
- To improve the quality of services for individuals receiving HCBS.

HCBS Settings Requirement

- This is a requirement from CMS – it applies to all HCBS, however in MO In Home and CDS are just that –services in the home – only our heightened scrutiny providers such as Adult Day Cares are required to attend the annual training and submit forms yearly

- Annual Trainings are held in November and forms are due by year end (December 31)

Self-Assessment Form



MISSOURI DEPARTMENT OF SOCIAL SERVICES
MISSOURI MEDICAID AUDIT AND COMPLIANCE UNIT
HCBS Settings – Provider Self-Assessment

Provider Name:	Date completed:
Signature person completing form:	Printed name of person completing form:
Setting Address:	NPI:
Average Daily Number of Participants:	Setting Type (circle all that apply): Adult Day Care / AIDS Waiver

Setting requirement	Yes	No	Not Yet	N/A	If No or N/A, please describe why the requirement is not applicable or NO to your setting or location. If Not Yet, please describe the steps you are taking in order for it to be applicable.
Are participants allowed snacks when they want?					
Do participants have optional meal choices/menu choices?					
Are there a variety of activities for various needs and goals?					
Are outside activities provided for the participants?					
Are there individual, small group, and large group activities?					
Are the activities matched to the participant's individual skills, abilities, and desires?					
Is information available to participants regarding activities in the community?					

- Per CMS rule – MMAC has to make this form available to all HCBS providers
- Make sure the form is filled out completely
- Provider information is included
- Signed(wet signature)
- Explanations provided on NO, N/A or Not Yet responses
- Complete form submitted back to MMAC via fax, email (.pdf) or post mail – NO PICTURES

THANK YOU

Contact Info:

Cindy Werdehausen

MMAC Contracts Unit

Please send emails to

mmac.ihscontracts@dss.mo.gov

Revalidation - Need to Know

- Revalidating by EIN, not by NPI
- Site visit required (each location must have a site visit conducted before revalidation is approved), please see Site Visit Slide
- Application Fee required - one fee per EIN; for the link please see Revalidation Links and Documents slide
- **Contract** will be renewed at time of approved revalidation
- If your due date is approaching but you do not have all documents required, please upload and submit what you currently have to avoid inactivity

Revalidation Links and documents

- Go to www.eMOMED.com to revalidate
- FAQs: https://www.emomed.com/wps/.mmisAppsJSF/ExportServlet?filename=ProviderRevalidationFAQs.pdf
- All MMAC required forms can be found here: https://mmac.mo.gov/revalidation-requirements/
- MO DOR & Vendor No Tax link: http://dor.mo.gov/forms/943.pdf
- Questions can be sent to: mmac.revalidation@dss.mo.gov
- Application Fee Link: https://magic.collectorsolutions.com/magic-ui/Login/mo-medicaid-audit
- Revalidation Phone: (573) 751-5238
- Revalidation Fax: (573) 761-3781

HCBS REVALIDATION DATES

11/15/2022:

To avoid any processing delays for **HCBS providers**, due to the large number of enrollments due for Revalidation in 2023/2024, **Missouri Medicaid Audit and Compliance is scheduling some providers to revalidate sooner than the current five year schedule.**

Providers and/or their authorized representative will begin receiving system emails 90 days prior to the due date directing them to revalidate at the www.emomed.com portal.

Any questions regarding the change in revalidation date or any other revalidation related question should be directed to: mmac.revalidation@dss.mo.gov

Revalidation Due Dates/Notices

- Notices for Revalidation are sent to the current email address and main location on file for the provider, please make sure your current email address is valid, also check SPAM and JUNK folders

- Notices are sent as follows:
  - **90 days** before the revalidation due date (email on file)
  - **60 days** before the revalidation due date (physical letter to main location on file and email on file)
  - **30 days** before the revalidation due date (email on file)
  - **EACH** time you log into the eMOMED portal, starting **90 days** before the due date
  - Until your Revalidation is **approved** or **terminated**

- If your revalidation is not completed by your due date, you are considered non-compliant and your contract with MMAC is expired, at this time you can be terminated from the program and will be required to re-enroll

MMAC.REVAL-DONOTREPLY@MOMED.COM

If you receive any of the below notices please DO NOT reply, this is an unmonitored email address. Any questions need to be sent to mmac.revalidation@dss.mo.gov

From: mmac.reval-donotreply@momed.com

Date: 03/21/23 14:55

To:

Subject: Provider Revalidation Rejected

On Tue, Apr 4, 2023 at 10:12 AM mmac.reval-donotreply@momed.com <mmac.reval-donotreply@momed.com> wrote:

Dear MO HealthNet Provider,

The revalidation you submitted for NPI has been approved. You may view your approved revalidation status at www.emomed.com. The provider will have a next revalidation date 5 years in the future and the revalidation status will be "Not Due".

From: mmac.reval-donotreply@momed.com <mmac.reval-donotreply@momed.com>
Sent: Saturday, April 1, 2023 1:14 AM
Subject: Provider Enrollment Revalidation Due

Dear MO HealthNet Provider,

State and federal regulations require all currently enrolled Medicaid providers to "revalidate" their enrollments at least every five years.

You are receiving this continuous email because the following National Provider Identifiers (NPIs) are due for revalidation:

You will continue to receive this e-mail until the revalidation(s) have been Approved.

Revalidation Submission

- Revalidation must be submitted at the latest 60 days prior to Revalidation due date
- **Faxing** documents to the Revalidation Portal documents must be in black and white, under 50 pages and must have Revalidation Cover sheet on top with QR code readable
- To avoid email returns and delivery delays only send documents to the mmac.revalidation@dss.mo.gov email when requested
- All documents submitted must be signed and dated using a wet, DocuSign, Hello Sign or Adobe Sign signatures
- MMAC does not accept pictures of documentation

Uploading Documentation

Make sure to **UPLOAD** all documents to your revalidation using the portal. If you are having issues with uploading documentation please make sure the documents are in **PDF format**, each upload is **under 3MB and in black and white**, if issues still occur please contact the eMOMED Help Desk (573) 634-3105. (do not submit screen shots, jpeg, image attachments).

DO NOT EMAIL DOCUMENTS UNLESS INSTRUCTED, emailing multiple large documents clogs up the email and returns other emails trying to send due to mailbox size.

Uploading documentation to the correct revalidation within the eMOMED portal is not a part of the Revalidation Staff process, this is the **PROVIDERS RESPONSIBILITY**

Revalidation Site Visits

- All providers must complete a Site Visit
- A Site Visit must be completed per enrolled location
- Please make sure the email address in the contact section of the revalidation is a valid email
- Please make sure to check JUNK and SPAM folders for Site Visit notification
- Site Visit email notification will come from a **dss.mo.gov** email address
- Site Visits are conducted BEFORE approval
- Completing the Site Visit DOES NOT mean your revalidation has been APPROVED

Revalidation Contract

- Contract documents will be sent out once Revalidation is approved.
- **Only** the Box C and the Participation Agreement need to be completed for the Revalidation. (do not submit screen shots, jpeg, image attachments).
- Each document must include an authorized representative signature (Director or Owner)
- Provider has 10 calendar days to complete. Anything after 10 days can result in billing suspension or Termination.
- MMAC CANNOT GIVE OUT YOUR E-VERIFY INFORMATION. E-Verfiy is a Federal work Authorization program. MMAC is a state program and does not have the Authority to give out that information.
- If you have lost your Information you can contact E-Verify by phone: 888-464-4218 or email at e-verify@dhs.gov or by phone: 888-464-4218 (this information can be found on the "BOX B" either page 14 or 15 of Program Requirements)

Revalidation Contract BOX C

I certify that 1. Legal Business Name of Provider/Agency (Business Entity Name) MEETS the definition of a business entity as defined in section 285.525, RSMo pertaining to section 285.530, RSMo and have enrolled and currently participates in the E-Verify federal work authorization program with respect to the employees hired after enrollment in the program who are proposed to work in connection with the services related to contract(s) with the State of Missouri. We have previously provided documentation to a Missouri state agency or public university that affirms enrollment and participation in the E-Verify federal work authorization program. The documentation that was previously provided included the following.

- ✓ The E-Verify Employment Eligibility Verification page OR a page from the E-Verify Memorandum of Understanding (MOU) listing the contractor's name and the MOU signature page completed and signed by the contractor and the Department of Homeland Security – Verification Division.
- ✓ A completed, notarized Affidavit of Work Authorization signed and dated on or after **September 1, 2009**.

Name of Missouri State Agency or Public University* to Which Previous E-Verify Documentation Submitted: 2. DSS/MMAC

(*Public University includes the following five schools under chapter 34, RSMo: Harris-Stowe State University – St. Louis; Missouri Southern State University – Joplin; Missouri Western State University – St. Joseph; Northwest Missouri State University – Maryville; Southeast Missouri State University – Cape Girardeau.)

Date of Previous E-Verify Documentation Submission: 3. Date of previous submissioni to MMAC

Previous Bid/Contract/ERS Number for Which Previous E-Verify Documentation Submitted:
4. ERS #
(if known)

5. Print Your Name
Authorized Business Entity Representative's Name (Please Print)

6. Actual Signature
Authorized Business Entity Representative's Signature

7. Company # off of MOU
E-Verify MOU Company ID Number

8. business email address
E-Mail Address

9. Legal Business Name of Provider/Agency
Business Entity Name

10. Date
Date

1. & 9. – Legal Business Name – as stated on contract – include DBA if applicable

2. Name of entity you previously submitted your E-Verify to – sent to **DSS/MMAC** when you originally contracted

3. Use previous date on E-Verify Electronically signature page

4. ERS# can be found on previous contract (top right hand box) Agreements Number **ERS104xxxxx**

5. Print Name legibly – this is required

6. Original Signature of authorized representative – do not use a cursive or hand written font

7. Company Number with E-Verify program - this can be found on the E-Verify MOU and Electronic Signature page

8. Current business email address

9. – see #1

10 – Date you are signing Box C form

Contract Participation Agreement

MISSOURI MEDICAID AUDIT AND COMPLIANCE UNIT

PARTICIPATION AGREEMENT FOR HOME AND COMMUNITY BASED SERVICES

AGREEMENT NUMBER	O.A. VENDOR NUMBER
ERS10423	

FUNDING SOURCE

STATE	FEDERAL
100%	

FEDERAL AGENCY NAME	FEDERAL AWARD YEAR	RESEARCH & DEVELOPMENT	SUBJECT TO A-133 REQUIREMENTS
N/A	N/A	YES ☐ NO ☒	YES ☐ NO ☒

FEDERAL AWARD NUMBER	FEDERAL AWARD NAME	CFDA NUMBER	CFDA TITLE
N/A	N/A	N/A	N/A

☒ **If checked, this agreement constitutes a vendor relationship, as defined by OMB Circular A-133, and therefore these funds are not federal awards, and are not subject to the federal audit requirements of OMB Circular A-133. This in no way precludes the Missouri Medicaid Audit and Compliance Unit ("MMAC") from performing monitoring, review, or any other procedures deemed necessary by the MMAC to ensure compliance with the provisions of this agreement.**

1. This agreement is between the MMAC and a vendor of consumer directed services as defined in §§208.900 – 208.930, RSMo Supp. 2009. The term provider as used in the Terms and Conditions incorporated by reference shall mean Vendor as used in this program.
2. By signing below, the Vendor (also referred to as "Contractor") agrees to provide services and comply with its proposal as amended and approved by the MMAC, the Program Requirements, the Terms and Conditions, and all applicable policies and procedures as set forth in §§208.900 – 208.930, RSMo Supp. 2009 and the regulations promulgated thereunder, and all other applicable federal and state laws in the delivery of services and in the submission of claims for reimbursement.
3. This Participation Agreement, together with the Program Requirements and the Terms and Conditions, which are attached hereto and are incorporated by reference herein, shall hereinafter be referred to as the "Agreement" or "Contract."
4. This Agreement shall become effective on the date it is executed by the MMAC's Director or his/her authorized representative or 01/03/2023, whichever is later, and shall end 12/31/2028.
5. This Agreement covers services authorized by DHSS's Division of Senior and Disability Services ("DSDS") regardless of funding source. Requests for reimbursement for services must be made in accordance with the requirements of the funding source. The DSDS shall not reimburse the Vendor for consumer directed services that are reimbursable under the Missouri Medicaid program. Requests for reimbursement from the DSDS shall be made in writing to: Missouri Department of Health and Senior Services, Division of Senior and Disability Services, P.O. Box 570, 912 Wildwood Drive, Jefferson City, MO 65102-0570.
6. Except as provided in Section 3.4.1 of the Program Requirements, any notice, form, communication, or request made in the performance of the terms of this Agreement must be submitted to the MMAC, HCS Provider Contracts, P.O. Box 6500, Jefferson City, MO 65102 or fax number 573-634-3105.
7. Any written notice or communication to the Vendor by the MMAC or the DSDS shall be deemed delivered when deposited in the United States mail, postage prepaid, and addressed to the Vendor at its address as listed below, or at such address as the Vendor may have requested in writing after the submission of this Agreement, to be used for notice, or transmitted by telecopier to a number listed on Vendor's correspondence, or sent via electronic mail (e-mail) to an address submitted by the Vendor, and/or hand carried and presented to an authorized employee of the Vendor at its last known physical address.
8. The Vendor will utilize a form provided by the MMAC to submit updated information at least five (5) days prior to any change in such information. The Vendor understands and agrees that no change can take place prior to the MMAC's approval of the proposed change.
9. An individual executing this Agreement on behalf of the Vendor represents and warrants that he/she is authorized to execute this Agreement on behalf of the Vendor and that upon his/her signature, this Agreement shall be binding upon the Vendor.
10. The MMAC reserves the right to terminate the contract or agreement, in whole or in part, at any time, for the convenience of the state agencies, without penalty or recourse. Termination of this Agreement may also be made by MMAC at any time after a material breach by the Provider.

VENDOR NAME	SSBG/GR VENDOR NUMBER	TELEPHONE NUMBER
MAILING ADDRESS (STREET)	FAX NUMBER	E-MAIL
CITY, STATE, ZIP	FEDERAL TAX I.D. OR SOCIAL SECURITY NO.	
DATE	TYPE OF HOME AND COMMUNITY BASED CARE	
	Consumer Directed Services	
PRINTED NAME OF AUTHORIZED REPRESENTATIVE	SIGNATURE OF AUTHORIZED REPRESENTATIVE	

VENDOR APPROVED

MISSOURI MEDICAID AUDIT AND COMPLIANCE UNIT	TITLE	DATE
▶	Director or Designee	

MISSOURI MEDICAID AUDIT AND COMPLIANCE UNIT

PARTICIPATION AGREEMENT FOR HOME AND COMMUNITY BASED SERVICES

AGREEMENT NUMBER	O.A. VENDOR NUMBER
ERS10423	

FUNDING SOURCE

STATE	FEDERAL
70%	30%

FEDERAL AGENCY NAME	FEDERAL AWARD YEAR	RESEARCH & DEVELOPMENT	SUBJECT TO A-133 REQUIREMENTS
N/A	N/A	YES ☐ NO ☒	YES ☐ NO ☒

FEDERAL AWARD NUMBER	FEDERAL AWARD NAME	CFDA NUMBER	CFDA TITLE
N/A	N/A	N/A	N/A

☒ **If checked, this agreement constitutes a vendor relationship, as defined by OMB Circular A-133, and therefore these funds are not federal awards, and are not subject to the federal audit requirements of OMB Circular A-133. This in no way precludes the Missouri Medicaid Audit and Compliance Unit ("MMAC") from performing monitoring, review, or any other procedures deemed necessary by the MMAC to ensure compliance with the provisions of this agreement.**

1. By signing below, the Provider (also referred to as "Contractor") agrees to provide Home and Community Based Services, as authorized by the Department of Health and Senior Services ("DHSS"), to DHSS clients.
2. This Participation Agreement, together with the Program Requirements and the Terms and Conditions which are attached hereto and are incorporated by reference herein, shall hereinafter be referred to as the "Agreement" or "Contract."
3. This Agreement shall become effective on the date it is executed by the Missouri Medicaid Audit and Compliance Unit's (MMAC) Director or his/her authorized representative or 01/06/2023, whichever is later, and shall end 12/31/2028.
4. The Provider shall comply with the Program Requirements, the Terms and Conditions, and all applicable policies and procedures in the delivery of services and in the submission of claims for reimbursement. The Provider shall also provide services and operate in accordance with its proposal as amended and approved by the MMAC and with applicable provisions of 13 CSR 70-3.020 through 13 CSR 70-3.150, 13 CSR 70-91.010, and 19 CSR 15-7.021 and all other applicable federal and state laws.
5. When completed for the provision of in-home services, this agreement is the contract referred to in 19 CSR 15-7.021 and 13 CSR 70-91.010.
6. This Agreement covers services authorized by the DHSS's Division of Senior and Disability Services ("DSDS") regardless of funding source. Requests for reimbursement for services must be made in accordance with the requirements of the funding source.
7. The Provider shall not request from the DHSS nor shall the Provider be reimbursed from the DHSS for services otherwise covered under Titles XVIII or XIX of the Social Security Act. Requests for reimbursement from the DSDS shall be made in writing to: Missouri Department of Health and Senior Services, Division of Senior and Disability, P.O. Box 570, 912 Wildwood Drive, Jefferson City, MO 65102-0570.
8. Except as provided in Section 3.3.1 of the Program Requirements, any notice, form, communication, or request made in the performance of the terms of this Agreement must be submitted to the MMAC, HCS Provider Contracts, P.O. Box 6500, Jefferson City, MO 65102 or fax number 573-634-3105.
9. Any written notice or communication to the Provider by the MMAC or the DHSS shall be deemed delivered when deposited in the United States mail, postage prepaid, and addressed to the Provider at its address as listed below, or at such address as the Provider may have requested in writing after the submission of this Agreement, to be used for notice, or transmitted by telecopier to a number listed on Provider's correspondence, or sent via electronic mail (e-mail) to an address submitted by the Provider, and/or hand carried and presented to an authorized employee of the Provider at its last known physical address.
10. The Provider will utilize a form provided by the MMAC to submit updated information at least five (5) days prior to any change in such information. The Provider understands and agrees that no change can take place prior to the MMAC's approval of the proposed change.
11. By signing below, the Provider certifies that all in-home service workers employed by this Provider received or upon employment shall receive training in accordance with 19 CSR 15-7.021(22) of the In-Home Service Standards prior to delivery of services to any Medicaid in-home service participant. Further, Provider will maintain written documentation of all basic and in-service training in accordance with 19 CSR 15-7.021(23) of the In-Home Service Standards. Non-compliance with these provisions may require repayment of any reimbursement received for in-home service workers who were not properly trained prior to the delivery of the in-home service.
12. An individual executing this Agreement on behalf of the Provider represents and warrants that he/she is authorized to execute this Agreement on behalf of the Provider and that upon his/her signature, this Agreement shall be binding upon the Provider. The MMAC reserves the right to terminate this Agreement, in whole or in part, at any time, for the convenience of the State, without penalty or recourse. Termination of this Agreement may also be made by MMAC at any time after a material breach by the Provider.

PROVIDER NAME	SSBG/GR PROVIDER NUMBER	TELEPHONE NUMBER
MAILING ADDRESS (STREET)	FAX NUMBER	E-MAIL
CITY, STATE, ZIP	FEDERAL TAX I.D. OR SOCIAL SECURITY NO.	
DATE	TYPE OF HOME AND COMMUNITY BASED CARE	
	In-Home Services	
PRINTED NAME OF AUTHORIZED REPRESENTATIVE	SIGNATURE OF AUTHORIZED REPRESENTATIVE	

PROVIDER APPROVED

MISSOURI MEDICAID AUDIT AND COMPLIANCE UNIT	TITLE	DATE
▶	Director or Designee	

Revalidation Contract Continued

- If you have multiple enrollments that were revalidated together i.e a CDS and an In-Home, you will have multiple Contracts to complete.
- Each Contract has its OWN BID/Contract/ERS number. Make sure that the correct Number goes to the correct Contract.
- Once completed providers will receive a full Program Requirement packet with all the signed documents and Mo HealthNet Resource page. **KEEP THESE DOCUMENTS IN YOUR FILES FOR FUTURE REVALIDATION CONTRACT USE.**