MISSOURI DEPARTMENT OF SOCIAL SERVICES
MISSOURI MEDICAID AUDIT & COMPLIANCE

MO HEALTHNET PERSONAL CARE PROGRAM
ADDENDUM TO TITLE XIX PARTICIPATION AGREEMENT FOR PERSONAL CARE SERVICES

It is agreed by _____ that, pursuant to and in compliance with all conditions
PROVIDER AGENCY NAME
of its MO HealthNet Participation Agreement for Personal Care Services, that the provider will comply with the standards, policies, and procedures as required by the MO HealthNet Division in providing advanced personal care services under the Personal Care Program, as set out in the MO HealthNet Personal Care Provider Manual and in 13 CSR 70-91.010.

It is agreed that the provider will deliver services and bill MO HealthNet only for Advanced Personal Care services prior authorized by case managers, care coordinators and service coordinators employed by the Department of Health and Senior Services, Division of Senior and Disability Services, or the Bureau of Special Health Care Needs.

MO HealthNet enrolled personal care providers submitting this addendum to their provider agreement must provide verification of a valid RCF license with the Division of Senior and Disability Services, **OR** a current contract with Missouri Medicaid Audit & Compliance to provide Title XX (SSBG) Advanced Personal Care services. However, if the RCF chooses to provide services to participants in the community, they **must** provide verification of a current contract with Missouri Medicaid Audit & Compliance to provide Title XX (SSBG) Advanced Personal Care services.

It is understood that this addendum is only in effect for the duration of the RCF license **OR** Title XX (SSBG) contract, and only during the period the provider's MO HealthNet Provider Agreement for Personal Care Services remains active. This addendum will be terminated in the event the RCF license or Title XX contract expires, is revoked or is otherwise terminated, or if the provider's MO HealthNet Provider Agreement for Personal Care Services is terminated by either the MO HealthNet Division or the provider.

PROVIDER AGENCY NAME:	PROVIDER ADDRESS:
ORIGINAL SIGNATURE OF AUTHORIZED REPRESENTATIVE:	BUSINESS TELEPHONE NUMBER:
PRINT NAME AND TITLE OF PERSON SIGNING:	DATE:

Submit this form to:

Missouri Medicaid Audit & Compliance
Attn: Contracts Unit
P.O. Box 6500
Jefferson City, MO 65102

E-mail: MMAC.IHSContracts@dss.mo.gov Fax Number: 573-634-3105

(1/2024)