Example F-00180: Wisconsin Medicaid Program Provider Agreement and Acknowledgement of Terms of Participation

Instructions

On page 1 of Form F-00180, enter the following information:

- Enter the Provider's contact information.

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DEPARTMENT OF HEALTH SERVICES
Division of Long Term Care
F-00180

STATE OF WISCONSIN
42 CFR 431.107

WISCONSIN MEDICAID PROGRAM PROVIDER AGREEMENT AND ACKNOWLEDGEMENT OF TERMS OF PARTICIPATION

FOR WAIVER SERVICE PROVIDER ENTITIES[1]

Completion of this form is required under Federal Law by the Centers for Medicare & Medicaid Services, Department of Health and Human Services, under the Code of Federal Regulations 42 CFR 431.107.

Name of Provider (Typed or Printed)		Telephone Number
Provider Name		###-###-####
Address – Street	**City (WI only)**	**Zip Code**
Provider Street Address	City, WI	#####

The above-referenced provider of home and community-based waiver services under Wisconsin's Medicaid program, hereinafter referred to as the provider, hereby agrees and acknowledges as follows:

1. The provider acknowledges it is subject to certain federal and state laws, regulations and policies, including those relating to Title XIX of the Social Security Act, those pertinent to Wisconsin's Medicaid program, official written policy as transmitted to the provider in the Wisconsin Medicaid program handbooks and bulletins, the standards for the specific Medicaid waiver service the provider will deliver and other requirements as defined in the Medicaid Home & Community-Based Waivers Manual. The provider acknowledges that it is responsible for knowing the provisions of federal and state laws, regulations, the Medicaid Waiver Manual and policies that apply to it and for complying with applicable federal and state law as a condition of its participation as a provider of home and community-based services under Wisconsin's Medicaid program.
2. The provider shall claim reimbursement only for covered services to individual waiver participants that are authorized by the local waiver administrative agency in the individual waiver participant's individual service plan.
3. In accordance with 42 CFR § 431.107 of the federal Medicaid regulations, the provider agrees to keep any records necessary to document the extent of services provided to recipients **for a period of 7 years** and upon request, to furnish to the Department, the federal Department of Health and Human Services, or the state Medicaid Fraud Control Unit, any information regarding services provided and payments claimed by the provider for furnishing services under the Wisconsin Medicaid Waiver program. For state policy related to record retention see DHS 106.02, Wis. Administrative Code or the DLTC numbered memo addressing record retention available at http://dhs.wisconsin.gov/dsl_info/NumberedMemos/DSL/CY_2001/NMemo2001-07.htm .
4. The provider agrees to comply with the disclosure requirements of 42 CFR Part 455, Subpart B, as now in effect or as may be amended. To meet those requirements, and address real or potential conflict of interest that may influence service provision, the provider shall furnish to the waiver agency and upon request, to the Department in writing:
   (a) The names and addresses of all vendors of drugs, medical supplies or transportation, or other providers in which it has a controlling interest or ownership;
   (b) The names and addresses of all persons who own or have a controlling interest in the provider;
   (c) Whether any of the persons named in compliance with (a) and (b) above are related to any owner or to a person with a controlling interest as spouse, parent, child or sibling;
   (d) The names and addresses of any subcontractors who have had business transactions with the provider;
   (e) The identity of any person, named in compliance with (a) and (b) above, who has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid or Title XIX services programs since the inception of those programs.
5. The provider hereby affirms that it and each person employed by or under contract with it for the purpose of providing services holds all licenses and/or similar entitlements or meets the qualifications specified in the Medicaid Home & Community-Based Waivers Manual, or as required by federal or state statute, regulation, or rule for the provision of the service.

[1] Entities here means Medicaid-certified providers (pharmacies, clinics, therapists, etc.) or Medicaid waiver service providers including, but not limited to, substitute care providers, personal care agencies, supportive home care providers, transportation service providers and other entities that have been specifically identified as covered service providers in the Medicaid Waivers Manual.

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6. The provider consents to the use of statistical sampling and extrapolation as the means to determine the amounts owed by the provider to the Medicaid program as a result of an investigation or audit conducted by the Department, the Department of Justice Medicaid Fraud Control Unit, the federal Department of Health and Human Services, the Federal Bureau of Investigation, or an authorized agent of any of these.
7. Unless earlier terminated as provided in paragraph 8 below, this agreement shall remain in full force and effect for a maximum of one year. In the absence of a notice of termination by either party, the agreement shall automatically be renewed and extended for a period of one year. Automatic annual extensions may not continue for more than four years or extend this agreement beyond the due date of the next provider standards certification.[1]
8. This agreement may be terminated as follows:
   (a) By the provider as provided at s. DHS 106.05, Wisconsin Administrative Code.
   (b) By the Department upon grounds set forth at s. DHS 106.06, Wisconsin Administrative Code or pursuant to terms set forth in the Medicaid Waivers Manual.
9. The provider agrees to provide the Wisconsin Medicaid program or any waiver agency with any information it requests to enable it to certify providers and to authorize payment for Medicaid-covered services provided to eligible recipients and to assess the health and safety of any waiver participant served by the provider. Failure to supply the information requested by the Wisconsin Medicaid program may result in denial of Medicaid payment or sanctions related to the provider's continued participation in the program.
10. The provider acknowledges that any statement made in this document or the provider application process, constitutes a statement or representation of a material fact made in an application for a benefit or payment, or made for use in determining rights to such benefit or payment, that is knowingly and willfully made or caused to be made by Provider, within the meaning of Wis. Stat. § 49.49 (1)(a) 1 and 2, which imposes criminal penalties for fraud committed in connection with a Medical Assistance Program.

Pursuant to 42 CFR § 447.10(e), I hereby voluntarily reassign my right to direct payment from the State to each local waiver administrative agency that has authorized me to provide waiver services to an individual waiver participant.

If you check yes, it means that you will receive payment from the local waiver administrative agency that is responsible for the participants to whom you are authorized to provide waiver services rather than directly from the State Medicaid Agency.

☑ Yes ☐ No

MODIFICATIONS TO THIS AGREEMENT CANNOT AND WILL NOT BE AGREED TO. THIS AGREEMENT IS NOT TRANSFERABLE OR ASSIGNABLE.

Name – Provider Agency Head (Typed or Printed)	Title – Agency Head
Provider Name	Position Title
SIGNATURE – Provider Agency Head	Date Signed
Provider Signature	mm/dd/yyyy
SIGNATURE – Waiver Agency Representative	Date Signed
Participant Signature	mm/dd/yyyy
Print Name – Waiver Agency Representative	
Participant Name	

[1] Provider standards certification is a local agency function, whereby every four years the agency must assess and ensure that the waiver service provider continues to meet all applicable waiver service standards

Instructions

On page 2 of Form F-00180, enter the following information:

- Select the "Yes" checkbox;
- Enter the name of the Provider Agency Head and their position title;
- Provider Agency Head signs and dates the forms;
- Participant (Employer) signs and dates the form;
- Enter the name of the Participant (Employer).