Employer of Record Name: ___________________

MEDICAID PROVIDER AGREEMENT

The purpose of the Medicaid Provider Agreement is to assure that all providers of services and supports funded by Medicaid agree to comply with the federal Medicaid requirements. **Every Medicaid provider must complete the Medicaid Provider Agreement, and this agreement must be on file with the fiscal intermediary prior to the first payment for services.**

This agreement is made on Click here to enter a date. between the County of Washtenaw on behalf of the Washtenaw County Community Mental Health Agency (CMHSP) and INSERT Medicaid Provider NAME ("Employee/Agency as Medicaid Provider").The purpose of this agreement is to define the roles and responsibilities of the above named parties. This agreement shall remain in effect until such time it must be terminated or modified. Any party can initiate a termination or modification by providing written notice within 10 days to the other of the desire to terminate or modify this agreement.

Upon receipt of this agreement, the CMHSP will certify the Medicaid Provider as available to provide services to individuals who receive services and/or supports in accordance with their individual plans of services and supports developed in a person-centered planning process, authorized by the CMHSP or one of its subcontractors, and financed through Michigan's Medicaid Specialty Pre-paid Mental Health Plan.

The Medicaid Provider stipulates that it agrees to the following:

1. The Medicaid Provider understands and agrees to the condition that the CMHSP will not pay for any services that exceed what has been authorized according to the participant's plan of service. As such, the CMHSP and/or the participant's fiscal intermediary are not responsible for any services the provider has rendered or documented on a timesheet that exceeds the CMHSP's authorization.

2. To keep any records required by the participant or CMHSP regarding the services provided to participants and to provide such information and any related invoices or billings, upon request, to the participant, CMHSP, the state Medicaid Agency, the Secretary of the Department of Health and Human Services or the state Medicaid fraud control unit.

3. To comply with the ownership disclosure requirements specified in 42 CFR 455, subpart B, (Disclosure of Information by Providers and Fiscal Agents) as applicable. http://cfr.regstoday.com/42cfr455.aspx

4. To comply with intent of the advance directive requirements specified in 42 CFR 489, Subpart I (Advance Directives) http://cfr.regstoday.com/42cfr489.aspx and 42 CFR 417.436(d) (Rules for Enrollees) http://cfr.regstoday.com/42cfr417.aspx , as applicable, by finding out if a participant has an advance directive to refuse life- sustaining medical treatment, and informing the participant, before the provider starts work, whether or not the provider will carry out that advance directive so the participant can make an informed choice during the hiring process.

5. Both parties expressly acknowledge that the sole purpose of this agreement is to assure compliance with 42 USC 1902 (a) 27. Further, both parties recognize and reaffirm that the CMHSP is not the employer of the Medicaid Provider, and that the participant is the sole employer of the Medicaid Provider.

This agreement sets forth the entire understanding between the parties with respect to the subject matters, and supersedes any and all other agreements, either oral or in writing between the parties pertaining to these matters. No change or modification of the terms of this agreement is valid unless it is in writing and signed by the parties.

[23] This requirement applies to home health agencies and providers of home health care and personal care services as well as health care institutions. However, under Michigan law, certain health professionals cannot refuse to honor a Do Not Resuscitate order (MCL 333.1051 et. seq.).

ATTESTED TO:

By:______________________________
Lawrence Kestenbaum (DATE)
County Clerk/Register

COUNTY OF WASHTENAW:

By:________________________________
Gregory Dill (DATE)
County Administrator

APPROVED AS TO CONTENT:

By:_____________________________
Trish Cortes (DATE)
Executive Director, WCCMH

EMPLOYEE/SERVICE PROVIDER

By:________________________________
(DATE)
Print Name: ________________________

APPROVED AS TO FORM:

By:______________________________
Michelle Billard (DATE)
Office of Corporation Counsel