



WAIVER PROGRAM PROVIDER AGREEMENT

Notice of Enrollment of Medicaid Waiver Providers in the IMPACT System

Illinois implemented a new electronic provider enrollment system in July 2015. The new web-based system is known as Illinois Medicaid Program Advanced Cloud Technology (IMPACT). IMPACT will be used by all Medicaid and Waiver Program providers doing business with Illinois. All Individual Providers seeking to provide services with the DHS Division of Rehabilitation Services (DHS-DRS) Medicaid Waiver Program will be required to be enrolled in IMPACT. DHS will be enrolling Individual Providers in the IMPACT system. In order to complete enrollment DHS will obtain the necessary information from the Individual Provider. The Individual Provider by signing the Waiver Program Provider Agreement agrees to the terms and conditions of the Trading Partner agreement in the IMPACT Provider Enrollment System. The full version of the IMPACT Provider Enrollment Terms and Conditions can be found at http://www.illinois.gov/hfs/impact/Documents/PE_Terms_Conditions.pdf

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WHEREAS, _____, hereinafter referred to as "the Provider", is enrolled with the Illinois
 (Print Full Legal Name)

Department of Healthcare and Family Services, hereinafter referred to as "HFS", as an eligible provider in the Medical Assistance Program; and

WHEREAS, the Provider is enrolling with the Department of Human Services, Division of Rehabilitation Services (DHS-DRS) (hereinafter referred to as "Waiver Agency") as a provider in the Persons with Disabilities, Persons with Brain Injuries, and/or Persons with HIV/AIDS Wavers.

WHEREAS, the Provider wishes to submit claims for services rendered to eligible Healthcare and Family Services clients via the the Waiver Agency. The Provider is agreeing to permit the Waiver Agency to act on their behalf in enrolling the Provider as an Illinois Medical Assistance Program Provider. Under penalties of perjury, the Provider certifies that the information given to complete the enrollment is correct. The Waiver Agency will have authority to complete the electronic application using the Illinois Medical Assistance Program Advanced Cloud Technology (IMPACT) provider enrollment system. The Waiver Agency will maintain the provider's enrollment records in IMPACT including, but not limited to, updating information, making changes to the provider's enrollment status and revalidating enrollment information. The Waiver Agency will have legal authority to execute the terms and conditions of the Trading Partner agreement in the IMPACT Provider Enrollment System.

NOW THEREFORE, the Provider agrees as follows to the provisions:

1. The Provider shall, on a continuing basis, comply with all current and future program policy provisions as set forth in any applicable Program handbooks/agreements with the appropriate administering Waiver Agency, Illinois Medical Assistance or Waiver Agency, as appropriate, shall notify the Provider of changes in policy 30 days before the effective date of the change unless there is an emergency, as defined in the Administrative Procedure Act, or the change is to comply with State or Federal law or regulation.
2. The Provider shall, on a continuing basis, comply with applicable licensing or certification standards as contained in State laws or regulations.
3. The Provider shall comply with Title VI of the Civil Rights Act of 1964, the Rehabilitation Act of 1973, the Americans with Disabilities Act of 1990, and regulations promulgated thereunder which prohibit discrimination on the grounds of sex, race, color, national origin or disability.
4. The Provider shall, on a continuing basis, comply with Federal standards specified in Title XIX on the Social Security Act, and also with all applicable Federal and State laws and regulations.
5. The Provider shall invoice Waiver Agency for Medical Assistance covered services; Waiver Agency will arrange payment for covered services from Illinois Medical Assistance, as is outlined in the Social Security Act, Section 1902 (a)(27) and (a)(32).
6. Payment to the Provider under this Agreement shall constitute payment in full. Any payments received by the Provider from other sources shall be shown as a credit and deducted from the Provider's charges.
7. The Provider shall be fully liable for the truth, accuracy, and completeness of all claims for payment submitted electronically or in hard copy. Furthermore, the Provider agrees to review, affix an original signature on, and retain in their files the billing certification. Any false or fraudulent claim or claims or any concealment of a material fact may be prosecuted under applicable Federal and State laws.
8. The Provider shall maintain all records necessary to fully disclose the nature and extent of services provided to individuals under Articles V, VI, and VII of the Public Aid Code. The Provider shall maintain said records for not less than six (6) years from date of service or as required by applicable Federal and State laws, whichever is longer, and shall furnish these records upon demand when so requested by Illinois Medical Assistance, the Waiver Agency or their designees. If an Illinois medical Assistance or a Waiver Agency audit is initiated, the Provider shall retain all original records until the audit is completed and every audit issue has been resolved, even it the retention period extends beyond the required period.

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(Waiver Program Provider Agreement - Continued)

9. If not a practitioner, the Provider shall comply with the Federal regulations requiring ownership and control disclosure found at 42 CFR part 455, Subpart B.
10. The Provider shall exhaust all other sources of reimbursement as required by medical Assistance Program policy prior to seeking reimbursement from Illinois Medical Assistance.
11. The Provider shall be fully liable to Illinois Medical Assistance and the Waiver Agency for any overpayments which may result from the Provider's billings to Illinois medical Assistance and the Waiver Agency. The Provider shall be responsible for promptly notifying Illinois Medical Assistance and the Waiver Agency of any overpayments of which the Provider becomes aware. Illinois Medical Assistance and the Waiver Agency shall recover any overpayments by setoff, crediting against future billings or by requiring direct repayment to Illinois Medical Assistance and the Waiver Agency.
12. There has not been a prohibitive transfer of ownership interest to or in the provider by a relative who is terminated or bared from participation in the Program pursuant to 305 ILCS 5/124.25.
13. The Provider shall furnish to Illinois Medical Assistance or the U.S. Department of Health and Human Services (Hereinafter referred to as "HHS") on request, information related to business transactions in accordance with 42CFR 455.105 paragraph (b). The Provider agrees to submit, within 35 days after the date of such information related to business transactions in accordance with 42 CFR 455.105 paragraph (b). The Provider agrees to submit, within 35 days after the date of such request by Illinois Medical Assistance or HHS, complete information about: (1) the ownership of any subcontractor with whom the Provider has had business transactions totaling more the \$25,000 during the 12 month period ending on the date of the request; and (2) any significant business transactions between the provider and any wholly owned supplier, or significant between the Provider and any subcontractor, during the 5 year period ending on the date of the request.
14. Knowingly falsifying or willfully withholding information on the Provider Enrollment Application and/or the Agreement for Participation may be cause for termination of participation in the Illinois Medical Assistance Program.
15. The Provider, if a Home Services Program provider per the definitions and requirements of 89 Ill. Administrative Code Part 686, shall maintain compliance with applicable parts of the most recently updated Attachment D to the Department of Human Services grant agreement - (available via <http://www.dhs.state.il.us/page.aspx?item=29741>).
16. The Provider (if a hospital, nursing facility, hospice, home health care provider, or personal care services provider) shall comply with Federal requirements, found at 42 CFR Part 489, Subpart I, related to maintaining written policies and providing written information to patients regarding advance directives.

The signature below certifies that the Provider agrees to all of the provisions as stated in the Waiver Program Provider Agreement for Participation in the Illinois Medical Assistance program.

Provider Name (Print Full Legal Name): _____

Last 4 digits of Social Security Number: _____

National Provider Identifier (NPI): _____
 (Applies only for CNA, LPN, and RN)

Provider Signature: _____

Date: _____

Note: This Form is applicable only to Individual Providers providing services under the Division of Rehabilitation Services, Home Services Program.