ADULT FOSTER CARE or HOME FOR THE AGED
PROVIDER AGREEMENT

Attached is an Adult Foster Care Facility or Home for the Aged Provider Agreement form and instructions for completing this form. This form must be completed by all **Adult Foster Care (AFC)** or **Home for the Aged (HA) providers** in order to receive payment for Personal Care Services provided to eligible Medical Assistance (Medicaid) Program beneficiaries. A separate agreement is required for **EACH** facility. The agreement may be initiated by contacting either a local Family Independence Agency or Community Mental Health Agency.

Submitting a completed agreement does not obligate you to provide services to Medical Assistance Program beneficiaries. If, however, you do render services, you must provide them in accordance with the conditions stated in the attached Provider Agreement.

If you have any questions about this Provider Agreement, please call your local Family Independence Agency or Community Mental Health agency.

IMPORTANT

- Do **NOT** send the completed agreement to the Department of Community Health.
- Send the completed agreement to your **LOCAL Family Independence Agency** OR your **LOCAL Community Mental Health Agency**.

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Michigan Department of Community Health

- This form is to be completed by all eligible providers who wish to receive payment for services provided under the Medical Assistance (Medicaid) program.
- A licensee who owns more than one facility must sign a Provider Agreement for **each facility**.
- Read ALL information and instructions.
- **TYPE or PRINT.**
- Photocopy the completed form (both sides) for your files.
- When completed, separate this agreement from the cover page and send it to your:
  LOCAL Family Independence Agency or **LOCAL Community Mental Health Agency**.

COMPLETION INSTRUCTIONS:

Item 1 - If an Individual Licensee: Enter Last Name, First Name, and Middle Initial;
- If a Corporation: Enter the Corporate Name.

Item 2 - Enter AFC License Number or HA Facility Number.

Item 3 - Enter the Name of the Facility **as it appears on the license**.

Items 4 & 5 - The Licensee or Authorized Representative MUST Sign and Date this Agreement.

1. Licensee(s) / Corporate Name	2. AFC or HA License Number
3. Facility Name (as it appears on the license)	

- As a condition of receiving payment from the Medical Assistance Program for services billed by or on behalf of the above listed applicant for an eligible beneficiary, the undersigned certify and / or agree to ALL conditions listed on the reverse side of this document.
- The licensee or authorized representative certifies that the undersigned has authority to execute this agreement.

IMPORTANT: A FACSIMILE SIGNATURE WILL NOT BE ACCEPTED	
4. Signature of Licensee or Authorized Representative	5. Date Signed

Authority:	Titles V and XIX of the Social Security Act and P.A. 280 of 1939.
Completion:	Is Voluntary, but is required if enrollment in the Medical Assistance program is desired.

The Department of Community Health is an equal opportunity employer, services and programs provider.

See Reverse Side for Agreement Conditions

DCH-1625-A (5-01) (W) Replaces and Obsoletes MSA-1625-A

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I affirm that I am applying to be a provider in the Medical Assistance (Medicaid) Program and in consideration of participating as a provider in the Medical Assistance Program, I represent and certify as follows:

1. All information furnished on this Adult Foster Care or Home for the Aged Provider Agreement form is true and complete.

2. I agree to comply with the terms and conditions of participation noted in this agreement.

3. I agree to comply with the provisions of 42 USC, Sec. 405 and Act No. 280 of the Public Acts of 1939, as amended, which state the conditions and requirements under which participation in the Medical Assistance Program is allowed.

4. I agree that, upon request and at a reasonable time and place, I will allow authorized state or federal government agents to inspect, copy, and/or take any records I maintain pertaining to the delivery of goods and services to or on behalf of a Medical Assistance Program beneficiary. These records will also include any service contract(s) I have with any billing agent/service or service bureau, billing consultant, or another medical services provider.

5. I agree to include a clause in any contract into which I enter, regarding the billing or provision of Medicaid services, that allows authorized state or federal government agents access to the subcontractor's accounting records and other documents needed to verify the nature and extent of costs and services furnished under the contract.

6. I understand that payment for services billed under my provider identification number will be made directly to me or my corporation, as indicated on the front of this agreement.

7. I am not currently suspended, terminated or excluded from the Medical Assistance Program by any state or by the US Department of Health and Human Services.

8. I agree to comply with all policies and procedures of the Medical Assistance Program when billing for services rendered. I also agree that disputed claims, including overpayments, may be adjudicated in administrative proceedings convened under Act No. 280 of the Public Acts of 1939, as amended, or in a court of competent jurisdiction. I further agree to reimburse the Medical Assistance Program for all overpayments and I acknowledge that the Medicaid Audit System, which uses random sampling, is a reliable and acceptable method for determining such overpayments.

9. I agree to accept the Michigan Medical Assistance Program payment as **PAYMENT IN FULL** for the personal care services rendered. I will not seek nor accept additional or supplemental payment from beneficiaries, their families or their representatives.

10. I understand that I may be prosecuted under applicable federal or state criminal and civil laws for submitting false claims, concealing material facts, misrepresentation, falsifying data, other acts of misrepresentation, or conspiracy to engage therein.