MSA MEDICAL SERVICES ADMINISTRATION

Bulletin

Michigan Department of Community Health

Bulletin: MSA 10-21

Distribution: Individual and Agency Home Help Providers

Issued: June 1, 2010

Subject: Home Help Provider Agreement

Effective: July 1, 2010

Programs Affected: Medicaid

Federal regulations require that all providers of Medicaid covered services complete and sign a provider agreement that states they will abide by Medicaid policies in providing services to program clients and in receiving payment from the program. In order to meet this requirement the Department of Community Health (DCH) has developed the Home Help Provider Agreement (MSA-4678).

All Home Help service providers must have a completed and signed MSA-4678 on file with DCH in order to receive payment for covered services. Providers currently participating in the program may complete the agreement at the opening, changing or re-determination of a client's Home Help service plan. New providers must complete the Provider Agreement before any services can be provided.

When signing the agreement, individual providers of Home Help services (those not affiliated with a Home Help provider agency) must also present current pictured identification (i.e., driver's license, state identification card, etc.) and social security card to the Department of Human Services (DHS) adult services worker. Home Help provider agencies must complete this agreement in addition to meeting all other agency requirements. DHS will forward completed forms to DCH.

Please note the following:

1. Instructions for completing the Home Help Provider Agreement are included as part of the agreement.
2. MSA-4678 does not replace the Home Help Services Statement of Employment (MSA-4676).
3. Providers should retain a photo copy of the completed agreement for their records.
4. Providers will be required to complete the agreement only once. It will be valid for all counties in the State of Michigan.

Providers are reminded that they must immediately notify DHS of any changes affecting enrollment information. Failure to notify the worker of any changes in provider information may result in the loss of enrollment, the lapse of eligibility, or nonpayment of services.

The attached MSA-4678 is a facsimile of the Home Help Provider Agreement. The actual form will be given to individual and new agency providers by the DHS Adult Services Specialist.

Current Agency Providers

The MSA-4678 will be mailed to currently approved agency providers. To avoid a delay in payment, these forms must be completed and returned by October 1, 2010 to:

Michigan Department of Human Services
Attention: Allison Pool - Suite 1406
P.O. Box 30037
Lansing, MI 48909

Manual Maintenance

Retain this bulletin until the information has been incorporated into the Department of Human Services, Adult Services Manual.

Questions

Any questions regarding this bulletin should be directed to Provider Inquiry, Department of Community Health, P.O. Box 30731, Lansing, Michigan 48909-8231, or e-mail at ProviderSupport@michigan.gov. When you submit an e-mail, include your name, affiliation, and phone number so you may be contacted if necessary. Providers may phone toll-free 1-800-292-2550.

APPROVED

Stephen Fitton, Director
Medical Services Administration

Michigan Department of Community Health

Medical Assistance Home Help Provider Agreement

Instructions for Completing the Home Help Provider Agreement

SECTION 1: TO BE COMPLETED BY INDIVIDUAL HOME HELP PROVIDERS NOT AFFILIATED WITH AN AGENCY.

1. **HOME HELP PROVIDER NAME:** Enter the first, middle initial and last name of the Home Help provider applicant.
2. **PROVIDER SSN:** Enter the Social Security Number of the provider applicant.
3. **DATE OF BIRTH:** Enter the birth date of the provider applicant (MM/DD/YYYY).
4. **PROVIDER ADDRESS:** Enter the full street address of the provider applicant including street number, street, and, if applicable, apartment or lot number.
5. **TELEPHONE NUMBER & E-MAIL ADDRESS:** a. Enter the current telephone number, including area code, to reach the provider applicant. b. Enter the current e-mail address (optional).
6. **P.O. BOX NUMBER:** Enter the Post Office Box number (where applicable).
7. **CITY:** Enter the city where the provider applicant resides.
8. **STATE:** Enter the state where the provider applicant resides.
9. **ZIP CODE:** Enter the corresponding zip code for the provider applicant's address.

SECTION 2: TO BE COMPLETED BY AGENCIES PROVIDING HOME HELP SERVICES.

10. **AGENCY PROVIDER NAME:** Enter the complete name of the agency provider.
11. **TAX ID NUMBER:** Enter the IRS Tax ID number for the agency.
12. **AGENCY PROVIDER ADDRESS:** Enter the full street address of the agency, including street number, street, and, if applicable, suite or unit number.
13. **AGENCY TELEPHONE NUMBER:** Enter the phone number where the authorized representative of the provider agency can be reached.
14. **P.O. BOX NUMBER:** Enter the Post Office Box number (where applicable).
15. **CITY:** Enter the city where agency provider is located.
16. **STATE:** Enter the state where agency provider is located.
17. **ZIP CODE:** Enter the corresponding zip code for agency provider's address.
18. **CONTACT PERSON & E-MAIL ADDRESS:** a. Enter the name of the agency owner or other authorized representative. b. Enter the current e-mail address (optional).
19. **OWNER NAME(S):** Enter the name(s) of any person owning at least a 5% share of the provider agency. (Attach additional pages if needed.)

SECTION 3: TO BE COMPLETED BY BOTH INDIVIDUAL AND AGENCY PROVIDERS.

20. The provider applicant must provide proper disclosure of any criminal convictions related to Medicare (Title XVIII), Medicaid (Title XIX) and other State Health Care Programs (Title V, Title XX, and Title XXI). Proper disclosure includes i.e., nature of the crime, court where the conviction was entered, date the conviction was recorded, and date the sentence was completed.
21. Home Help Provider Applicant must re-enter the Individual applicant's Social Security Number or the IRS Tax ID number for the agency.
22. The Home Help Provider Applicant must indicate by checking the appropriate box, if they are in agreement with the terms and conditions of the application. All Agreements must be signed.

Michigan Department of Community Health

Medical Assistance Home Help Provider Agreement

(FOR OFFICIAL USE ONLY)	
PROVIDER ID NUMBER	PROVIDER TYPE **01**

SECTION 1 (INDIVIDUAL PROVIDERS ONLY)

As an individual provider of Home Help services, I agree that the beneficiary is considered the employer. I will not be employed by the Department of Community Health (DCH), the Department of Human Services (DHS), or the State of Michigan.

1. INDIVIDUAL HOME HELP PROVIDER NAME (FIRST, MI, LAST)		2. PROVIDER SSN (Required) - -	3. DATE OF BIRTH / /
4. PROVIDER ADDRESS (NO. AND STREET, APARTMENT OR LOT NO)		5. A. TELEPHONE NUMBER ( ) -	5. B. E-MAIL ADDRESS (optional)
6. P.O. BOX NO.	7. CITY	8. STATE	9. ZIP CODE

SECTION 2 (AGENCY PROVIDERS ONLY)

As a Home Help provider agency, I agree that the agency contract is with the beneficiary. The agency contract is not with the Department of Community Health (DCH), the Department of Human Services (DHS), or the State of Michigan.

10. AGENCY PROVIDER NAME		11. TAX ID NO. (Required for Agencies)	
12. AGENCY PROVIDER ADDRESS (NO. AND STREET, SUITE NO)		13. AGENCY TELEPHONE NUMBER ( ) -	
14. P.O. BOX NO.	15. CITY	16. STATE	17. ZIP CODE
18. A. CONTACT PERSON (AGENCY OWNER OR AUTHORIZED REPRESENTATIVE)		18. B. E-MAIL ADDRESS (optional)	
19. A. OWNER NAME(S):	EFFECTIVE	% OWNED	OWNER SSN - -
B. OWNER NAME	EFFECTIVE	% OWNED	OWNER SSN - -
C. OWNER NAME	EFFECTIVE	% OWNED	OWNER SSN - -

SECTION 3 (TO BE COMPLETED BY *BOTH* INDIVIDUAL AND AGENCY PROVIDERS)

20. HAVE YOU OR ANY OF YOUR EMPLOYEES BEEN CONVICTED OF A CRIME PROHIBITING YOU FROM RECEIVING PAYMENTS FROM FEDERAL OR STATE FUNDS? ☐ NO ☐ YES - If YES, attach explanation on a separate sheet.

- I agree that personal care services will be provided for a Michigan Medicaid beneficiary, as authorized by the Michigan Department of Human Services (DHS) according to the DHS Adult Services Comprehensive Assessment.
- In order to receive payment, I agree to keep and submit to DCH, DHS or their designee, any and all records necessary to disclose the extent of services provided to the client.
- Under Section 3504 of the Internal Revenue Code, I agree to accept the Michigan Department of Community Health (DCH) as the acting agent of the beneficiary for the deduction of withholding taxes and union dues. I further agree to accept payments issued by DCH as payment in full and not to seek or accept additional payments from the beneficiary or any other source. I agree to return any payments received for Home Help services not provided.
- Upon request, I agree to provide DCH, DHS or their designee, any information regarding services or purchases for which payment was made.
- I agree to cooperate with DCH, DHS, or their designee, regarding any audits, investigations or inquiries related to Home Help services provided.

Michigan Department of Community Health

Medical Assistance Home Help Provider Agreement

21.	PROVIDER SSN (Required for Individuals) - -
	TAX ID NO. (Required for Agencies)

SECTION 3 (TO BE COMPLETED BY *BOTH* INDIVIDUAL AND AGENCY PROVIDERS) - *continued.*

- I agree to comply with the privacy, security and confidentiality provisions of all applicable laws governing the use and disclosure of protected health information (PHI), including the privacy regulations adopted by the U.S. Department of Health and Human Services under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and Public Acts 104-191 (45 CFR parts 106 and 164, Subparts A, C, and E).
- I agree to comply with the provisions of 42 CFR 431.107 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.

By signing the Provider Agreement, I acknowledge that I have read the Provider Agreement, and the included instructions. I agree to fully comply with all program requirements.

23. ☐ Individual Home Help Provider **OR** ☐ Authorized Home Help Agency Representative	
SIGNATURE	DATE

By virtue of the signature date on this form, it is understood that this document supersedes all previous versions (paper and electronic) of this form.

AUTHORITY: P.A. 280 of 1939, as amended.
COMPLETION: Required.
PENALTY: Application may not be approved.