INDEPENDENT LIVING SUPPORTS PILOT (ILSP) PROGRAM PROVIDER AGREEMENT AND ACKNOWLEDGEMENT OF TERMS OF PARTICIPATION

To be completed by ILSP provider agencies or individual providers.

Name of Provider (Typed or Printed—Must exactly match name used on all other documents)			
Address – Street	City	State	Zip Code
Email Address	Phone Number	Tax ID Number	

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

1. To provide only the items or services authorized by the ILSP program.
2. To educate the participant of the full cost of service and to bill the participant directly for any charges above the amount authorized in their ILSP service plan.
3. To refund any overpayment to the ILSP program.
4. To keep any records necessary to disclose the extent of services provided consistent with the provider’s business type.
5. To submit before and after pictures with claims for vehicle and home modifications costing greater than $1,000.
6. To provide, upon request the ILSP program or the Department of Health Services (DHS) or its designee, information regarding items or services provided.
7. To comply with all other applicable federal and state laws, regulations, and policies relating to providing home and community-based care including the caregiver background check law.
8. Confidentiality Policies and Procedures: To maintain the confidentiality of all records or other information relating to each participant’s status as an ILSP participant and items or services the participant receives from the provider.
9. To respect and comply with the participant’s right to refuse medication and treatment and other rights granted the participant under federal and state law.
10. To keep records necessary to disclose the extent of services provided to ILSP participants **for a period of ten (10) years** and to furnish upon request to the DHS any information regarding services provided and payments claimed by the provider for furnishing services.
11. The provider agrees to furnish to the fiscal agent 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 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;

c) The names and addresses of any subcontractors who have had business transactions with the provider;

d) 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 XX services programs since the inception of those programs.

G- To provide to the DHS identifying information, including name, specialty, date of birth, Social Security number, national provider identifier, (NPI) (if eligible for an NPI), Federal taxpayer identification number, and State license or certification for purposes of enrollment with the ILSP program.

H- To include its NPI (if eligible for an NPI) on all claims submitted under the ILSP program

I- To comply with the advance directives requirements specified in 42 CFR Part 489, Subpart I.

J- To refrain from influencing an individual to not enroll in or to disenroll from a healthcare, long-term care program or the ILSP program.

Modifications to this agreement cannot and will not be agreed to. Altering this document in any way voids the agreement. This agreement is not transferable or assignable.

Name – Provider (Typed or Printed)	
SIGNATURE – Provider	Date Signed

Fiscal Agent Receipt of Agreement	
SIGNATURE – Fiscal Agent	Date Received