TEXAS
Health and Human Services

MCO LTSS APPLICATION PACKET CHECKLIST

***Please answer all questions in the application and submit all forms from the packet. If the question does not apply a response is still needed* All applications must be typed. Incomplete application packets will not be processed and will be rejected.**

	MCO LTSS Provider Enrollment Application	***All questions require a response**. Please enter NA if not applicable. *Verify that your NPI, and taxonomy match according to the National NPI Registry- https://npiregistry.cms.hhs.gov/ *Please read question 13, and 25 thoroughly
	Disclosure of Ownership and Control Interest Statement	***All questions require a response.** If the question does not apply, please check the "no" response. *All individuals listed in section **III** (a) require a PIF-2. *
	Provider Information Form (PIF-1)	***A PIF-1 is required for all providers.** Please be sure to complete the entire document. *No response should be left blank.
	Principal Information Form (PIF-2)	* PIF-2 form needed for **each person and entity** listed on the Disclosure of Ownership form Section III (a). *Entity or Person should be checked. **Do not check both***
	Medicaid Provider Agreement	*Please return pages 1, 11, and 16 **ONLY**.
	W-9	
	Check/Proof of payment	*Please review page 5 of the MCO LTSS Application to determine if the enrollment fee is necessary for your facility.
	Certification/Licenses	*A copy of **ALL** licenses and certifications are required.
	Corporate Board of Resolution	When claiming "Corporation" on the Disclosure of Ownership and Control Interest Statement providers must complete and return the following forms: • Corporate Board of Directors Resolution Form, (must be notarized) • Certificate of Formation, Certificate of Filing, Certificate of Authority, or Certificate of Registration • Franchise Tax Account Status, available at https://mycpa.cpa.state.tx.us/coa/Index.html
	Fingerprints	***If your taxonomy is 251E00000X, 253Z00000X, or 251G00000X fingerprints are required.** * The website for Texas Medicaid's fingerprinting vendor is **https://uenroll.identogo.com/servicecode/11H7TG**. You can

	[redacted]	schedule appointments online or by phone at **1-877-289-6114**. For online scheduling, we recommend using Google Chrome to access the vendor's website. To book an appointment by phone, you need a six-digit service code. Texas Medicaid's service code is 11H7TG.

Instructions for Completing the Disclosure of Ownership and Control Interest Statement

Completion and submission of this form is a condition of participation, certification or recertification under any of the programs established by Titles V, XVIII, XIX and XX or as a condition of approval or renewal of a contractor agreement between the disclosing entity and the secretary of appropriate state agency under any of the above-titled programs, a full and accurate disclosure of ownership and financial interest is required. Failure to submit requested information may result in a refusal by the appropriate State agency to enter into an agreement or contract with any such institution in termination of existing agreements.

GENERAL INSTRUCTIONS

Please answer all questions as of the current date. If the yes block for any item is checked, list requested additional information under the Remarks Section referencing the item number to be continued. If additional space is needed, use an attached sheet.

DETAILED INSTRUCTIONS

These instructions are designed to clarify certain questions on the form. Instructions are listed in order of question for easy reference. NO instructions have been given for questions considered self-explanatory.

IT IS ESSENTIAL THAT ALL APPLICABLE QUESTIONS BE ANSWERED ACCURATELY AND THAT ALL INFORMATION BE CURRENT.

ITEM I – Identifying Information

(a) Under identifying information specify in what capacity the entity is doing business as (DBA), example, and name of trade or corporation.

ITEM II – Self–explanatory.

ITEM III – Owners, Partners, Officers, Directors, and Principals

List the names of all individuals and organizations having direct or indirect ownership interests, or controlling interest separately or in combination amounting to an ownership interest of 5 percent or more in the disclosing entity. 501 (c) (3) nonprofit and state-owned entities must list the officers or directors that have a control interest in the entity and managing employees in Section III(a). Since there will be no entries for any person with an ownership interest (Section III[b]), the percentage of ownership will always be less than 100 percent.

Direct ownership interest is defined as the possession of stock, equity in capital or any interest in the profits of the disclosing entity. A disclosing entity is defined as a Medicare provider or supplier or other entity that furnishes services or arranges for furnishing services under Medicaid or the Maternal and Child Health program or health related services under the social services program.

Indirect ownership interest is defined as ownership interest in an entity that has direct or indirect ownership interest in the disclosing entity. The amount of indirect ownership in the disclosing entity that is held by any other entity is determined by multiplying the percentage of ownership interest at each level. An indirect ownership interest must be reported if it equates to an ownership interest of 5 percent or more in the disclosing entity. Example: if "A" owns 25 percent of the stock in a corporation that owns 80 percent of the stock of the disclosing entity, "A's" interest equates to a 20 percent indirect ownership and must be reported.

Controlling interest is defined as the operational direction or management of a disclosing entity which may be maintained by any or all of the following devices; the ability or authority, expressed or reserved to amend or change the corporate identity (i.e., joint venture agreement, unincorporated business status) of the disclosing entity; the ability or authority to nominate or name members of the Board of Directors or Trustees of the disclosing entity; the ability or authority, expressed or reserved to amend or change the by-laws, constitution or other operating or management direction of the disclosing entity; the right to control any or all of the assets or other property of the disclosing entity upon the sale or dissolution of that entity; the ability or authority, expressed or reserved to control the sale of any or all of the assets to encumber such assets by way of mortgage or other indebtedness, to dissolve the entity or to arrange for the sale or transfer of the disclosing entity to new ownership or control.

Note: *All individuals listed in Section III(a) must submit a PIF-2.*

ITEMS IV through VII – Changes in Provider Status

Change in provider status is defined as any change in management control. Examples of such changes would include a change in Medical or Nursing Director, a new Administrator, contracting the operation of the facility to a management corporation, a change in the composition of the owning partnership which under applicable State law is not considered a change in ownership, or the hiring or dismissing of any employees with 5 percent or more financial interest in the facility or in an owning corporation, or any change of ownership.

For items IV through VII, if the **Yes** box is checked, list additional information requested under Remarks. Clearly identify which item is being continued.

ITEM IV – Ownership

(a & b) If there has been a change in ownership within the last year or if you anticipate a change, indicate the date in the appropriate space.

ITEM V – Management

If the answer is **Yes**, list name or the management firm and employer identification number (EIN) or the leasing organization. A management company is defined as any organization that operates and names a business on behalf of the owner of that business with the owner retaining ultimate legal responsibility for operation of the facility.

ITEM VI – Staffing

If the answer is **Yes**, identify which has changed (Administrator, Medical Director or Director of Nursing) and the date the change was made. Be sure to include name of the new administrator, Director of Nursing or Medical Director, as appropriate.

ITEM VII – Affiliation

A chain affiliate is any freestanding health-care facility that is owned, controlled, or operated under lease or contract by an organization consisting of two or more freestanding health-care facilities organized within or across State lines which is under the ownership or through any other device, control and direction of a common party. Chain affiliates include such facilities whether public, private, charitable or proprietary. They also include subsidiary organizations and holding corporations. Provider-based facilities such as hospital–based home health agencies are not considered to be chain affiliates.

ITEM VIII – Capacity

If the answer is **Yes**, list the actual number of beds in the facility now and the previous number.

ITEM IX - Disclosure of Relationship

Please disclose any of familial relationships between principals and/or the provider (i.e., Husband, Wife, Natural or Adoptive Parent, Natural or Adoptive Child, Natural or Adoptive Sibling).

This form is required for all individuals, groups, and facilities (exclude performing providers and SHARS providers).

I.	Identifying information				
(a)	Legal Name: *(according to the IRS)*	DBA:	Telephone number:		
	Webb County	Meals on Wheels Program	(956) 722-4664		
	Physical/Corporate Address: Number Street	Suite	City	State	ZIP
	1110 Washington St.	#204	Laredo	Tx.	78040

II.	Answer the following questions by checking Yes or No. *If any of the questions are answered Yes, list names and addresses of individuals or corporations under Remarks on the Disclosure of Ownership and Control Interest Statement form. Identify each item number to be continued.*	
(a)	Are there any individuals or organizations having a direct or indirect ownership or control interest of five percent or more in the institution, organizations, or agency that have been convicted of a criminal offense related to the involvement of such persons, or organizations, in any of the programs established by Titles XVIII, XIX, or XX?	☐ Yes ☑ No
(b)	Does this provider have any current employees in the position of manager, accountant, auditor, or in a similar capacity and who were previously employed by this provider's fiscal intermediary or carrier within the last 12 months? *(Medicare providers only)*	☐ Yes ☑ No

III.	Owners, Partners, Officers, Directors, and Principals *All individuals and entities identified in this section are required to complete a PIF-2 which must be submitted with this enrollment application.*
(a)	Identify individuals who are sole proprietors or owners, partners, officers, directors, and principals (as defined in the Principal Information Form [PIF-2]) of the applicant and list the percentage of ownership, if applicable. Total ownership should equal 100 percent unless otherwise noted in the instructions (see previous page). If ownership does not total 100 percent, the provider must submit a letter explaining the discrepancy. As it relates to owners, include all individuals with 5 percent or more ownership in the company, whether this ownership is direct or indirect. *(Add additional pages if necessary.)*

	Name:	Percentage Owned:
1.		
2.		
3.		
4.		

(b) Identify the entities with ownership of a controlling interest in the applicant (whether such ownership of the controlling interest is direct or indirect). Provide the entity's name and federal tax identification number. *See Instructions for Completing the Disclosure of Ownership and Control Interest Statement. List any additional names and addresses under Remarks on the Disclosure of Ownership and Control Interest Statement. If more than one individual is reported and any of these persons are related to each other, this must be reported under Remarks.*

Name:	Address:	Federal Tax ID:
Webb County	1110 Washington St. Ste.# 204	74-6001587
Meals on Wheels	1310 Convent Ave.	74-1679668

*?

(c)	**Do you currently have a creditor with a security interest in a debt that is owed by you?**	☐ Yes ☑ No
	Is the creditor(s) security interest protected by at least 5 percent of your property?	☐ Yes ☑ No

List each creditor with a security interest in a debt that is owed by you if the creditor's security interest is protected by at least 5 percent of your property. *All listed creditors must also complete a Principal Information Form (PIF-2).*

Last Name/Company Name:	First Name:	Percent of Security Interest:

(d) **Type of Entity:** *Select only one - must match entity on W9*

☐ Individual/sole proprietor ☐ C Corporation ☐ S Corporation ☐ Partnership

☐ Limited liability company. (*Enter the tax classification [C=C corporation, S=S corporation, P=partnership]*) _____

☐ Trust/estate ☑ Other *(specify)* Government

(e) **If the disclosing entity is a corporation, list names, addresses of the directors and EINs for corporations in remarks.**
Note: Each director identified in this section must also complete a PIF-2. All PIF-2 documents must be submitted with this application. Attach additional pages if needed.

Remarks:

IV.	Ownership	
(a)	**Has there been a change in ownership or control within the last year?**	☐ Yes ☑ No
	If Yes, *give date:*	
(b)	**Do you anticipate any change of ownership or control within the year?**	☐ Yes ☑ No
	If Yes, *give date:*	
(c)	**Do you anticipate filing for bankruptcy within the year?** *(see provider agreement for additional information)*	☐ Yes ☑ No
	If Yes, *give date:*	
(d)	**Are any of the new owners related to any of the former owners?**	☐ Yes ☑ No
(e)	**Did any former owners transfer their ownership interest to any new owners in anticipation of or following the assessment of a civil monetary penalty?** *If yes, please list the name of the former owners below.*	☐ Yes ☑ No

Last Name:	First Name:	Middle Initial:

V.	Management	
	Does the provider identified in Section I. above comprise or include a facility that is operated by a management company, or a facility that is leased in whole or in part by another organization?	☐ Yes ☑ No
	If Yes, *give date of change in operations:*	

VI.	Staffing	
(a)	Has there been a change in Administrator, Director of Nursing, or Medical Director within the last year?	☐ Yes ☑ No

VII.	Affiliation	
(a)	Is the provider identified in Section I. above chain affiliated?	☐ Yes ☑ No
	If Yes, *provide the name, address, and Federal Tax ID number of the chain's corporate/home office:*	
	Name Address Federal Tax ID	

VIII.	Capacity	
(a)	Have you increased your bed capacity by 10 percent or more or by 10 beds, whichever is greater, within the last two years? *(For Hospitals only)*	☐ Yes ☑ No
	If Yes, *give:* **Year of change:** **Current Beds:** **Prior Beds:**	

IX.	Disclosure of Relationship		
(a)	Please disclose any of the following familial relationships between principals and/or the provider (Husband, Wife, Natural or Adoptive Parent, Natural or Adoptive Child, Natural or Adoptive Sibling):		
	Provider/Principal 1:	Has a Relationship as:	To Provider/Principal Name 2:

Please Note: When claiming "Corporation" providers must complete and return the following forms:

- Corporate Board of Directors Resolution Form, original signature and notarized.
- Certificate of Formation, Certificate of Filing, Certificate of Authority, or Certificate of Registration.
- Franchise Tax Account Status, available at https://mycpa.cpa.state.tx.us/coa/Index.html.

Do you have a 501(c)(3) Internal Revenue Exemption? ☐ Yes ☑ No

Providers who answer "yes" to the question "Do you have a 501©(3) Internal Revenue Exemption" must submit a copy of their IRS Exemption Letter with submission of this application's signature page. Providers who have a 501(c)(3) Internal Revenue Exemption are not required to submit a copy of the Franchise Tax Account Status from the State Comptroller's Office.

TEXAS
Health and Human Services

Medicaid CHIP Services Department
Affordable Care Act Managed Care Organization (MCO)
Long Term Services & Supports (LTSS) Provider Application

MCO LTSS PROVIDER APPLICATION

PROVIDER TYPE INFORMATION

What kind of provider are you: ☐ **Individual** ☑ **Performing Provider** ☐ **Group** ☐ **Facility**

Name of individual/performing provider/group/facility wanting to enroll:

A. If an individual:

Last Name:	First Name:	Middle Initial:

B. If a performing provider/group/facility:

Company Name: Webb County - Community Action Agency - Meals on Wheels

Legal Provider Name: C.A.A. Meals on Wheels Program.

Mailing address: 520 Reynolds

City: Laredo	State: Texas	ZIP Code: 78040

Physical address: 1310 Convent Ave.

City: Laredo	State: Texas	ZIP Code: 78040

PROVIDER NUMBERS/IDENTIFIERS

Provide all applicable numbers/identifiers.

Medicare Certification Number:	Medicare Certification Date:
Federal Tax I.D. (TIN) Number: 74-6001587	Social Security Number:
National Provider Identifier (NPI) Number: 1952597734	Texas Provider Identifier (TPI) Number: 332U00000X
Atypical Provider Identifier (API) Number:	Primary Provider Taxonomy Code:

PROVIDER TYPES

Select the provider type that applies to this application.

☐ Adult Foster Care	☐ Primary Home Care / Nursing Services
☐ Agency Adult Foster Care	☐ Primary Home Care / Nursing Services / Attendant Carte / CFC
☐ Emergency Response System	☐ Respite Care / Assisted Living
☐ Employment Assistance	☐ Supported Employment
☐ Habilitation	☐ Transition Assistance Services
☑ Home Delivered Meals	☐ Value Added
☐ Minor Home Modifications	☐ Adult Daycare/DAHS
☐ Hospice	

CONTACT INFORMATION – POINT OF CONTACT FOR THIS APPLICATION

Last Name: Ramos-Valdez	First Name: Isa	Middle Initial: A.
Email Address: iramos@webbcountytx.gov		Phone (956) 791-6819

Address: 1310 Convent Ave.

City: Laredo	State: Texas	ZIP Code: 78040

Title/Position: Program Manager

PROFESSIONAL LICENSURE/MEDICARE CERTIFICATION:

MCO LTSS PROVIDER APPLICATION

Please list all professional licenses, accreditations, or certifications that apply for your application. ***Copies of current licenses, accreditations or certifications must be submitted with this applications.***

A. Professional Licensing Board:	Professional Licensing State:	Professional Licensing Number:
Professional License Issue Date:	Professional License Expiration Date:	
B. Professional Licensing Board:	Professional Licensing State:	Professional Licensing Number:
Professional License Issue Date:	Professional License Expiration Date:	
C. Professional Licensing Board:	Professional Licensing State:	Professional Licensing Number:
Professional License Issue Date:	Professional License Expiration Date:	

	YES	NO
1. Is your professional license, accreditation, or certification revoked, suspended, or otherwise restricted?	☐	☑
2. Have you ever had your professional license, accreditation, or certification revoked, suspended, or otherwise restricted?	☐	☑
3. Are you currently or have you ever been subject to a licensing, accreditation, or certification board order?	☐	☑
4. Have you voluntarily surrendered your professional license, accreditation, or certification in lieu of disciplinary action against your license?	☐	☑
5. Have you ever enrolled in or applied to any other State's Medicaid or CHIP program?	☐	☑
6. Have you ever been unenrolled or banned from enrolling in the federal Medicare program?	☐	☑
7. Are you currently or have you ever been subject to the terms of a settlement agreement, corporate compliance agreement or corporate integrity agreement in relation to any state or federally funded program?	☐	☑
8. Do you currently have any outstanding debt in relation to any state or federally funded program? *If yes was answered to any of the questions above, fully explain the details including date, and the state if applicable.*	☐	☑
9. Are you currently charged with or have you ever been convicted of a crime (excluding Class C misdemeanor traffic citations)?	☐	☑
10. Have you been arrested for a crime but not yet charged?	☐	☑
11. Is there an outstanding warrant for your arrest? If yes, fully explain the details, including date, the state and county where the incident occurred, the cause number(s), and specifically what you were convicted of:	☐	☑
12. Are you currently subject to court ordered child support payments?	☐	☑
13. Do you have the legal right to work in the United States? If the United States is not your Country of Citizenship please provide a copy of your green card, visa or other documentation demonstrating your right to reside and work in the United States.	☑	☐

MCO LTSS PROVIDER APPLICATION

OWNERSHIP DISCLOSURE AND CONTROL INTERESTS:

	YES	NO
14. Do you currently have a creditor with a security interest in a debt that is owed by you? a. Is the creditor's security interest protected by at least 5% of your property? b. First Name: c. Last Name: d. Company Name: e. Percent of Security Interest: %	☐ ☐	☑ ☑
15. Are you seeking enrollment due to change of ownership?	☐	☑
16. Are any of the new owners related to any of the former owners?	☐	☑
17. Did any former owners transfer their ownership interest to any new owners in anticipation of or following the assessment of a civil monetary penalty? If yes, please list the last name, first name, middle initial of the former owners below.	☐	☑
18. Is anyone on this application chain store affiliated? If yes, complete the following for each affiliate.	☐	☑

Chain store affiliation #1

Principal or subcontractor:	Last Name:	First Name:
Percent Owned: %	Social Security Number:	
Physical address:		
City:	State:	ZIP Code:

Chain store affiliation #2

Principal or subcontractor:	Last Name:	First Name:
Percent Owned: %	Social Security Number:	
Physical address:		
City:	State:	ZIP Code:

Chain store affiliation #3

Principal or subcontractor:	Last Name:	First Name:
Percent Owned: %	Social Security Number:	
Physical address:		
City:	State:	ZIP Code:

	YES	NO
19. Does any owner or controlling interest party have one or more professional licenses, accreditations or certifications? If yes, complete the following for each. *Copies of current licenses, accreditations or certifications must be submitted with this applications.*	☐	☑

MCO LTSS PROVIDER APPLICATION

Ownership and Controlling Interest Professional license, accreditation, or certification #1	
License Accreditation/Certification Issuer:	License Accreditation/Certification Number:
License Accreditation/Certification Issue Date:	License Accreditation/Certification Expiration Date:
Ownership and Controlling Interest Professional license, accreditation, or certification #2	
License Accreditation/Certification Issuer:	License Accreditation/Certification Number:
License Accreditation/Certification Issue Date:	License Accreditation/Certification Expiration Date:
Ownership and Controlling Interest Professional license, accreditation, or certification #3	
License Accreditation/Certification Issuer:	License Accreditation/Certification Number:
License Accreditation/Certification Issue Date:	License Accreditation/Certification Expiration Date:

	YES	NO
20. Does the applicant, owner, or controlling interest party have a relationship (family or business) with a separate provider?	☐	☑
21. Is the owner or controlling interest party currently or have you ever been subject to the terms of a settlement agreement, corporate compliance agreement or corporate integrity agreement in relation to any State or Federally funded program?	☐	☑
22. If yes was answered to any of the questions above, fully explain the details including the date, state, name of the board or agency (if applicable), any adverse action against your license (if applicable) and details of outstanding debt or settlement agreements (if applicable).		
23. Has the owner or controlling interest party been arrested for a crime but not yet charged or is there an outstanding warrant for arrest? If yes, fully explain the details, including date, the state and county where the conviction occurred, the cause number(s), and specifically what you were convicted of:	☐	☑
24. Is the owner or controlling interest party currently subject to court ordered child support payments?	☐	☑
25. Does the owner or controlling interest party have the legal right to work in the United States?	☑	☐

26. Please disclose any of the following familial relationships between principals and/or the provider: Husband, Wife, Natural or Adoptive Parent, Natural or Adoptive Child, Natural or Adoptive Sibling.
    a. Provider/Principle 1: Has a Relationship as: To Provider/Principle 2:

27. **Provider must complete and submit the Disclosure of Ownership and Control Interest Statement located at** http://www.tmhp.com/Provider_Forms/Provider%20Enrollment/F00108_Disclosure_of_Ownership.pdf.

28. **Provider must complete and submit Principal Information Form (PIF2) located at** http://www.tmhp.com/Provider_Forms/Provider%20Enrollment/PIF2%20Principal%20Information%20Form.pdf.

29. **Provider must submit the Internal Revenue Service (IRS) W-9 Form.**

APPLICATION FEE

MCO LTSS PROVIDER APPLICATION

In accordance with ACA and 42 CFR 455.460, certain providers are subject to an application fee for all enrollment applications. The calendar year 2019 application fee amount is $586.00 per application (entity enrollment). If the applicant is required to pay the application fee, you must submit payment in the form of a paper check, money order, or cashier's check, when submitting this application. Payment should be made out to the Texas Health and Human Services Commission (HHSC). Please include "ACA MCD MCO LTSS Provider Re-enrollment Fee" in the memo line of the check.

An application fee is not required and will not be accepted if the applicant is enrolled in and has paid the Medicare enrollment application fee or another state's Medicaid program's enrollment application fee. If the applicant claims they are not required to pay the Texas application fee, you must submit proof of payment to Medicare or another state's Medicaid program when submitting this application. Otherwise, please include the application fee with your application paperwork.

SIGNATURES	
Signature of applicant:	Date:
Applicant Printed Name:	
Signature of applicant:	Date
Applicant Printed Name:	

Written Communication
Enrollment Applications:
Attn: MCD MCO LTSS Provider Enrollment Mail Code H312
HHSC Medicaid & CHIP Services Department, Operations Management
909 W. 45th Street Bldg. 2
Austin, Texas 78751

Email Communication
MCO_LTSS_Provider_Re-Enrollment@hhsc.state.tx.us

MEDICAID PROVIDER AGREEMENT

I. APPLICANT/PROVIDER INFORMATION

(1) Legal name of applicant or provider (hereinafter, jointly referred to as the "Provider")	(2) Business Name (if different than legal name)
Webb County dba Meals on Wheels	
(3) National Provider Identifier (NPI) or Atypical Provider Identifier (API)	**(4) Taxpayer ID No. (EIN or SSN)**
1952597734	74-6001587
(5) Medicaid TPI: *(if applicable)*	**(6) Medicare provider ID number:** *(if applicable)*
332U000000X	

Provider, named in Section 1.1 of this Medicaid Provider Agreement (the "Agreement") as a condition of enrollment or continued enrollment as a provider under the Texas Medical Assistance Program (Medicaid), agrees to comply with all of the following terms and conditions of this Agreement.

II. LEGAL AUTHORITY

This Agreement between Provider and the Health and Human Services Commission (HHSC) is authorized by, and in compliance with, the provisions of the Code of Federal Regulations (CFR), 42 CFR § 431.107 and the Texas Administrative Code (TAC), 1 TAC §§ 352.5 and 352.7.

III. TERM

The effective date of this Agreement is the date stated in the provider enrollment notification letter sent by HHSC or its designee to Provider. The Agreement will end on the date stated in such provider enrollment notification letter, unless terminated sooner in accordance with any of the terms set forth in Article X of this Agreement (relating to Termination). Provider must revalidate for enrollment in Medicaid and obtain a new Medicaid Provider Agreement when required. Provider understands and agrees that no HHSC signature is required to make this Agreement valid and enforceable.

IV. REQUIREMENTS-ALL PROVIDERS

4. 1 COMPLIANCE WITH LAWS, REGULATIONS, RULES, POLICIES AND PROCEDURES RELATING

TO MEDICAID.

(a) Provider, its employees, and its agents must comply with the requirements of the *Texas Medicaid Provider Procedures Manual* (Provider Manual) as applicable, as well as all state and federal laws and rules, regulations, governing or regulating Medicaid, as they may be amended from time to time. Provider Manual may be accessed via the internet at www.tmhp.com. Provider must comply with Title 1, Part 15, Chapter 352 of the Texas Administrative Code (TAC).

(b) Provider is responsible for ensuring that the Provider, its employees and its agents comply with the requirements of Title 1, Part 15, Chapter 371 of the Texas Administrative Code, related to fraud and abuse program integrity. Provider and its principals will be held responsible for violations of this Agreement through any acts or omissions of the Provider, its employees, and its agents.

(c) For purposes of this Agreement, a principal (Principal) of the Provider, includes all owners with a direct or indirect ownership or control interest of five percent or more; all corporate officers and directors; all limited and non-limited partners; all shareholders of a legal entity, including a professional corporation, professional association, or limited liability company; and managing employee(s) or agents who exercise operational or managerial control or who directly or indirectly manage the conduct of day-to-day operations.

(d) Provider must comply with any change in federal or state laws, regulations, rules or policy that modifies any term of this Agreement on the date such a change in statutes, regulations, rules or policy becomes effective.

4.2 MEDICARE CERTIFICATION OR ENROLLMENT.

Provider must be actively enrolled in Medicare or certified by Medicare (if applicable), or both, unless otherwise specified by HHSC or its designee or specifically exempted in accordance with 1 TAC § 352.13.

4.3 LICENSE, CERTIFICATION, OR ACCREDITATION.

Provider must be licensed, certified, or accredited to the extent required by state and federal laws, regulations, statutes, rules, and policy to enroll or re-enroll in Medicaid. Provider must be in good standing related to its licensure, certification, and accreditation throughout the term of this Agreement.

4.4 OUT-OF-STATE PROVIDERS.

Out-of-State Providers must meet the requirements for out-of-state provider eligibility in accordance with 1 TAC § 352.17.

4.5 EXCLUSION, SUSPENSION, DEBARMENT, REVOCATION OR OTHER ACTION.

Provider and its principals must not be excluded, suspended, debarred, revoked or any other synonymous action from participation in any program under Title XVIII (Medicare), Title XIX (Medicaid), or under the provisions of Executive Order 12549, relating to debarment and suspension. Provider and its principals must not be excluded, suspended, debarred, revoked or any other synonymous action from participation in any other state or federal health-care program. Provider must notify HHSC or its designee within ten business days of the time it receives notice that any action is being taken against Provider or any person defined under the

provisions of Section 1128(A) or (B) of the Social Security Act (42 USC §1320a-7), which could result in exclusion from the Medicaid program. Provider must fully comply at all times with the requirements of 48 CFR, Ch. 3, relating to Health and Human Services.

4.6 SCREENING EXCLUDED PARTIES.

Provider must search the U.S, Department of Health and Human Services (HHS) Office of the Inspector General (OIG) (HHS-OIG), or any successor agency's, List of Excluded Individuals/Entities (LEIE) and website, and the HHSC-Office of Inspector General (OIG), or any successor agency's Exclusions Database website to determine if any of Provider's prospective or current employees, suppliers, and contractors have been excluded from participation in Medicare, Medicaid, the State Children's Health Insurance Program or any other federal and state health care program since the last search, and to immediately report to HHS-OIG and HHSC-OIG any exclusion information the Provider discovers. Exclusionary searches for prospective employees, suppliers, or contractors shall be performed prior to employment or contracting. Except as provided under 42 CFR 1001.1901(c), no Medicaid payments will be made for any items or services directed or prescribed by a physician or other authorized person who is excluded from Medicare, Medicaid or any other federal or state health care program when the individual or entity furnishing the items or services either knew or should have known of the exclusion. This prohibition applies even when the Medicaid payment itself is made to another contractor, practitioner, provider, or supplier who is not excluded. See 42 CFR 1001.1901(b). Additionally, Provider shall be subject to: (1) civil monetary penalties if it employs or enters into contracts with excluded individuals or entities; and (2) any other remedies or sanctions available under federal or state law.

4.7 DISCLOSURE BY PROVIDERS REGARDING SUBCONTRACTORS AND SUPPLIERS.

(a) In accordance with 42 CFR.455.105, Provider must submit, within 35 days of the date of a request by the Secretary of the United States Department of Health and Human Services or HHSC, full and complete information about the ownership of any subcontractor with whom the Provider has had business transactions totaling more than $25,000.00 during the 12 month period ending on the date of the request; and any significant business transactions between the Provider and any wholly owned supplier, or between the Provider and subcontractor during the five-year period ending on the date of the request.

(b) In accordance with 42 CFR Part 455, Federal Financial Participation is not available for providers who fail to comply with a request made by the Secretary or HHSC.

4.8 DISCLOSURE BY PROVIDERS REGARDING INFORMATION ON PERSONS CONVICTED OF CRIMES.

(a) In accordance with 42 CFR §455.106, Provider shall disclose information on persons convicted of crimes as follows:

(1) INFORMATION THAT MUST BE DISCLOSED. Before the Provider is enrolled, has its enrollment revalidated, or at any time upon request by HHSC, Provider must disclose to HHSC the identity of any person who:

i. Has ownership or control interest in the Provider, or is an agent or managing employee of the provider; and

ii. Has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid or the title XX services program since the inception of those programs.

(b) Provider must disclose all convictions of Provider or Provider's principals within ten business days of the date of conviction. For purposes of this disclosure, Provider must use the definition of "Convicted" contained in 42 CFR 1001.2, which includes all convictions, deferred adjudications, and all types of pretrial diversion programs. Provider must fully explain the details, including the offense, the date, the state and county where the conviction occurred, and the cause number(s). Information must be sent in writing to the following address:

Texas Health and Human Services Commission-Office of Inspector General
P.O. Box 85211 – Mail Code 1350
Austin, Texas 78708

4.9 INFORMATION PROVIDED TO HHSC.

(a) Provider certifies that it reviewed all of the information submitted in connection with its application to participate in the Medicaid program, including the Provider information forms (PIF-1) and principal information form (PIF-2), and Provider certifies that this information is current, complete, and correct.

(b) As a condition of continued enrollment, Provider must keep information submitted as part of its application for participation in the Medicaid program current at all times by informing HHSC or its designee in writing of any changes to the information contained in its application, including, but not limited to, changes in ownership or control, federal tax identification number, Provider licensure, certification, or accreditation, phone number, or Provider business addresses. Changes due to a change of ownership or control interest must be reported to HHSC or its designee within 30 days of the change. All other changes must be reported to HHSC or its designee within 90 days of the change.

(c) HHSC or its designee may review Provider's application any time after the application has been accepted and for the term of this Agreement. Upon review, HHSC or its designee may determine that the information contained therein does not meet the Medicaid program enrollment requirements. Information supplied by the Provider is material to the determination as to whether or not the Provider is eligible to participate in the Medicaid Program. Any material misrepresentation shall constitute good cause for the termination of the Provider, and Provider may no longer be eligible to participate in the Program. Provider may have the opportunity to correct any errors or omissions as determined by HHSC or its designee within a timeframe designated by HHSC or its designee.

4.10 SURETY BOND.

As applicable, the Provider must maintain a current surety bond for each enrollment location, in accordance with 1 TAC § 352.15.

4.11 RECORD KEEPING.

In accordance with 42 CFR § 431.107, Provider must create and maintain all records necessary to disclose the extent and medical necessity of services the Provider furnishes to clients or members in the Medicaid program and any information relating to payments claimed by the

Provider for furnishing Medicaid services. On request, Provider also agrees to provide these records immediately and unconditionally to HHSC, HHSC's designee, the Texas Attorney General's Medicaid Fraud Control Unit, the Department of Family and Protective Services (DFPS), the Department of State Health Services (DSHS), and the United States Department of Health and Human Services. Providers must provide this information to HHSC contractors and subcontractors as directed by HHSC. The records must be retained in the form in which they are regularly kept by the Provider for a minimum of seven years from the date of service (ten years for hospital based rural health clinics); the individual about whom the records relate becomes 21 years of age; or, until all audit questions, administrative hearings, investigations, court cases, or appeals are resolved; whichever period is longest.

4.12 FRAUD, WASTE, AND ABUSE.

Provider must cooperate and assist HHSC and any state or federal agency charged with the duty of identifying, investigating, sanctioning, or prosecuting suspected fraud, waste, and abuse. Provider must also allow these agencies and their designees unconditional and unrestricted access to its records and premises as required by Title 1 TAC § 371.1667. HHSC payment for goods and services under this Agreement is conditioned upon the existence and accessibility to HHSC of all records required to be maintained under the Medicaid program, including all records necessary to fully disclose the extent and medical necessity of services provided, and the correctness of the claim amount paid. If Provider fails to create, maintain, or produce such records in full accordance with this Agreement, HHSC may seek full recoupment, and Provider will be ineligible for payment for the services either under this Agreement or under any legal theory of equity.

4.13 AUDITS.

The Texas Attorney General's Medicaid Fraud Control Unit, HHSC's Office of Inspector General (OIG), and internal and external auditors for the state and federal government may conduct interviews of Provider employees, agents, subcontractors, and their employees, witnesses, and clients or members without the Provider's representative or Provider's legal counsel present. Provider's employees, agents, subcontractors and their employees, witnesses, and clients or members must not be coerced by Provider or Provider's representative to accept representation from or by the Provider, and Provider agrees that no retaliation will occur to a person who denies the Provider's offer of representation. Nothing in this Agreement limits a person's right to counsel of his or her choice. Providers must comply with requests for interviews in the form and the manner requested. Provider must ensure by contract or other means that its agents, employees and subcontractors cooperate fully in any investigation conducted by the Texas Attorney General's Medicaid Fraud Control Unit or the OIG or its designee. Subcontractors include those persons and entities that provide medical or dental goods or services for which the Provider bills the Medicaid program, and those who provide billing, administrative, or management services in connection with Medicaid covered services.

4.14 COST REPORT, AUDIT AND INSPECTION.

Provider must comply with all state and federal laws and rules relating to the preparation and filing of cost reports, audit requirements, and inspection and monitoring of facilities, quality, utilization, and records.

4.15 SITE VISITS.

Centers for Medicare and Medicaid Services (CMS), its agents, its designated contractors, or HHSC or its designees may conduct unscheduled and unannounced site visits. A failure to permit a site visit by CMS, its agents, its designees or HHSC or its designees shall be grounds for termination of this Agreement.

4.16 NONDISCRIMINATION.

Provider must not exclude or deny aid, care, service, or other benefits available under Medicaid or in any other way discriminate against a person because of that person's race, color, national origin, gender, age, disability, political or religious affiliation or belief. Provider must provide services to Medicaid members or clients in the same manner, by the same methods, and at the same level and quality as provided to the general public. Provider must grant Medicaid recipients all discounts and promotional offers provided to the general public. Free services to the general public must not be billed to the Medicaid program for Medicaid members or clients and discounted services to the general public must not be billed to Medicaid for a Medicaid member or clients as a full price, but rather the Provider must bill only the discounted amount that would be billed to the general public

4.17 AIDS and HIV.

Provider must comply with the provisions of Texas Health and Safety Code Chapter 85, and HHSC's rules relating to workplace and confidentiality guidelines regarding HIV and AIDS.

4.18 CLAIMS AND ENCOUNTER DATA.

(a) Provider must submit claims for payment in accordance with billing guidelines and procedures promulgated by HHSC, or other appropriate payer, including electronic claims. Provider must ensure that information submitted regarding claims or encounter data is true, accurate, and complete, and that the Provider's records and documents are both accessible and validate the services and the need for services billed and represented as provided. HHSC may refer any falsification or concealment of a material fact for prosecution under state and federal laws.

(b) Provider must submit encounter data required by HHSC or any managed care organization to document services provided, even if the Provider is paid under a capitated fee arrangement by a Health Maintenance Organization or Insurance Payment Assistance.

(c) All claims or encounters submitted by Provider must include the Provider's National Provider Identifier (NPI) or, as applicable, Atypical Provider Identifier (API), and be for services actually rendered by Provider, with the following exception. Physician Providers must submit claims for services rendered by another in accordance with HHSC rules regarding Providers practicing under physician supervision. Claims must be submitted in the manner and in the form set forth in the Provider Manual, as applicable, and within the time limits established by HHSC for submission of claims. Claims for payment or encounter data submitted by the Provider to a Managed Care Organization (MCO), Health Maintenance Organization (HMO) or Independent Practice Association (IPA) are governed by the Provider's contract with the MCO, HMO or IPA. HHSC is not liable or responsible for payment for any Medicaid covered services provided under the MCO, HMO or IPA Provider contract, or any agreement other than this Medicaid Provider Agreement.

(d) Provider is prohibited by federal and state law from charging a member or client or any financially responsible relative or representative of the client or member for Medicaid covered services, except where a co-payment is authorized under the Medicaid State Plan (42 CFR §447.20).

(e) As a condition of eligibility for Medicaid benefits, a client or member assigns to HHSC all rights to recover from any third party or any other source of payment (42 CFR §433.145 and Human Resources Code §32.033). Provider must accept the amounts paid under Medicaid as payment in full for all covered services (42 CFR § 447.15), except as provided by HHSC's third-party recovery rules (*Texas Administrative Code* Title 1 Part 15 Chapter 354 Subchapter J).

(f) Provider must verify that claims and encounters submitted for payment are true and correct and are received by HHSC or its designee, and must implement an effective method to track submitted claims against payments made by HHSC or its designees.

(g) Provider must verify that payments received are for actual services rendered and medically necessary. Provider must refund any overpayments, duplicate payments and erroneous payments that are paid to Provider by Medicaid or a third party as soon as any such payment is discovered or reasonably should have been known.

V. ADVANCE DIRECTIVES- NURSING FACILITIES, HOME HEALTH CARE PROVIDERS, PERSONAL CARE SERVICES PROVIDERS, AND HOSPICES

5.1 Provider must comply with the provisions of 42 CFR § 431.107(b)(4), regarding advanced directives requirements.

5.2 Provider must maintain written policies and procedures concerning advance directives in compliance with state and federal laws.

5.3 The client or member must be informed of their right to refuse, withhold, or have medical treatment withdrawn under the following state and federal laws:

(a) The individual's right to self-determination in making health-care decisions;

(b) The individual's rights under the Natural Death Act (Health and Safety Code, Chapter 166) to execute an advance written Directive to Physicians, or to make a non-written directive regarding their right to withhold or withdraw life-sustaining procedures in the event of a terminal condition;

(c) The individual's rights under Health and Safety Code, Chapter 166, relating to written Out-of-Hospital Do-Not-Resuscitate Orders; and,

(d) The individual's rights to execute a Durable Power of Attorney for Health Care under the Probation Code, Chapter XII, regarding their right to appoint an agent to make medical treatment decisions on their behalf in the event of incapacity.

5.4 Provider must document whether or not the individual has executed an advance directive and ensure that the document is in the individual's medical record.

5.5 Provider cannot condition giving services or otherwise discriminate against an individual based on whether or not the client or member has or has not executed an advance directive.

5.6 The Provider must provide written information to all adult clients or members on the Provider's policies concerning the client or Member's rights.

5.7 The Provider must provide education for staff and the community regarding advance directives.

VI. STATE FUND CERTIFICATION REQUIREMENT FOR PUBLIC ENTITY PROVIDERS

6.1 Public Providers are those that are owned or operated by a state, county, city, or other local government agency or instrumentality. Public entity Providers of the following services must certify to HHSC the amount of state matching funds expended for eligible services according to established HHSC procedures:

(a) School health and related services (SHARS);
(b) Case management for blind and visually impaired children (BVIC);
(c) Case management for early childhood intervention (ECI);
(d) Service coordination for intellectual and developmental disabilities (IDD);
(e) Service coordination for mental health (MH);
(f) Mental health rehabilitation (MHR);
(g) Tuberculosis clinics; and
(h) State hospitals.

VII. STAFF AND SUBCONTRACTORS-HOME AND COMMUNITY SERVICE SUPPORT SERVICES AGENCY

7.1 If Provider is a Home and Community Support Services agency (HCSSA), Provider must hire Personal Assistance Services and Support Services providers chosen by the client or member or the client or member's legally authorized representative, if requested, and provided the individual who will provide the services:

(a) meets minimum requirements for the service;
(b) is willing to be employed as an attendant by the Provider; and
(c) is willing and determined competent by the Provider to deliver one or more of the services according to the clients or members individual service plan.

VIII. CLIENT OR MEMBER RIGHTS

8.1 Provider must maintain the client or member's state and federal right of privacy and confidentiality to the medical and personal information contained in Provider's records.

8.2 Providers cannot not restrict the client or member's right to choose a Provider unless that right has been restricted by HHSC or by waiver of this requirement from CMS. Provider must ensure that the client or member's acceptance of any service is voluntary.

8.3 Provider cannot restrict the client or member's right to choose any qualified Provider of family planning services.

IX. THIRD PARTY BILLING VENDOR PROVISIONS

9.1 In accordance with 1 TAC § 352.5(b)(9), Provider must ensure that, if a third-party billing vendor (Biller) is used for claim submission, the third-party billing vendor is registered with HHSC pursuant to 1 TAC § 354.1187, relating to Responsibilities of Third Party Billing Vendors. Provider must submit notice of the initiation and termination of a contract with

any person or entity for the purpose of billing Provider's claims, unless the person is submitting claims as an employee of the Provider and the Provider is completing an IRS Form W-2 on that person. This notice must be submitted within five working days of the initiation and termination of the contract and submitted in accordance with Medicaid requirements pertaining to Third Party Billing Vendors. Any delay in the required submittal time or failure to submit may result in delayed payments to the Provider and recoupment from the Provider for any overpayments resulting from the Providers failure to provide timely notice.

9.2 Provider must have a written contract with any person or entity for the purpose of billing Provider's claims, unless the person is submitting claims as an employee of the Provider and the Provider is completing an IRS Form W-2 on that person. The contract must be signed and dated by a Principal of the Provider and the Biller. It must also be retained in the Provider's and Biller's files according with the Medicaid records retention policy. The contract between the Provider and Biller may contain any provisions they deem necessary, but, at a minimum, must contain the following provisions:

(a) Biller must not alter or add procedures, services, codes, or diagnoses to the billing information received from the Provider, when billing the Medicaid program.

(b) Biller may be criminally convicted and subject to recoupment of overpayments and imposed penalties for submittal of false, fraudulent, or abusive billings.

(c) Provider must submit to Biller true and correct claim information that contains only those services, supplies, or equipment Provider has actually provided to recipients.

(d) Provider may be criminally convicted and subject to recoupment of overpayments and imposed penalties for submittal of false, fraudulent, or abusive billings, directly or indirectly, to the Biller or to Medicaid or its contractor.

(e) Provider and Biller must not establish a reimbursement methodology to Biller that contains any type of incentive, directly or indirectly, for inappropriately inflating, in any way, claims billed to the Medicaid program.

(f) Biller must enroll and be approved by the Medicaid program as a Third Party Billing Vendor prior to submitting claims to the Medicaid program on behalf of the Provider.

(g) Biller and Provider must notify the Medicaid program within five business days of the initiation and termination, by either party, of the contract between the Biller and the Provider.

X. TERMINATION

10.1 Correspondence/notice of enrollment from HHSC or its designee states a termination date; this Agreement terminates on that date with or without other advance notice of the termination date.

10.2 Provider may terminate this Agreement by providing at least 30 days written notice to HHSC of intent to terminate.

10.3 HHSC may terminate this Agreement without cause at any time, when, in its sole discretion, HHSC determines that termination is in the best interests of the state of Texas. Reasons for termination may include, but are not limited to circumstances listed below, and which may include the actions or circumstances involving the Provider or any person or entity with an affiliate relationship to the Provider:

(a) failure to meet the requirements of participation for the category of service provided;

(b) failure to repay an overpayment;
(c) failure to provide true and accurate information on claims;
(d) failure to comply with site visits;
(e) the exclusion from participation in Medicare, Medicaid, or any other publically funded health-care program;
(f) the loss or suspension of professional license or certification;
(g) any failure to comply with the provisions of this Agreement or any applicable law, rule, regulation, or policy of the Medicaid program;
(h) any circumstances indicating that the health or safety of clients or members is or may be at risk, including abuse, neglect or exploitation;
(i) the circumstances for termination listed in 42 C.F.R. § 455.416, as amended; an
(j) the circumstances for termination listed in 1 T.A.C. §§§371.1703, 371.1705, and 371.1707, as amended;
(k) upon further review of the Provider's application, at any time during the term of this Agreement, HHSC or its designee, determines Provider is ineligible to participate in the Medicaid program; and the errors or omission cannot be corrected;
(l) if the Provider has not submitted a claim to the Medicaid program for at least 24 months;
(m) the Provider or a controlling person of the provider is listed on:
(1) the HHSC employee misconduct registry as unemployable;
(2) the nurse aide registry as revoked or suspended;
(3) the United States System for Award Management maintained by the General Services Administration;
(4) the List of Excluded Individuals and Entities Database maintained by the United States Department of Health and Human Services, Office of Inspector General;
(5) the Exclusions Database maintained by the Texas Health and Human Services Commission-Office of Inspector General;
(6) the Debarred Vendor List maintained by the Texas Comptroller of Public Accounts and the period of debarment has not expired;
(7) HHSC's debarment list;
(8) any other applicable database.
(n) Provider is required to register with the Texas Secretary of State and the provider's status with the Secretary of State is "not in existence,"
(o) Provider or a controlling person of the Provider has been confirmed by the Department of Family and Protective Services as having committed abuse, neglect or exploitation;
(p) any other circumstances resulting in Provider's ineligibility to participate in the Medicaid program.

10.4 HHSC will provide written notification of the termination of the Agreement and any rights to appeal HHSC's determination will be included with the notice of termination.

XI. ELECTRONIC SIGNATURES

11.1 Provider's signature on a document submitted to HHSC certifies, to the best of the Provider's knowledge, the information in the document is true, accurate, and complete. Documents submitted to HHSC with electronic signatures may be accepted by mail or fax when the sender has met the national and state standards for electronic signatures set by HHSC and the Texas Uniform Electronic Transactions Act (UETA).

11.2 Both Provider and the Provider's representative whose signature is on an electronic signature method bear the responsibility for the authenticity of the information to which the Provider and Provider's representative are certifying.

XII. COMPLIANCE PROGRAM REQUIREMENT

Provider must have a compliance program, or be employed by or be a performing Provider for a Texas Medicaid Provider that has a compliance program, containing the core elements as established by the Secretary of Health and Human Services referenced in § 1866(j)(8) of the Social Security Act (42 U.S.C. § 1395cc(j)(8)), as applicable.

I attest I have a compliance plan. Yes ☐ No ☐

XIII. INTERNAL REVIEW REQUIREMENT

Provider must ensure that neither Provider, nor any of its employees, owners, managing partners, or contractors (as applicable), have been excluded from participation in a program under Title XVIII, XIX, or XXI of the Social Security Act.

If the applicant is enrolling as a performing Provider for a Texas Medicaid Provider, the applicant need only attest to the applicant's own status.

I attest that an internal review was conducted to confirm that neither the applicant or the re-validating provider nor any its employees, managing partners, or contractors (as applicable), have been excluded from participation in a program under Title XVIII, XIX, or XXI of the Social Security Act.

☐ Yes ☐ No

XIV. PRIVACY, SECURITY, AND BREACH NOTIFICATION

14.1 "Confidential Information" means any communication or record (whether oral, written, electronically stored or transmitted, or in any other form) provided to or made available to the Provider electronically or through any other means that consists of or includes any or all of the following:

- **(a)** Protected Health Information in any form including without limitation, Electronic Protected Health Information or Unsecured Protected Health Information (as defined in 45 CFR 160.103 and 45 CFR 164.402);
- **(b)** Sensitive Personal Information (as defined in Texas Business and Commerce Code section 521.002);
- **(c)** Federal Tax Information (as defined in IRS Publication 1075);
- **(d)** Personally Identifiable Information (as defined in OMB Memorandum M-07-16);
- **(e)** Social Security Administration data; and
- **(f)** All information designated as confidential under the constitution and laws of the state of Texas and of the United States, including the Texas Health & Safety Code and the Texas Public Information Act, Texas Government Code, Chapter 552.

14.2 Any Confidential Information received by the Provider under this Agreement may only be disclosed in accordance with applicable law. By signing this agreement, the Provider certifies that the Provider is, and must remain for the term of this agreement, in compliance with all applicable state and federal laws, rules, regulations and guidance (and amendments thereto) with respect to privacy, security, and breach notification, including without limitation the following:

(a) The relevant portions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 42 U.S.C. Chapter 7, Subchapter XI, Part C;

(b) 42 CFR Part 2 and 45 CFR Parts 160 and 164;

(c) The relevant portions of The Social Security Act, 42 U.S.C. Chapter 7;The Privacy Act of 1974, as amended by the Computer Matching and Privacy Protection Act of 1988, 5 U.S.C. § 552a;

(d) Internal Revenue Code, Title 26 of the United States Code, including IRS Publication 1075;

(e) OMB Memorandum M-07-16;

(f) Texas Business and Commerce Code Chapter 521;

(g) Texas Health and Safety Code, Chapters 181 and 611;

(h) Texas Government Code, Chapter 552, as applicable; and

(i) Any other applicable law controlling the release of information created or obtained in the course of providing the services described in this Agreement.

14.3 Provider will comply with all amendments, regulations, and guidance relating to those laws, to the extent applicable.

14.4 Provider must ensure that any subcontractor of Provider who has access to HHSC Confidential Information signs a HIPAA-compliant Business Associate Agreement with Provider and Provider must submit a copy of that Business Associate Agreement to HHSC upon request.

XV. MISCELLANEOUS

15.1 REPORTING FRAUD, WASTE, AND ABUSE.

Provider must inform and train all of Provider's employees, agents, and independent contractors regarding their obligation to report fraud, waste, and abuse. Individuals with knowledge about suspected fraud, waste, and abuse in any HHSC program must report the information to the Texas Health and Human Services Commission's-Office of Inspector General. To report fraud, waste, and abuse Providers may go to www.oig.hhsc.texas.gov and select "Report Fraud" or call the Inspector General's hotline (1-800-436-6184) to report fraud, waste and abuse.

15.2 DEFICIT REDUCTION ACT OF 2005, SECTION 6032.

If Provider receives annual payments of at least or totaling $5,000,000.00 from HHSC or its designee, Provider shall stablish written policies for all its employees (including management), and its contractor or agents that provide detailed information about:

(a) the False Claims Act established under sections 3729 through 3733 of Title 31 United States Code; and

(b) and state laws pertaining to civil and criminal penalties for false claims and statements, and whistleblowers protections under such laws with respect to the role of such laws in preventing and detecting fraud, waste, and abuse in federal health care programs, as defined in Section 1128(b)(f).

Provider shall include as part of such policies, detailed provisions regarding the Provider's policies or guidelines and procedures for detecting fraud, waste and abuse; and
Provider shall include in any employee handbook for the Provider, a specific discussion of the laws discussed in sections 15.2 (a) and 15.2.(b) of this Agreement, the rights of employees to be protected as whistleblowers and the Provider's policies and procedures for detecting and preventing fraud, waste and abuse.

15.3 ASSIGNMENT

Provider may not assign, transfer, or convey this Agreement, in whole or in part, without the prior written consent of HHSC, which may withheld or granted at the sole discretion of HHSC. Except where otherwise agreed in writing by HHSC, assignment will not release Provider from its obligations under the Agreement.

15.4 SOVEREIGN IMMUNITY.

Nothing in this Agreement or any conduct by a representative of HHSC or its designees relating to this Agreement shall be construed as a waiver of the state's sovereign immunity to suit.

15.5 BANKRUPTCY.

Provider must notify HHSC or its designee if the Provider files or is the subject of a bankruptcy petition. The Provider must provide HHSC or its designee with notice of the bankruptcy no later than ten days after the case is filed. The Provider must serve HHSC or its designee with all pleadings Provider files in the case.

15.6 TITLES.

The titles of the provisions to this Agreement are for reference only are not to be considered in interpreting this Agreement.

15.7 ELECTRONIC SIGNATURES.

Provider's signature on a document submitted to HHSC certifies, to the best of the Provider's knowledge, the information in the document is true, accurate, and complete. Documents submitted to HHSC with electronic signatures may be accepted by mail or fax when the sender has met the national and state standards for electronic signatures set by HHSC and the Texas Uniform Electronic Transactions Act (UETA).

Both Provider and the Provider's representative whose signature is on an electronic signature method bear the responsibility for the authenticity of the information to which the Provider and Provider's representative are certifying.

15. 8 GOVERNING LAW AND FORUM

This Agreement shall be governed and construed in accordance with the laws of the state of Texas without reference to its conflicts of law provisions. Provider consents to personal jurisdiction in the state of Texas.

15.9 INDEMNIFICATION

Provider will indemnify, defend, and hold harmless HHSC, its officers, agents, designees and employees, from any loss, damage, claim, liability or expense arising out of Provider's performance as a Texas Medicaid long-term services and supports Provider, except that Provider will not be liable for the negligence or willful misconduct of HHSC.

15.10 INDEPENDENT CONTRACTOR

Provider is, and will be an independent contractor without authorization, express or implied, to bin HHSC or the state of Texas to any agreement, settlement, liability or understanding whatsoever.

15.11 SUPERSEDING EFFECT

On its effective date, this Agreement supersedes and replaces any existing agreements or contracts previously executed by Provider to provide long-term services and supports through a Texas Health and Human Services (HHS) agency. This Agreement does not impair Provider's obligation to repay HHSC any money owed to HHSC pursuant to prior agreements or contracts with HHSC or other Texas HHS agency, or the ability of HHSC to recoup such amounts from payment made pursuant to this Agreement.

15.12 INCORPORATION OF DOCUMENT

Provider agrees that the provider enrollment notification letter is incorporated by reference into this Agreement

XVI. ACKNOWLEDGEMENTS AND CERTIFICATIONS

By signing below, Provider acknowledges and certifies to all of the following:

16.1 Provider acknowledges and certifies that Provider understands the requirements of this Agreement and must comply all of its terms and conditions.

16.2 Provider acknowledges and certifies that Provider understands that falsifying entries, concealment of a material fact, or pertinent omissions may constitute fraud and may be prosecuted under applicable federal and state law. Fraud is a felony, which can result in fines or imprisonment.

16.3 Provider acknowledges and certifies that HHSC may declare an overpayment and seek recoupment for any and all paid services, as well as seek other administrative remedies including payment hold, exclusion, debarment, termination of this Agreement, and monetary penalties, as a result of any falsification, omission, or misrepresentation in connection with the Provider's application for enrollment or with claims filed by the Provider.

16.4 Provider acknowledges and certifies that Provider must abide by all

Medicaid state and federal laws, rules, regulations, policy program instructions, and Title XIX of the Social Security Act. The state and federal Medicaid laws, rules regulations, policy and program instructions are available through the Medicaid contractor. Provider understands and acknowledges that payment of a claim by Medicaid is conditioned upon the claim and the underlying transaction complying with such state and federal laws, rules, regulations, policy and program instructions (including, but not limited to, the Federal anti-kickback statute and the Stark law), and on the Provider's compliance with all applicable conditions of participation in Medicaid.

16.5 LOBBYING CERTIFICATIONS.

Provider certifies to the best of one's knowledge and belief, that:

(a) No federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of an agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any federal contract, the making of any federal grant, the making of any federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any federal contract, grant, loan, or cooperative agreement.

(b) If any funds other than federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions.

(c) The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans, and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

(d) This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by section 1352, title 31, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

16.6 CHILD SUPPORT.

HHSC shall withhold payments from any Provider who is found to be ineligible to receive payment in accordance with Texas Family Code § 231.006, related to ineligibility to receive state grants or loans or receive payment on state contracts due to delinquency in the payment of child support .

Under Section 231.006, Family Code, the vendor or applicant certifies that the individual

or business entity named in this contract, bid, or application is not ineligible to receive the specified grant, loan, or payment and acknowledges that this contract may be terminated and payment may be withheld if this certification is inaccurate.

16.7 AFFIRMATIONS.

Provider affirms, without exception, as follows:

(a) Pursuant to Texas Government Code §2270 002, Provider affirms that it: (a) does not boycott Israel; and (b) and will not boycott Israel during the term of this Agreement.

(b) Provider affirms that it is not engaged in business with Iran, Sudan, or any foreign terrorist organization.

Print Name of Applicant/Provider: Webb County - C.A.A. Meals on Wheels Program

Applicant/Provider's Signature:_____
Date Signed: _____

For applicants that are entities, facilities, groups, or organizations, an authorized representative must complete this application with authority to sign on the applicant's behalf. The authorized representative must fill out the information above and print their name and title where indicated below.

Representative's Name: ____
Representative's Position/Title: ____

Provider Information Form (PIF-1)

Each Provider must complete this Provider Information Form (PIF-1), before enrollment. A provider is any person or legal entity that meets the definition below.

Each Provider must also complete a Principal Information Form (PIF-2), for each person who is a Principal of the Provider (see the PIF-2 form for a complete definition of every person who is considered to be a Principal of the Provider).

All questions on this form must be answered by or on behalf of the Provider, by ALL provider types (all spaces must be completed either with the correct answer or a "NA" on the questions that do not apply to the Provider).

All high-categorical risk level providers must submit fingerprints for enrollment or revalidation in Texas Medicaid.

The Provider or provider's duly authorized representative must personally review this completed form and certify to the validity and completeness of the information provided by signing the HHSC Medicaid Provider Agreement or other State Health-Care Program Agreement.

"Provider" - Any person or legal entity, including a managed care organization and their subcontractors, furnishing Medicaid services under a State Health-Care Program provider agreement or contract in force with a State Health-Care Program, and who has a provider number issued by the Commission or their designee to:

1. provide medical assistance under contract or provider agreement with HHSC, DSHS or its designee; or
2. provide third party billing services under a contract or provider agreement with HHSC, DSHS or its designee.

A "Third-Party Biller" is a type of "Provider" under the above definition and is a person, business, or entity that submits claims on behalf of an enrolled health care provider, but is not the health care provider or an employee of the health care provider. For these purposes, an employee is a person for which the health care provider completes an IRS Form W-2 showing annual income paid to the employee.

Name of Provider Enrolling: *(Group/Company name or Last, First, Middle Initial)*	**Maiden Name:**
Webb County - C.A.A. Mealson Wheels Program	
List any other alias, name, or form of your name ever used:	**National Provider Identifier (NPI):** *(10-digit)*
	1952597734
Primary Taxonomy Code: *(10-digit)*	
332U00000X	
Secondary Taxonomy Code: *(10-digit – the provider may indicate up to 15 taxonomy codes; attach additional pages if needed)*	
Non-Texas-enrolled Taxonomy Code: *(these codes are informational and describe services the provider performs but for which the provider does not currently bill Texas Medicaid)*	

For additional names or addresses, attach pages as necessary.

Physical Address (where health care is rendered): *Providers MUST enter the physical address where the services are rendered to clients. If the accounting, corporate, or mailing address is entered in this physical address field, the application may be denied.*

Number	Street	Suite	City	State	ZIP
1310	Convent Ave.		Laredo	Texas	78040

Accounting/Billing Address:

Number	Street	Suite	City	State	ZIP
520	Reynolds		Laredo	Texas	78040

If your accounting address is different than your physical address, indicate your relationship to the accounting address:

☐ Third Party Biller ☑ Management Company ☐ Employer ☐ Self ☐ Other *(explain below)*

If you chose **Other**, *please explain:*

Supervising /Consulting/Referring Physician License Number and State: (if required by your licensing or certification board:	Issue Date: MM/DD/YYYY	Expiration Date: MM/DD/YYYY

Social Security Number:	Federal Tax ID Number:
	74-6001587
Specialty of Practice: *(i.e., pediatrics, general practice, etc.)*	Medicare Intermediary: *(if applicable)*
Home-Delivered Meals	
Medicare Provider Number: *(if applicable)*	Medicare Effective Date: MM/DD/YYYY *(if applicable)*

Driver's License Number:	State:	Driver's License Expiration Date: MM/DD/YYYY

Date of Birth: MM/DD/YYYY		Gender:	☐ Male ☐ Female

Do you have one or more professional licenses, accreditations, or certifications?

☐ Yes ☑ No *If Yes, provide the following information.*

1.	Professional Licensing or Certification Board:	Licensing State:
	License Accreditation Certification Issuer:	License Accreditation Certification Number:
	Issue Date: MM/DD/YYYY	Expiration Date: MM/DD/YYYY
2.	Professional Licensing or Certification Board:	Licensing State:
	License Accreditation Certification Issuer:	License Accreditation Certification Number:
	Issue Date: MM/DD/YYYY	Expiration Date: MM/DD/YYYY

3.	**Professional Licensing or Certification Board:**	**Licensing State:**
	License Accreditation Certification Issuer:	**License Accreditation Certification Number:**
	Issue Date: MM/DD/YYYY	**Expiration Date: MM/DD/YYYY**
4.	**Professional Licensing or Certification Board:**	**Licensing State:**
	License Accreditation Certification Issuer:	**License Accreditation Certification Number:**
	Issue Date: MM/DD/YYYY	**Expiration Date: MM/DD/YYYY**

CLIA Certification Number: *(attach a copy of the CLIA certification, if applicable)*
Hospitals providing laboratory services, and independent laboratories (including those located in physician's offices), must answer all CLIA certification questions. The CLIA rules and regulations are available on the CMS website at www.cms.gov.

CLIA Certification Address: *(list the address listed on the CLIA Certificate, if applicable)*
Number Street Suite City State ZIP

CLIA Certification Effective Date (*if applicable*):	**CLIA Certification Expiration Date (*if applicable*):**

Previous Physical Address:
Number Street Suite City State ZIP

Previous Accounting Address:
Number Street Suite City State ZIP

Do you plan to use a Third Party Biller to submit your health-care claims?

☐ Yes ☑ No *If* **Yes**, *provide the following information about the billing agent.*

Billing Agent Name:	**Address:**
Federal Tax ID Number:	
Contact Person Name:	**Telephone Number:**

List all Providers and medical entities that you have a contractual relationship with and, if known, the NPI/API and TPI of each provider or entity. *(attach additional sheets if necessary)*

1.	**Name:** Superior Health Plan	**Social Security Number:**	**Date of Birth:** MM/DD/YYYY
	Physical address: Number Street Suite City State ZIP		
	Federal Tax ID:	**TPI:**	**NPI/API:**
2.	**Name:** HealthSpring	**Social Security Number:**	**Date of Birth:** MM/DD/YYYY
	Physical Address: Number Street Suite City State ZIP		
	Federal Tax ID:	**TPI:**	**NPI/API:**
3.	**Name:** Molina Healthcare	**Social Security Number:**	**Date of Birth:** MM/DD/YYYY
	Physical Address: Number Street Suite City State ZIP		
	Federal Tax ID:	**TPI:**	**NPI/API:**
4.	**Name:**	**Social Security Number:**	**Date of Birth:** MM/DD/YYYY
	Physical Address: Number Street Suite City State ZIP		
	Federal Tax ID:	**TPI:**	**NPI/API:**
5.	**Name:**	**Social Security Number:**	**Date of Birth:** MM/DD/YYYY
	Physical Address: Number Street Suite City State ZIP		
	Federal Tax ID:	**TPI:**	**NPI/API:**

"Sanction" is defined as recoupment, payment hold, imposition of penalties or damages, contract cancellations, exclusion, debarment, suspension, revocation, or any other synonymous action. **Have you ever been sanctioned (as defined above) in any state or federal program?**	☐ Yes ☑ No

If **Yes**, *fully explain the details, including date, the state where the incident occurred, the agency taking the action, and the program affected. (attach additional sheets if necessary)*

Is your professional license or certification currently revoked, suspended or otherwise restricted?	☐ Yes ☑ No
Have you ever had your professional license or certification revoked, suspended, or otherwise restricted?	☐ Yes ☑ No
Are you currently, or have you ever been, subject to a licensing or certification board order?	☐ Yes ☑ No
Have you voluntarily surrendered your professional license or certification in lieu of disciplinary action?	☐ Yes ☑ No
(You may be subject to a license or certification verification/status check with your licensing or certification board.)	

If **Yes** *was answered to any of these questions, fully explain the details, including date, the state where the incident occurred, name of the board or agency, and any adverse action against your license. (attach additional sheets if necessary)*

Have you ever enrolled in or applied to any other State's Medicaid or CHIP program?	☐ Yes ☑ No
Are you currently or have you ever been subject to the terms of a settlement agreement, corporate compliance agreement or corporate integrity agreement in relation to any State or Federally funded program?	☐ Yes ☑ No
Do you currently have any outstanding debt in relation to any State or Federally funded program?	☐ Yes ☑ No

If **Yes** *was answered to any of the questions, fully explain the details including date, and the state if applicable.*

"Convicted" means that: (a) A judgment of conviction has been entered against an individual or entity by a Federal, State or local court, regardless of whether: (1) There is a post-trial motion or an appeal pending, or (2) The judgment of conviction or other record relating to the criminal conduct has been expunged or otherwise removed; (b) A Federal, State or local court has made a finding of guilt against an individual or entity; (c) A Federal, State or local court has accepted a plea of guilty or nolo contendere by an individual or entity, or (d) An individual or entity has entered into participation in a first offender, deferred adjudication or other program or arrangement where judgment of conviction has been withheld.	
Are you currently charged with or have you ever been convicted of a crime (excluding Class C misdemeanor traffic citations)? *To answer this question, use the federal Medicaid/Medicare definition of "Convicted" in 42 CFR. § 1001.2 as described above, and which includes deferred adjudications and all other types of pretrial diversion programs. You may be subject to a criminal history check.*	☐ Yes ☑ No
Have you been arrested for a crime but not yet charged?	☐ Yes ☑ No
Is there an outstanding warrant for your arrest?	☐ Yes ☑ No
If **Yes**, *fully explain the details, including date, the state and county where the conviction occurred, the cause number(s), and specifically what you were convicted of. (attach additional sheets if necessary)*	
Are you currently subject to court-ordered child support payments?	☐ Yes ☑ No
If **Yes**, *provide details.*	
Are you currently behind 30 days or more on court ordered child support payments?	☐ Yes ☑ No
If **Yes**, *provide details of how these past-due payment obligations will be met. (attach additional sheets if necessary)*	
Are you a citizen of the United States?	☑ Yes ☐ No
If **No**, *provide the country of which you are a citizen.*	
If you are not a citizen of the United States, do you have a legal right to work in the United States? *If* **Yes**, *attach a copy of your green card, visa, or other documentation demonstrating your right to reside and work in the United States.*	☐ Yes ☐ No

Fingerprint Criminal Background Check (FCBC) for High-Categorical Risk Providers

☐ I acknowledge that I am required to submit proof of fingerprinting. n/a

Principal Information Form (PIF-2)

Required for any person or entity that meets the definition of a "Principal" or "Subcontractor" as defined below.

A separate copy of this Principal Information Form (PIF-2) must be completed in full for each Principal or Subcontractor of the Provider, before enrollment.

A **Principal** of the Provider is defined as follows:

- All owners with a direct or indirect ownership or control interest of 5 percent or more.
- All corporate officers and directors, all limited and non-limited partners, and all shareholders of a provider entity (including a professional corporation, professional association, or limited liability company).
- All managing employees or agents who exercise operational or managerial control, or who directly or indirectly manage the conduct of day-to-day operations.
- All individuals, companies, firms, corporations, employees, independent contractors, entities or associations who have been expressly granted the authority to act for or on behalf of the provider.
- All individuals who are able to act on behalf of the provider because their authority is apparent.

A **Subcontractor** of the Provider is defined as follows:

- An individual, agency, or organization to which a disclosing entity has contracted or delegated some of its management functions or responsibilities of providing medical care to its patients; or
- An individual, agency, or organization with which a fiscal agent has entered into a contract, agreement, purchase order, or lease (or leases of real property) to obtain space, supplies

All spaces must be completed either with the correct answer or a "NA" on the questions that do not apply to the Principal or Subcontractor.

All owners that have a 5 percent or more direct or indirect ownership interest in a provider that is assigned a high-categorical risk level must submit fingerprints for enrollment or revalidation in Texas Medicaid.

The Provider or provider's duly authorized representative must personally review each copy of this completed form and certify to the validity and completeness of the information provided by signing the Provider Agreement.

Check person or entity: ☐ Person ☑ Entity

*If **Entity**, please complete the following information.*

Tax ID number as shown on the W9 IRS form:	**Legal name as shown on the W9 IRS form:**
74- 6001587	Webb County

Company Name:

Community Action Agency - Meals on Wheels Program

Address as shown on the W9 IRS form:

Number Street	Suite	City	State	ZIP
1110 Washington St	201	Laredo	Tx.	78040

How is the entity organized to conduct business activities? *Examples include: Sole Proprietor (Unincorporated), Professional Association, General Partnership, Limited Partnership, Limited Liability Partnership, Limited Liability Company, Corporation, Nonprofit, Governmental*

Governmental

Do you conduct business under an assumed name? ☐ Yes ☑ No

If Yes, provide the assumed name below.

Assumed Name:

If you selected **Person** *above, please complete the following information.*	
Last Name:	**First Name/Middle Initial:**
Maiden Name:	**List any other alias, name, or form of your name ever used:**

The following information must be completed by all Principals, Subcontractors, and Creditors. For additional names or addresses, attach pages as necessary.

Check **principal** or **subcontractor** ☑ Principal ☐ Subcontractor

Physical address: Number	Street	Suite	City	State	ZIP
1310	Convent Ave.		Laredo	Texas	78040

Accounting/billing address: Number	Street	Suite	City	State	ZIP
520	Reynolds	2nd Floor	Laredo	Texas	78040

If your accounting address is different than your physical address, indicate your relationship to the accounting address:

☐ Billing agent ☑ Management company ☐ Employer ☐ Self ☐ Other *(explain below)*

If you chose **Other**, *please explain:*

Social Security Number:	**Federal Tax ID number:**
	74-6001587
Specialty of practice: *(i.e., pediatrics, general practice, etc.)*	**Medicare intermediary:** *(if applicable)*
Home - Delivered Meals	
Medicare provider number: *(if applicable)*	**Medicare effective date:** MM/DD/YYYY *(if applicable)*

Driver's license number:	**State:**	**Driver's license expiration date:** MM/DD/YYYY

Date of birth: MM/DD/YYYY		**Gender:**	☐ Male ☐ Female

Do you have one or more professional licenses, accreditations, or certifications?		
☐ Yes ☑ No *If Yes, provide the following information.*		
1.	**Professional Licensing or Certification Board:**	**Licensing State:**
	License Accreditation Certification Issuer:	**License Accreditation Certification Number:**
	Issue Date (MM/DD/YYYY):	Expiration Date (MM/DD/YYYY):
2.	**Professional Licensing or Certification Board:**	**Licensing State:**
	License Accreditation Certification Issuer:	**License Accreditation Certification Number:**
	Issue Date (MM/DD/YYYY):	Expiration Date (MM/DD/YYYY):
3.	**Professional Licensing or Certification Board:**	**Licensing State:**
	License Accreditation Certification Issuer:	**License Accreditation Certification Number:**
	Issue Date (MM/DD/YYYY):	Expiration Date (MM/DD/YYYY):
4.	**Professional Licensing or Certification Board:**	**Licensing State:**
	License Accreditation Certification Issuer:	**License Accreditation Certification Number:**
	Issue Date (MM/DD/YYYY):	Expiration Date (MM/DD/YYYY):

Previous Physical address:					
Number	Street	Suite	City	State	ZIP
Previous Accounting address:					
Number	Street	Suite	City	State	ZIP

Your title in the provider organization for which enrollment is being sought:
Your duties to the provider organization: *(attach additional sheets if necessary)*

Your role in the provider organization: *Examples are Accountant, Agency, Attorney, Banker, Bookkeeper, Business, Care Giver, Consultant, Contractual, Corporate Officer, Director, Doctor, Elected Official, Employee, Employer, Government Official , Individual (Contracted), Individual (Fiscal Agent), Limited Partner, Managing Employee, Medical Director, Non-Limited Partner, Nurse, Official, Owner (Direct), Owner (Indirect) Parent, Recruiter, Representative, Shareholder, Subcontractor, or Unknown: (attach additional sheets if necessary)*		
Effective date of your role in the provider organization: MM/DD/YYYY		
05/01/2003		
Do you have a relationship with a separate provider?	☐ Yes ☑ No	**If "Yes," explain relationship with the separate provider below:**
List all TPIs, provider names, and physical locations under which you have billed or in which your were a principal. Include current and previous TPIs : *(attach additional sheets if necessary)*		
332U00000X		

List all Providers and medical entities that you have a contractual relationship with and, if known, the NPI/API and TPI of each provider or entity. *(attach additional sheets if necessary)*

1.	**Name:**	**Social Security Number:**	**Date of birth:** MM/DD/YYYY
	Superior Health Plan		
	Physical address: Number Street	Suite	City State ZIP
	Federal Tax ID:	**TPI:**	**NPI/API:**
2.	**Name:**	**Social Security Number:**	**Date of birth:** MM/DD/YYYY
	Health Spring		
	Physical address: Number Street	Suite	City State ZIP
	Federal Tax ID:	**TPI:**	**NPI/API:**
3.	**Name:**	**Social Security Number:**	**Date of birth:** MM/DD/YYYY
	Molina Health Care		
	Physical address: Number Street	Suite	City State ZIP
	Federal Tax ID:	**TPI:**	**NPI/API:**
4.	**Name:**	**Social Security Number:**	**Date of birth:** MM/DD/YYYY
	Physical address: Number Street	Suite	City State ZIP
	Federal Tax ID:	**TPI:**	**NPI/API:**

"Sanction" is defined as recoupment, payment hold, imposition of penalties or damages, contract cancellations, exclusion, debarment, suspension, revocation, or any other synonymous action. **Have you ever been sanctioned (as defined above) in any state or federal program?**	☐ Yes ☑ No

If **Yes**, *fully explain the details, including date, the state where the incident occurred, the agency taking the action, and the program affected. (attach additional sheets if necessary)*

Is your professional license or certification currently revoked, suspended or otherwise restricted?	☐ Yes ☑ No
Have you ever had your professional license or certification revoked, suspended, or otherwise restricted?	☐ Yes ☑ No
Are you currently, or have you ever been, subject to a licensing or certification board order?	
Have you voluntarily surrendered your professional license or certification in lieu of disciplinary action?	☐ Yes ☑ No
(You may be subject to a license or certification verification/status check with your licensing or certification board.)	☐ Yes ☑ No

If **Yes** *was answered to any of these questions, fully explain the details, including date, the state where the incident occurred, name of the board or agency, and any adverse action against your license. (attach additional sheets if necessary)*

Are you currently or have you ever been subject to the terms of a settlement agreement, corporate compliance agreement or corporate integrity agreement in relation to any State or Federally funded program?	☐ Yes ☑ No
Do you currently have any outstanding debt in relation to any State or Federally funded program?	☐ Yes ☑ No

If **Yes** *was answered to any of these questions, fully explain the details, including date, the state where the incident occurred, and name of the board or agency. (attach additional sheets if necessary)*

"Convicted" means that:

(a) **A judgment of conviction has been entered against an individual or entity by a Federal, State or local court, regardless of whether:**
   (1) **There is a post-trial motion or an appeal pending, or**
   (2) **The judgment of conviction or other record relating to the criminal conduct has been expunged or otherwise removed;**

(b) **A Federal, State or local court has made a finding of guilt against an individual or entity;**

(c) **A Federal, State or local court has accepted a plea of guilty or nolo contendere by an individual or entity, or**

(d) **An individual or entity has entered into participation in a first offender, deferred adjudication or other program or arrangement where judgment of conviction has been withheld.**

Are you currently charged with or have you ever been convicted of a crime (excluding Class C misdemeanor traffic citations)? *To answer this question, use the federal Medicaid/Medicare definition of "Convicted" in 42 CFR. § 1001.2 as described above, and which includes deferred adjudications and all other types of pretrial diversion programs. You may be subject to a criminal history check.*	☐ Yes ☑ No
Have you been arrested for a crime but not yet charged?	☐ Yes ☑ No
Is there an outstanding warrant for arrest?	☐ Yes ☑ No

If **Yes**, *fully explain the details, including date, the state and county where the conviction occurred, the cause number(s), and specifically what you were convicted of. (attach additional sheets if necessary)*

Are you currently subject to court ordered child support payments?	☐ Yes ☑ No
If **Yes**, *please provide details.*	
Are you currently behind 30 days or more on court ordered child support payments?	☐ Yes ☑ No
If **Yes**, *provide details of how these past-due payment obligations will be met. (attach additional sheets if necessary)*	
Are you a citizen of the United States?	☑ Yes ☐ No
If **No**, *provide the country of which you are a citizen.*	
If you are not a citizen of the United States, do you have a legal right to work in the United States? *If* **Yes**, *attach a copy of your green card, visa, or other documentation demonstrating your right to reside and work in the United States.*	☐ Yes ☐ No

Form **W-9**
(Rev. November 2017)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

▶ Go to *www.irs.gov/FormW9* for instructions and the latest information.

Give Form to the requester. Do not send to the IRS.

Print or type. See Specific Instructions on page 3.

1 Name (as shown on your income tax return). Name is required on this line; do not leave this line blank.

2 Business name/disregarded entity name, if different from above

3 Check appropriate box for federal tax classification of the person whose name is entered on line 1. Check only **one** of the following seven boxes.

☐ Individual/sole proprietor or single-member LLC ☐ C Corporation ☐ S Corporation ☐ Partnership ☐ Trust/estate

☐ Limited liability company. Enter the tax classification (C=C corporation, S=S corporation, P=Partnership) ▶ _____

Note: Check the appropriate box in the line above for the tax classification of the single-member owner. Do not check LLC if the LLC is classified as a single-member LLC that is disregarded from the owner unless the owner of the LLC is another LLC that is **not** disregarded from the owner for U.S. federal tax purposes. Otherwise, a single-member LLC that is disregarded from the owner should check the appropriate box for the tax classification of its owner.

☐ Other (see instructions) ▶

4 Exemptions (codes apply only to certain entities, not individuals; see instructions on page 3):

Exempt payee code (if any) _____

Exemption from FATCA reporting code (if any) _____

(Applies to accounts maintained outside the U.S.)

5 Address (number, street, and apt. or suite no.) See instructions.

Requester's name and address (optional)

6 City, state, and ZIP code

7 List account number(s) here (optional)

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on line 1 to avoid backup withholding. For individuals, this is generally your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the instructions for Part I, later. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN*, later.

Note: If the account is in more than one name, see the instructions for line 1. Also see *What Name and Number To Give the Requester* for guidelines on whose number to enter.

Social security number

			–			–				

or

Employer identification number

		–							

Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me); and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding; and
3. I am a U.S. citizen or other U.S. person (defined below); and
4. The FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct.

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the certification, but you must provide your correct TIN. See the instructions for Part II, later.

Sign Here | **Signature of U.S. person** ▶ | **Date** ▶

General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

Future developments. For the latest information about developments related to Form W-9 and its instructions, such as legislation enacted after they were published, go to *www.irs.gov/FormW9.*

Purpose of Form

An individual or entity (Form W-9 requester) who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) which may be your social security number (SSN), individual taxpayer identification number (ITIN), adoption taxpayer identification number (ATIN), or employer identification number (EIN), to report on an information return the amount paid to you, or other amount reportable on an information return. Examples of information returns include, but are not limited to, the following.

- Form 1099-INT (interest earned or paid)
- Form 1099-DIV (dividends, including those from stocks or mutual funds)
- Form 1099-MISC (various types of income, prizes, awards, or gross proceeds)
- Form 1099-B (stock or mutual fund sales and certain other transactions by brokers)
- Form 1099-S (proceeds from real estate transactions)
- Form 1099-K (merchant card and third party network transactions)
- Form 1098 (home mortgage interest), 1098-E (student loan interest), 1098-T (tuition)
- Form 1099-C (canceled debt)
- Form 1099-A (acquisition or abandonment of secured property)

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN.

If you do not return Form W-9 to the requester with a TIN, you might be subject to backup withholding. See What is backup withholding, *later.*