MI CHOICE

Home & Community Based Service Waiver For The Elderly And Disabled

SUBCONTRACTOR AGREEMENT

Senior Services, Inc.

A PREPAID AMBULATORY HEALTH PLAN (PAHP)
MI CHOICE WAIVER PROGRAM
SUBCONTRACTOR AGREEMENT

Overview of the MI Choice Waiver Program

Senior Services, Inc., in contract with the Michigan Department of Health and Human Services (MDHHS), serves as a Prepaid Ambulatory Health Plan (PAHP) to provide the Home and Community Based Services for Elderly and Disabled (HCBS E/D) Waiver Program, more commonly referred to as the MI Choice Waiver Program. This Medicaid program funds a variety of home and community-based services to participants aged 18 years and older who, without such services, would require nursing facility level of care. The waiver increases traditional Medicaid services so that people in need of nursing facility care can choose to remain home to receive long term care.

Under a capitated, managed care system, Senior Services, Inc. accesses and manages home and community-based care for adults whose needs are at a level of complexity requiring a specialized resource management effort. Senior Services identifies the needs of participants through a comprehensive assessment performed by a nurse and social worker team. Senior Services accesses these services from community vendors, monitoring performance and client condition and adjusts services as necessary.

Direct Service Purchase System

Senior Services, Inc. purchases needed services for participants from an established network of approved community service providers, when other payment options are not available. The Direct Purchase of Services (DPOS) network is established through formal subcontractor agreements with providers that submit completed applications for the services they choose to provide and are approved by Senior Services, Inc. Senior Services is responsible to determine and ensure that service providers meet all program and administrative standards as set by Medicaid (MSA), the Michigan Department of Health and Human Services (MDHHS), and the Center for Medicaid/Medicare Services (CMS). Senior Services is also responsible for authorizing services delivered and establishes the frequency and duration of all services purchased. Services available for selection are described in "Minimum Operating Standards For MI Choice Waiver Program Services"

Funding Structure

Senior Services, Inc. uses a unit cost reimbursement system to purchase "direct care" services. The Purchase of Service Agreement form establishes rates for those services provided for under the MI Choice Waiver. Subcontractor providers select the services which they are willing and have capacity to provide. Monthly reimbursement from Senior Services is based on the exact number of service units provided and verified during the month.

Target Population

Client eligibility for all services is determined by Senior Services staff. It is the responsibility of Senior Services to determine appropriate service interventions. Clients who are medically eligible for nursing home level of care, financially eligible for Medicaid under special expanded income guidelines and require at least one waiver service, are qualified to receive services through MI Choice Waiver.

Subcontractor/Provider Eligibility Standards

Eligible Organizations - Eligible providers of waiver services can include, private non-profit or for profit organizations which provide services that meet minimum MI Choice Waiver service standards, certifications and/or licensure requirements.

Insurance - Service providers shall have sufficient insurance to indemnify loss of federal, state and local resources, due to casualty or fraud. Insurance **required** for each service provider are: workers compensation; unemployment; property and theft coverage, fidelity bonding (for persons handling cash); Automobile liability (for transportation purposes); General liability and hazard insurance including facilities coverage. Providers shall submit with this Agreement and upon expiration thereafter, Certificates of Insurance listing Senior Services, Inc. as the "Additional Insured". MDHHS recommends several additional types of insurance for agency protection. Please see Attachment F (H), Section 1.F of this document for complete insurance information and requirements.

Confidentiality - All client information shall be maintained to HIPAA standards. Service providers shall have procedures to protect confidential client information. No information will be disclosed without the prior informed consent of an individual or his/her legal representative. Disclosures may be allowed by court order, or for program monitoring by authorized federal, state or local agencies (which are also bound to protect the confidentiality of client information) so long as acting in conformity with the Health Insurance Portability and Accountability Act (HIPAA).

1. APPLICATION PROCESS

Organizations proposing to participate in this system must agree to comply with all required standards and assurances contained in this document and attachments. The Subcontractor Agreement document: "Contracting Forms and Assurances" is structured in the following Attachments:

A. Purchase of Service Agreement Form

This contains services available for bid along with the maximum allowable unit rate as authorized by Senior Services PAHP. Rates for services that do not fall under specific units, such as Environmental Accessibility Adaptations, Specialized Medical Equipment and Supplies, etc. will be determined (TBD) based on the specific services as contained in the service authorization. Service rates listed as BID mean that the bidder will submit a rate for approval from the PAHP. All services must be ordered and authorized by the Senior Services PAHP. When selecting the specific services that you wish to provide.

Applicants please complete this form as follows:

Service Provider Information

Complete all information requested including the contact person(s) for ordering services and for billing inquires.

Service Information Bid Agreement

For each service being applied for, provide information regarding the capacity or number of potential units available for purchase each week and the counties to be served. Add additional pages if more than four services are being bid on. Fiscal year 2022 service rates have all been frozen to the previous fiscal year (FY 21) rates.

B. Accessibility Assurances and Service Standards

This includes the Accessibility Assurances and Service Standards Assurance form that includes the Provider's assurances that the organization and its employees meet the minimum standards developed by the MDHHS and PAHP. Please review all information, fill in the agency name and services applied for.

C. Home & Community Based Service Waiver For The Elderly & Disabled Subcontractor Enrollment Agreement
All providers must complete this form, regardless of current or past participation in Medicaid. Box Numbers 1, 3, 4, 5, 6 and 7 must all be completed with signature and date at bottom of form.

D. Subcontractor Assurance Agreement.
Please review the document which itemizes the various Public Acts.

E. Provider Agency Agreement.
This document contains specific items agreed upon by the subcontractor/provider, the Senior Services PAHP, and both parties. Please review.

F. Minimum Operating Standards for MI Choice Waiver Program Services (also referenced as Attachment H).
This contains all the required standards as established by the Michigan Department of Health and Human Services (MDHHS) which must be met in regard to provider overall operations as well as those specific service(s) provided.

G. Vendor View Enrollment Form
Complete a new form for all users with each new contract and update as needed.

H. Electronic Funds Transfer Form (EFT)
Complete a new form with each new contract and update as needed.

I. W-9 Form
Complete a new form with each new contract and update as needed.

J. Provider Integrity Agreement Form
Review of Critical Incidents, Mandatory Reporting and OIG Reporting. Please review and sign.

K. OIG Attestation Form
Review form and acknowledge your understanding of the required monthly OIG sanction checks on all specified people by signing and dating it at the bottom.

L. **Provide Grievance Form**
Review form and sign acknowledgement of understanding of Provider Grievance procedure and form.

2. REPORTING/PAYMENT SYSTEM

All vendors must use the Vendor Billing system to report and submit bills.

A Bill covers a one-month period - from the first day through the last day of the month. Bills are due to Senior Services no later than the 8th of each month following the month of service (previous month). Bills received after the 8th of the month will not be paid until the following month. Bills are verified against Senior Services care plans, with payment issued by the last business day of the of the month. Payment will be made by electronic transfer **only**. If the information submitted is incomplete or incorrect, payment will be delayed until the following month. Billing received after 30 days from the date of service will not be honored.

Please note that any previously paid claims will be recouped should it be determined that the Provider did not comply with documentation requirements to verify the claim.

Selection
Senior Services, Inc. will select providers on a case-by-case basis, utilizing the following criteria. (Please note that providers must deliver services at levels specified in the client care plans, approved by the participant):

Client Preference
Some clients prefer providers they are familiar with. Participant choice is honored.

Cost
The cost of services is a factor in selecting a service provider.

Accessibility
Practical application involved in selecting a provider include the geographic area of service and ease of service delivery to clients.

Ability to Provide Quality Services
The providers past performance in furnishing quality services as authorized in the client care plan is considered. Quality includes performance, client outcome and accountability as monitored by Senior Services. Therefore, it is required that Critical Incidents are **reported within 24 hours** to the appropriate Supports Coordinator. Vendors are also required to report Private Duty Nursing (PDN) notes on a monthly basis along with their billing.

Comprehensive Care
Senior Services, Inc. will make a reasonable effort to minimize the number of agencies involved in providing services to each client. The ability of the provider to provide the different types of services needed by each client is considered.

3. CERTIFICATION OF AUTHORITY TO SIGN THE AGREEMENT

The persons signing this Agreement on behalf of the parties hereto certify by said signatures that they are duly authorized to sign the Agreement on behalf of said parties and that this Agreement has been authorized by said parties. This Agreement shall be deemed executed, valid, enforceable, and binding upon the parties once signed and may be delivered by mail.

Senior Services PAHP and Provider agree that this Contract includes all referenced sections, forms, and attachments and are intended to constitute the entire and integrated agreement between them.

4. AUTHORIZED SIGNATURES

_____ _____
SENIOR SERVICES PAHP AUTHORIZED OFFICIAL DATE AND TITLE

_____ _____
PROVIDER AUTHORIZED OFFICIAL DATE AND TITLE

Return to: Heather Marshall, MSW, Quality Coordinator
Senior Services, Inc.
918 Jasper Street
Kalamazoo, MI 49001

Home & Community Based Service Waiver For The Elderly And Disabled

CONTRACTING FORMS AND ASSURANCES

Home & Community Based Service Waiver For The Elderly And Disabled

ATTACHMENT A

ATTACHMENT A
PURCHASE OF SERVICE AGREEMENT

The following services are available for purchase by the Senior Services PAHP at the maximum cost per unit as indicated

SERVICE	To be billed as *
Nursing Services, up to 15 minutes	15 min.
LPN/LVN Services, up to 15 minutes	15 min.
Respite In-Home	15 min
Adult Day Health, per 15 min. (With or Without Transportation)	15 min.
Adult Day Health, per diem	Per Diem
Training (family)	15 min.
Training (non-family)	15 min.
Chore Services	15 min.
Chore Service per diem, i.e. 1x snow removal, snow plowing	Per Diem
Respite Out-of-Home	Per Diem
Home Modification/Environment Aids	Per Diem
Home Delivered Meals – (hot, frozen, cold, liquid)	Per Meal
Community Transportation	1x Purchase
Community Health Worker	Per Diem
Personal Emergency Response- Installation	Per Diem
Personal Emergency Response- Monthly Fee	1x Install
Personal Emergency Response System: purchase only	Per Month
Private Duty Nursing/Respiratory Care	15 min.
Counseling	Per Hour
Durable Medical Equipment	Per Item
Medical Supplies	Per Item
Comprehensive Community Living Support Services	15 min
Comprehensive Community Living Support Services At Risk	15 min
Comprehensive Community Living Support Services	Per Diem

Exceptions to the rate caps will be considered for individual cases that may be deemed to require a higher level or more complex care. *One unit = 15 minutes.

PLEASE NOTE THAT ALL RATES FOR THE FISCAL YEAR 21-22 CONTRACT ARE FROZEN TO THE FISCAL YEAR 2020-2021 RATES.

LENGTH OF AGREEMENT
Fiscal Year 2021 through 2022. Approved Period: From 10/01/2021 to 09/30/2022

SENIOR SERVICES, INC.
Bid Agreement Form
Service Provider Information
(PLEASE TYPE OR PRINT CLEARLY ALL INFORMATION)

AGENCY: _____

SERVICE AND BID INFORMATION

SERVICE #1: _____

Number of units you can handle per week: _____ Cost (per unit) $ _____

Counties you will serve (not less than entire county[s]) _____

SERVICE #2: _____

Number of units you can handle per week: Cost (per unit) $

Counties you will serve (not less than entire county[s]) _____

SERVICE #3: _____

Number of units you can handle per week: _____ Cost (per unit) $ _____

Counties you will serve (not less than entire county[s]) _____

SERVICE #4: _____

Number of units you can handle per week: _____ Cost (per unit) $ _____

Counties you will serve (not less than entire county[s]) _____

FY 2017-2018

SENIOR SERVICES, INC.

Service Provider information

(PLEASE TYPE OR PRINT CLEARLY ALL INFORMATION)

AGENCY:_____

AUTHORIZED AGENCY REPRESENTATIVE:_____

ADDRESS:_____

ADDRESS:_____

CITY, STATE, ZIP:_____

TELEPHONE:_____TOLL FREE_____

FAX:_____EMAIL ADDRESS:_____

NPI#_____ EIN#_____

AGENCY TYPE: (check one) Public___ Private "for profit" ___ Private "not for profit" ___

PRIMARY CONTACT:_____

PHONE: _____EMAIL ADDRESS_____

CONTACT PERSON (WHEN ORDERING SERVICES):_____

PHONE_____ EMAIL ADDRESS_____

BILING CONTACT:_____

PHONE_____ EMAIL ADDRESS_____

STAFFING LOCATIONS, OTHER:_____

ADDRESS:_____

ADDRESS:_____

CITY, STATE, ZIP:_____

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ATTACHMENT B

SENIOR SERVICES, INC.

ACCESSIBILITY ASSURANCES AND SERVICE STANDARDS

Any waiver service funded by Senior Services, Inc. must be in full compliance with the Department of Health and Human Services service definitions, unit definitions and, minimum service standards as prescribed. The following signature is evidence of assurance for compliance.

(Enter your company name) _____, (herein after referred to as the Contractor)

THE CONTRACTOR HEREBY ASSURES that personnel involved in implementing this contract have read the attached minimum standards for each and all services for which funds are being requested.

FURTHERMORE, the Contractor assures that it is in compliance with all standards for the following services: (List all services for which you are requesting funding)

SERVICE_____ SERVICE_____

SERVICE_____ SERVICE_____

FURTHERMORE, the Provider Agency assures that it possesses insurance coverage as required by the Department of Health and Human Services in the Service Standards/Definitions and that a "Certificate of Insurance" indicating Senior Services, Inc. as the "Additional Insured" is included as an appendix to this Agreement. The Provider Agency understands that service purchasing cannot begin until such time as Senior Services has in its possession such a Certificate of Insurance.

This assurance is given in consideration of and for the purpose of obtaining Federal and State funds, contracts, or other financial assistance from Senior Services, Inc. The Contractor recognizes and agrees that any approved financial assistance will be extended based on agreements made in this assurance and that Senior Services, Inc. shall have the right to seek enforcement of this assurance.

The contractor *also agrees to offer priority to Senior Services participants for access to non-DSP services available within the Contractor's regulatory and capacity limitations*.

This assurance is binding on the Contractor, its successors, transferees and assignees.

Home & Community Based Service Waiver For The Elderly And Disabled

ATTACHMENT C

HOME & COMMUNITY BASED SERVICES WAIVER FOR THE ELDERLY & DISABLED SUBCONTRACTOR ENROLLMENT AGREEMENT Michigan Department of Community Health	OHCDS Use Only Eligilbility Begin Date: Eligilbility End Date:

This form is to be completed by all providers who wish to receive payment for the Medicaid-enrolled health care delivery system for services provided under the Home & Community Based Services Waiver for the Elderly & Disabled. An orginal payment agreement must be submitted for each business location and for each eligible person.

COMPLETION INSTRUCTIONS **PLEASE TYPE OR PRINT CLEARLY**

Item #1: Individual providers must enter their last name, first name, and middle initial. All other applicants (e.g. a licensed business) must enter the complete business name as licensed/certified.

Item #2: If the applicants employed/contracted by a business, or in partnership, enter the name of the business you are employed by, affiliated with, contracted with, or in partnership with.

Item #3: Proof of the EIN number (federal tax number)is **REQUIRED**

Item #4: Providers must attach a copy of the licensure/certification, as applicable.

Item #5: The SSN is required for an individual and is confidential to be sued only for the administration of the program.

APPLICATON INFORMATION

1. **PROVIDER'S NAME** (see instructions)	2. **PROFESSIONAL TITLE**, IF APPLICABLE
3. **EMPLOYER'S NAME** (see instructions)	4. **EIN NUMBER** (see instructions)
5. **STATE LICENSE NUMBER** (see instructions)	**APPLICANT'S SOCIAL SECURITY NUMBER** (see instructions)

BUSINESS LOCATION

7. **MAILING ADDRESS** (NO & STREET)			**P.O. BOX**
CITY	**STATE**	**ZIP**	**PHONE NUMBER**

MEDICAL ASSISTANCE (MEDICAID) PROVIDER PAYMENT AGREEMENT CONDITIONS

1. All information furnished on the payment agreement form is true and complete.
2. I consent that, upon request and at a reasonable time and place, I will permit authorized agends of the State of Michigan or the federal government to inspect, and copy, any records related to my delivery of goods or services to, or on behalf of, a participant under the Medicaid Program.
3. I am not currently suspend, terminated, or excluded from any state Medicaid Program or by the U.S. Department of Health and Human Services.
4. I agree to accept the Michigan Medicaid payment as payment in full for the service rendered. Except for patient liablity as determined by the Michigan Medicaid Program including applicable co-payments, I will not seek nor accept additional or supplemental payment form the participant, his/her family or representative(s).
5. I may be prosecuted under applicable federal or state criminal and civil law for subitting false claims, concealing material facts, misrepresentation, falsifying data, other acts of misrepresentation, or conspiracy to engage therein.
6. I agree to comply with the MDCHs policies and procedures for the Medical Assistance Program and the Home and Community Based services for the Elderly and Disabled contained in manuals, manual updates, providers bulletins, and other program notifications.

As a condition of receiving payment from the Michigan Medicaid Program for services provided to an eligible participant, I certify and/or agree to all of the conditions listed above. I certify that the undersigned has the authority to excute this agreement.

IMPORTANT: FACSIMILE SIGNATURE WILL NOT BE ACCEPTED

APPLICANT'S SIGNATURE	**DATE**	**TITLE**

The Michigan Department of Community Health will not discriminate against any individual or group because of race, sex, religion, age, national origin, marital status, political beliefs, or disability.

MAIL THIS FORM TO THE MI CHOICE PROVIDER YOU ARE CONTRACTING WITH (#3)

Senior Services Southwest Michigan
MI Choice Waiver

Home & Community Based Service Waiver For The Elderly And Disabled

ATTACHMENT D

Home & Community Based Service
Waiver For The Elderly And Disabled
Subcontractor Assurance Agreement

Senior Services, Inc.-Waiver Service Provider Application Packet

The Michigan Department of Health and Human Services
Assurance of Compliance with Section 504 of the Rehabilitation Act of 1973, as Amended

The undersigned recipient of funds from the Michigan Department of Health and Human Services (hereinafter called "*recipient*") HEREBY AGREES THAT it will comply with section 504 of the Rehabilitation Act of 1973, as amended (29. U.S.C. 794), all requirements imposed by the applicable HHS regulations (45.C.F.R. Part 84), and all guidelines and interpretations issues pursuant thereto.

Pursuant to 84.5(a) of the regulation (45 C.F.R. 84.5(a) the *recipient* gives this assurance in consideration of and for the purpose of obtaining any and all grants, loans, contracts and contracts of insurance of guaranty, property, discounts, or other financial assistance extended by the Michigan Department of Health and Human Services after the date of this assurance, including payments or other assistance made after such date on applications for financial assistance that were approved before such date. The *recipient* recognizes and agrees that such financial assistance will be extended in reliance on the representations and agreements made in this assurance and that the Michigan Department of Health and Human Services will have the right to enforce this assurance through lawful means. This assurance is binding on the *recipient*, its successors, transferees, and assignees, and the person or persons whose signatures appear below are authorized to sign this assurance on behalf of the *recipient*.

This assurance obligates the *recipient* for the period during which Federal financial assistance is extended to it by the Michigan Department of Health and Human Services or, where the assistance is in the form of real or personal property for the period provided for in 84.5(b) of the regulation (45 C.F.R. 84.5(b).

Assurance of Compliance with the Department of Health, Education, & Welfare Regulation Under title VI of the Civil Rights Act of 1964, Michigan Handicappers Civil Rights Act of 1976, Elliott-Larsen Civil Rights Act of 1976.

The Subcontractor named below HEREBY AGREES THAT it will comply with Title VI of the Civil Rights Act of 1964 (P.L. 88-352), the Michigan Handicapper's Civil Rights Act of 1976 (P.A. 220), and the Elliott-Larsen Civil Rights Act of 1976 (P.A. 453, Section 209) and will comply with requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 80) issued pursuant to that Title to the end that, in accordance with Title IV of that Act and the Regulation, no person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity for which the Subcontractor receives Federal or State financial assistance from Senior Services, Inc. and HEREBY GIVES ASSURANCE THAT it will immediately take any measures necessary to effectuate this agreement.

If any real property or structure thereon is provided or improved with the aid of Federal or State financial assistance extended to the Subcontractor, said property or structure must be used for a purpose for which Federal or State financial assistance is extended. This Assurance further certifies that the applicant agency has no commitments or obligations which are inconsistent with compliance of these and any other pertinent Federal or State regulations and policies, and that any other agency, organization or party which participates in this project shall have no such commitments or obligations, and all activities shall not run counter to the purpose and intent of this agreement.

THIS ASSURANCE is given in consideration for the purpose of obtaining any and all Federal or State grants, loans, contracts, property, discounts, or other Federal or State grants, loans, contracts, property, discounts, or Federal or State financial assistance extended after the date hereof to the Subcontractor by the Contractor, including installment payments after such date on account of applications for Federal or State financial assistance which are approved before such date. The Subcontractor recognizes and agrees that such Federal and State financial assistance will be extended in reliance on the representations and agreements made in the Assurance, that the Contractor or the United States or both shall have the right to seek judicial enforcement of this Assurance. This Assurance is binding on the Subcontractor, its successors, transferees, and assignees, and the person or persons whose signatures appear below are authorized to sign this Assurance on behalf of the Subcontractor.

Home & Community Based Service Waiver For The Elderly And Disabled

ATTACHMENT E

PROVIDER AGENCY AGREEMENT

As a result of this Agreement the Provider Agency shall:

1. Accept and serve on a priority basis Waiver clients referred to it by Senior Services. Where openings do not exist in the Provider Agency caseload, the Provider Agency agrees to negotiate alternative arrangements with the Senior Services Waiver staff where possible in order to meet the needs of the client.
2. Review the comprehensive assessment, available in Vendor View, as completed by the Senior Services Waiver staff . Providers may also utilize their own assessment, providing it follows MDHHS assessment guidelines.
3. Provide service delivery as prescribed in the directions (i.e. service within Vendor View, direct contact with SC) received from the Senior Services Waiver staff during service requisition.
4. Provide the Senior Services staff with the regular, on-going feedback (i.e. nursing notes, progress notes, etc.), regarding clients referred to it for services.
5. Inform the Senior Services Waiver staff of the appropriate Provider Agency contact person to be notified in care plan development and modification.
6. Enroll at least one representative from your Agency in the Vendor View software system by completing and returning the Enrollment form. Use of the Vendor View software system is mandatory.
7. Utilize the Vendor View software system to immediately notify the Senior Services Waiver staff if, for any reason, the Provider Agency is unable to provide service to the Senior Services waiver client, as negotiated, or if a service is not provided as agreed to (Non-Service, reduction in hours notification, hospitalization, etc.).
8. Utilize the Vendor Billing software system to report and submit all claims and billing.
9. Participate in all required trainings conducted by Senior Services Waiver including, but not limited to: participant health and safety, Critical Incident Reporting, Emergency Reporting, Service interruption reporting, Grievance and Appeals, etc.
10. Comply with all licensing standards as may be prescribed, to assure quality of services delivered to Waiver clients, to comply with all standards and definitions as established by the Michigan Department of Health and Human Services (MDHHS). Private providers must submit copies of current license(s) with this signed agreement, as appropriate.
11. Follow Senior Services screening criteria when referring individuals who may be eligible for Waiver intervention.
12. Indemnity, save and hold harmless Senior Services, Inc. and the Michigan Department of Health and Human Services against expense or liability of any kind arising out of service delivery performed by the Provider Agency, and to immediately notify the Senior Services Waiver staff if the Provider Agency becomes involved in, or is threatened with litigation related to any Senior Services Waiver client.
13. Maintain, in effect at all times during the course of the Agreement, insurance coverage as indicated and required by the Michigan Department of Health and Human Services. Further, Provider shall submit at the beginning of the Agreement and throughout the year, Certificates of Insurance listing Senior Services, Inc. as the "Additional Insured".
14. Protect client confidentiality and agree to not identify Senior Service Waiver clients by name or otherwise, in any report(s), without prior consent from the client and approval by Senior Services and the MDHHS, and in full compliance of HIPAA.

    Legal limitations exist on both the Provider Agency and Senior Services Waiver staff regarding the disclosure of information about a client. The law treats all communication received from the client as confidential, whether oral or written, including records derived from those communications. HOWEVER, the disclosure of information to others does not, by itself abrogate a client's expectation of privacy as protected by law. Those to whom disclosure is made have a duty to maintain the confidentiality of the disclosure. As such, it is permissible for the Senior Services Waiver staff to share with or request information from a provider for the purpose of better serving the clients based on the general release of information obtained from the client in writing by Senior Services Waiver staff at the time of the initial assessment.
15. Accept from and share any information that may be necessary to better serve the client, that may be viewed as confidential, upon receipt of a copy of the general release of information signed by the client, and avoid requiring the signing of additional release by the client. **Providers are also expected to have and utilize their own releases of information forms when sharing/receiving any information in compliance with HIPAA regulations.**
16. **Conduct and maintain initial and ongoing criminal history screenings of all direct care employees. Maintain a worker service record (in home log). Follows the Michigan Office of Inspector General guidelines for verifying upon hire, and then monthly, that employees serving Waiver participants are not on the OIG sanctions list.**

16. Accept as payment in full the reimbursement amount from Senior Services PAHP. The Provider may not bill consumers for the difference between the Provider's charge and the Senior Services PAHP's rate for covered services. The Provider shall not seek nor accept additional supplemental payment from the consumer, his/her family, or representative in addition to the amount paid by Senior Services PAHP. The Provider agrees not to maintain any action against a consumer to collect sums that are owed to Provider under the terms of this contract, even in the event Senior Services PAHP fails to pay, becomes insolvent, or otherwise breaches the terms and conditions of this contract. This section shall survive the termination of this contract, regardless of the cause of termination and shall be construed to be for the benefit of the consumer.

For licensed AFCs, HFAs and "Assisted Living Facilities providing Community Living Services the following also apply:

17. Maintain a Community Living Services Tracking Sheet which documents daily services provided and maintain the documents on file for review. Providers may choose to use their own tracking forms as long as they adequately document services, dates and amount of time provided for CLS services on a daily basis and keep the forms on file for review.

18. Request payment for licensed residential services to MI Choice Participants which are only those services that have been authorized and that which exceeds what is usual and customary for the licensed residential provider and/or exceeds that which is required and defined under the State of Michigan AFC (MCL) licensing rules.

19. Provider shall refrain from marketing its services in any form or fashion which states, suggests or otherwise infers access to the Senior Services MI Choice Waiver Program**. Failure to comply with this stipulation shall result in immediate suspension of the agreement and the initiation of formal termination of this agreement**.

20. Comply with Federal regulations regarding Home and Community Based Settings (HCBS). For more information go to Michigan.gov.

Senior Services PAHP, MI Choice Waiver program shall:

1. Provide prescreening of all individuals referred for the MI Choice Waiver program.
2. Provide a comprehensive assessment and additional information about a referred participant sufficient for the provider to adequately complete the services to the participant.
3. Provide person centered service plan development in consultation with the participant inclusive of a determination of amount, scope, frequency and duration of all services required under the care plan.
4. Authorize all types, frequencies, and amounts of services as indicated and appropriate.
5. Monitor provider agencies to ensure compliance with all standards, regulations, and requirements.
6. Provide timely payment of services rendered per billing procedures.
7. Provide 24-hour availability for emergency information.
8. Exclusively maintain the ownership and right of control of contract information and keep secure all contract records for a period of not less than ten (10) years after the expiration or termination of this Agreement in a location that is readily accessible and preserves contract information.
9. Ensure that the participant is informed of all options available for home and community-based care and will respect and support the choices made by the participant.
10. Provide Waiver contracted providers with a Grievance Resolution Policy and Procedure, including means of filing a grievance in writing.

Both Parties agree that:

1. The Provider is an independent contractor with respect to Senior Services PAHP and that nothing in this agreement is intended to create an employer/employee relationship, a joint venture relationship, or any other relationship that

allows Senior Services PAHP to exercise control or direction over a manner or method by which the Provider furnishes the services covered in this agreement. The services to be performed shall be provided in a manner consistent with all applicable laws, regulations, rules and standards governing such services, the provisions of the master contract with MDHHS, and the provisions of this agreement.

2. Each party shall preserve the privacy and security of confidential participant information except as otherwise permitted or required by law. Where federal and state legal standards respecting disclosure of confidential participant information are in conflict, the stricter standard shall apply. Each party shall have in place and observe policies and procedures for maintaining the privacy and security of confidential participant information and the prevention of its improper use or disclosure in full compliance with HIPAA. Each party will not use or disclose confidential participant information in a manner that would violate any provision of HIPAA.
3. Senior Services PAHP retains the right to review, approve, and monitor the Provider's compliance with all rules, regulations, requirements applicable to the MI Choice Waiver program and that the PAHP, MDHHS, and CMS reserve the right as a condition of funding to require the development and implementation of corrective action plans if the Provider demonstrates inadequate performance. Provider shall fully cooperate with any audit from the PAHP, MDHHS, and CMS and provide access to and copies of any required documentation, policies, and procedures as necessary to demonstrate compliance.
4. This contract is effective from 10/01/2021 through 09/30/2022 unless sooner terminated. Provider understands that this contract does not assure or imply continued funding beyond 09/30/2021. If neither party has informed the other in writing that the contract will not be renewed and if the parties have not agreed to a new contract on or before the expiration date, the contract shall automatically be extended on a month-to-month basis for ninety (90) days at which time a new contract must be reached or the contract will be terminated.
5. This contract may be terminated prior to the expiration date by either party by giving sixty (60) days written notice to the other party by certified mail, except for circumstances in which federal, state or local resources for this program are reduced in which case termination of the contract requires thirty (30) days notice. Termination shall not relieve either party of any obligations incurred prior to the effective date of termination. In the event of the termination of this contract, the Provider agrees to promptly submit to Senior Services PAHP all information necessary for the reimbursement of any outstanding Medicaid claims, as requested. For Providers that have been issued a Plan of Corrective action, failing to meet the Plan of Correction in the allotted time can result in contract termination.
6. This contract may be terminated with twenty-four (24) hours notice based on any of the following actions on the part of the Provider agency or any member of its staff: 1) Charges of gross misconduct of either a professional or personal nature, 2) Suspension, revocation, or restriction of professional license or registration, 3) Conviction of a crime, irrespective of whether such conviction is final, 4) Is included in the Medicare/Medicaid list of providers who are suspended or excluded, 5) Is subject to an adverse action, 6) Is determined to have committed a compliance violation, 7) Fails to perform any services required in accordance with this agreement or standards of quality, or 8) Violates Senior Services PAHP policies and procedures after being given notice of failure to comply.
7. No assignment or delegation of this agreement or of any right or obligation hereunder shall be valid without specific written prior consent of both parties hereto, except that this agreement may be assigned to any successor entity operating PAHP, which assignment shall forever release Senior Services PAHP hereunder except for any obligations which accrued prior to the date of such assignment. Any attempted assignment or delegation or purported assignment or delegation by the Provider in violation of this section shall be void and of no force and effect and shall not operate to create any liability or performance obligation on the part of Senior Services PAHP to any third party.

PROVIDER BILLING PROCEDURES <u>REMINDERS</u>

<u>BILL RECIEPT:</u> All billings must be received at Senior Services on or before the 8th of each month, following the month of service (previous month). Billing received after the 8th of the month will not be paid until the following month. Any bills received after 90 days, PAYMENT for services will be denied. All billings will be done through the Vendor Billing software system. Vendor Payments will be issued the last business day of the month.

<u>SERVICE ORDERS:</u> ***PLEASE FOLLOW YOUR AUTHORIZED CARE PLAN*** Bills are verified against Senior Services Authorized Care Plans. If the billing is inconsistent with the Care Plan, payment will be denied.

OVERAGE REQUEST: Any anticipated overages MUST be requested in advance and are subject to approval. Authorization request for additional services/units, for any reason including medical emergencies, will be denied if you do not notify us prior to or within two hours after the overage occurs. Acceptable notification will be 1. Sending a Vendor View message or 2. If the overage occurs after hours, calling our 24 hour after hour emergency line.

NON-SERVICE REPORTING: Reporting Non-Services is pertinent not only for billing purposes, but for the health and safety of the Client. Reporting of Non-Services should be done using Vendor View as they occur and prior to submission of your monthly bill.

NURSING and COUNSELING NOTES: To avoid delay and/or denial of payments, Client Nursing and/or Counseling Notes are to be faxed, mailed or can be entered directly into Vendor View, in conjunction with each monthly billing. Payments for billings sent without Nursing Notes and/or Counseling Notes, where applicable, will be delayed until the following month and every month there-after until the Nursing Notes and/or Counseling Notes are received.

RESIDENTIAL SERVICE TRACKING SHEET: To avoid delay and/or denial of payments, Residential Service Tracking Sheets are to be kept on file and available for review. Providers may choose to utilize their own residential services tracking sheets, as long as they meet the criteria of the tracking sheet of this agency that document includes the date, amount of time and type of ADL and IADL assistance provided. Tracking sheets must be kept on file and available for review at any time.

This Agreement will be reviewed annually, and amended if necessary, for the purpose of focusing the provisions herein to more specifically address the agreed upon interactions between the parties.

Periodic review will include amending the Agreement to appropriately reflect pertinent agreements that may be developed between Senior Services and other federal, state and local agencies.

_____ _____

SENIOR SERVICES PAHP AUTHORIZED OFFICIAL DATE AND TITLE

_____ _____

PROVIDER AUTHORIZED OFFICIAL DATE AND TITLE

Return to: Heather Marshall, MSW, Quality Coordinator
Senior Services, Inc.
918 Jasper Street
Kalamazoo, MI 49001

Senior Services
Southwest Michigan
MI Choice - Waiver Program

PROVIDER INTEGRITY AGREEMENT

Participant Complaint Resolution/Critical Incidents

Provider will have a policy/procedure to protect information gathered on the complaint to maintain participant confidentiality and to show action relating to resolution of the issue and how it will be prevented in the future.

Each provider MUST have a written procedure to record, investigate and report concerns/complaints from participants regarding their DPOS workers to Senior Services supports coordinator for supervision.

The report should be submitted to Senior Services supports coordinator or supervisor within 1-2 days of receiving information from the participant. Information should include an incident/complaint form with date(s) of reported situation, details of concern reported, name of staff person receiving and investigating concern, and include results of investigation/action taken by provider staff.

Provider will identify staff persons who will be responsible for working to resolve complaint with both participant and Senior Services supports coordinator or supervisor.

Reporting Suspected Abuse, Neglect, and Exploitation

Reporting of Abuse, Neglect and/or Exploitation MUST be reported to Michigan Department of Human Services (DHS)/Adult Protective Services (APS), as specified in P.A. 519 of 1982, (as amended)
which mandates that all human service providers and health care professionals
make FIRST PERSON referrals to the DHS Adult Protective Services unit when an adult is suspected of being, or believed to be abused, neglected and/or exploited.

Provider MUST have a written policy/procedure to record, investigate, and report any suspected abuse, neglect, and/or exploitation of participants observed over the course of interaction with and/or delivering services to a participant.

The provider is required to submit this observation/information to law enforcement authorities (APS, Law Enforcement-911) as part of the
Mandated Reporting requirements with the SoM.

This information should also be reported to Senior Services supports coordinator or supervisor as soon as possible after the discovery and report to law enforcement.

Information gathered during the course of this investigation is also required to be held confidential to protect the participant.

Office of Inspector General Reporting

The Michigan Department of Health and Human Services (MDHHS) Office of Inspector General (OIG) is responsible for overseeing the program integrity activities of the Michigan Medicaid MI Choice Waiver Agencies (Grantees)

consistent with this Contract and the requirements at 42 CFR 438.608.

The provider is required to report any suspected fraud, waste or abuse of Medicaid funds to the OIG.
(800) 222-8558
https://oig.hhs.gov/fraud/report-fraud

The OIG provided the following definitions of fraud, waste and abuse:

Fraud is defined as the wrongful or criminal deception intended to result in financial or personal gain. Fraud includes false representation of fact, making false statements, or by concealment of information.

Waste is defined as the thoughtless or careless expenditure, mismanagement, or abuse of resources to the detriment (or potential detriment) of the U.S. government. Waste also includes incurring unnecessary costs resulting from inefficient or ineffective practices, systems, or controls.

Abuse is defined as excessive or improper use of a thing, or to use something in a manner contrary to the natural or legal rules for its use. Abuse can occur in financial or non-financial settings.

The provider agrees Follows the Michigan Office of Inspector General guidelines for verifying upon hire, and then monthly, that employees serving Waiver participants are not on the OIG sanctions list. The following websites are recommended for verifying staff exclusion of the sanctions lists:

- https://www.sam.gov/SAM/
- https://oig.hhs.gov/exclusions/exclusions_list.asp
- https://www.michigan.gov/mdhhs/0,5885,7-339-71551_2945_42542_42543_42546_42551-16459--,00.html

I have read and understand the above policy and procedure regarding the Provider Integrity Agreement.

_____ _____

PROVIDER AUTHORIZED OFFICIAL DATE AND TITLE

Minimum Operating Standards (MOS)

By signing below, I acknowledge that I have received and read a copy of Senior Services minimum operating standards (provided as a separate link) as outlined by the State of Michigan. I agree that as a service provider all staff will be trained and abide by the requirements stated within the MOS.

_____ _____

SENIOR SERVICES PAHP AUTHORIZED OFFICIAL DATE AND TITLE

_____ _____

PROVIDER AUTHORIZED OFFICIAL DATE AND TITLE

Home & Community Based Service Waiver For The Elderly And Disabled

ATTACHMENT F

Home & Community Based Service Waiver For The Elderly And Disabled

Reporting Forms

Purchase of Service Monthly Client Billing-Payment Voucher Form

Purchase of Service Monthly Summary Report

Vendor View Enrollment Form

Nursing/Counseling Notes

Reporting Forms Continued

Community Living Supports

Direct Deposit Authorization

W-9 Form: Please see the note below (by the Asterisk) on how to fill out section 3 of the W-9 form correctly.

*One item that is missed the most is in box 3 at the top of the page. In box 3 you are instructed to select the appropriate box as it applies to your company. If you select limited liability, then you are instructed to put either C, S, or P as it applies, in the box to the right of this selection. Please double check that this is completed correctly before returning the contract.

Provider Grievance Form

OIG Attestation Form

Senior Services
Southwest Michigan
MI Choice - Waiver Program

PURCHASE OF SERVICE MONTHLY CLIENT BILLING

BILLING MONTH: _____ YEAR: _____

SERVICE PROVIDER: _____ PHONE: _____

CLIENT'S NAME: _____ CLIENT' S PROGRAM ID#: _____

USE ADDITIONAL PAGES AS NECESSARY

SERVICE:	INDICATE DATE(S) AND UNITS PER DATE THIS MONTH THAT SERVICE WAS PROVIDED																													
1	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
2	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
3	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
4	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31

PROVIDERS - CLIENT SERVICE SUMMARY

	SERVICE	TOTAL UNITS	X	UNIT COST	=	TOTAL
1.						
2.						
3.						
4.						

TOTAL DUE: _____

NOTES/COMMENTS:

The Purchase of Service Monthly Client Billing form(s) will be submitted to Senior Services, Inc. by the 10th of each month following the month in which service was provided. I certify that the expenditures being reported are correct and appropriate. Documentation is available and will be maintained as required.

SIGNED: _____ DATE: _____

FY 21-22

Senior Services
Southwest Michigan
MI Choice - Waiver Program

Return by mail or fax to :
ATTN: Waiver Billing
918 Jasper St. Kalamazoo, MI
49001
Fax: (269) 382-3189

PURCHASE OF SERVICE MONTHLY SUMMARY REPORT

MONTH: _____ _____

PROVIDER: _____ PHONE: _____

USE ADDITIONAL PAGES AS NEEDED

Service:		Total Units:		Unit Cost:		Total:	COMMENTS
1.			X		=		
2.			X		=		
3.			X		=		
4.			X		=		
5.			X		=		
6.			X		=		
7.			X		=		
8.			X		=		
					TOTAL DUE		

Notes/comments: (problems, deviations from ordered services, etc.)

The Direct Service Purchase Monthly Service Report Summary form(s) will be submitted to Senior Services, Inc. by the 8th of each month following the month in which the service was provided. I certify that the expenditures being reported are correct and verifiable. Documentation is available and will be maintained as required.

Signed: _____ Date: _____

SENIOR SERVICES, INC. USE ONLY:

Received: _____

Entered: _____ Verified: _____

Posted: _____ Paid: _____

Senior Services
Southwest Michigan
MI Choice - Waiver Program

918 Jasper Street
Kalamazoo, MI 49001-2853
www.seniorservices1.org

VENDOR VIEW ENROLLMENT FORM

(PLEASE PRINT)

Vendor Name: _____

VV user with another Agent?: Yes_____ No _____

Agent: _____ Current User ID:_____

Type of Vendor Connection: **Internet_____** **Fax_____**

Fax #: _____

User #1: _____

Phone number: _____

User #1 Email Address: _____

Send new notice emails: Yes_____ No_____

Temporary Password*: _____

User #2: _____

Phone number: _____

User #2 Email Address: _____

Send new notice emails?: Yes_____ No_____

Temporary password*: _____

**** Cannot use name, "password", symbols, or start with a number***

PLEASE FAX COMPLETED FORM TO: ATTN WAIVER BILLING, 269-382-3189

Senior Services
Southwest Michigan
MI Choice - Waiver Program

918 Jasper St., Kalamazoo, MI 49001
269-382-0515
www.seniorservices1.org

NURSING NOTES

(Please complete in detail and return with your statement for consideration of payment)

PATIENT NAME: _____ **DOB:**_____

VITAL SIGNS
RANGE: T_____ **P**_____ **R**_____ **BP**_____ **BLOOD SUGAR RANGE:**_____

HOSPITALIZATIONS
WHEN:_____**WHERE:**_____**WHY:**_____
WHEN:_____**WHERE:**_____**WHY:**_____

ER ROOM VISITS
WHEN:_____**WHERE:**_____**WHY:**_____
WHEN:_____**WHERE:**_____**WHY:**_____

DOCTOR OR SPECIALIST VISITS
WHEN:_____**WHERE:**_____**WHY:**_____
WHEN:_____**WHERE:**_____**WHY:**_____

FALLS
DATES: _____ _____ _____

CHANGES
SKIN BREAKDOWN:_____

MEDICATION CHANGES:_____

ANY MISSED MEDS:_____

OVERALL MEDICAL CHANGES:_____

IS THERE ANYTHING THE SUPPORTS COORDINATOR NEEDS TO BE AWARE OF?_____

Please call if any significant changes

PROFESSIONAL SIGNATURE:_____ **DATE:**_____

FY 21-22

Senior Services
Southwest Michigan
MI Choice Waiver

For Office Use Only:
AP _____

Electronic Funds Transfer (EFT) Authorization Form
Automatic Payment

Please complete the information listed below for the checking or savings account you are designating for the direct deposit of your monthly MI Choice Waiver payment. PRINT legibly and complete all fields. **Failure to do so may result in the inability to process your request.**

1. Type of account _____Checking _____Savings
2. Agency Name: _____
3. Send Remittance to : (Email address) _____
4. Financial institution name: _____
5. Account number: _____
6. Routing/Transit number: _____

- I hereby authorize Senior Services of SW Michigan to initiate credit entries to the account indicated above and for the financial institution named above to credit the same to such account. I acknowledge that the origination of ACH (Direct Deposit) transactions must comply with the provisions of U.S. Law.
- Make changes or to cancel this authorization by completing a new form. Allow 2 weeks for processing.
- This authorization is to remain in force and effect until Senior Services of SW Michigan has written notification of its termination in such time and in such manner as to afford Senior Services of SW Michigan a reasonable opportunity to act on it.
- For questions, please contact Tonee Poechhacker at (269) 382-0515 x 118 or tpoechhacker@seniorservices1.org

_____ _____

Signature (Vendor agrees to terms above) **Print Name**

_____

Date

Verification of Account Number Required:

For Deposit to Checking Account: Attach copy of VOIDED check or Direct Deposit Authorization form from your financial institution ***(no checking account deposit slips, please).***

For Deposit to Savings Account: Attach copy of Direct Deposit Authorization form from your financial institution.

Return to: Senior Services of SW Michigan
ATTN: Accounts Payable
918 Jasper St.
Kalamazoo, MI 49001

Senior Services
Southwest Michigan
MI Choice Waiver

COMMUNITY LIVING SUPPORT SERVICES TRACKING SHEET

This sheet is **required** to be completed daily to track residential services provided to your MI Choice Medicaid Waiver resident. This sheet **must** be returned with your monthly billing sheets each month for Waiver to process your payment.

Name of AFC/HFA: _____ Month: _____ Year: _____

Recipient name: _____ Telephone: _____

PLEASE INDICATE THE **AMOUNT OF TIME** SPENT BY YOUR STAFF EACH DAY MEETING THE NEEDS OF THIS RESIDENT:

Day of the Month:	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Services provided:																															
Bathing																															
Dressing																															
Hygiene																															
Grooming																															
Toileting																															
Incontinence care																															
Eating																															
Mobility assistance																															
Transfers																															
Addition needs:																															
Communication																															
Cognition																															
Wandering																															
Elopement																															
Aggressiveness																															
Resistance to care																															

Additional Comments: _____

_____

_____ _____

Signature of AFC/HFA responsible party Date

FY 21-22

Form **W-9**
(Rev. October 2018)
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.*

Senior Services
Southwest Michigan
MI Choice - Waiver Program

Subject: Grievance and Appeal-Waiver Providers

Originated: 08/01/2019 Reviewed/revised: 08/06/21

Application:

This applies to Senior Services MI Choice Waiver Program Vendors

Purpose:

Every vendor contracted with Senior Services Inc MI Choice Waiver Program is recognized as having civil, service, and personal rights. These rights will not be abridged as the result of becoming a provider of MI Choice Waiver services at Senior Services Inc of SW MI. To ensure that these rights are maintained, a grievance and appeal procedure has been developed to protect these provider rights.

Contracted service providers, such as those within the MI Choice Waiver provider network, are customers of Senior Services. If a provider has a conflict/complaint regarding Senior Services, its staff and/or programs this Grievance and Appeals process shall apply.

Procedure:

1. All providers contracted with Senior Services MI Choice Waiver program shall receive written notification of their rights as providers to file a grievance.
2. Complaints/grievances regarding services received, denied, or requested or ethical or professional violations by any Waiver staff person have the right to file a grievance, and if warranted, a subsequent appeal.
3. Contracted providers can file a grievance in writing, by utilizing the Waiver Provider Grievance Form, or orally, by contacting the Waiver Program Supervisor. It is suggested that for confidentially purposes, that the Grievance Form be emailed directly to the program supervisor. A written, signed grievance is required following an oral filing of a grievance.
4. The Waiver Program Supervisor will respond to a grievance within 10 business days.
5. Should the provider feel that the grievance was not adequately resolved by the Waiver Program Supervisor, the provider can further file an appeal, in writing, to the Director of Clinical and Quality Assurance at Senior Services, Inc of SW MI.
6. Should the provider feel that the grievance was not adequately resolved by the Director of Clinical and Quality Assurance, a final appeal can be filed, in writing, to the Director of Quality at Senior Services Inc. of SW MI.
7. Lastly, if the provider feels that grievance resolution was not adequately resolved provider by the Director of Quality at Senior Services Inc of SW, the provider can file a written appeal with the Michigan Department of Health and Human Services.

I have read and understand the above policy and procedure regarding Provider Grievances.

_____ _____ _____

PROVIDER AUTHORIZED OFFICAL TITLE DATE

Senior Services
Southwest Michigan
MI Choice - Waiver Program

Provider Grievance Form

Please email this completed form to Waiver Program Supervisor, Amy Fialkoff:
afialkoff@seniorservices1.org

Provider Agency Name:_____

Provider Agency Contact Name:_____ **Telephone Number:**_____

Provider Agency Contact Email:_____

Provider Agency Address:_____

Date of Complaint/Incident:_____

COMPLAINT:

You will receive a response from the Waiver Program Supervisor within 10 business days. Please refer to the Waiver Provider Grievance Policy for further appeals procedure if you are not satisfied with the results of your appeal. Verbal responses will be followed by a written response.

Program Supervisor Recommendation:

_____ _____
Program Supervisor Signature Date

Senior Services
Southwest Michigan
Trusted. Dependable. Caring. Since 1963.

918 Jasper Street
Kalamazoo, MI 49001
Phone (269) 382-0515
Fax (269) 382-3189
www.seniorservices1.org

200 W. Michigan Avenue
Battle Creek, MI 49017
Phone (866) 200-8877
Fax (269) 441-0544
www.seniorservices1.org

August 06, 2021

Dear Provider

As you may be aware, the privacy provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires Senior Services, Inc., a "Covered Entity" under the Act, to obtain Business Associate Agreements from those non-covered organizations that, through contract, business arrangement or relationship perform certain services for Senior Services, Inc.

I am requesting that you review and sign the enclosed Business Associate Agreement regarding protecting the privacy of any health information that your organization may have access to in the course of providing prescribed services for Senior Services, Inc. Once signed, please return a copy of the agreement to Senior Services, Inc.

Additionally, I am requesting that you provide a copy of your company's Privacy Practices/HIPAA policy be returned with your Waiver contract. Should you be a small business owner (i.e. lawn care service) and do not have a HIPAA policy, please contact me and I will forward Senior Service's HIPAA policy and a covered entity form for you to sign and return.

Please feel free to call me should you have any questions or concerns.

Sincerely,

Heather Marshall, MSW, Quality Coordinator
Senior Services, Inc of SW MI
(269) 382-0515 ext 134
hmarshall@seniorservices1.org

Senior Services Southwest Michigan

BUSINESS ASSOCIATE AGREEMENT

This Business Associate Agreement ("Agreement") is made effective _____, 20__ by and between _____ (the "Business Associate") and __Senior Services, Inc. (the "Covered Entity").

RECITALS

A. The purpose of this Agreement is to comply with the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") which sets forth the standards for protecting the privacy of certain Protected Health Information (PHI).

B. The Covered Entity, Senior Services, Inc., has contracted the Business Associate to provide certain products and/or Services (collectively, the "Services") pursuant to an existing contract, business arrangement, or relationship (collectively, the "Underlying Contract").

C. The Business Associate regularly receives PHI in its performance of the Services pursuant to the Underlying Contract.

D. Covered Entity has requested Business Associate to perform the Services pursuant to the requirements set forth in the HIPAA Regulations. NOW, THEREFORE, in consideration of the foregoing and of the mutual covenants contained in this Agreement, parties agree as follows:

1. Definitions. The following terms used in this Agreement have the following meanings:

Business Associate. "Business Associate" shall generally have the same meaning as the term "business associate" at 45 CFR 160.103, and in reference to the party to this agreement, shall mean the Business Associate as named above.

Covered Entity. "Covered Entity" shall generally have the same meaning as the term "covered entity" at 45 CFR 160.103, and in reference to the party to this agreement, shall mean Senior Services, Inc.

HIPAA Rules. "HIPAA Rules" shall mean the Privacy, Security, Breach Notification, and Enforcement Rules at 45 CFR Part 160 and Part 164.

Protected Health Information"(PHI) means any information, kept or maintained in any format or medium by the Covered Entity, which identifies an individual or be used to identify an individual and relates to any of the following: (a) the past, present, or future physical or mental health condition of an individual; (b) the provision of services to an individual; or (c) the past, present, or future payment for the provision of services to an individual.

Notice of Privacy Practices means the Covered Entity's Notice of Privacy Practices attached hereto and incorporated herein, and as amended from time to time by the Covered Entity.

2. Obligations and Activities of Business Associate. With regard to the use and/or disclosure of PHI the Business Associate agrees that all uses and disclosures will be in accordance with the Notice of Privacy Practices and applicable federal, state, and local law. The Business Associate will not use or disclose any PHI in violation of HIPAA. In all instances where the use or disclosure of PHI is necessary, the Business Associate will use or disclose only the minimum necessary to achieve the intended purpose for such use or disclosure. Business Associate agrees that it will de-identify all PHI prior to its use or disclosure, to the extent possible. Business further agrees to:

(a) Not use or further disclose PHI other than as permitted or required by this Agreement or as required by law.

(b) Use appropriate safeguards to prevent the use or disclosure of PHI other than as

provided for by this Agreement.

(c) Mitigate, to the extent practicable, any harmful effect that is known to Business Associate from a use or disclosure of PHI by Business Associate in violation of the requirements of this Agreement.

(d) Use appropriate safeguards, and comply with Subpart C of 45 CFR Part 164 with respect to electronic protected health information, to prevent use or disclosure of protected health information other than as provided for by the Agreement;

(e) Report to covered entity any use or disclosure of protected health information not provided for by the Agreement of which it becomes aware, including breaches of unsecured protected health information as required at 45 CFR 164.410, and any security incident of which it becomes aware;

(f) Ensure that any agent, including a subcontractor, to whom it provides PHI, agrees to the same restrictions and conditions that apply through this Agreement to the Business Associate with respect to such information.

(g) Provide access, at the request of Covered Entity, and in the time and manner designated by Covered Entity, to PHI in a Designated Record Set (if applicable), to Covered Entity or, as directed by Covered Entity, to an Individual.

(g) Make any amendment(s) to PHI in a Designated Record Set that the Covered Entity directs or agrees to at the request of Covered Entity or an Individual, and in the time and manner designated by Covered Entity.

(h) Make internal practices, books, and records relating to the use and disclosure of PHI received from, or created or received by Business Associate on Behalf of Covered Entity available to the Covered Entity, or at the request of the Covered Entity to the Secretary, in a time and manner designated by the Covered Entity or the Secretary, for purposes of the Secretary determining Covered Entity's compliance with the HIPAA Regulations.

(i) Document such disclosures of PHI and information related to such disclosures as is required for Covered Entity to respond to a request by an Individual for an accounting of disclosures of PHI in accordance with HIPAA.

(j) Provide to Covered Entity or an Individual in a time and manner designated by Covered Entity, information collected in accordance with Section (i) above, in order to permit Covered Entity to respond to a request by an Individual for an accounting of disclosures of PHI in accordance with HIPAA.

3. Permitted Uses and Disclosures by Business Associate.

(a) General Use and Disclosure Provisions: Except as otherwise limited in this Agreement, Business Associate may use or disclose PHI on behalf of, or to provide the Services to, Covered Entity, for the purposes described in the Underlying Contract, if such use or disclosure of PHI would not violate the requirements of HIPAA if done by Covered Entity.

(b) Specific Use and Disclosure Provisions

(i) Except as otherwise limited in this Agreement, Business Associate may use PHI for the proper management and administration of the Business Associate or to carry out the

legal responsibilities of the Business Associate, provided such uses do not violate the requirements of HIPAA.

(ii) Except as otherwise limited in this Agreement, Business Associate may disclose PHI for the proper management and administration of the Business Associate, provided that disclosures are required by law, or Business Associate obtains reasonable assurances from the person to whom the information is disclosed that it will remain confidential and used or further disclosed only as required by law or for the purpose for which it was disclosed to the person, and the person notifies the Business Associate of any instances of which it is aware in which the confidentiality of the information has been breached.

(iii)Except as otherwise limited in this Agreement, Business Associate may use PHI to provide Data Aggregation services to Covered Entity as permitted by HIPAA.

(iv) The Business Associate is not authorized to use protected health information to de- identify the information in accordance with 45 CFR 164.514(a)-(c).

4. Provisions for Covered Entity to Inform Business Associate of Privacy Practices and Restrictions

(a) Covered entity shall provide Business Associate with the notice of privacy practices (the "Notice") that Covered Entity produces in accordance with HIPAA. Covered entity shall notify business associate of any limitation(s) in the notice of privacy practices of covered entity under 45 CFR 164.520, to the extent that such limitation may affect business associate's use or disclosure of protected health information.
(b) Covered entity shall notify business associate of any changes in, or revocation of, the permission by an individual to use or disclose his or her protected health information, to the extent that such changes may affect business associate's use or disclosure of protected health information.
(c) Covered entity shall notify business associate of any restriction on the use or disclosure of protected health information that covered entity has agreed to or is required to abide by under 45 CFR 164.522, to the extent that such restriction may affect business associate's use or disclosure of protected health information.

5. Term and Termination.

(a) Term. The Term of this Agreement shall be effective as of the date first above written and shall terminate when all of the PHI provided by Covered Entity to Business Associate, or created or received by Business Associate on behalf of Covered Entity, is destroyed or returned to Covered Entity, or, if it is not feasible to return or destroy the PHI, protections are extended to such information, in accordance with the termination provisions in this Section.

(b) Termination for Cause. Irrespective of any provision in the Underlying Contract, Covered Entity may terminate the Underlying Contract in its sole discretion and without compensation of any kind to Business Associate if it reasonably suspects or determines that Business Associate has improperly used or disclosed PHI in violation of HIPAA, the Regulations, other statutes or laws, or in violation of the terms of this Agreement. Covered Entity may in lieu of termination, in its sole discretion, provide notification to Business Associate of an opportunity to cure the improper use or disclosure within a specific cure period.

(c) Effect of Termination.

(i). Except as provided below in paragraph ii. of this subsection, upon termination

of this Agreement, for any reason, Business Associate shall return or destroy all PHI received from Covered Entity or created or received by Business Associate on behalf of Covered Entity. This provision shall apply to PHI that is in the possession of subcontractors or agents of Business Associate. Business Associate shall retain no copies, summaries or excerpts of the PHI. Business Associate shall certify in writing within thirty (30) days from the date of termination or expiration of this Agreement or the Underlying Contract that all PHI has been returned or disposed of as provided and the PHI has not been retained in any form.

(ii). In the event that Business Associate determines that returning or destroying the PHI is infeasible, Business Associate shall provide to Covered Entity notification of the conditions that make return or destruction infeasible. Upon mutual agreement of the Parties that return or destruction of PHI is infeasible; Business Associate shall extend the protections of this Agreement to such PHI and limit further uses and disclosures of such PHI to those purposes that make the return or destruction infeasible, for so long as Business Associate maintains such PHI.

6. Miscellaneous:

(a) Waiver and Severability. The waiver by either party of a violation of any provision of this Agreement shall not operate as, or be construed to be, a waiver of any subsequent breach of the same or other provisions hereof. If any provision of this Agreement or the application thereof to any person or circumstance shall, to any extent, be invalid or unenforceable, the remainder of this Agreement shall not be affected thereby, and each provision of this Agreement shall be valid and enforceable to the fullest extent permitted by law.

(b) Assignment. Neither party shall assign or transfer or permit the assignment or transfer of this Agreement without the prior written consent of the other.

(c) Applicable Law. This Agreement shall be governed by the laws of the State of Michigan.

(d) Binding Effect and Third Party Rights. This Agreement shall be binding upon and inure to the benefit of the parties hereto and their permitted successors and assigns; and is not entered into for the benefit of and shall not be construed to confer any benefit upon, any other party or entity.

(e) Notices. Notices, statements and other communications to be given under the terms of this Agreement shall be in writing and delivered by hand, or sent by certified or registered mail or by Federal Express or other similar overnight mail service, return receipt requested to such address as from time to time is designated by the Party receiving the notice. Notice
shall be deemed effective upon receipt.

(f) Entire Agreement and Amendment. This Agreement, together with the other documents signed by the parties expressly stated to be supplementing hereto and together with any instruments to be executed and delivered pursuant to this Agreement, constitutes the

entire Agreement between the parties and supersedes all prior understandings and writings, and may be changed only by a written statement signed by the parties hereto. This Agreement will automatically amend to comply with any final regulation or amendment to a final regulation adopted by the Department of Health and Human Services concerning the subject matter of this Agreement upon the effective date of the final regulation or amendment.

(g) Counterparts and Facsimiles. This Agreement may be executed and delivered in any number of counterparts, all of which when executed and delivered shall have the force and effect of an original. Facsimile copies hereof shall be deemed to be originals.

(h) Survival of Rights and Obligations. Business Associate's duties and obligations of confidentiality and compliance with applicable law shall survive the expiration or termination of this Agreement.

(i) Interpretation. Any ambiguity in this Agreement shall be resolved in favor of a meaning that permits Covered Entity to comply with the HIPAA Privacy Rule.

(j) Indemnification. Business Associate agrees to defend, indemnify and hold Covered Entity harmless from and against any and all claims, liabilities, judgments, fines, assessments, penalties, awards or other expenses of any kind or nature whatsoever, including without limitation, attorney's fees, expert witness fees, costs of investigation, costs of litigation or dispute resolution relating to or arising out of any breach or alleged breach of this Agreement by Business Associate.

(k) Insurance. At the sole discretion of Covered Entity, Business Associate shall obtain and maintain insurance coverage with such limits and with such companies as Covered Entity shall direct naming Covered Entity as an additional insured against the improper uses and disclosures of PHI by Business Associate.

(l) Disclaimer. Business Associate is responsible for its own HIPAA compliance. Covered Entity is not responsible or liable to Business Associate for its failure to comply with HIPAA or the Regulations. Further, Covered Entity will not be liable to Business Associate for any claim, loss or damage relating to unauthorized use or disclosure of any information received by Business Associate from Covered Entity or from any other source.

(m) Headings and Terms. Headings, in this Agreement, are provided solely for the convenience of the parties and shall not be used to interpret or construe its provisions. Nouns and pronouns will be deemed to refer to the masculine, feminine, neuter, singular and plural, as the identity of the person or persons, firm or corporation may in the context require.

(n) Arbitration. The sole and exclusive method for resolving any dispute arising out of the interpretation or application of this Agreement (or relating to the services provided hereunder or any termination of the services) shall be arbitrated in accordance with this paragraph. The Commercial Rules of Arbitration of the American Arbitration Association (AAA) shall govern arbitration. A party wishing to obtain arbitration of an issue must deliver the written demand for arbitration to the AAA, including a description of the issue to be arbitrated no later than one hundred eighty (180) days after the alleged breach occurred or the occurrence of the act or event upon which the dispute is based. The party filing the

demand shall be solely responsible for any filing fee required by the AAA. A neutral arbitrator shall be selected pursuant to the rules of the AAA. The Arbitrator shall hold a hearing at a mutually acceptable location in Kalamazoo, Michigan within ninety (90) days after the appointment. The Arbitrator shall have the power to issue subpoenas directing either party to disclose information to the other party prior to the hearing, and to direct the appearance of witnesses at the hearing. The fees and expenses of the arbitrator shall be paid one-half by each party. Both the Business Associate and the Covered Entity may be represented by counsel and may present testimony and other evidence at the hearing. Within thirty (30) days after the commencement of the hearing, the arbitrator will issue a written decision. The decision of the arbitrator will be final and binding on the parties and shall be enforceable in accordance with law. Judgment may be entered on the arbitrator's award in any court having jurisdiction. Either party shall be entitled to specific performance of such party's rights under or connected with this Agreement. The arbitrator shall award costs and expenses, including reasonable attorney fees, to the prevailing party; if neither party prevails on all issues, the arbitrator shall allocate costs and expenses, in the arbitrator's discretion based on the extent to which each party has prevailed.

IN WITNESS WHEREOF, each of the parties has executed this Agreement as of the date first above written.

COVERED ENTITY	BUSINESS ASSOCIATE
Senior Services, Inc.	_____
	{Enter Name of Entity)
By:_____	By:_____
Its:_____	Its:_____

Senior Services
Southwest Michigan
Trusted. Dependable. Caring. Since 1963.

918 Jasper Street, Kalamazoo, MI 49001
200 W. Michigan Avenue, Battle Creek, MI 49017
TELEPHONE: (269) 382-0515
www.seniorservices1.org

Michigan Department of Health and Human Services
Compliance Attestation Document

PROGRAM INTEGRITY
Authority: MI Choice Waiver Agency Contract Attachment E, (F); 42CFR438.610; 42CFR455§B

MI Choice Waiver Agency Contractor, Screening and Disclosure Requirements Attestation
I, _____, as a legally authorized representative of_____,
hereby certify that the following statements are true and accurate:

The organization has screened monthly and prior to all new hires and found that:

- ☐ The organization has no director, officer, partner, managing employee, or person with beneficial ownership of 5% or more of the equity who is currently debarred or suspended by any State or Federal agency

- ☐ The organization has no contract, employee, consulting service, or any other agreement with people or entities debarred or suspended for the provision of items or services

- ☐ The organization's subcontractors have no director, officer, partner, managing employee, or person with beneficial ownership of 5% or more of the equity who is currently debarred or suspended by any State or Federal agency

- ☐ The organization's subcontractors have no contract, employee, consulting service, or any other agreement with people or entities debarred or suspended for the provision of items or services

- ☐ Disclosures, if any, have been made to MDHHS-OIG or the Centers for Medicare and Medicaid Services (CMS)

Organization Name

_____
Signature of Authorized Representative

_____
Title of Authorized Representative

_____
Date

_____
Email address of Authorized Representative

_____
Phone Number of Authorized Representative