FMS – Applications Department
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Department of Social Services (DSS) Provider Agreement for Providers of Individual, Self-Directed Home and Community-Based Services to Participants in the Connecticut Medical Assistance Program (CMAP): Personal Care Attendants (PCAs), Independent Living Skills Trainers, Acquired Brain Injury Companions, Personal Support Workers, Recovery Assistants and All Other Self-Directed Providers

I, _____, understand and agree as follows:
Print Name of Provider

General Requirements

1. All the information I provided to DSS or the Fiscal Agent in my application and in my supporting provider qualification documentation is true and accurate and I will immediately let DSS and the Fiscal Agent know if any information changes;

2. I will follow all federal and state statutes, regulations and DSS policies and procedures that apply to the services I provide and for which I am paid through DSS and CMAP.

3. I will submit all requested documentation to DSS or to the Fiscal Agent that fully discloses the extent of the services I provide to CMAP participants;

4. I am physically and mentally able to perform to the highest standards the duties necessary to provide the Home and Community Based Services for the position for which I have applied;

5. Except while the participant is in a hospital, nursing facility or other institution, I will provide all services listed as those to be provided by my provider type in the participant's service plan;

6. I am at least 16 years old (if I am PCA) or at least 18 years old (if I am a provider other than a PCA);

7. I am not an employee of the Fiscal Agent. The Fiscal Agent, acting on behalf of the participant, will process payment/payroll and handle tax withholding for me;

8. If I have worked for any agencies in the past, I left those agencies in good standing and DSS or the Fiscal Agent may contact said agencies and obtain any and all information and employment records;

9. The rate DSS pays for my services under CMAP, through the Fiscal Agent, is payment in full. I will not request or accept any payment directly from the participant for whom I am providing services.

10. I will comply with all requirements established by DSS for the type of service I provide to CMAP participants, including, but not limited to, having and maintaining credentials and participating in mandatory training. I will immediately notify DSS and the Fiscal Agent if I have not complied with such requirements.

11. If I have not obtained all required approvals and completed all required paper work for DSS or the Fiscal Agent, I will not be paid for providing any services.

12. If there is a credible allegation of fraud against me and an investigation is pending, DSS must stop payments for services I provide to participants and I will be removed from the Fiscal Agent's provider directory, unless DSS has good cause not to suspend payments.

Prohibited Activities

13. It is illegal, and considered fraud, if I report hours worked on my timesheet/enter time into the electronic visit verification (EVV) system that I have not actually worked, and I may be prosecuted for fraud to the fullest extent of the law under both state and federal laws should I commit this crime;

14. If DSS or the Fiscal Agent finds that I have engaged in abuse of program requirements or fraud or have otherwise failed to comply with any of the requirements in this Agreement, I may be suspended or removed from the Fiscal Agent's provider directory and will not get paid for services provided to CMAP clients;

15. I will not engage in any conduct, including, but not limited to, health care fraud, patient abuse, making false statements, misrepresenting material facts, or any other activities listed in state or federal law, that could result in my not getting paid under state or federal health programs or in the imposition of civil or criminal activities;

16. I will not bill for any services if the participant is in a hospital, nursing facility or other institution;

17. I will not use or disclose any protected health information (PHI) about participant, except as permitted or required by law, and I will use safeguards to prevent improper use or disclosure of PHI;

18. I will not bill DSS for PCA services (a) to a participant who is my spouse or my child under 18 years old; or (b) to a participant for whom I am a conservator or a guardian.

19. I will not discriminate against any person or group of persons based on age, marital status, religion, national origin, ancestry, color, race, sex, gender identity or expression, sexual orientation, intellectual disability, learning disability, mental disability, physical disability, including, but not limited to, blindness, or status as a veteran.

20. I will not provide any Home and Community-Based Services or submit a timesheet to the Fiscal Agent /enter any time into the EVV system until I receive notification from the Fiscal Agent that I am approved by the Fiscal Agent to provide services and am given an effective date of such approval; have been named as a provider on a participant's consumer plan; and have completed all of the new-hire paper work required by the Fiscal Agent.

Audits and Recoupment

21. Amounts paid to a provider by DSS, through the Fiscal Agent, are subject to review and adjustment upon audit or if DSS or the Fiscal Agent has information that the amount paid was incorrect, or as otherwise required by law;

22. If DSS or the Fiscal Agent determines that a provider has been overpaid, DSS or the Fiscal Agent may take back (recoup) the amount of the overpayment and will work with the provider to establish a schedule of recoupment.

Termination

23. This Agreement may be terminated
    (a) by DSS or its Fiscal Agent upon 30 days written notice
    (b) by the provider upon 30 days written notice, subject to any requirements in federal and state law;
    (c) by DSS or its Fiscal Agent if the provider fails to comply with any of the provisions of this Agreement or any applicable law, rule or policy of CMAP, or if a participant's safety or health is or may be at risk, as determined by DSS;

24. There is no right to renew this Agreement.

By signing this agreement, I consent to the Fiscal Agent doing a criminal background check prior to my providing services to CMAP clients, and to the Fiscal Agent releasing the results of the criminal background check to the participant or the participant's designated representative. If, as a result of the criminal background check, DSS or the Fiscal Agent determines that I am not suited to be a provider in CMAP, I may not be listed on the Fiscal Agent's provider directory and may not be permitted to obtain payment for services provided to CMAP clients.

This Agreement is in effect from _____ to _____.

I have read, and understand, accept and agree to comply with the terms of this Agreement. I further understand and agree that violation of the terms of the Agreement is grounds for termination of the Agreement, and may be grounds for other sanctions as provided by state or federal law.

_____ _____

Provider's Signature Date