

471-000-104 Instructions for Completing Form MC-81. "Medical Assistance Long Term Care Provider Agreement"

Use: Form MC-81, "Medical Assistance Long Term Care Provider Agreement," is used for the required agreement between NDSS and long term care facilities. The agreement is effective only after it is signed by both the facility and NDSS.

Number Prepared: One copy of the two-part Form MC-81 are completed.

Completion: The facility administrator or authorized representative completes the following items of Form MC-81:

License Number of Facility: Enter the facility's license number as assigned by the Nebraska Department of Health, or if out of state, the appropriate licensing agency in that state.

Federal Employer I.D. Number: Enter the federal employer I.D. number as assigned by the Internal Revenue Service. If this is a new number, list the date issued.

Names of Owners: Enter the names of all owners of the facility who have five or more percent interest in the facility.

Name and Address of Provider: Enter the facility's name, address, city, state, and zip code. Check the appropriate box for type of ownership.

Pay to Name and Address: Enter the name to which NDSS will make payment. Enter the address, city, state, and zip code.

The next section lists the terms of the agreement between the facility and NDSS.

Signature: The facility administrator or authorized representative shall sign this section and include his/her title, the date signed, and the facility's telephone number.

After completing the previous sections, the facility sends both parts of Form MC-81 to NDSS.

The designated long term care representative completes the following items:

State Use Only: Enter this facility's Medicaid provider number as assigned by NDSS. Enter the number of certified beds for each care classification as indicated on the current Form HCFA-1539, "Medicare/Medicaid Certification and Transmittal" Enter the effective date, if applicable, and termination date indicated on Form HCFA-1539.

Cancellation Clause: Enter the cancellation date from the current Form HCFA-1539, if applicable.

Authorized Signature: The designated long term care representative shall sign this section and include his/her title and the date signed.

Distribution: After the NDSS representative signs Form MC-81, NDSS retains the original and returns the yellow copy to the facility.

Retention: NDSS retains its copy of Form MC-81 permanently in the NDSS facility file. The facility may retain its copy for at least one year, or longer if desired.

**MEDICAL ASSISTANCE LONG TERM
CARE PROVIDER AGREEMENT**



1. License Number of Facility		2. Federal Employer I.D. Number (If new Federal I.D., list date issued)	
3. Type of Ownership Government: <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> City Nonprofit: <input type="checkbox"/> Corporation Profit: <input type="checkbox"/> Corporation <input type="checkbox"/> Partnership <input type="checkbox"/> Proprietorship <input type="checkbox"/> Proprietorship <input type="checkbox"/> LLC <input type="checkbox"/> LLP State of Incorporation/Registration _____ Foreign Corporation registered to do business in Nebraska <input type="checkbox"/> Yes <input type="checkbox"/> No		Federal I.D. # Issued To:	
		4. Level of Care (check all that apply): <input type="checkbox"/> Nursing Facility <input type="checkbox"/> ICF-MR <input type="checkbox"/> Assisted Living	
5. NAME AND ADDRESS OF PROVIDER		6. PAY TO NAME AND ADDRESS	
Name		Legal Name of Owner	
Street Address		Street Address	
City	State	Zip Code	City
			State
			Zip Code

The provider agrees to participate in the Nebraska Medical Assistance Program, and assures the Nebraska Department of Health and Human Services Finance and Support (HHS-F&S):

- A. That HHS-F&S regulations, policies and procedures in the administration of the Nebraska Medical Assistance program will be followed.
- B. Reimbursement:
 - 1. That reimbursement will be determined (check one):
 - Cost based, Retroactively Adjusted Determination (reference 471 NAC 12-011.07A)
 - Contract Rate Alternative (reference 471-NAC 12-011.07B)
 - 2. That the reimbursement rate determined in accordance with the above checked HHS-F&S regulation will be the full and complete reimbursement rate for the services provided. The amount paid by the Medicaid program for those claims submitted for payment will be accepted as payment in full and no additional payment will be claimed. If any additional payment is received, or will be received from any other source, the amount will be deducted from the amount charged to the Department; and any payment from another source that is received after payment by the Department shall be remitted to the Department.
- C. That all goods and services for which payment will be claimed will be provided in compliance with Title VI of the Civil Rights Act of 1964, as amended; the Rehabilitation Act of 1973, Public Law 93-112, as amended; the Americans With Disabilities Act of 1990, Public Law 101-336; and the Nebraska Fair Employment Practice Act, as amended.
- D. That I will keep such records as are necessary to fully disclose the extent of the services provided to individuals receiving assistance under the State plan (42 CFR 431.107).
- E. That the authorized representatives of HHS-F&S and the Federal Department of Health and Human Services, will be afforded the right to review and/or receive copies of my Medicaid client/patient records to substantiate claims submitted by me to the Department upon receipt of proper patient waiver. The client's/patient's signed Medical Assistance Application includes a proper patient waiver (42 CFR 431.107).
- F. That any false claims, statements, documents or concealment of a material fact may be prosecuted under applicable State or Federal laws (42 CFR 455.18).
- G. That the facility meets applicable Title XVIII and Title XIX certification requirements.

Signature of Provider	Title	Date Signed	Telephone Number
SIGN HERE			

STATE USE ONLY			
Medicaid Provider Number	Number of Certified Beds NF _____ ICF-MR _____	Effective Date	Termination Date
CANCELLATION CLAUSE: In accordance with 42 CFR 442.110(c), 442.12(c), this agreement will be automatically cancelled on _____ unless: (1) The survey agency finds that all deficiencies have been satisfactorily corrected, or (2) The survey agency finds and notifies the Medicaid agency that the facility has made substantial progress in correcting the deficiencies and has a new plan for correction that is acceptable.			
NEBRASKA DEPARTMENT OF HEALTH AND HUMAN SERVICES FINANCE AND SUPPORT			
Authorized Signature	Title	Date Signed	
CHANGE OF OWNERSHIP In accordance with 42 CFR 442.14, when there is a change of ownership the Medicaid agency must automatically assign the agreement to the new owner. In this event the new owner will be asked to sign Form MC-81 (Provider Agreement) to effect the transition.			

WHITE - Department of Health and Human Services-F&S; YELLOW - Provider File

