

Medicaid & Long-Term Care Use Only	
Medicaid ID #	
N-Focus ID #	

Provider Identification

Provider Name	Date of Birth
<input type="text"/>	<input type="text"/>
Social Security Number	FTIN
<input type="text"/>	<input type="text"/>

General Provider Requirements

By signing this agreement, the service provider agrees to:

1. Keep current any state or local license/certification required for service provision.
2. Not provide services if s/he is the legally responsible relative (i.e., spouse of client or parent of minor child who is a client).
3. Not use any federal funds received to influence agency or congressional staff.
4. Not engage in or have an ongoing history of criminal activity that may be harmful or may endanger individuals for whom s/he provides services. This may include a substantiated listing as a perpetrator on the child and/or adult central registries of abuse and neglect, and/or the sex offender registries and the U.S. Department of Health & Human Services Office of Inspector General's List of Excluded Individuals/Entities.
5. Allow Central Registry checks on himself/herself, family member if appropriate, or if an agency, agree to allow the Department staff to review agency policies regarding hiring and reporting to ensure that appropriate procedures regarding abuse, neglect, and law violations are in place.
6. Have the knowledge, experience, and/or skills necessary to perform the task(s).
7. Submit billing documents after service is provided and within six months from date of service.
8. Assure that the rate negotiated or charged does not exceed the amount charged to private payers; bill only for services which are authorized and actually provided.
9. Respect every client's right to confidentiality and safeguard confidential information.
10. Understand and accept responsibility for the client's safety and property.
11. Report changes to appropriate Department staff (e.g., no longer able/willing to provide service, changes in client function).
12. Agree and assure that any suspected abuse or neglect will be reported to law enforcement and/or appropriate Department staff.

Service Provision

Service Code	Service	Maximum Rate	Frequency
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

The party requesting a change in the above terms must notify the other party at least thirty (30) days before the date the proposed change is to be implemented, except for rate changes due to minimum wage changes, rates regulated by governmental agencies, or other changes required by law.

Attach documentation of basic or specialized status of Medicaid Personal Assistance Service Provider.

Comments

Signatures and Dates

I certify that I have read and understand the standards as stated and referenced above and agree to comply with all the terms of this Agreement.

 Provider/Agency Representative Signature Date

 Parent or Legal Guardian Signature (If required) Date

 Signature of Authorized Representative - Nebraska Department of Health and Human Services Date