

## Provider Agreement to Conditions of Participation

**To be approved as a Qualified Service Provider to render services and supports to participants in DDA's waivers, the applicant, or the applicant's agent authorized to sign on the applicant's behalf, shall initial agreement to the following conditions in each line:**

\_\_\_\_\_Agrees to provide all new services in settings that meet the federal Community Settings Rule (set forth at 42 C.F.R. § 441.301(c)(4)), and for locations which do not meet requirement, has a transition plan approved by DDA which will result in compliance;

\_\_\_\_\_Agrees to ensure that staff providing services or supports meet required qualifications including education, licensing, certifications, and training prior to service delivery and continuing thereafter;

\_\_\_\_\_Agrees to comply with the DDA's Policy on Reportable Incidents and Investigations and agrees to receive appropriate training regarding this policy;

\_\_\_\_\_Agrees to comply with DDA's training requirements for staff who work with people with developmental disabilities;

\_\_\_\_\_Agrees to comply with all regulatory provisions in COMAR 10.22.10 (governing Behavior Plans) when applicable for participants served;

\_\_\_\_\_Agrees to comply with applicable Medicaid regulations for each waiver and COMAR 10.09.36;

\_\_\_\_\_Agrees to cooperate with inspections, reviews, audits, and other oversight activities by DDA staff and governmental representatives;

\_\_\_\_\_Agrees to comply with DDA's Policy on Reportable Incidents and Investigations, including cooperating with inspection or monitoring by the Office of Health Care Quality in response to a reported incident or complaint concerning the abuse, neglect, death, exploitation of a participant or any matter deemed a serious reportable incident or complaint as set forth in COMAR 10.22.02.01 and .03 and 10.09.36.03;

\_\_\_\_\_Agrees to follow best practices and reasonable standards (meaning professional methods, procedures, or goods which have been deemed acceptable, prudent and most effective) when providing services or goods to participants with developmental disabilities;

\_\_\_\_\_Agrees to maintain records (written or electronic) of services or products rendered and dates of services and goods delivered for a period of six (6) years and in accordance with applicable laws governing confidentiality of those records;

\_\_\_\_\_Agrees to provide the contracted person-centered services and goods as set forth in each participant's Person-Centered Plan and Service Funding Plan and to honor the choices of the participants served;

\_\_\_\_\_Agrees to bill the Maryland Department of Health in accordance with its reimbursement methodology and in a manner approved by the Department;

\_\_\_\_\_Agrees to only render services to eligible participants which DDA has approved for services and to not bill for services during participants' school hours or when staff fail to meet required training and qualification standards;

\_\_\_\_\_ Agree to ensure staff providing services meet required qualifications including training, certifications, and licenses prior to service delivery and continuing thereafter;

\_\_\_\_\_Agrees to comply with applicable laws and regulations, including but not limited to The Civil Rights Act of 1964, The Rehabilitation Act of 1973, The Americans with Disabilities Act, and The Drug Free Workplace Act of 1988, and

**Provider Agreement to Conditions of Participation (continued)**

certifies, as a business owner, manager, or employee, that I have not been sanctioned, charged or convicted for violating these acts;

\_\_\_\_\_Agrees not to suspend, terminate, increase, or reduce services for a participant without prior authorization from the DDA;

\_\_\_\_\_Agrees to assist with development of a transition plan should the participant and DDA agree to terminate services provided by your business or organization;

\_\_\_\_\_Agrees to adopt written policies and procedures as needed to ensure employees' and contracted staff's compliance with this provider agreement;

**As an authorized agent of the applicant provider entity and its owners and directors acting on their behalf, I**

\_\_\_\_\_Certify that action has not been taken or is pending to suspend or revoke the applicant's, owners', or directors' license in Maryland or in another state, nor have I voluntarily surrendered my license currently or in the past;

\_\_\_\_\_Certifies that action has not been taken or is pending to suspend or revoke the applicant's, owners', or directors' certification(s) in Maryland or in another state, nor has the applicant, owner, or director voluntarily surrendered its certification currently or in the past;

\_\_\_\_\_Certifies that the applicant, owners, or directors have not resigned or been dismissed after notice of allegations of misconduct involving a participant with a developmental disability or a minor;

\_\_\_\_\_Certifies that the applicant, owners, or directors have not been convicted of or received probation before judgement with respect to a violation of law other than minor traffic violations; and

\_\_\_\_\_Certifies that the applicant, owners, or directors have not been convicted of or received probation before judgement with respect to a violation of law other than minor traffic violations.

**NOTE:** A conviction record will not necessarily bar you from being approved. All applicants will be subject to a criminal background investigation.

\_\_\_\_\_Certifies that the applicant, owners, or directors have never been disciplined in a manner which resulted in a reprimand, suspension, or expulsion from participating in a state, federal or local program or contract, (i.e., Medicaid or Medicare), or a private program.

**Privacy Notice** – The information in my application is not routinely shared with other governmental agencies. However, by accepting this notice of privacy, I understand that the Department of Health's Medicaid Program, auditors, inspectors and other government officials may review it.

**Provider Applicant's Signature of Agreement to the Conditions of Participation.**

\_\_\_\_\_  
Executive Director Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Governing Board President (if applicable) Signature

\_\_\_\_\_  
Date