



Department of Aging/Department of Public Welfare Office of Long-Term Living

Organized Health Care Delivery System (OHCDS) Provider Enrollment Form

By submitting this enrollment form _____ (Agency) seeks designation from the Office of Long-Term Living (OLTL) to be a member of an Organized Health Care Delivery System (OHCDS). As a member of the OHCDS, _____ (agency) will have authorization to subcontract with or reimburse qualified providers for certain services provided under OLTL waiver programs. By submitting this form, the agency agrees that:

1. The Agency shall comply with all applicable state and federal statutes, regulations, policies and announcements that pertain to participation in the Pennsylvania Medical Assistance Program including OLTL Waivers.
2. The Agency shall accept the Waiver payment as payment in full for the service rendered and shall not seek any additional payment from a waiver participant under any circumstances.
3. The Agency shall be responsible for the accuracy of all claims submitted under his or her Agency number, whether submitted by the Agency or on the Agency's behalf.
4. The Agency shall not bill or receive payment for services that are not authorized in the Individual Service Plan (ISP).
5. The Agency acknowledges that the submission of false or fraudulent claims could result in criminal prosecution and civil and administrative sanctions, including exclusion from participation in Medicare, the Pennsylvania Medical Assistance Program, other State Medicaid programs, and all other Federal and State health care programs.
6. The Agency shall comply with the disclosure requirements specified in federal regulations at 42 CFR Chapter 455, Subpart B (relating to disclosure of information by Providers and fiscal agents).
7. The Agency shall submit claims for Waiver services in accordance with instructions issued by the Department.
8. The Agency shall comply with all federal audit requirements, including the Single Audit Act, 31 U.S.C. §§ 7501-7507; the revised Office of Management and Budget (OMB) Circular A-133, Audits of States, Local Government, and Non-Profit Organizations; 45 CFR § 74.26 (relating to non-federal audits); and any other applicable statutes or regulation.
9. If the Agency is subcontracting or reimbursing the cost of the service provided by a provider or vendor under the Waiver, the cost billed by the Agency may not exceed the cost charged by the vendor.

OHCDS Provider Enrollment Form

Agency Name: _____

Medical Assistance (PROMISE) Provider Number: _____

Address of the Provider shown in number one above:

_____ Street

_____ City

_____ State

_____ Zip Code

_____ County

(____) _____ Phone

Identify how your agency **will provide** the following services under OHCDS.

(Check the appropriate box)

| | Directly Providing | Subcontracting |
|------------------------------------|--------------------|----------------|
| Environmental Modifications | | |
| Home Delivered Meals | | |
| Personal Emergency Response System | | |
| Transportation (non-medical) | | |
| Durable Medical Equipment | | |
| Community Transition Services | | |

I certify that the information provided on this Enrollment Information Form is true to the best of my knowledge.

Signature of Authorized Representative

Title

Date