CORE PROVIDER AGREEMENT

The Department of Social and Health Services (the department) administers medical assistance and medical care programs for eligible clients. The department provides medical assistance or medical care to certain eligible clients by enrolling eligible providers of medical services.

The department reimburses enrolled eligible providers for covered medical services, equipment, and supplies they provide to eligible clients. To be eligible for enrollment, a provider must:

a. Complete the attached enrollment application;
b. Be an eligible provider and meet the conditions contained in WAC 388-502-0010;
c. Complete and sign a debarment form; and
d. Meet all the applicable state and/or federal licensure requirements to assure the department of his/her qualifications to perform services under this Agreement. This includes maintaining professional licensure in good standing without any stipulation in the provider's license.

A provider will be considered a participating provider once the provider completes the above requirements and signs this Agreement, the department issues a provider number, and the provider bills and accepts payment from the department.

As a participating provider in the medical assistance and medical care programs, hereafter known as Provider, the Provider agrees to the following:

1. **Governing Law and Venue.** This Agreement shall be governed by the laws of the State of Washington. In the event of a lawsuit involving this Agreement, venue shall be proper only in Thurston County, Washington.

   The medical assistance and medical care programs are authorized and governed by Title XIX of the Social Security Act, Title XXI of the Social Security Act, Chapter IV of Title 42 of the Code of Federal Regulations, Chapter 74.09 of the Revised Code of Washington, and Title 388 of the Washington Administrative Code. The Provider is subject to and shall comply with all federal and state laws, rules, and regulations and all program policy provisions, including department numbered memoranda, billing instructions, and other associated written department issuances in effect at the time the service is rendered, which are incorporated into this Agreement by this reference.

2. **License.** The Provider shall be licensed, certified, or registered as required by State and/or Federal law. The Provider will notify the Department within seven (7) days of learning of any adverse action initiated against the license, certification, or registration of the Provider or any of its officers, agents, or employees.

3. **Billing and Payment.** The Provider agrees:

   a. To submit claims for services rendered to eligible clients, as identified by the department, in accordance with rules and billing instructions in effect at the time the service is rendered.
   b. To accept as sole and complete remuneration the amount paid in accordance with the reimbursement rate for services covered under the program, except where payment by the client is authorized by applicable WAC. In no event shall the department be responsible, either directly or indirectly, to any subcontractor or any other party that may provide services.
   c. To be held to all the terms of this Agreement even though a third party may be involved in billing claims to the department. It is a breach of this Agreement to discount client accounts (factor) to a third party biller or to pay a third party biller a percentage of the amount collected.

4. **Disclosure.** The Provider agrees to submit full and complete disclosure on the enrollment application the following:

a. Ownership and control information as required by 42 Code of Federal Regulations, parts 455.100 through 455.106;

b. Identity of any person who has ownership or control interests in the Provider, or is an agent or managing employee of the Provider who has been convicted of any felony and/or convicted of a criminal offense (felony or misdemeanor) relating to program crimes as required by 42 Code of Federal Regulations, part 455.106; and

c. Any denial, termination, or lack of professional liability coverage, or any change in professional liability coverage, including restrictions, modifications, or discontinuing coverage.

At any time during the course of this Agreement, the Provider agrees to notify the department of any material and/or substantial changes in information contained on the enrollment application given to the department by the Provider. This notification must be made in writing within thirty (30) days of the event triggering the reporting obligation. Material and/or substantial changes include, but are not limited to changes in:

a. Ownership;
b. Licensure;
c. Federal tax identification number;
d. Additions, deletions, or replacements in group membership; and
e. Any change in address or telephone number.

5. **Inspection; Maintenance of Records.** For six (6) years from the date of services, or longer if required specifically by law, the Provider shall:

   a. Keep complete and accurate medical and fiscal records that fully justify and disclose the extent of the services or items furnished and claims submitted to the department.

   b. The Provider shall make available upon request appropriate documentation, including client records, supporting material, and any information regarding payments claimed by the Provider, for review by the professional staff within the department or the Secretary of the U.S. Department of Health and Human Services. The Provider understands that failure to submit or failure to retain adequate documentation for services billed to the department may result in recovery of payments for medical services not adequately documented, and may result in the termination or suspension of the Provider from participation in the medical assistance and medical care programs.

6. **Audit or Investigation.** Audits or investigation may be conducted to determine compliance with the rules and regulations of the program. If an audit or investigation is initiated, the Provider shall retain all original records and **supportive** materials until the audit is completed and all issues are resolved even if the period of retention extends beyond the required 6 year period.

7. **Disputes.** Either party who has a dispute concerning this Agreement may request an administrative review hearing in accordance with applicable WAC.

8. **Termination.** The department shall deny, suspend, or terminate the Provider's enrollment for cause according to applicable WAC. Either the department or the Provider may terminate this agreement for convenience at any time upon 30 days written notification to the other. In the event that funding from state, federal, or other sources is withdrawn, reduced, or limited in any way, the department may terminate this Agreement. If this Agreement is terminated for any reason, the Department shall pay only for services authorized and provided through the date of termination.

9. **Advance Directives.** Hospitals, nursing facilities, providers of home health care and personal care services, hospices and HMO's must comply with the advance directive requirements as required by 42 Code of Federal **Regulations,** parts 489, subpart 1, and 417.436.

10. **Provider Not Employee Or Agent.** The Provider or its directors, officers, partners, employees and agents are not employees or agents of the department.

11. **Assignment.** The Provider may not assign this Agreement, or any rights or obligations contained in this Agreement, to a third party without the written consent of the department.

12. **Confidentiality.** The Provider may use Personal Information and other information gained by reason of this Agreement only for the purpose of this Agreement. The Provider shall not disclose, transfer, or sell any such information to any party, except as provided by law.

13. **Indemnification and Hold Harmless.** The Provider shall be responsible for and shall indemnify and hold the department harmless from all liability resulting from the acts or omissions of the Provider or any subcontractor.

14. **Severability.** The provisions of the Agreement are severable. If any provision of the Agreement is held invalid by any court, that invalidity shall not affect the other provisions of this Agreement and the invalid provision shall be considered modified to conform to existing law.

15. **Certification.** This is to certify that the information provided in support of this agreement is true and accurate and I completely understand that any falsification or concealment of a material fact may be prosecuted under Federal and State Laws. Willful misstatement of any material fact in the enrollment application may result in criminal prosecution. I acknowledge that this is being signed under the penalties of perjury and understand that the department is relying on the accuracy of the information I have presented. I agree to abide by the terms of this Agreement including all applicable federal and state statutes, rules, and policies.

SIGNATURE OF PROVIDER OR OWNER/MANAGER	TITLE	DATE
If provider is a legal entity other than a person, the person signing the provider agreement on behalf of the Provider warrants that he/she has legal authority to bind Provider.		
FULL NAME (PRINTED)	PROVIDER SPECIALTY	

Mail completed Enrollment Application and copies of licenses to:
Provider Enrollment
PO Box 45562
Olympia WA 98504-5562

Questions? Toll-Free 1-800-562-3022

Washington State Department of Social & Health Services
MAA Medical Assistance Administration

ENROLLMENT APPLICATION

CURRENT PROVIDER NUMBER

Provider must notify the Department within seven (7) days of learning of any adverse action or within thirty (30) days of any status changes to information provided in this agreement. A change in ownership cancels this agreement and a new agreement and provider number must be requested. Providers are required to submit copies of current licensure upon renewal

PROVIDERS PRACTICING UNDER AN INDIVIDUAL PROVIDER NUMBER: The agreement must be signed by the individual practitioner. Section I and II must be completed.

PROVIDERS PRACTICING UNDER A GROUP PROVIDER NUMBER: The agreement must be signed by the Clinic Manager. Section I must be completed for the Clinic Facility; Section II must be completed for each provider practicing under the group number. Additional spaces for Section II are printed on Page 4 of this application.

PHARMACIES: The agreement must be signed by the Owner or Manager of the pharmacy. Section II must be completed for each pharmacist practicing under the pharmacy provider number.

HOSPITALS: The agreement is to be signed by the Hospital Administrator. Section I is to be completed by the facility.

SUPPLY, AMBULANCE, OPTICAL OR TRANSPORTATION COMPANIES: The agreement must be signed by the Owner or Manager of the company. Section I is to be completed for the company.

Mail completed Enrollment Application and copies of licenses to: Provider Enrollment, PO Box 45562, Olympia WA 98504-5562. Questions? Toll-Free 1-800-562-3022.

I. TO BE COMPLETED BY ALL PROVIDERS (Complete all blocks, where appropriate.)

NAME OF OWNER			EFFECTIVE DATE
BUSINESS NAME		BUSINESS TELEPHONE	BUSINESS FAX
PHYSICAL BUSINESS ADDRESS		MAILING ADDRESS	
TYPE OF PRACTICE	SPECIALTY	NCPDP NUMBER	IRS NUMBER
PROFESSIONAL LICENSE NUMBER / STATE	MEDICARE PROVIDER NUMBER	NPI	SOCIAL SECURITY NUMBER
SIGNATURE OF AUTHORIZED AGENT		SIGNATURE OF AUTHORIZED AGENT	

II. TO BE COMPLETED BY EACH PROVIDER PRACTICING UNDER THE ABOVE PROVIDER NAME/NUMBER (Please see Page 4 if additional space is needed.)

NAME	PROFESSIONAL LICENSE NO.	STATE	MEDICARE PROVIDER NUMBER	NPI
TYPE OF PRACTICE	SPECIALTY	SUBSPECIALTY		
SOCIAL SECURITY NUMBER	DEA (NARCOTIC) NUMBER	MEDICAID PROVIDER NUMBER		
GENDER (Check one) ☐ Male ☐ Female	DATE OF BIRTH	SIGNATURE		

NAME	PROFESSIONAL LICENSE NO.	STATE	MEDICARE PROVIDER NUMBER	NPI
TYPE OF PRACTICE	SPECIALTY	SUBSPECIALTY		
SOCIAL SECURITY NUMBER	DEA (NARCOTIC) NUMBER	MEDICAID PROVIDER NUMBER		
GENDER (Check one) ☐ Male ☐ Female	DATE OF BIRTH	SIGNATURE		

III. TO BE COMPLETED BY ALL PROVIDERS

		Yes	No
1.	Has any provider of service included on this agreement ever been convicted of a felony? If yes, please explain, include dates, charges and final disposition of charges.	☐	☐
2.	Has any provider of service included on this agreement ever been denied malpractice insurance? If yes, please explain, including date(s), of denial and reinstatement date(s)	☐	☐
3.	Does any provider of service included on this agreement have any restrictions placed upon his/her license? If yes, explain, including date(s), of restriction period.	☐	☐

These instructions are designed to clarify certain questions on the disclosure of or change in ownership form.

No instructions have been given for the questions, considered self-explanatory.

Completion and submission of this form is a condition of participation and full and accurate disclosure of ownership and financial interest is required. A failure to submit the requested information may result in a refusal by the State agency to enter into an agreement or contract with the individual and/or entity or in termination of any existing agreements.

Please answer all questions as of the current date. If additional space is needed please use an attached sheet.

I. Under identifying information, specify in what capacity the entity is doing business as (DBA), example, name or trade or corporation.

II. List the names of all individuals and organizations having possession of stock, equity in capital or any interest in the profits of the disclosing entity. (Government owned, tribal, and school based entities may enter N/A.)

III. List the names of all individuals with an ownership or control interest in a subcontractor (a person who or business that contracts to provide some service or material necessary for the performance of your contract).

IV. List the names of any officer, owner, agent or managing employee who has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or the Title XVIII, XIX, or XX.

V. List individuals who have been suspended or debarred from participation in Medicare, Medicaid, or the Title XVIII, XIX, or XX services programs. These individuals would have been placed on the federal Office of the Inspector General, Health and Human Services (OIG/HHS) exclusions list. The current list to excluded individuals can be found at: http://exclusions.oig.hhs.gov/search.aspx

VI. Indicate any anticipated changes within the next year and list the names of the Board of Directors.

VII. Enter the name of the person completing the form along with their title and enter the date the form was completed.

Federal statues and regulations clearly prohibit States from paying for items or services furnished, ordered or prescribed by excluded persons. States are required to search the exclusions database not only by the name of an entity seeking to participate in the program, but also by the name of any owner or managing employee.

DISCLOSURE OF OR CHANGE IN OWNERSHIP AND CONTROL INTEREST STATEMENT

I. Identifying Information

Initial Enrollment ☐ Change ☐	Existing Medicaid Provider Number(s)	NPI Taxonomy

NAME OF INDIVIDUAL AND FACILITY OR ORGANIZATION	PHONE NUMBER	FAX NUMBER

PHYSICAL ADDRESS	MAILING ADDRESS

DBA NAME	FEDERAL TAX ID	SOCIAL SECURITY NUMBER

Entity Govt Owner ☐ Sole Proprietor ☐ LLC ☐ Other ☐

Entity For-Profit Corp ☐ Non-Profit Corp ☐ Partnership ☐ Specify _____

II. Ownership and Control Information

List each office and/or individual, organization, corporation or entity that has direct or indirect ownership or controlling interest, separately or in combination, amounting to an ownership interest of 5% or more of the provider entity. Attach additional pages as necessary.

NAME AND TITLE	SSN/TIN	PERCENTAGE
ADDRESS		
NAME AND TITLE	SSN/TIN	PERCENTAGE
ADDRESS		
NAME AND TITLE	SSN/TIN	PERCENTAGE
ADDRESS		
NAME AND TITLE	SSN/TIN	PERCENTAGE
ADDRESS		
NAME AND TITLE	SSN/TIN	PERCENTAGE
ADDRESS		

List those persons named that are related to each other (spouse, parent, child, or sibling)

NAME	RELATIONSHIP

III. Subcontractor Information

List each person with an ownership or control interest in any subcontractor in which the disclosing entity has direct or indirect ownership of 5% or more. Attach additional pages as necessary.

NAME AND TITLE	SSN/TIN	PERCENTAGE
ADDRESS		
NAME AND TITLE	SSN/TIN	PERCENTAGE
ADDRESS		
NAME AND TITLE	SSN/TIN	PERCENTAGE
ADDRESS		

Does any owner of the disclosing entity also have an ownership or controlling interest 5% or more in any other entity?

NAME AND TITLE	SSN/TIN	PERCENTAGE
ADDRESS		
NAME AND TITLE	SSN/TIN	PERCENTAGE
ADDRESS		
NAME AND TITLE	SSN/TIN	PERCENTAGE
ADDRESS		

IV. Criminal Offenses

List each officer and/or individual who has ownership or control interest in the disclosing entity, or is an agent or managing employee of the disclosing entity and has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid or Title XVIII, XIX, or XX, since the inception of those program. Attach additional pages as necessary.

NAME AND TITLE	SSN/TIN	PERCENTAGE
ADDRESS		
NAME AND TITLE	SSN/TIN	PERCENTAGE
ADDRESS		
NAME AND TITLE	SSN/TIN	PERCENTAGE
ADDRESS		

V. Suspension or Debarment

Have you, any of your employees, or, any individual who has an ownership or controlling interest in the disclosing entity ever been placed on the federal Office of the Inspector General, Health and Human Services (OIG/HHS) exclusions list or otherwise been suspended or debarred from participation in Medicare, Medicaid or Title XVIII, XIX, or XX services programs. If yes, list each person below. Attach additional pages as necessary.

NAME AND TITLE	SSN/TIN	PERCENTAGE
ADDRESS		

NAME AND TITLE	SSN/TIN	PERCENTAGE
ADDRESS		

VI. Status Changes

Is a change of ownership anticipated within the next year?	Yes ☐ No
Is this facility operated by a management company or leased in whole or party by another organization?	Yes ☐ No
If yes, list date of change in operations:	
Has there been a past bankruptcy or do you anticipate filing for bankruptcy within the next year?	Yes ☐ No
If yes, when?	

List each of the Board of Directors of the disclosing entity. Attach additional pages as necessary.

NAME AND TITLE	SSN/TIN	PERCENTAGE
ADDRESS		

NAME AND TITLE	SSN/TIN	PERCENTAGE
ADDRESS		

NAME AND TITLE	SSN/TIN	PERCENTAGE
ADDRESS		

Who ever knowingly and willfully makes or causes to be made a false statement or representation of this statement, may be prosecuted under applicable federal or state laws. In addition, knowingly and willfully failing to fully and accurately disclose the information requested may result in denial of a request to participate or where the entity already participates, a termination of its agreement or contract with the appropriate state agency. By signature I certify that the information provided within, is true and correct and I fully understand the consequences as explained above.

VII. SIGNATURE AND TITLE OF INDIVIDUAL COMPLETING THIS FORM — DATE

TO BE COMPLETED BY EACH PROVIDER PRACTICING UNDER THE ABOVE PROVIDER NAME/NUMBER				
NAME	PROFESSIONAL LICENSE NO.	STATE	MEDICARE PROVIDER NUMBER	NPI
TYPE OF PRACTICE	SPECIALTY	SUBSPECIALTY		
SOCIAL SECURITY NUMBER	DEA (NARCOTIC) NUMBER	MEDICAID PROVIDER NUMBER		
GENDER (Check one) ☐ Male ☐ Female	DATE OF BIRTH	SIGNATURE		
NAME	PROFESSIONAL LICENSE NO.	STATE	MEDICARE PROVIDER NUMBER	NPI
TYPE OF PRACTICE	SPECIALTY	SUBSPECIALTY		
SOCIAL SECURITY NUMBER	DEA (NARCOTIC) NUMBER	MEDICAID PROVIDER NUMBER		
GENDER (Check one) ☐ Male ☐ Female	DATE OF BIRTH	SIGNATURE		
NAME	PROFESSIONAL LICENSE NO.	STATE	MEDICARE PROVIDER NUMBER	NPI
TYPE OF PRACTICE	SPECIALTY	SUBSPECIALTY		
SOCIAL SECURITY NUMBER	DEA (NARCOTIC) NUMBER	MEDICAID PROVIDER NUMBER		
GENDER (Check one) ☐ Male ☐ Female	DATE OF BIRTH	SIGNATURE		
NAME	PROFESSIONAL LICENSE NO.	STATE	MEDICARE PROVIDER NUMBER	NPI
TYPE OF PRACTICE	SPECIALTY	SUBSPECIALTY		
SOCIAL SECURITY NUMBER	DEA (NARCOTIC) NUMBER	MEDICAID PROVIDER NUMBER		
GENDER (Check one) ☐ Male ☐ Female	DATE OF BIRTH	SIGNATURE		
NAME	PROFESSIONAL LICENSE NO.	STATE	MEDICARE PROVIDER NUMBER	NPI
TYPE OF PRACTICE	SPECIALTY	SUBSPECIALTY		
SOCIAL SECURITY NUMBER	DEA (NARCOTIC) NUMBER	MEDICAID PROVIDER NUMBER		
GENDER (Check one) ☐ Male ☐ Female	DATE OF BIRTH	SIGNATURE		
NAME	PROFESSIONAL LICENSE NO.	STATE	MEDICARE PROVIDER NUMBER	NPI
TYPE OF PRACTICE	SPECIALTY	SUBSPECIALTY		
SOCIAL SECURITY NUMBER	DEA (NARCOTIC) NUMBER	MEDICAID PROVIDER NUMBER		
GENDER (Check one) ☐ Male ☐ Female	DATE OF BIRTH	SIGNATURE		

FREQUENTLY ASKED QUESTIONS ABOUT DEBARMENT

What is "Debarment, Suspension, Ineligibility, and Voluntary Exclusion"?

These terms refer to the status of a person that cannot contract with or receive grants from a federal agency.

In order to be debarred, suspended, ineligible, or voluntarily excluded, you must:

- Have had a contract or grant with a federal agency, and
- Have gone through some process where the federal agency notified or attempted to notify you that you could not contract with the federal agency
- Generally, this process occurs where you, the contractor, are not qualified or are not adequately performing under a contract, or have violated a regulation or law pertaining to the contract.

Why am I required to sign this certification?

You are requesting a contract or grant with DSHS. Federal law (Executive Order 12549) requires DSHS to ensure that persons or companies that contract with DSHS are not prohibited from having federal contracts.

What is Executive Order 12549?

Executive Order 12549 refers to Federal Executive Order Number 12549. The executive order was signed by the President of the United States and directed federal agencies to ensure that federal agencies, and any state or other agency receiving federal funds were not contracting or awarding grants to persons, organizations, or companies who have been excluded from participating in federal contracts or grants.

What does the word "proposal" mean when referred to in this certification?

Proposal means a solicited or unsolicited bid, application, request, invitation to consider or similar communication from you to DSHS.

What or who is "lower tier participant"?

Lower tier participant means a person or organization that submits a proposal, enters into contracts with, or receives a grant from DSHS, OR any subcontractor of a contract with DSHS. If you hire subcontractors, you should require them to sign a certification and keep it with your subcontract.

What is a covered transaction when referred to in this certification?

Covered Transaction means a contract, oral or written agreement, grant, or any other arrangement where you contract with or received money from DSHS. Covered Transaction does not include mandatory entitlements and individual benefits.

NAME	DOING BUSINESS AS (DBA)	
ADDRESS	WASHINGTON UNIFORM BUSINESS IDENTIFER (UBI)	FEDERAL EMPLOYER ID NUMBER

This certification is submitted as part of a request to contract. The applicable Procurement or Solicitation Number, if any, is _____

Instructions For Certification Regarding Debarment, Suspension, Ineligibility and Voluntary Exclusion- -Lower Tier Covered Transactions

READ CAREFULLY BEFORE SIGNING THE CERTIFICATION. Federal regulations require contractors and bidders to sign and abide by the terms of this certification, without modification, in order to participate in certain transactions directly or indirectly involving federal funds.

1. By signing and submitting this proposal, the prospective lower tier participant is providing the certification set out below.
2. The certification in this clause is a material representation of fact upon which reliance was placed when this transaction was entered into. If it is later determined that the prospective lower tier participant knowingly rendered an erroneous certification, in addition to other remedies available to the Federal Government the department or agency with which this transaction originated may pursue available remedies, including suspension and/or debarment.
3. The prospective lower tier participant shall provide immediate written notice to the person to which this proposal is submitted if at any time the prospective lower tier participant learns that its certification was erroneous when submitted or had become erroneous by reason of changed circumstances.
4. The terms covered transaction, debarred, suspended, ineligible, lower tier covered transaction, participant, person, primary covered transaction, principal, proposal and voluntarily excluded as used in this clause, have the meaning set out in the Definitions and Coverage sections of rules implementing Executive Order 12549. You may contact the person to which this proposal is submitted for assistance in obtaining a coy of those regulations.
5. The prospective lower tier participant agrees by submitting this proposal that, should the proposed covered transaction be entered into, I shall not knowingly enter into any lower tier covered transaction with a person who is proposed for debarment under 48 CRF part 9, subpart 9.4, debarred, suspended, declared ineligible, or voluntarily excluded from participation in this covered transaction, unless authorized by the department or agency with which this transaction originated.
6. The prospective lower tier participant further agrees by submitting this proposal that it will include this clause titled “Certification Regarding Debarment, Suspension, Ineligibility and Voluntary Exclusion- -Lower Tier Covered Transaction,” without modification, in all lower tier covered transactions and in all solicitations for lower tier covered transactions.
7. A participant in a covered transition may rely upon a certification of a prospective participant in a lower tier covered transaction that it is not proposed for debarment under 48 CFR part 9, subpart 9.4, debarred, suspended, ineligible, or voluntarily excluded from covered transactions unless it knows that the certification is erroneous. A participant may decide the method and frequency by which it determines the eligibility of its principals. Each participant may, but is not required to, check the LIST of Parties Excluded from Federal Procurement and Nonprocurement Programs.
8. Nothing contained in the foregoing shall be construed to require establishment of a system of records in order to render in good faith the certification required by this clause. The knowledge and information of a participant is not required to exceed that which is normally possessed by a prudent person in the ordinary course of business dealings.
9. Except for transactions authorized under paragraph 5 of these instructions, if a participant in a covered transaction knowingly enters into a lower tier covered transaction with a person who is proposed for debarment under 48 CFR part 9, subpart 9.4, suspended debarred, ineligible, or voluntarily excluded from participation in this transaction, in addition to other remedies available to the Federal Government, the department or agency with which this transaction originated may pursue available remedies, including suspension and/or debarment.

Certification Regarding Debarment, Suspension, Ineligibility and Voluntary Exclusion- - Lower Tier Covered Transactions

1. The prospective lower tier participant certifies, by submission of this proposal, that neither it nor its principals is presently debarred, suspended, proposed for debarment, declared in eligible, or voluntarily excluded from participation in this transaction by any Federal department or agency.

2. Where the prospective lower tier participant is unable to certify to any of the statements in this certification, such prospective participant shall attach an explanation to this proposal.

BIDDER OR CONTRACTOR SIGNATURE	DATE
PRINT NAME AND TITLE	