STATE OF TENNESSEE
DEPARTMENT OF FINANCE AND ADMINISTRATION
DIVISION OF HEALTH CARE FINANCE AND ADMINISTRATION
BUREAU OF TENNCARE
310 Great Circle Road
NASHVILLE, TENNESSEE 37243

SNF Providers Recertification

In response to your interest in participating in the Tennessee TennCare/Medicaid Program, we are providing the necessary documents for enrollment. This site includes, but is not limited to enrollment applications for hospitals, hospice, laboratories, and groups.

Tennessee TennCare/Medicaid Providers must have completed applications forms on file before claims can be processed for payment. Please complete all documents and return to

Department of Finance and Administration
Bureau of TennCare
Provider Enrollment Unit
310 Great Circle Road
Nashville, TN 37243

All incomplete applications and requested documents not included will be returned to the pay-to address on your application. Original signature is required for all documents.

After receipt of the completed recertification packet you will receive a copy of a new written working agreement.

Should you have any questions concerning your agreement, or status of your Facility please contact Provider Enrollment at 1-800-852-2683.

Thank you for your continued participation in the TennCare/Medicaid program.

STATE OF TENNESSEE
DEPARTMENT OF FINANCE AND ADMINISTRATION
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BUREAU OF TENNCARE
310 Great Circle Road
NASHVILLE, TENNESSEE 37243

CHECKLIST
SNF/ Level II Nursing Home Recertification

This check list will assist you in completing and returning the correct forms along with this document. Enrollment Packets must include the following

Note: Please complete all forms in black ink only.

Medicare Provider Number _____

NPI Number _____

NPI Collection Form (required) _____

Copy of License (required) _____

CMS Medicare Approval letter (required)
New _____
Change of Ownership _____

Disclosure of Ownership (required) _____

No. 3 Application SNF Level II
Recertification _____
New _____
Change of ownership _____

Substitute W-9 Form _____

Participating Agreement for Level II (Contract) Signed by Provider: _____

For Office Use Only

Contract: Signed by Commissioner/Assistant Commissioner _____ **(date)**

File Completed **Yes**_____ **No** ____ _____ **(date)**

_____ **(INITIALS)**

NOTE: PLEASE RETURN THIS FORM WITH THE ENROLLMENT PACKET AND PROVIDE AN EMAIL ADDRESS TO RECEIVE A COPY OF THE COMPLETED CONTRACTS.

EMAIL COPY OF EXCUTED CONTRACT TO: _____

SNF/Level II Nursing Home

Application

Provider Registration
310 Great Circle Road
Nashville, TN 37243

STATE OF TENNESSEE
DEPARTMENT OF FINANCE AND ADMINISTRATION
DIVISION OF HEALTH CARE FINANCE AND ADMINISTRATION
BUREAU OF TENNCARE
www.tn.gov/tenncare/longtermcare2.html

(Check all that apply)	**_____ Reactivation**
_____ New Enrollment	**_____ Revalidation**
_____ Change of Ownership	**_____ Name Change**
_____ Rcertification	**_____Tax ID # Change**

Legal Business Name: _____
D/B/A: _____
Practice Location: (No P.O. Box #) _____
City: _____ **State:** _____ **Zip Code + 4:** _____
Telephone: _____ **Fax:** _____ **County:** _____

If the name and address to which checks and remittance advices are to be sent is different from the name and address above, please provide that information below. This pay-to information should match the W-9 form.

Legal Business Name as reported to the IRS: _____
D/B/A Name: _____
(Pay-To Address)
Street Address or P.O. Box: _____
City: _____ **State:** _____ **Zip Code + 4:** _____
Telephone No.: _____ **Fax No.:** _____

Federal Tax No. (IRS No.): _____ **NPI No:** _____ **Taxonomy:** _____

Applying For: Part A _____ **Part B** _____ **Medical Specialty:** _____

Briefly describe the services you propose to offer to Medicaid recipients: _____
_____

Medical supplies and durable medical equipment only — briefly describe the types of items and equipment you propose to supply to Medicaid recipients:

_____

Federal Medicare No.:_____ **State Medicaid No.:** _____

Submit copies of professional and/or business licenses, accreditations, certifications, and registrations specifically required to operate as a health care provider.

License No: _____ **Date of Issuance:** _____ **Expiration Date:** _____

DEA No: _____ **Date of Issuance:** _____ **Expiration Date:** _____

Application Surety Statement: "I certify that the information provided on this application is complete and correct to the best of my knowledge."
Signature: _____ **Date:** _____
(Original Signature of Administrator, Agent, or Owner)

Printed Name: _____ **Title:** _____

SUBSTITUTE W-9 FORM

REQUEST FOR TAXPAYER IDENTIFICATION NUMBER AND CERTIFICATION

1. Please complete general information:

Taxpayer Name: _____ Phone Number: _____

Business Name (if applicable): _____

Address: _____

City: _____ State: _____ ZIP Code: _____

2. Circle the most appropriate category below: (please circle only one)

1) Individual (not an actual business)
2) Joint account (two or more individuals)
3) Custodian account of a minor
4) a. Revocable savings trust (grantor is also trustee)
   b. So-called trust account that is not a legal or valid trust under state law
5) Sole proprietorship (using a social security number for the taxpayer ID)
6) Sole proprietorship (using a federal employer identification number for the taxpayer ID)
7) A valid trust, estate, or pension trust
8) Corporation
9) Association, club, religious, charitable, educational, or other non-profit organization (for entities that are exempt from federal tax, use category 13 below)
10) Partnership
11) A broker or registered nominee
12) Account with the U.S. Department of Agriculture in the name of a public entity that receives agricultural program payments
13) Government agencies and organizations that are tax-exempt under Internal Revenue Service guidelines (i.e., IRC 501(c)3 entities)

3. Fill in your taxpayer identification number below: (please complete only one)

1) If you circled number 1-5 above, fill in your Social Security Number

   ___ ___ ___ - ___ ___ - ___ ___ ___ ___

2) If you circled number 6-13 above, fill in your Federal Employer Identification Number (EIN).

   ___ ___ - ___ ___ ___ ___ ___ ___ ___

Sign and date the form:

Certification – Under penalties of perjury, I certify that the number shown on this form is my correct taxpayer identification number. If I circled category 13 above, I also certify that my agency or organization is tax-exempt per Internal Revenue Service guidelines and not subject to backup withholding.

Signature: _____ Date: _____

Title (if applicable): _____

National Provider Identifier (NPI) Collection Form
Group Practices/Facilities

Any form not containing all required fields will be rejected.

Section 1 – Provider General Information

Business Name _____

Doing Business As (Name) _____

_____ _____ _____

Medicaid ID **EIN** **NPI**

Taxonomy Codes _____ _____ _____

_____ _____ _____

Section 2 – NPI Information

(Please Complete this Section for each Individual Provider that is associated with your Group. Please Make additional copies if required)

Provider Name	Medicaid ID	NPI	SSN	Taxonomy	Taxonomy

Section 3 – Primary Practice Location (As Entered on NPPES)

Address _____

_____ _____ _____

City **State** **ZIP**

_____ _____ _____

Phone Number **Fax Number** **Provider Email Address**

Section 4 – Contact Information

Name of Individual Completing Form _____

_____ _____ _____

Phone Number **Fax Number** **Contact Email Address**

Signature _____ **Title** _____

NPI Collection Form Surety Statement:
"I certify that the information provided on this application is complete and correct to the best of my knowledge."

Instructions
Group Practices/Facilities

Send the completed NPI Collection Form via one of the following means:

Mail	Provider Enrollment Attn: NPI Collection 310 Great Circle Rd. Nashville, TN 37243
Fax	(615) 248-4386 or (866) 456-0859
Field	**Instruction**
Section 1 – Provider General Information and NPI Information	
Provider Business Name	(Required) Enter the provider's name (Facilities, Agencies, Groups, Hospitals, etc.).
D/B/A Name	(Required If Applicable).
Medicaid ID No.	(Required) Enter the 7-digit Medicaid provider number.
EIN	(Required for a business entity) Enter the Employer Identification Number.
National Provider Identification Number	(Required) Enter the National Plan and Provider Enumeration System (NPPES) assigned NPI.
Section 2 – Group Member - NPI Information	
Provider Name	(Required) Enter the individual provider name linked to this group number.
Medicaid ID No.	(Required) Enter the 7-digit Medicaid provider number.
NPI Individual Provider Identifier	(Required) Enter the National Plan and Provider Enumeration System (NPPES) assigned NPI.
Social Security Number	(Required) Enter the Individual Provider SSN.
Taxonomy Codes	(Required) Enter the Taxonomy codes associated with the assigned NPI.
Section 3 – Primary Practice Location	
Address	(Required) Enter the primary practice location address of the provider as entered in the NPPES.
City	(Required) Enter the primary practice location City of the provider as entered in the NPPES.
State	(Required) Enter the primary practice location State of the provider as entered in the NPPES.
ZIP	(Required) Enter the primary practice location zip of the provider as entered in the NPPES. If known, include the ZIP +4.
Phone Number with area code	(Required) Enter the primary practice location phone number of the provider as entered in the NPPES.
Fax Number with area code	(Optional) Enter the primary practice location fax number of the provider as entered in the NPPES.
Provider Email Address	(Optional) Enter the primary practice location e-mail address of the provider as entered in the NPPES.
Section 4 – Contact Information	
Name of Individual Completing Form	(Required) Enter the name of the individual completing this form.
Phone Number with area code	(Required) Enter the phone number of the individual completing this form.
Fax Number with area code	(Optional) Enter the fax number of the individual completing this form.
Contact Email Address	(Optional) Enter the email address of the individual completing this form.
Signature/Title	Signature and Title of the person who has legally binding authority to provide information to the Bureau of TennCare with regards to the provider identified on the form.

DISCLOSURE FORM FOR PROVIDER ENTITIES

Directions: Use this form if you are trying to get a new TennCare/Medicaid ID number for a **Provider Entity**, or if you are re-credentialing or re-contracting a **Provider Entity**, or if there have been significant changes to the information required on this form, for example an ownership change, the addition of a new managing employee or the change of your business location. A **Provider Entity** is a business entity. i.e. a partnership or corporation, that provides TennCare covered services to TennCare enrollees.

Please answer all questions as of the current date. If additional space is needed, please note on the form that the answer is being continued, and attach a sheet referencing the item number that is being continued. Return this form to the address on the application packet. Please retain a copy for your files. Completely answer the applicable questions. If a question is not applicable please respond **N/A** for that question. ***NO QUESTIONS SHOULD BE LEFT BLANK***. The SSN must be provided. Tennessee Code Annotated § 4-4-125 creates an exception to the public records act by prohibiting state agencies from disclosing Social Security Numbers (SSN).

I. IDENTIFYING INFORMATION

Name of person Completing form	Phone number of person completing form

Provider Entity Name	Provider Entity DBA Name (if different from Provider Entity name)	Provider Entity Federal Tax Id number

Provider Entity NPI number (If you have one, if not indicate if applied for.)	Provider Entity TennCare/Medicaid ID number (If you have one, if not indicate if applied for.)	Provider Entity telephone Number

Provider Entity Address- Must include at least one street address. (attach a separate sheet if needed).List all Practice locations	City	State	Zip

II. OWNER OR CONTROL INFORMATION

Directions: An **"Owner"** is a person or business entity which owns 5% or more of the assets, stock or profits of the **Provider Entity**. This 5% may be **Direct** ownership or **Indirect** ownership i.e, an individual might own 50% of a company that owns the actual **Provider Entity** meaning their indirect ownership is 50%. In addition to ownership of stock, an **Owner** is also a person who owns a legal obligation like a mortgage or loan that is secured by the assets of the **Provider Entity**.

A person with **"Control Interest**" is someone who directs the **Provider Entity** and includes Directors, Trustees and Officers of Corporations and Partners in a Partnership. If the **Provider Entity** is a non-profit entity, respond **N/A** in the column for % of ownership.

A **"Managing Employee"** is someone who makes the day to day decisions for the **Provider Entity**. These individuals include office or billing managers for smaller providers, and for larger **Provider Entities** the heads of the major operating groups of the provider like, Head of Accounting, or Director of same day services. In other words, the line of individuals typically listed below the corporate officers on an organizational chart.

An **"Agent"** is an individual who has the legal ability to bind the **Provider Entity,** i.e., the **Provider Entity** may use an **Agent** to obtain contracts for it.

Please provide the following information for **Owners**, persons with **Control** interests, **Agents** and **Managing employees** of the **Provider Entity**. Attach a separate sheet if needed. If the company is a non-profit please put N/A in % ownership column.

A. Master List

Name	Address (For *individuals* use Home address. For *business entities* that might have Ownership/Control interest use all street addresses (if more than one location), and P.O. Box address if any.)	City	ST	ZIP	DOB	**SSN** for individuals or Tax ID for business entities	% own er-ship.	Title

B. Specific Questions

1) Is any person on the **Master List** related to another person on the **Master List** as a spouse, parent, child or sibling?
   Yes ☐ No ☐. If yes, please provide the following information about the related persons:

Name of First related person	Name of Second related Person	Type of relation

2) Does any person or entity in the **Master List** have an **Ownership** or **Control** interest in any other **Provider Entity**?

Yes ☐ No ☐ If "yes", please provide the following information about the other **Provider Entity** the person on the **Master List** has an interest in.

Name of other Provider entity	Address	City	State	Zip	Tax I.D.

3) Have any of the individuals or entities on the **Master list** been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, Tricare or the CHIP services program since the inception of those programs? Yes ☐ No ☐ If yes, please provide the information requested below:

Name on Court records	SSN /TIN	Matter of the Offense	Date of the Conviction	Exclusion Period of the Offense if you were excluded by the Federal Office of the Inspector General(OIG)

4) Have any of the individuals or entities on the **Master List** ever been **Debarred** from participation in Federal Government contracts? **"Debarred"** means an individual is not allowed to participate in contracts paid for by the Federal government, whether or not those contracts are in the health care area.

Yes ☐ No ☐ If 'yes' is checked, provide the following information:

When you were debarred	Length of Debarment	Reason for Debarment

5) Has any person or entity on the **Master List** ever been **Excluded** from participation in Federal health care programs (Medicare, Medicaid, CHIP or Tricare) in the past. "Excluded" means that a provider or entity has been told by the Department of Health and Human Services, Office of the Inspector General (HHS,OIG) that they may no longer be a provider for any federally funded healthcare program.

Yes ☐ No ☐ If "Yes" please supply the following information:

Name of Individual	Beginning date of exclusion or termination	End date of exclusion or termination	Reason for exclusion or termination

6) Has any person or entity on the **Master List** ever been **Terminated** from a State's Medicaid or CHIP programs for reasons having to do with Program Integrity (fraud or abuse)? **Terminated** means the Provider lost the right to bill a State's Medicaid or CHIP programs for a cause related to fraud or abuse.

Yes ☐ No ☐ If "Yes", please supply the following information:

State where practicing when terminated	Reason for termination	Date of termination

7) Has any person or entity on the **Master List** ever had **Civil Monetary Penalties (CMPs)** assessed against them? A CMP is a type of fine assessed against a Provider by a governmental agency that manages a federal healthcare program.

Yes ☐ No ☐ If "Yes" please supply the following information:

Name Of Individual	State where practicing when CMP assessed	Reason for CMP	Amount of CMP	Date of CMP

8) Did anyone on the **Master List** obtain their **Direct or Indirect Ownership** interest 1) as a result of a transfer of Direct or Indirect ownership from someone who was about to be Excluded or Terminated from participation in a Federal healthcare program, or was in fact Excluded or terminated from

participation in a federal healthcare Program.: And 2) where the original **Owner** is or was a member of the **current Owner's Immediate Family** or M**ember of** the current owner's H**ousehold**, at the time of the transfer of ownership? [**Immediate Family**] is defined as a person's husband or wife; natural or adoptive parent; child or sibling; stepparent, stepchild, stepbrother or stepsister; father-, mother-, daughter-, son-, brother- or sister-in-law; grandparent or grandchild; or spouse of a grandparent or grandchild. **Membe**r **of Household** is, with respect to a person, any individual with whom they are sharing a common abode as part of a single family unit, including domestic employees and others who live together as a family unit. A roomer or boarder is not considered a member of household.]

Yes ☐ No ☐ If "Yes" please supply the following information:

Name of original **Owner**	SSN or TAX ID of original **Owner**	Place of Transfer	Date of Transfer

9a) List any **Subcontractor** in which this **Provider Entity** has a Direct or Indirect **Ownership** interest of at least a 5%. A **Subcontractor** is a person or company that this **Provider Entity** has contracted with to do some of the **Provider Entities'** management functions, i.e., billing agent, or provide medical services i.e. a medical lab.

Name of Subcontractor	Address	City	State	Zip	Tax I.D.

9b) For each **Subcontractor(s)** listed in 8a above please provide the following information for the individuals with an Direct or Indirect **Ownership** or **Control Interest** in the **Subcontractor(s).** See the Introduction section above for a definition of those terms. Attach a separate sheet if necessary.

Name	Address (for individuals use Home address, for business entities that might have a Direct or Indirect Ownership or Control **Interest** use business street address, and P.O. Box address if any.)	City	ST	Zip	DOB	SSN for individuals or Tax ID for business entities	% of own er-ship	Title

9c) Is anybody in the list in 9b list related to any person in the **Master List** above?

Yes ☐ No ☐ If yes, please supply the following information about the related persons:

Name of First related person	Name of Second related Person	Type of relation

III. BUSINESS TRANSACTIONS

1) Please list the **Subcontractors** with whom you have done business over the last 5 years where the contract is worth at least 5% of your **Provider Entities'** total operating expenses *or* $25,000 *whichever is less*. Use a separate sheet if necessary. *Do not* include the Subcontractors listed in II.8a. in which you have an **Direct or Indirect Ownership interest**. A **Subcontractor** is a person or company that this **Provider Entity** has contracted with to do some of the **Provider Entities'** business functions, i.e., billing agent, or to provide medical services, i.e., a medical lab.

Name	Address	City	State	Zip

2) Does the **Provider Entity** *wholly own* a **Supplier**? **Supplier** means an individual, agency, or organization from which the **Provider Entity** *purchases goods and services* used in carrying out its responsibilities under Medicaid (e.g., a commercial laundry, a manufacturer of hospital beds or a pharmacy.)

Yes ☐ No ☐. If yes, supply the following information about the **Supplier:**

Name	Address	City	State	Zip	NPI	TIN

IV. SIGNATURE

The State or Federal Medicaid agency may refuse to enter into, renew, or terminate an agreement with a Provider if it is determined that a Provider did not fully, accurately, and truthfully make the disclosures required by this statement. Additionally, false statements or representations of the required disclosures may be prosecuted under applicable federal or state laws. 42 C.F.R. § 455.106. The signature below **MUST** be the written signature of an individual who can legally bind this **Provider Entity**;

Name of Person (Printed)	Signature of Person	Title	Date

MEDICAL ASSISTANCE PARTICIPATION AGREEMENT
(MEDICAID/TENNCARE TITLE XIX PROGRAM)
Between
THE STATE OF TENNESSEE
DEPARTMENT OF FINANCE AND ADMINISTRATION
Bureau of TennCare
And

_____

PROVIDER NAME

FOR
LEVEL II (Skilled) NURSING SERVICES

This Provider Agreement, hereinafter referred to as the "Contract" and/or "Agreement", by and between the State of Tennessee, Department of Finance and Administration, Bureau of TennCare, hereinafter referred to as the "Department" or "TennCare" and _____, hereinafter referred to as the "Contractor," or "Nursing Facility" is for the provision of Long Term Care Services in a Skilled Nursing Facility (SNF), as further defined below:

WHEREAS, persons receiving public assistance payments from the Department of Human Services and other persons eligible for care under the Medical Assistance Program operating under Title XIX of the Social Security Act, are in need of medical care in the form of skilled nursing services;

WHEREAS, Section 1902(a) (27) of the Title XIX of the Social Security Act requires states to enter into written agreement with every person or institution providing services under the State Plan for Medical Assistance (Title XIX);

WHEREAS, acting pursuant to the Tennessee Medical Assistance Act of 1968 which makes the Department of Health the agency responsible for administering the Medical Assistance Program (Title XIX) in Tennessee, and authorizes the Department of Finance and Administration to take all necessary steps for the proper and efficient administration of the Tennessee Medical Assistance Program (Title XIX);

WHEREAS, to participate in the Tennessee Medical Assistance Program (Title XIX), the Nursing Facility must: (1) be licensed as a nursing home under the laws of Tennessee; (2) be currently meeting on a continuing basis standards for licensure; (3) be administered by a

licensed nursing home administrator who holds a current license; and (4) meet, on a continuing basis, Federal standards for participation in Title XIX;

WHEREAS, The Nursing Facility has filed an application with the Department to provide medical care in the form of Level II services to any and all persons eligible under the Title XIX Medical Assistance Program and said application is incorporated by reference into this Contract and made a part hereof the same as if it were written herein.

NOW THEREFORE, the aforesaid application is approved by the Department subject to the following stipulations, terms, and conditions.

I. The Nursing Facility agrees:

A. To provide room and board, and medical care in the form of Level II services to eligible individuals in accordance with all applicable State and Federal laws, rules, and regulations;

B. To accept for payment for supplying the services in A. above, the Department's vendor payment now in effect, or as hereafter modified:

1. The vendor payment will be accepted as payment in full for the care of the patient.

2. No additional charge will be made to the patient or any member of his/her family for any item except as allowed within Title XIX policies and regulations.

C. To supply the Department full and complete information on all persons having an ownership, managerial or controlling interest in the Nursing Facility and to promptly report any changes which would affect the current accuracy of the information required to be supplied.

D. To have and maintain an organized nursing service for Title XIX patients, which is under the direction of a professional registered nurse who is employed full-time by such nursing facility and which is composed of sufficient nursing and auxiliary personnel to provide and properly supervise Level II nursing services, as required by Title XIX standards, for such patients during all hours of each and every day of each week.

E. To make satisfactory arrangements as required by Title XIX standards for professional planning and supervision of menus and meal service for patients, including special diets or dietary restrictions that are medically prescribed.

F. To have satisfactory policies and procedures for:

1. Maintaining all medical records on each patient in the nursing facility;

2. Dispensing and administering drugs and biologicals;

3. Assuring that each patient is under the care of a physician; and

4. Making adequate provision for medical attention to any patient during emergencies.

G. To have arrangements with one or more general hospitals under which such hospital or hospitals will provide needed diagnostic and other services to patients of such Nursing Facility under which such hospital or hospitals agree to timely acceptance, as patients thereof, of acutely ill patients of such Nursing Facility who are in need of hospital care.

H. To meet the provisions of the Applicable Edition of the Life Safety Code (National Fire Protection Association, Bulletin No. 101, or such comparable State Fire and Safety Code), as are applicable to Skilled Nursing Homes.

I. To have a licensed administrator and a medical director licensed to practice medicine in Tennessee.

J. To meet sanitation standards approved by the Department.

K. To allow regular medical reviews of each patient covered under the Title XIX program, including a medical evaluation of the patient's need for Level II services.

L. To cooperate with State and Federal personnel who make periodic inspections, medical reviews, and audits.

M. To promptly inform the Department when individuals covered under the Title XIX program enter and leave the Nursing Facility.

N. To immediately notify the Department of any change in its license to operate as issued by the Department of Health.

O. To respect the observance of religious beliefs of all Title XIX patients.

P. To provide cooperative methods and procedures as required by Title XIX standards:

1. Relating to the utilization of care and services available as may be necessary to safeguard against unnecessary utilization of such care and services;

2. Assuring that any changes made under the Title XIX program will be consistent with efficiency, economy, or quality of care;

3. Assuring that the Nursing Facility shall not profiteer on drugs (or other items) for Title XIX patients, nor shall the Nursing Facility enter into any agreement with any supplier of drugs (or other items) for rebates or cutbacks for supplies;

Q. To make available to the appropriate state and federal personnel at all reasonable times all necessary records, including but not limited to the following:

1. Medical records as required by Section 1902(a)(28) of Title XIX of the Social Security Act, and any amendments thereto;

2. Records of all treatments, drugs, and services for which vendor payments are to be made under the Title XIX program including the authority for the administration of such treatment, drugs or services and keep these records for a period of ten years;

3. Documentation in each patient's record which will enable the Department to verify that each charge is due and proper prior to payment;

4. Financial records of the Nursing Facility;

5. All other records as may be found necessary by the Department in compliance with any Federal or state laws, rules, or regulations promulgated by the United States Department of Health and Human Services, or by the Department.

R. To accept periodic compliance reviews and to comply with the provisions of Title VI of the Civil Rights Act of 1964 and Section 504 of the Rehabilitation Act of 1973. The Facility further gives assurance that, as a condition of receiving payment from TennCare for care and services for which Federal funds are used, no distinction on grounds of race, color, national origin or handicap is made in accepting individuals for care or in the treatment or services provided. It is further agreed that subject to appropriate legal and professional limitations, records of admission (or intake), discharge, and other operations controlling the conditions of care or service provided will be made available to the Commissioner of the Department or his designated representative for review at any time that the Department or the Tennessee Department of Health receives an official complaint of discrimination made by or on behalf of any applicant, recipient, or other beneficiary of the nursing home program.

S. To complete and sign a Nursing Home Application to participate in the Medical Assistance Program (Title XIX), and to keep the information in the application current with the understanding that the application becomes a part of this Agreement and that each succeeding change in the application constitutes an amendment to the Agreement and that the failure to keep the information current constitutes a breach of the Agreement.

T. That any breach or violation of any one of the above provisions shall make this entire Agreement, at the Department's option, subject to immediate cancellation.

U. To allow access of appropriate State and Federal personnel to the premises of the Nursing Facility and allow such personnel to contact, if necessary, nursing home patients.

V. To make every reasonable effort to correct any deficiencies of the Nursing Facility as reported by the State Certification Team.

W. To comply with federal regulations requiring quarterly staffing reports (Ref – Part 405 of 42 CFR).

X. Disclosure of Ownership and Related Information:

1. To keep any records necessary to disclose the extent of services the provider furnishes to recipients.

2. To furnish the Medicaid/TennCare agency, the Centers for Medicaid and Medicare Services (CMS), or the State Medicaid/TennCare fraud control unit on request any information contained in the records including information regarding payments claimed by the provider for furnishing services under the plan.

3. To disclose to the Department the identity of any person who has an ownership or control interest in the Facility, or is an agent or managing employee of the Facility.

4. To disclose to the Department the name and address of each person with an ownership or control interest in the Facility, or is an agent or managing employee of the Facility.

5. To inform the Department of the name and address of each person with an ownership or control interest in the disclosing entity or in a subcontractor in which the disclosing entity has a direct or indirect ownership interest of five (5) percent or more.

6. To name any other disclosing entity in which a person(s) with an ownership or control interest in the disclosing entity also has an ownership or control interest. This applies to the extent that the disclosing entity can obtain this information by requesting it in writing from the person.

7. To keep copies of all requests and the responses to them in accordance with I. X. 6. above and to make them available to CMS or the Medicaid agency upon request and advise the Medicaid agency when there is no response to a request.

8. To submit within thirty-five (35) days of the date of request by the CMS or the Medicaid agency full and complete information about:

(1) The ownership of any subcontractor with whom the provider has had business transactions totaling more than $25,000.00 during the twelve (12) month period ending on the date of the request.

(2) Any significant business transactions between the provider and any wholly owned supplier, or between the facility and any subcontractor, during the five (5) year period ending on the date of the request.

9. To disclose to the Department the identity of any person in accordance with I. X. 3. above that has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid/TennCare or the Title XX services Program since the inception of those programs.

II. The Department Agrees:

A. To pay for such Level II services in the form of vendor payments (in amounts and under conditions determined by the Department) for all persons receiving Level II services who have been determined by the Department to be eligible for such assistance under the Title XIX program.

B. To make such payments in accordance with the applicable laws and as promptly as is feasible after a proper claim is submitted and approved.

C. To withhold payments if necessary because of irregularity from whatever cause until such irregularity or difference can be adjusted.

D. To make proper adjustment in the vendor payments, as is indicated, to compensate for either overpayment or underpayment.

E. To give to the Nursing Facility reasonable notice of any impending change in its status as a participating Nursing Facility.

F. To notify the Nursing Facility of any major changes in Title XIX rules and regulations and to work with the individual Nursing Facility with the view toward providing the best Level II services available within the limitations of the law and available money.

G. To provide a fair hearing to the Nursing Facility in the event the Department suspends or cancels the Nursing Facility from participation in the Title XIX program.

H. To provide methods and procedures for establishing medical review of care and services in accordance with Title XIX standards.

I. When it is determined that a patient requires a lesser level of care, payment for skilled care will be made up to a maximum of three days from the date it is determined lesser care is needed, to allow for a reasonable period to make an orderly transfer from skilled to a lesser type of care.

III. The Department and the Nursing Facility mutually Agree:

A. That in the event the federal and/or state laws should be amended or judicially interpreted so as to render the fulfillment of this agreement on the part of either party infeasible or impossible, or if the parties to this Agreement should be unable to agree upon modifying amendments which would be needed to enable

substantial continuation of the Title XIX programs the result of amendments or judicial interpretations, then, and in that event, both the Nursing Facility and the Department shall be discharged from further obligation created under the terms of this Agreement, except for equitable settlement of the respective accrued interest up to the date of termination.

B. That the term of this Agreement shall be for a period of Fifteen months, or until the Federal and/or State government cease to participate in the program, or by mutual consent of the Department and the Nursing Facility, or if not by such mutual consent, either party to this Agreement may consider it canceled by giving notice in writing to the other party. If the Nursing Facility wishes to continue its participation in the program, it shall file a reapplication at least thirty (30) days before the expiration date unless otherwise agreed upon by the parties. This Agreement will automatically cancel no later than the 60th day following the end of the time period specified for the correction of non–waived deficiencies cited during the federal certification process if such deficiencies have not been corrected or substantial progress made in correcting these deficiencies. This process is subject to applicable State and Federal regulations pertaining to appeals.

C. That the effective date for vendor payments will be the date that the Nursing Facility attains participating status as determined by the Department under the Federal standards for participation, and that such determination shall be made a part of this Agreement;

D. That this Agreement shall not be transferable or assignable;

E. It is agreed and understood that by signing this Agreement, and/or the accompanying application (if applicable), the Nursing Facility and the Department accept all of the stipulations in the Agreement, and agree to each and every provision therein.

F. The Facility or the State may cancel this agreement by providing the other party with thirty (30) days written notice of such intent.

Confidentiality of Records.

Strict standards of confidentiality of records and information shall be maintained in accordance with applicable state and federal law. All material and information, regardless of form, medium or method of communication, provided to the Contractor by the State or acquired by the Contractor on behalf of the State shall be regarded as confidential information in accordance with the provisions of applicable state and federal law, state and federal rules and regulations, departmental policy, and ethical standards. Such confidential information shall not be disclosed, and all necessary steps shall be taken by the Contractor to safeguard the confidentiality of such material or information in conformance with applicable state and federal law, state and federal rules and regulations, departmental policy, and ethical standards.

The Contractor's obligations under this section do not apply to information in the public domain; entering the public domain but not from a breach by the Contractor of this Contract; previously possessed by the Contractor without written obligations to

the State to protect it; acquired by the Contractor without written restrictions against disclosure from a third party which, to the Contractor's knowledge, is free to disclose the information; independently developed by the Contractor without the use of the State's information; or, disclosed by the State to others without restrictions against disclosure. Nothing in this paragraph shall permit Contractor to disclose any information that is confidential under federal or state law or regulations, regardless of whether it has been disclosed or made available to the Contractor due to intentional or negligent actions or inactions of agents of the State or third parties.

It is expressly understood and agreed the obligations set forth in this section shall survive the termination of this Contract.

HIPAA Compliance.

Contractor warrants to the State that it is familiar with the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and its accompanying regulations, and will comply with all applicable HIPAA requirements in the course of this Contract. Contractor warrants that it will cooperate with the State in the course of performance of the Contract so that both parties will be in compliance with HIPAA, including cooperation and coordination with State privacy officials and other compliance officers required by HIPAA and its regulations. Contractor will sign any documents that are reasonably necessary to keep the State and Contractor in compliance with HIPAA, including but not limited to business associate agreements.

Tennessee Bureau of Investigation Medicaid Fraud and Abuse Unit (MFCU) Access to Contractor and Provider Records Office of TennCare Inspector General Access to Contractor, Provider, and Enrollee Records

Pursuant to the Health Insurance Portability and Accountability Act (HIPAA) privacy regulations, MFCU and TennCare OIG shall be health oversight agencies as defined at 45 C.F.R. §§ 164.501 and 164.512(d) and 65 F.R. § 82462. When acting in their respective capacities as health oversight agencies, MFCU and TennCare OIG do not need authorization to obtain enrollee protected health information (PHI). Because MFCU and TennCare OIG will request the information mentioned above for health oversight activities, "minimum necessary" standards do not apply to disclosures to MFCU or TennCare OIG that are required by law. See 45 C.F.R. §§ 164.502(b)(2)(iv), 164.502(b)(2)(v), and 164.512(d).

The Contractor shall immediately report to MFCU all factually based known or suspected fraud, abuse, waste and/or neglect of a provider or Contractor, including, but not limited to, the false or fraudulent filings of claims and/or the acceptance or failure to return money allowed or paid on claims known to be false or fraudulent. The Contractor shall not investigate or resolve the suspicion, knowledge or action without informing MFCU, and must cooperate fully in any investigation by MFCU or subsequent legal action that may result from such an investigation.

The Contractor and all its health care providers who have access to any administrative, financial, and/or medical records that relate to the delivery of items or

services for which TennCare monies are expended, shall, upon request, make them available to MFCU or TennCare OIG. In addition, the MFCU must be allowed access to the place of business and to all TennCare records of any Contractor or health care provider, during normal business hours, except under special circumstances when after hour admission shall be allowed. MFCU shall determine any and all special circumstances.

The Contractor and its participating and non-participating providers shall report TennCare enrollee fraud and abuse to TennCare OIG. The Contractor and/or provider may be asked to help and assist in investigations by providing requested information and access to records. Shall the need arise, TennCare OIG must be allowed access to the place of business and to all TennCare records of any TennCare Contractor or health care provider, whether participating or non-participating, during normal business hours.

The Contractor shall inform its participating and non-participating providers that as a condition of receiving any amount of TennCare payment, the provider must comply with this Section of this Contract regarding fraud, abuse, waste and neglect.

Debarment and Suspension.

To the best of its knowledge and belief, the Contractor certifies by its signature to this Contract that the Contractor and its principals:

A. are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any federal or State department or Contractor;

B. have not within a three (3) year period preceding this Contract been convicted of, or had a civil judgment rendered against them from commission of fraud, or a criminal offence in connection with obtaining, attempting to obtain, or performing a public (federal, State, or Local) transaction or grant under a public transaction; violation of federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification, or destruction of records, making false statements, or receiving stolen property;

C. are not presently indicted for or otherwise criminally or civilly charged by a government entity (federal, State, or Local) with commission of any of the offenses detailed in section b. of this certification; and

D. have not within a three (3) year period preceding this Contract had one or more public transactions (federal, State, or Local) terminated for cause or default.

Contract Beginning Date : _____

Contract Ending Date: _____

Automatic Cancellation Clause Date: _____
Subject to Provision III – B (See Page 7)

Nursing Facility : _____

Address : _____

_____

NH License # _____

Provider Number : _____

By : _____ _____
Date

Name and Title

Tennessee Department of Finance and Administration, Title XIX Agency

By : _____ _____
Commissioner Date

STATE OF TENNESSEE
DEPARTMENT OF FINANCE AND ADMINISTRATION

ACH (AUTOMATED CLEARING HOUSE) CREDITS (NOT WIRE TRANSFERS)

NAME_____

Federal Identification Number or Social Security Number _____
(Under which you are doing business with the State)

I (We) hereby authorize the State of Tennessee, hereafter called the STATE, to initiate credit entries to my (our) *(select type of account)* _____ **CHECKING** or _____ **SAVINGS** account indicated below and the depository named below, hereinafter called DEPOSITORY, to credit the same to such account.

This authority is to remain in full force and effect until the STATE has received written notification from me (or either of us) of its termination in such time and in such manner as to afford the STATE and DEPOSITORY a reasonable opportunity to act on it.

********** Do you currently receive payments from the STATE through ACH? ____ (*Yes or No).* If yes, do you intend for this account information to replace other existing account information currently used by the STATE? ____ *(yes or no)*. If yes, please specify the account that should be changed: ABA No. _____ Account No. _____. Is this authorization only for certain types of payments? _____ *(Yes or No),* If yes, please indicate types:

_____

_____

_____

****

Many banking institutions use different numbers for ACH. Please call your bank for verification of ACH transit and account number.

Bank official contacted: _____ Phone No. _____

****

DEPOSITORY/BANK NAME _____BRANCH _____

CITY _____STATE _____

ACH TRANSIT/ABA NO. _____ACCOUNT NO. _____

NAME(S) _____
Please print names of authorized account signatory)

DATE _____ SIGNED X _____ SIGNED X _____

PLEASE ATTACH A VOIDED CHECK (OR FOR SAVINGS ACCOUNTS, A DEPOSIT SLIP):

PLEASE INDICATE ADDRESS TO WHICH YOU WOULD LIKE YOUR REMITTANCE ADVICES ROUTED WHEN PAYMENTS ARE PROCESSED:

_____
_____
_____
_____ Contact name:
_____ Telephone no:
_____

FOR STATE USE ONLY
Contact Agency: _____
Contact Person: _____
Telephone No.: _____

FA-0825
(Rev. 2.04)