RTC WAIVER

Community Treatment and Support for Maryland Children and Youth with Intensive Mental Health Needs

GENERAL CONDITIONS FOR PROVIDER PARTICIPATION

Instructions: Provider applicant must initial each line item and sign at the end.

All RTC Waiver providers must:

_____ 1. Meet all of the conditions for participation set forth in COMAR 10.09.36. regarding General Medical Assistance Provider Participation Criteria, including authorization and billing requirements.

_____ 2. Agree to provide services in accordance with the requirements of the approved waiver proposal, the waiver regulations at COMAR 10.09.79 and 10.21.10, and all other relevant, federal, and local laws and regulations.

______3. Have a signed provider agreement in effect with the Medical Assistance Program, and be approved for each waiver service the provider intends to provide.

______4. Meet the following conditions:

- Have not been suspended or removed from participating as a Medicaid provider in the past 24 months;
- Have not undergone the imposition of sanctions by the Medicaid program in the past 24 months;
- Have no cited deficiencies in the past 24 months of operation which present serious danger to service recipients' health and safety;
- Demonstrate substantial, sustained compliance for at least 24 months of operation after a cited deficiency which presented serious danger to service recipients' health and safety;
- Have not experienced a termination of a reimbursement agreement with or been barred from work or participation by a public or private agency due to failure to meet contractual obligations or due to fraudulent billing practices within the past 24 months; and,
- Have not had a license or certificate as a health provider revoked with the past 24 months.

______ 5. Agree to bill the Mental Hygiene Administration and to accept payment from the Department for approved waiver services that are rendered to waiver participants, and for the Mental Hygiene Administration to submit claims in the provider's behalf to the Medicaid Program.

______ 6. Maintain detailed, written documentation of services rendered to waiver participants.

______7. Agree not to suspend, terminate, increase, or reduce services for a waiver participant without authorization from DHMH or its designee.

______ 8. Make available to the Department and federal funding agents all records, including but not limited to, personnel files for each individual employed, and financial, treatment, and service records for inspection and copying and agree to cooperate with required inspections, reviews, and audits by authorized governmental representatives and their designees.

______ 9. Agree to inform the Mental Hygiene Administration and Medicaid Program within 1 business day, and within 7 business days file a report on a form designated by the Department, about any interruption of the participant's service or threat to the participant's health, safety, or welfare (e.g., potential eviction or suspected abuse or neglect).

______ 10. Agree to immediately notify Child Protective Services at the local department of social services if the provider has a reason to believe that the waiver participant has been subjected to abuse, neglect, self-neglect, or exploitation, in accordance with Family Law Article, Title 5, Annotated Code of Maryland.

_______ 11. Provide documentation required by the Department at the time of initial approval and provider recertification, or as requested by DHMH.

_______ 12. Attend additional trainings and obtain certifications as required by MHA the level and scope of services provided.

_______ 13. Maintain general liability insurance and provide proof of such insurance at the time of initial approval and provider recertification, or as requested by DHMH.

_______ 14. Comply with the prohibitions of utilization of staff listed in 10.21.10.05.

_______ 15. Agree to comply with the requirements in the Department's quality plan for this waiver program, to include the reportable events policy and procedures.

______ 16. Agree to participate on the Child and Family Team for any waiver participants with whom the provider is working.

_______ 17. Agree to provide monthly reports on employee background checks from CJIS.

By signing below, I agree, on behalf of the provider organization applicant, to adhere to the general conditions for provider participation detailed above.

Signature: ____ Date:_______________________

Printed Name: ___________________________________

Organization Name: ________________________________