Lee County Board Of County Commissioners
Agenda Item Summary

Blue Sheet No. 20060335

1. ACTION REQUESTED/PURPOSE: Approve and execute Florida Medicaid Provider Application Packet Documents. Approve one Sr. Account Clerk position, contingent on Medicaid approval of applications.

2. WHAT ACTION ACCOMPLISHES: Allows Lee Tran to negotiate a rate with the Medicaid, Medicaid – waiver, Developmental Disabilities Program, for the door-to-door transportation service that is provided by the Lee Tran Passport Division, and allow Lee Tran to electronically direct bill the Agency for services provided.

3. MANAGEMENT RECOMMENDATION: Approve and execute Medicaid provider Enrollment Packet.

4. Departmental Category: CoD		5. Meeting Date: 04-04-2006
6. Agenda:	7. Requirement/Purpose: *(specify)*	8. Request Initiated:
X Consent	___ Statute	Commissioner
___ Administrative	___ Ordinance	Department TRANSIT
___ Appeals	___ Admin. Code	Division
___ Public	X Other	By: Steven L. Myers, Director
___ Walk-On		

9. Background: Currently, the Lee Tran Passport Division is providing daily round trip transportation to approximately 117 Medicaid-waiver, Developmental Disabilities Program clients as "ADA" clients. The Medicaid Med-waiver program has been paying the $2.00 ADA co-pay on behalf of these clients. The Medicaid –waiver Program pays these fares directly to Good Wheels. Good Wheels retains these funds and uses them as a credit against the billings that Lee Tran owes Goodwheels for providing ADA trips. The submission of this Medicaid Enrollment Application is the first administratively necessary step to allow Lee Tran to negotiate with the Medicaid office for a higher payment than the current $2.00 fare and to be eligible to directly bill the sponsoring agency electronically and thereby eliminate the current complex billing mechanism. This Medicaid Waiver program pertains to the developmentally disabled clients that are transported to the various day care sites as agency group trips and not to individual Medicaid clients going to doctor appointment.

One additional employee, Sr. Account Clerk, is required to perform the billing, monitoring and accounting duties at an annual cost with salary and benefits of approximately $41,500.00. Potential new revenue from this Medicaid Billing program is anticipated at between $100,000 and $375,000 annually.

10. Review for Scheduling:

Department Director	Purchasing or Contracts	Human Resources	Other	County Attorney	Budget Services				County Manager/P.W. Director
					Analyst	Risk	Grants	Mgr.	
3/21/06	N/A		N/A	3/23/06	3/23		3/23/06	3/23/06	

11. Commission Action:

___Approved
___Deferred
___Denied
___Other

RECEIVED BY COUNTY ADMIN: 3-22-06 4:26
COUNTY ADMIN FORWARDED TO: 3/23/06 4:00pm

Rec. by CoAtty
Date: 3/22/06
Time: 1:16 pm
Forwarded To: Admin 3/22/06

Florida Medicaid Provider Enrollment Application

- Any person or entity that wants to be paid for rendering medical, medical-related and waiver-related services to Medicaid recipients must complete this form.
- Use only the current application form. If you are unsure about whether you have the most current form, call the Medicaid fiscal agent at 1-800-377-8216.
- Please type or print in blue or black ink. Do not use red ink.
- Out-of-state providers: call the Medicaid fiscal agent at 1-800-377-8216 for instructions before completing this form.

NOTE: Step by step instructions are found in the *Guide for Completing A Medicaid Provider Enrollment Application*.

I. Who Are You and How Do We Reach You?

1. **Name of Business or Individual:** Lee County Board of County Commissioners
   (An individual's name entered here must also be entered in Question 29.)

2. **Doing Business As (D/B/A):** Lee Tran Passport Service

3. **Tax Identification Number:**
   (Enter either the SSN or FEIN by which the IRS knows you. The tax id you enter here is what will be reported to the IRS as required by law. If you are individually incorporated, list your FEIN and not your SSN. Do not enter both. Attach a legible copy your SSN card, IRS Form SS-4, 1072, or W-9 as proof of your tax id.)

   Social Security Number (SSN): ___ - __ - ____

   OR

   Federal Employer Identifier Number (FEIN): 59-6000702

4. **Physical Street Address:** 5711-1 Independence Circle
   (Required)

   Building, Suite Number:
   (or P. O. Box if applicable)

   City: Fort Myers **State:** FL **ZIP:** 33912

5. **County Name:** Lee

6. **Business Location Telephone Number:** (239) 533-0300
   Area Code

   Business Location Fax Number: (239) 432-2035
   Area Code

   Contact Person: Peter Gajdjis, Deputy Director
   (List the person who AHCA should contact if there are questions about the application package.) Martha Nagata, Financial Officer

   Contact Person's Telephone Number: (239) 533-0350
   Area Code 533-0351

7. **Business E-mail Address:**
   Visit http://www.fdhc.state.fl.us/Medicaid/hipaa/lyrissubscribe.shtml to register for the Florida Medicaid Email Alert System. These automated email alerts are used to keep providers informed of late-breaking Medicaid information.

Visit the fiscal agent web site for electronic versions of all enrollment forms: http://floridamedicaid.acs-inc.com

II. What Type Of Provider Are You?

8. **Provider Type Code** 67/41 (Non emergency transport for Med Waiver clients)

9. **Practice Type Code** 30

10. **Category of Service Code** 80/40 (Transportation services for Med Waiver Clients)

11. **Specialty Code**
(Any physician adding a specialty code designation of Pediatric Surgery or Urology must also submit a copy of their Board Certification with this application. All other specialists may attest to the following statement.)

By submitting this application, I do hereby certify that I have successfully completed the required post-graduate training in the specialty medical code(s) the training was completed at an American Council on Graduate Medical Education or American Osteopathic Association approved program(s).

Primary Specialty Code 96 (Transport of Developmental Disability clients, Med-Waiver).

Name of Approved Training Program ~~N/A~~

Location of Program _____ (City) _____ (ST)

Date(s) Attended _____ to _____

Secondary Specialty Code _____

Name of Approved Training Program _____

Location of Program _____ (City) _____ (ST)

Date(s) Attended _____ to _____

12. **License Information**

Professional License Number _____

Facility License Number _____

CLIA License Number _____

13. **NPI Number** _____ And / Or **UPI Number** _____

14. **Medicare Number** _____

15. **Provider Handbooks:** Check here if you wish to receive handbooks by mail ☐

NOTE: Up-to-date Medicaid provider handbooks are available for no charge on the fiscal agent web site (http://floridamedicaid.acs-inc.com). Copies of the handbooks will not be mailed to you unless requested above.

III. Are You One Of These Provider Types?

(The next four questions pertain only to certain provider types. Please review carefully to determine if you must respond.)

16. Collaboration Agreement for Individual PA, ARNP, RN, CRNA, and RNFA

(All individual Physician Assistant (PA), Advanced Registered Nurse Practitioner (ARNP), Registered Nurse (RN), Certified Registered Nurse Anesthetist (CRNA), and Registered Nurse First Assistant (RNFA) applicants must complete this section.)

This signature certifies that the undersigned will collaborate in the provision of medically necessary services provided to Medicaid recipients.

Signature: _____ M.D. D.O. D.D.S. (circle one)

Print Name of Collaborator. _____ License # _____

17. Ownership Certification for Physician Groups

(Physician group applicants must complete this section. Do not complete for individuals linking to a group.)

The applicant certifies the ownership of the entity as:

- ☐ 50% or more owned by physicians or a not-for-profit hospital, or
- ☐ More than 50% owned by non-physicians or a for-profit hospital.

($50,000 Surety Bond required if this box is checked.)

NA

The applicant certifies the location of the entity as:

- ☐ Independently located, or
- ☐ Owned by and located in a hospital, or
- ☐ Located in (not owned by) a hospital

(If the applicant is located in (not owned by) a hospital, submit letter with original signature from the hospital CEO authorizing privileges.)

18. Home Medical Equipment License Exemption

(Durable Medical Equipment (DME) applicants must complete this section.)

Check the appropriate box if you meet any of the following exemptions:

- ☐ Business that supplies only diabetic monitors and disposable supplies, e.g., diabetic, ostomy, urological or wound care supplies.
- ☐ Orthotics and prosthetic provider licensed under Chapter 468, part XIV, F.S., which sells only orthotics and prosthetics.
- ☐ DME business that is owned by a pharmacy licensed under Chapter 465, F.S.
- ☐ DME business that is owned by a nursing facility, assisted living facility, home health agency, hospice, intermediate care facility, home for special services, or transitional living facility licensed under Chapter 400, F.S.
- ☐ DME business that is owned by a hospital or ambulatory surgical center licensed under Chapter 395, F.S.
- ☐ N/A

19. Pharmacy Information
(Pharmacy applicants must answer all sections (a – e) of this question.)

a. Board of Pharmacy Permit

Business Name _____
(as it appears on the permit):
Type of Pharmacy _____
License Number _____ NA

b. Prescription Department Manager
(The prescription department manager must also be listed in Question 28.)

Print Name: _____
License Number: _____

c. DEA Number _____

d. Is this facility affiliated with or part of a chain? Yes ☐ No ☐
(If YES, list chain's name, corporate address and Tax ID)

Name: _____
Federal Tax ID: _____
Corporate Address: _____
_____
City: _____ ST: _____ ZIP: _____

e. Point of Service (POS)
(If you plan to submit pharmacy claims electronically through a POS device, see Question 22 and then provide the following:)

System Vendor Name _____
System Vendor Certification # _____

IV. How Do You Wish To Submit Claims?

20. Group Membership Information for Individual Providers

NA

(Individual providers who will be submitting Medicaid claims under a group number must complete section (a) below. Up to 15 group links are accepted.)

a.

Group Provider Number:	Effective Date:	Group Provider Number:	Effective Date:	Group Provider Number:	Effective Date:

b. Is a group enrollment pending with this application? Yes ☐ No ☐
(If yes, list name and tax ID of group provider below.)

Group Name: _____
Federal Tax ID: _____

21. Billing Agent Agreement

The following billing agent is authorized to submit claims to and follow up with Medicaid and the Medicaid fiscal agent on my behalf. I understand that all payments and payment information are in my name and that this agreement does not exempt me from responsibility for claims filed on my behalf or from established claim filing policies. I further understand that the billing agent must be enrolled in the Medicaid program and is held to the same requirements of confidentiality and access to records that I am subjected to in my agreement with Medicaid. I will immediately notify the Medicaid fiscal agent of any change in this authorization.

Billing Agent Name: _____

Billing Agent Provider Number: _____ (Required)

Billing Agent Address: _____

_____

City: _____ ST: _____ ZIP: _____

22. Electronic Claims Submission

Providers who choose to submit claims electronically, including pharmacies that use Point of Service (POS) devices, must be aware that payment of claims will be from federal and state funds and that any falsification or concealment of material fact may be prosecuted under Federal and State laws. Further, providers must understand and agree to the following:

- Safeguard the Medicaid program against abuse in the use of electronic claims submission, including POS.
- Correctly enter the claims data, monitor the data and certify that the data entered is correct.
- Assure that the transmission of claims data is restricted to authorized personnel to prevent erroneous payments by the Agency's fiscal agent that might result from carelessness or fraud.
- Have on file the applicable source data to substantiate the claim submitted to the Medicaid program.
- Allow the Agency or any of its designees and representatives of the office of the Auditor General or the Attorney General to review and copy all records, including source documents and data related to information entered through electronic claims submission, including POS.
- Abide by all Federal and State statutes, rules, regulations, and manuals governing the Florida Medicaid program.
- Sign and adhere to all conditions of the Medicaid Provider Agreement and be officially enrolled in the Medicaid program to participate in electronic claims submission, including POS.

In addition, Pharmacy providers who use POS devices to submit claims must understand and agree to the following:

- Maintain the original prescription on file.
- Reverse any claim adjudicated and then not dispensed to a Medicaid recipient. Claim reversals are limited in their use by Medicaid policy.
- Allow the Agency or its representatives to perform audit functions.

Indicate which of the following will be used to submit claims electronically:

✓ ☒ **WinAsap** Phone # for Submissions ( ) TBD
Area Code

☐ **Vendor Software** Vendor Name _____

☐ **Billing Agent** Agent's Name and _____

Medicaid Provider Number _____

V. How Do You Wish To Receive Payment?

23. Electronic Remittance Voucher

Allow the entity indicated below to receive remittance vouchers through Internet download from the fiscal agent's Internet website:

☒ Provider or ☐ Billing Agent

24. Mailing Address For Payment: 5711-1 Independence Circle

(Reimbursement checks and paper remittance vouchers will be sent to this address.)

City: Fort Myers State: FL ZIP: 33912

25. Payment Method

Choose one of the following payment methods:

- If you are an individual or group provider who will receive direct payment from Medicaid, complete **Option 1, Electronic Funds Transfer (EFT) Agreement.**
- If you are an individual who will NOT receive direct payment from Medicaid, skip Option 1 and complete **Option 2, Electronic Funds Transfer Agreement Exception Request**, to assign your payment to a group provider.

NOTE: If you work for a group AND will also bill separately for yourself, complete Option 1 with *your* personal banking information. *Do not place an employer's information on your individual file.*

Option 1. Electronic Funds Transfer (EFT) Agreement:

The undersigned authorize the fiscal agent for the Florida Medicaid Program to make deposits to the checking or savings account at the depository bank indicated.

List all individuals authorized to sign on this account:

Print Name	Signature
Tammara Hall, Chairwoman BOCC	
Bob Janes, Vice Chairman BOCC	
Charlie Green, Clerk of the Court	

NOTE: All individuals listed above must also be listed in Q.29 and meet Medicaid Enrollment Background Screening Requirements. If this agreement is for an individual provider number, the individual who owns the number MUST sign here. Any future changes to this EFT account will require a signature of an individual authorized as listed below.

Name On Bank Account: Lee County BOCC/Pooled Cash

Bank Account Number: 0055005104519

Bank Name: Bank of America

Branch: Bell Tower

City: Fort Myers ST: FL ZIP: 33907

Bank Telephone #: (239-433-6135

Area Code

NOTE: A letter from the depository bank verifying the bank transit / ABA routing number, the account number and account name must be attached to this application. ON BANK LETTERHEAD, SIGNED BY BANK OFFICIAL ✓

Visit the fiscal agent web site for electronic versions of all enrollment forms: http://floridamedicaid.acs-inc.com

Option 2. Electronic Funds Transfer (EFT) Agreement Exception Request:

"I work under group provider number _____ and all disbursements made for services performed by myself will be made directly to the group on my behalf. I understand that by requesting this exemption, I will not be able to receive direct disbursements from Medicaid for the services I render, and I will not be able to file Medicaid claims under my individual provider number."

VI. Who Are your Owners And Operators?

26. Change of Ownership

Is this application based on a change of ownership (CHOW)? Yes ☐ No ☒

(If yes, submit a copy of stock transfer document or bill of sale and complete the following information about the previous owner.)

Name: _____

Provider Number: _____

Federal Tax ID: _____ Date of CHOW: _____

27. Ownership Code 1

28. Records Custodian(s)

(List a person not an entity.)

a. Medical Records Custodian: N/A

Name: _____

Phone Number: ( ) _____ (Area Code)

Physical Address of Medical Files: Exempt unit of local government

City/State: _____

Zip Code: _____

b. Financial Records Custodian: N/A

(The Financial Records Custodian must also be entered in Q.29).

Name: Exempt unit of local Governmen

Phone Number: ( ) _____ (Area Code)

Physical Address of Financial Files: _____

City/State: _____

Zip Code: _____

29. Owner(s) and Operator(s):

All of the individuals listed below **must** submit a completed fingerprint card for background screening to become a Medicaid provider unless they meet one of a few specific exemptions. See the Guide for Completing a Medicaid Provider Enrollment Application for details.

Name (denotes required field)	Title	*Relationship (See Note Below)	*SSN	License #	* % Owner
Government Entity			59-6000702		

NOTE: Select one or more from the following list when indicating each owner and operator's relationship to the applicant: Owner, Officer, Director, Financial Records Custodian (FRC), Shareholder, Sub-Contractor, EFT Authorized Individual, Partner, Manager, or Family (Specify Relationship, i.e., Spouse, Parent, Sibling, or Child).

N/A Exempt as unit of local Government

NA

30. Applicant History

(Answer all sections (a – f) of this question.)

Have you, or any of the individuals listed in Question 29, ever:

a. Been convicted of a felony, had adjudication withheld on a felony, pled nolo contendere to a felony, or entered into a pre-trial agreement for a felony? Yes ☐ No ☐

If yes, list the name(s) of the individuals(s) and provide a copy of the administrative complaint and final disposition.

Name: _____

b. Had any disciplinary action taken against any business or professional license held in this or any other state or surrendered a license in this or any state? Yes ☐ No ☐

If yes, list the name(s) of the individual(s) and the date of the action. Provide a copy of the final disposition. Attach documentation from the proper authorities that approved the reinstatement of the license.

Against whom? _____

What date? _____

c. Been denied enrollment, been suspended or excluded from Medicare or Medicaid in any state, or been employed by a corporation, business or professional association that has ever been suspended or excluded from Medicare or Medicaid in any state? Yes ☐ No ☐

If yes, list the name(s) and provider number(s) of the individual(s) and provide a copy of the documentation.

Name: _____

Provider Number: _____

d. Had suspended payments from Medicare or Medicaid in any state, or been employed by a corporation, business or professional association that ever had suspended payments from Medicare or Medicaid in any state? Yes ☐ No ☐

If yes, list the name(s) and provider number(s) of the individual(s) and provide a copy of the documentation.

Name: _____

Provider Number: _____

e. Owes money to Medicaid or Medicare that has not been paid? Yes ☐ No ☐

If yes, list the name(s) and provider number(s) of the individual(s) and provide a copy of the documentation.

Name: _____

Provider Number: _____

f. Have ownership in any other Medicaid enrolled business? Yes ☐ No ☐

If yes, list the name and Medicaid provider number of the other Medicaid enrolled business and the names of all owners of five percent or more of the business. Attach additional pages if necessary.

Name of Other Business: _____

Provider Number: _____

Name of Owner(s): _____

VIII. Certification

"For the purposes of establishing eligibility to receive direct or indirect payment for services rendered to recipients of the Florida Medicaid Program, I understand that, under Section 409.920(2)(f), Florida Statutes, the filing of materially incomplete or false information with this enrollment request is a third degree felony and is sufficient cause for termination from the Florida Medicaid Program. I further understand that false claims, statements, documents, or concealment of material facts may be prosecuted under applicable federal and state laws. I understand that I am responsible for the information presented on this application and that the information is true, accurate, and complete. Furthermore, I agree to abide by the provisions of this provider agreement effective from the date that the services or goods were provided, pursuant to Section 409.907(11), Florida Statutes.

I understand that it is my responsibility to notify Medicaid's fiscal agent of any change to the information on this application, including but not limited to, a change of address, group affiliation, ownership, officers, directors, tax identification number, or EFT bank account."

Signature of Provider or Authorized Agent/Registered Agent

Date

Tammara Hall or Bob Janes
Name of Provider or Authorized Agent/Registered Agent
(Please Type or Print Legibly)

Chairwoman or Vice Chair,BOCC
Title

Keep a copy of the Enrollment Application and all required documentation for your files.
Mail this application and all required documentation to the appropriate office indicated on the following page.
Note: See the Guide for Completing Medicaid Provider Enrollment Applications, the web site listed at the bottom of this page or contact the fiscal agent at 1-800-377-8216 for a complete list of required documentation. If you have any questions, please call ACS Provider Enrollment at 1-800-377-8216.

(Office use only - do not write below this line)

APPROVAL:

Signature | Print Name | Approval Date

Comments:

Visit the fiscal agent web site for electronic versions of all enrollment forms: http://floridamedicaid.acs-inc.com

Mail this application and all required documentation to the appropriate office as indicated below.

If you are enrolling as...	Specialty Code	Applications are sent to...
Early Steps Provider, or Children's Medical Services (CMS) Targeted Case Manager, or Case Mgt Agency	N/A	CMS District Office (See Appendix J of the instruction guide for the office near you.)
Adult Cystic Fibrosis Waiver	CF	Department of Health Attention: BSCIP/Adult CF 4052 Bald Cypress Way Tallahassee, FL 32399-1701
Aged/Disabled Adults Waiver	95	Local Area Agency on Aging (See Appendix H of the instruction guide for the office near you.)
Assisted Living for the Elderly Waiver	89	Local Area Agency on Aging (See Appendix H of the instruction guide for the office near you.)
Channeling Waiver	97	Agency for Health Care Administration Medicaid Services 2727 Mahan Drive Mail Stop 20 Tallahassee, Florida 32308
Family and Supported Living Waiver	98	Local Agency for Persons with Disabilities (See Appendix I of the instruction guide for the office near you.)
Consumer Directed Care Waiver	68	Local Agency for Persons with Disabilities Local Area Agency on Aging (See Appendices H and I of the instruction guide for the office near you.)
Developmental Disability Waiver	96	Local Agency for Persons with Disabilities (See Appendix I of the instruction guide for the office near you.)
Model Waiver	94	Agency for Health Care Administration Medicaid Services 2727 Mahan Drive Mail Stop 20 Tallahassee, Florida 32308
Project AIDS Care Waiver	99	Agency for Health Care Administration Medicaid Services 2727 Mahan Drive Mail Stop 20 Tallahassee, Florida 32308
Traumatic Brain Injury & Spinal Cord Injury Waiver	79	Department of Health Attention: BSCIP/Adult CF 4052 Bald Cypress Way Tallahassee, FL 32399-1701
School-based Services Provider (certified match programs)	N/A	Agency for Health Care Administration Medicaid Services 2727 Mahan Drive Mail Stop 20 Tallahassee, Florida 32308
Transportation Provider	N/A	Medicaid Area Office (See Appendix G of the instruction guide for the office near you.)
All other provider types	**For Regular Mail:** **ACS State Healthcare** **Provider Enrollment** **P.O. Box 7070** **Tallahassee, FL 32314-7070**	For Overnight or Express Delivery: ACS State Healthcare Provider Enrollment 2308 Killearn Center Blvd STE 100 Tallahassee, FL 32309

Visit the fiscal agent web site for electronic versions of all enrollment forms: http://floridamedicaid.acs-inc.com

This page left blank intentionally.

Jeb Bush
Governor

Alan Levine
Secretary

2727 Mahan Drive
Tallahassee, FL 32308
www.fdhc.state.fl.us

Visit the fiscal agent web site for electronic versions of all enrollment forms: http://floridamedicaid.acs-inc.com

NON-INSTITUTIONAL
MEDICAID PROVIDER AGREEMENT

The Provider agrees to participate in the Florida Medicaid program under the following terms and conditions:

(1) Discrimination. The parties agree that the Agency for Health Care Administration (AHCA) may make payments for medical assistance and related services rendered to Medicaid recipients only to a person or entity who has a provider agreement in effect with AHCA; who is performing services or supplying goods in accordance with federal, state, and local law; and who agrees that no person shall, on the grounds of sex, handicap, race, color, national origin, other insurance, or for any other reason, be subjected to discrimination under any program or activity for which the provider receives payment from AHCA.

(2) Quality of Service. The provider agrees that services or goods billed to the Medicaid program must be medically necessary, of a quality comparable to those furnished by the provider's peers, and within the parameters permitted by the provider's license or certification. The provider further agrees to bill only for the services performed within the specialty or specialties designated in the provider application on file with AHCA. The services or goods must have been actually provided to eligible Medicaid recipients by the provider prior to submitting the claim.

(3) Compliance. The provider agrees to comply with local, state, and federal laws, as well as rules, regulations, and statements of policy applicable to the Medicaid program, including the Medicaid Provider Handbooks issued by AHCA.

(4) Term and signatures. The parties agree that this is a voluntary agreement between AHCA and the provider, in which the provider agrees to furnish services or goods to Medicaid recipients. Provided that all requirements for enrollment have been met, this agreement shall remain in effect for ten (10) years from the effective date of the provider's eligibility unless otherwise terminated. This agreement shall be renewable only by mutual consent. The provider understands and agrees that no AHCA signature is required to make this agreement valid and enforceable.

(5) Provider Responsibilities. The Medicaid provider shall:

(a) Possess at the time of the signing of the provider agreement, and maintain in good standing throughout the period of the agreement's effectiveness, a valid professional, occupational, facility or other license appropriate to the services or goods being provided, as required by law.

(b) Keep, maintain, and make available in a systematic and orderly manner all medical and Medicaid-related records as AHCA requires for a period of at least five (5) years.

(c) Safeguard the use and disclosure of information pertaining to current or former Medicaid recipients as required by law.

(d) Send, at the provider's expense, legible copies of all Medicaid-related information to authorized state and federal employees, including their agents. The provider shall give state and federal employees, including their agents, access to all Medicaid patient records and to other information that can not be separated from Medicaid-related records.

(e) Bill other insurers and third parties, including the Medicare program, before billing the Medicaid program, if the recipient is eligible for payment for health care or related services from another insurer or person.

(f) Within 90 days of receipt, refund any moneys received in error or in excess of the amount to which the provider is entitled from the Medicaid program.

(g) To the extent allowed by in and accordance with section 768.28, F.S. (2001), and any successor legislation, be liable for and indemnify, defend, and hold AHCA harmless from all claims, suits, judgments, or damages, including court costs and attorney's fees, arising out of the negligence or omissions of the provider in the course of providing services to a recipient or a person believed to be a recipient.

(h) Accept Medicaid payment as payment in full, and not bill or collect from the recipient or the recipient's responsible party any additional amount except, and only to the extent AHCA permits or requires, co-payments, coinsurance, or deductibles

to be paid by the recipient for the services or goods provided. This includes situations in which the provider's Medicare coinsurance claims are denied in accordance with Medicaid's payment.

(i) Agrees to submit claims to AHCA electronically and to abide by the terms of the Electronic Claims Submission Agreement.

(j) Agrees to receive payment from AHCA by Electronic Funds Transfer (EFT). In the event that AHCA erroneously deposits funds to the provider's account, then the provider agrees that AHCA may withdraw the funds from the account.

(6) AHCA Responsibilities. AHCA:

(a) Is required to make timely payment at the established rate for services or goods furnished to a recipient by the provider upon receipt of a properly completed claim.

(b) Will not seek repayment from the provider in any instance in which the Medicaid overpayment is attributable solely to error in the state's determination of eligibility of a recipient.

(7) Termination For Convenience. This agreement may be terminated without cause upon thirty (30) days written notice by either party.

(8) Ownership. The provider agrees to give AHCA sixty (60) days written notice before making any change in ownership of the entity named in the provider agreement as the provider. The provider is required to maintain and make available to AHCA Medicaid-related records that relate to the sale or transfer of the business interest, practice, or facility in the same manner as though the sale or transaction had not taken place, unless the provider enters into an agreement with the purchaser of the business interest, practice, or facility to fulfill this requirement.

(9) Complete Information. All statements and information furnished by the prospective provider before signing the provider agreement shall be true and complete. The filing of a materially incomplete, misleading or false application will make the application and agreement voidable at the option of AHCA and is sufficient cause for immediate termination of the provider from the Medicaid program and/or revocation of the provider number.

(10) Interpretation. This agreement shall not be construed against either party on the basis of this agreement having been prepared by one of the parties.

(11) Governing Law. This agreement shall be governed by and construed in accordance with the laws of the State of Florida.

(12) Amendment. This agreement, the application and other documents being executed and delivered pursuant hereto constitute the full and entire agreement and understanding between the parties hereto with respect to the subject matter hereof. No amendment shall be effective unless it is in writing and signed by each party.

(13) Severability. If one or more of the provisions contained in this agreement or application shall be invalid, illegal or unenforceable, the validity, legality and enforceability of the remaining provisions shall not in any way be affected or impaired.

(14) Agreement Retention. The parties agree that AHCA may only retain the signature page of this agreement, and that a copy of this standard provider agreement will be maintained by the Director of Medicaid, or his designee, and may be reproduced as a duplicate original for any legal purpose and may also be entered into evidence as a business record.

(15) Funding. This contract is contingent upon the availability of funds.

THE PARTIES AGREE THAT THIS AGREEMENT IS A LEGAL AND BINDING DOCUMENT AND IS FULLY ENFORCEABLE IN A COURT OF COMPETENT JURISDICTION. THE SIGNATORIES HERETO REPRESENT AND WARRANT THAT THEY HAVE READ THE AGREEMENT, UNDERSTAND IT, AND ARE AUTHORIZED TO EXECUTE IT ON BEHALF OF THEIR RESPECTIVE PRINCIPALS OR CO-OWNERS. THIS AGREEMENT BECOMES NULL AND VOID UPON TRANSFER OF ASSETS; CHANGE OF OWNERSHIP; OR UPON DISCOVERY BY AHCA OF THE SUBMISSION OF A MATERIALLY INCOMPLETE, MISLEADING OR FALSE PROVIDER APPLICATION UNLESS SUBSEQUENTLY RATIFIED OR APPROVED BY AHCA.

ALL SHAREHOLDERS (WITH FIVE PERCENT OR GREATER OWNERSHIP INTEREST), PRINCIPALS, PARTNERS AND FINANCIAL CUSTODIANS ARE REQUIRED TO SIGN THIS AGREEMENT. A CHIEF EXECUTIVE OFFICER (CEO) OR PRESIDENT OF AN ORGANIZATION MAY SIGN THIS AGREEMENT IN LIEU OF THE ABOVE. FAILURE TO SIGN THE AGREEMENT WILL MAKE THIS APPLICATION, AGREEMENT AND PROVIDER NUMBER VOIDABLE BY AHCA.

FOR OFFICE USE ONLY

The provider's name is: _____.

The facility's name is: _____.

The provider number is: _____.

IN WITNESS WHEREOF, the undersigned have caused this agreement to be duly executed under the penalties of perjury, swear or affirm that the foregoing is true and correct.

Signature of Provider	Date	Signature of Provider	Date
Chairwoman or Vice Chair, BOCC (legibly print the above signature)	Title	(legibly print the above signature)	Title
Signature of Provider	Date	Signature of Provider	Date
(legibly print the above signature)	Title	(legibly print the above signature)	Title
Signature of Provider	Date	Signature of Provider	Date
(legibly print the above signature)	Title	(legibly print the above signature)	Title
Signature of Provider	Date	Signature of Provider	Date
(legibly print the above signature)	Title	(legibly print the above signature)	Title
Signature of Provider	Date	Signature of Provider	Date

(USE ADDITIONAL PAGES IF NECESSARY)

Policy Directive #PD01-05: Statewide Provider Enrollment

Florida Department of CHILDREN & FAMILIES

DEVELOPMENTAL DISABILITIES PROVIDER SUPPLEMENT TO HCBS WAIVER APPLICATION

GEOGRAPHIC LIMITATION	CASELOAD LIMITATION
Unless you indicate limits of geographic areas of interest below, your services will be available statewide. Areas (districts) of Interest: Lee County	☐ I am enrolling to serve _____(#) of individuals. Please do not place my name on a list for additional individuals.

SERVICES

1. Check all services for which the applicant is requesting certification.

____	Adult Day Training	____	Physical Therapy/Assessment
____	Accessibility Adaptations	____	Private Duty Nursing
____	Behavior Analysis Services	____	Psychological Assessment
____	Chore Services	____	Residential Habilitation
____	Companion Services	____	Residential Nursing
____	Consumable Medical Supplies	____	Respiratory Therapy/Assessment
____	Dental Services, Adult	____	Respite Care
____	Dietitian Services	____	Skilled Nursing
____	Durable Medical Equipment	____	Special Medical Home Care
____	Homemaker Services	____	Specialized Mental Health Services
____	In-Home Support	____	Speech Therapy/Assessment
____	Medication Review	____	Support Coordination
____	Non-Residential Support Services	____	Supported Employment
____	Occupational Therapy/Assessment	____	Supported Living Coaching
____	Personal Care Assistance	____	Therapeutic Massage/Assessment
____	Personal Emergency Response	X	Transportation

Agencies or individuals applying for support coordination shall not apply to provide any other service.

Applicant is applying as:
INDIVIDUAL ___X___ (Applicant alone will be providing services.)

AGENCY _____ (Applicant will be hiring others to perform services.)
NOTE: The provider and employees of a provider agency must meet qualifications required to perform the specified services.

Applicant Name: Lee County Board of County Commissioners DBA Lee Tran Passport

2. Have you ever provided services to individuals with developmental disabilities? If so, under what name and in what district?

x Yes ___ No Lee Tran (Name(s)) Area 8 (District(s))

3. List all current or past services provided by the applicant to individuals who are customers of Developmental Disabilities, including type of service, dates and district(s) where provided.

Service	Date(s)	District(s)
Transportation	Currently transporting clients	Area 8

4. List the qualifications, history, experience, background, licenses and certificates that make the applicant qualified to perform each service checked in #1 of this supplement. **(You must attach a resume or employment history (see page 4).)**

Lee County Government (Transit Division) has provided fixed route transportation for 30 years and paratransit for 15 years. Lee Tran is currently providing service to 117 Med Waiver clients, transporting clients to various service center sites.

LICENSE, REGISTRATION OR CERTIFICATION:	Number	Effective Date	Expiration Date	State Licensing Agency

5. Have you ever been decertified in any other district or disenrolled from Medicaid? ___ Yes x No

If yes, what date(s) and district(s)?

Date(s): _____ District(s): _____

6. If applicant is an agency or group provider, attach a current table of organization that contains, as appropriate to the organization, the board of directors, directors, supervisors, support staff, and all other employees (the number and type of staff available).

N/A County Government

7. Complete if applicant is an agency or group provider; or a solo provider wishing to provide one or more of the following service(s): Adult Day Training, Non-residential Support Services, Residential Habilitation, Support Coordination, Supported Employment, Supported Living Coaching:

a. A description in detail of how **each service** being applied for will be implemented. Include in the description how services being provided will meet the needs and/or support the individual (person-centered). (How will consumer needs be assessed and training or services be implemented? How

N/A

will success or needed change be determined for the training and/or service)

b. If the population you plan to serve is a specific targeted population, **then** describe the population to be served.

8. Applicants of Support Coordination, Residential Habilitation and Supported Living Coaching services applicants only:

   - Attach a detailed description of your plan for 24-hour/7 days a week service and appropriate qualified back-up.

9. All applicants must submit a copy of your valid driver's license.

I certify that all licenses, insurance, certificates, etc. are current and any changes will be transmitted to the district office of the application orientation.

_____ _____

Signature Date

Chairwoman or Vice Chair, BOCC

NOTE: Upon submission of check and fingerprint card for background screening purposes, processing will occur while application is being reviewed.

e-mail address: _____

FDLE Criminal History Check and Fingerprinting Exemption Request

LEE COUNTY BOCC has applied
(print name of organization or individual provider)
to become a Medicaid provider.

This organization is requesting exemption from the fingerprinting and criminal history check requirements under Chapter 409, Florida Statutes, on the following basis:

(Check all that apply and include copy of applicable licenses.)

- ☐ This organization is a School District, and is exempt under Section 409.908, Florida Statutes.
- ☐ This organization is a hospital licensed under Chapter 395, Florida Statutes.
- ☐ This organization is a nursing home licensed under Chapter 400, Florida Statutes.
- ☐ This organization is a hospice licensed under Chapter 400, Florida Statutes.
- ☐ This organization is an assisted living facility licensed under Chapter 400, Florida Statutes.
- ☒ This organization is a unit of local government.
- ☐ This organization derives more than 50% of its revenue from the sale of goods to final consumers **AND**
  - ☐ 1. Is required to file a form 10K with the Securities and Exchange Commission **OR**
  - ☒ 2. Has a net worth of $50 million or more.

Documentation (annual report including audited financial statements and/or 10K form) must be submitted with any exemption request under this category.

NOTE: If the organization is a contractor with a unit of local government, this exemption does not apply.

Under penalty of perjury, I do hereby certify that LEE COUNTY BOCC
(Name of Organization or Individual Provider)
meets one or more of the criteria specified above.

Signature of CEO of Organization or Superintendent of School District: Chairwoman or Vice Chairman BOCC

Date

Print name of above signatory party