Home and Community-Based Alternatives Waiver Personal Care Services Provider Agreement

HCBA Waiver Agency Name:

HCBA WPCS Provider's First and Last Name:

Provider's Street Address:

City: State: Zip:

Provider's Telephone Number: IHSS Provider Number:

WPCS Member's First and Last Name:

Provider's Relationship to Member:

- Parent
- Adult Child
- Conservator/Guardian
- Spouse/Domestic Partner
- Other

The Department of Health Care Services (DHCS) administers the Medi-Cal HCBA Waiver and delegates responsibilities for certain administrative functions to contracted HCBA Waiver Agencies. Two of the administrative responsibilities delegated to HCBA Waiver Agencies include monitoring the implementation of services provided under the HCBA Waiver and providing technical assistance to WPCS providers when necessary. Technical assistance includes monitoring the quality of WPCS, explaining the provider enrollment processes to prospective providers, instructing members on how to access the services for authorization, and submitting requests for WPCS authorization to DHCS to be processed.

The WPCS provider agrees under penalty of perjury that all claims for services provided to an HCBA Waiver member have been rendered as prescribed by the HCBA Waiver member's attending physician, and in accordance with the member's written Plan of Treatment. The WPCS provider shall also ensure that all information submitted to the HCBA Waiver Agency is accurate and complete, as it relates to the authorization of the requested service. The WPCS provider understands that federal and state funding is used to pay for services rendered under the HCBA Waiver. Therefore, the provider is required to adhere to all federal Medicaid requirements pertaining to the provision of WPCS. **Any falsification or concealment of a material fact by the WPCS provider may result in the provider being prosecuted under federal and/or state laws.** The WPCS provider agrees to keep, for a minimum period of ten years from the date of service, a printed, legible representation of all records that are necessary to disclose the full extent of services furnished to the HCBA Waiver member. The WPCS provider agrees to furnish these records, and any information regarding payments claimed for rendering the services within the State of California, upon request, to: DHCS; the California Department of Justice; the Office of the State Controller; the U.S. Department of Health and Human Services; or any duly authorized representative of these entities.

The WPCS provider also agrees that services are offered and provided without unlawful discrimination based on sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity, or sexual orientation.

THIS AGREEMENT MUST BE SIGNED, DATED, AND RETURNED TO THE WAIVER AGENCY BEFORE WPCS SERVICE HOURS WILL BE AUTHORIZED. For billing purposes, the date that the WPCS provider began providing WPCS care to the member must be included below and confirmed by the HCBA Waiver member.

WPCS Provider's Start Date: HCBA Waiver Member's Confirmation (please initial):

By signing and submitting this agreement to the HCBA Waiver Agency, the provider indicates willingness to comply with all requirements outlined in this agreement, the HCBA Waiver, HCBA Policy Letters, and all applicable laws, including the California Code of Regulations, Title 22, Division 3, and the Welfare and Institutions Code, Division 9, Part 3.

HCBA WPCS Provider Signature Date

HCBA WPCS Provider Printed Name Title

HCBA Waiver Agency Representative Signature Date

HCBA Waiver Agency Representative Printed Name Title

Please return the signed HCBA WPCS Provider Agreement to the HCBA Waiver Agency by mail or by FAX.

Fax Number:

Privacy Notice on Collection

The purpose of this form is to request information regarding enrollment of the listed individual as a Home & Community-Based Alternatives (HCBA) provider. The information is being requested by DHCS' Integrated Systems of Care and Delivery Division under Section 1915(c) of the Social Security Act and Title 22 of the California Code of Regulations Section 51000.30. Information you provide on this form may be protected by the Information Practices Act (California Civ. Code, § 1798 et seq.), and may be protected by other laws, such as the Health Insurance Portability and Accountability Act (45 C.F.R. Parts 160, 164).

Information requested in this form is mandatory unless otherwise stated. If you do not provide the information requested, then DHCS will return the Provider Agreement to you. DHCS may share the information with: (1) other state agencies to perform their legal duties where the use is compatible with a purpose for which it was requested, (2) government entities if required by state or federal law, and (3) other entities as permitted by state or federal law, as outlined in DHCS' Notice of Privacy Practices. Please do not provide any personal or medical information other than the information that is specifically requested.

In most cases, individuals have a right to access information about them that is in state records. For more information or access to the information requested on this form, contact:

Department of Health Care Services
Integrated Systems of Care Division
1501 Capitol Avenue, MS 4502
P.O. Box 997437
Sacramento, CA 95899-7437
Phone: (916) 552-9105
HCBAlternatives@dhcs.ca.gov

DHCS' policies regarding personal information are available online in DHCS' Notice of Privacy Practices
(https://www.dhcs.ca.gov/formsandpubs/laws/priv/Pages/NoticeofPrivacyPractices.aspx) and the Privacy Policy Statement (https://www.dhcs.ca.gov/pages/privacy.aspx).

This privacy notice is required by California Civil Code section 1798.17.