Agenda Item #: **3S2**

PALM BEACH COUNTY
BOARD OF COUNTY COMMISSIONERS

AGENDA ITEM SUMMARY

Meeting Date:	March 1, 2016	[X] Consent [ ] Workshop	[ ] Regular [ ] Public Hearing
Department:	Fire-Rescue		

I. EXECUTIVE BRIEF

Motion and Title: Staff recommends motion to:

A) approve Florida Medicaid Provider Renewal Enrollment Application, Non-Institutional Medicaid Provider Agreement, and Special Exempt Entity Certifications – Fingerprinting Exemption; and

B) authorize the County Administrator or designees (Fire-Rescue Administrator and Fire Rescue Director of Finance and Planning, as applicable) to act as the County's representative for the purpose of executing and electronically submitting the Florida Medicaid Provider Renewal Enrollment Application, the Non-Institutional Medicaid Provider Agreement, and the Special Exempt Entity Certifications – Fingerprinting Exemption, via the State of Florida Agency for Health Care Administration (AHCA) website.

Summary: Approval of the Florida Medicaid Provider Renewal Enrollment Application and related forms will allow for the continued submission of Fire Rescue transport claims to Medicaid for those patients with Medicaid insurance. Fire Rescue's current enrollment will expire on March 6, 2016. Countywide (SB)

Background and Justification: On March 7, 1995, the Board of County Commissioners approved a Florida Medicaid Enrollment application and a Non-Institutional Professional and Technical Medicaid Provider agreement (R95-326D). This application and agreement allowed Palm Beach County Fire-Rescue to submit claims directly to Medicaid for those patients with Medicaid insurance. Medicaid requires periodic renewal of Medicaid Provider Enrollment, including the electronic submission of the Renewal Enrollment Application, the Non-Institutional Medicaid Provider Agreement, and the Fingerprinting Exemption forms. A re-enrollment package was last submitted to the Board on December 6, 2005 (R2005-2369). AHCA now requires that all providers revalidate their enrollment at least every five years. Failure to submit these executed forms before the expiration date would result in suspension of our provider number.

Attachments:
1. Notice of Renewal from AHCA
2. Florida Medicaid Provider Renewal Enrollment Application
3. Medicaid Provider Renewal Application Guide
4. Non-Institutional Medicaid Provider Agreement
5. Special Exempt Entity Certifications – Fingerprinting Exemption (2)

Recommended by:	Deputy Chief	2/18/16 Date
Approved by:	Fire Rescue Administrator	2/18/2016 Date
Approved by:	County Administrator	2/23/16 Date

II. FISCAL IMPACT ANALYSIS

A. Five Year Summary of Fiscal Impact:

Fiscal Years	2016	2017	2018	2019	2020
Capital Expenditures					
Operating Costs					
External Revenues					
Program Income (County)					
In-Kind Match (County)					
NET FISCAL IMPACT					
# ADDITIONAL FTE POSITIONS (Cumulative)	0				

Is Item Included in Proposed Budget? Yes ___ No ___

Budget Account No.: Fund ____ Dept ____ Unit ____ Rev Source ____

B. Recommended Sources of Funds/Summary of Fiscal Impact:

There is no direct fiscal impact associated with the approval of these forms; however, approval does provide the County with the authority to submit transport claims to Medicaid for patients with Medicaid insurance.

C. Departmental Fiscal Review: _____

III. REVIEW COMMENTS

A. OFMB Fiscal and/or Contract Development and Control Comments:

KP 2/17 JJ 2/17 _____ **OFMB**

_____ 2/19/16 **Contract Development and Control**

B. Legal Sufficiency

_____ 2/22/16
Assistant County Attorney

C. Other Department Review:

_____
Department Director

REVISED 9/03
ADM FORM 01

(THIS SUMMARY IS NOT TO BE USED AS A BASIS FOR PAYMENT.)

1/79

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

0254869382

PRV-0043-R/XX/0254869382/1
PBC FIRE RESCUE
ATTN: EMERGEMCY TRANSPORT BILLING
405 PIKE RD
WEST PALM BEACH FL 33411-0000

December 8, 2015

RE: Florida Medicaid Provider ID: 400028500

ACTION REQUIRED

Dear Medicaid Partner:

It is time to renew your Medicaid provider enrollment.

Per Florida Statute 409.907, the agency may make payments for medical assistance and related services rendered to Medicaid recipients only to an individual or entity who has a provider agreement in effect with the agency.

Your current Non-Institutional Medicaid Provider Agreement for participation in the Title XIX Medicaid Program will expire **03/06/2016**. In order to continue participation in the Florida Medicaid program, you must submit a successful renewal application including a new provider agreement before **03/06/2016**.

Failure to complete the renewal process by that date will lead to suspension of Medicaid payments and termination of your provider ID resulting in non-payment for services rendered after that date.

The renewal form is available online in the secure **Florida Medicaid Web Portal** under the **Quick Links** dialog box. Through the online renewal process you may verify the information currently on your provider file, submit any necessary corrections and upload any supporting documentation including a signed Non-Institutional Medicaid Provider Agreement and proof of a current, Medicaid eligible background screening.

For assistance with completing the renewal form, please contact HP, 1-800-289-7799, option 4. For assistance with access to the secure Florida Medicaid Web Portal, please contact HP, 1-800-289-7799, option 7.

I look forward to continuing our work together.

Sincerely,

Gay L. Munyon

Gay L. Munyon, Chief
Medicaid Fiscal Agent Operations

PRV0043R 08/14

2727 Mahan Drive • Mail Stop # 22
Tallahassee, FL 32308
AHCA.MyFlorida.com

Facebook.com/AHCAFlorida
Youtube.com/AHCAFlorida
Twitter.com/AHCA_FL
SlideShare.net/AHCAFlorida

Renewal Enrollment Application

If you have questions about completing the online provider enrollment application, please review the Medicaid Provider Renewal Application Guide or call the Florida Medicaid fiscal agent's Provider Enrollment Unit at 1-800-289-7799, Option 4.

Instructions>Identifying Information

Identifying Information

We have pre-populated the Provider Name, DBA name (if applicable), and Tax ID information that is currently on file for this Medicaid provider.
Please review the accuracy of this information. If any changes need to be made to existing information, check the Edit box and enter the new information in the field below. If you are indicating a change in the provider's information, you will be required to upload supporting documentation before you can continue.

Click here for a list of valid supporting documentation.

Existing Name of Business or Individual Last Name	PBC FIRE RESCUE
New Name of Business or Individual Last Name	Edit ☐
Existing First Name, MI	
New First Name, MI	Edit ☐
Existing Doing Business As DBA	
New Doing Business As DBA	Edit ☐
Existing Tax ID Type	◉ FEIN ○ SSN
New Tax ID Type	○ FEIN ○ SSN Edit ☐
Existing Tax ID	596000785
New Tax ID	Edit ☐
Is this application based on a change of ownership (CHOW)?	◉ No ○ Yes

Upload Other Documentation Browse...

Renewal Enrollment Application

If you have questions about completing the online provider enrollment application, please review the Medicaid Provider Renewal Application Guide or call the Florida Medicaid fiscal agent's Provider Enrollment Unit at 1-800-289-7799, Option 4.

Instructions>Identifying Information>Contact Information

Contact Information

Contact Last Name*	COLLINS	
Contact First, MI*	JEFFREY	P
Contact Phone, Ext.*	(561)616-7000	
Email*	JPCOLLIN@PBCGOV.ORG	

Renewal Enrollment Application

If you have questions about completing the online provider enrollment application, please review the Medicaid Provider Renewal Application Guide or call the Florida Medicaid fiscal agent's Provider Enrollment Unit at 1-800-289-7799, Option 4.

Instructions>Identifying Information>Contact Information>Owners and Operators

Owners and Operators

Business Name	Last Name	First Name	Title	Affiliation	Tax ID	Effective Date	End Date	BGS Exemption	% Owner	Date of Birth
	COLLINS	JEFFREY	ADMINISTRATOR	AFFILIATED PERSON	[redacted]	03/01/2013	12/31/2299	Exempt from Background Screening	0%	[redacted]
	BRICE	HERMAN		AFFILIATED PERSON		03/15/1995	08/14/2009		0%	
	ROBINSON	FRANKLIN		AFFILIATED PERSON		03/15/1995	01/30/1998		0%	
	JERAULD	STEVEN		AFFILIATED PERSON		07/14/2011	03/01/2013		0%	
	MARTZ	MICHAEL		AFFILIATED PERSON		07/14/2011	12/31/2299	Exempt from Background Screening	0%	

Type data below for new record.

Florida Medicaid requires all individuals listed above to undergo fingerprinting unless specific exemptions are met.
(See the Provider Renewal Application Guide for details on submitting fingerprints or requesting consideration of an exemption.)
We have pre-populated the owner and operator information that is currently on file for this Medicaid provider. Please review the accuracy
of this information, and indicate whether each individual will complete background screening or if they are exempt from background screening.
If any data on an Owner record is incorrect and cannot be modified, upload a written request at the bottom of this page to have it changed.
Attach documentation to verify the changes.

Click here for a list of valid supporting documentation.

If you are:
a) **An Individual Provider Who Bills Medicaid Through A Group Membership:** If you bill solely through a group membership and do
not submit claims or receive payment directly from Medicaid, list only yourself and the requested information.

OR
b) **An Individual Provider Who Bills Medicaid Directly:** If you submit claims to Medicaid and receive payments directly, list yourself,
your financial records custodian, your medical records custodian, and all individuals who hold signing privileges on your depository account, and the requested information for each.

OR
c) **A Provider Group or other Business Entity:** List all shareholders (five percent or more ownership), all partners of your business
and subcontractors AND all individual officers, directors, managing employees, the financial and medical records custodian(s), and all
individuals who hold signing privileges on the depository account, and the requested information for each. **NOTE:** If a subcontractor is declared, you must also disclose if the provider entity or any of the individuals listed have an ownership of 5% or more in that subcontractor.

Business Name
Last Name COLLINS
First Name, MI JEFFREY P
Affiliation* AFFILIATED PERSON
Title ADMINISTRATOR
Lic. Source* ○ DOH ○ HQA ◉ OTHER
License
Tax ID Type ○ FEIN ◉ SSN
Tax ID* [redacted]
Date of Birth* [redacted]
Effective Date* 03/01/2013
End Date* 12/31/2299
% Owner 0%
Background Screening (BGS)* Exempt from Background Screening

Home Address (This should be home address of the individual listed above):
Address 1* [redacted]

Social Security Numbers (Tax ID) of employees are exempt from Public Records per Florida State Statute 119.071(4)(a)1

Dates of Birth and Home Addresses are exempt from Public Records per Florida State Statute 119.071(4)(d)2

Address 2	
City*	[redacted]
State*	[redacted]
Zip*	[redacted]
Upload proof of background screening exemption	Browse...
Upload Other Documentation	Browse...

Renewal Enrollment Application

If you have questions about completing the online provider enrollment application, please review the Medicaid Provider Renewal Application Guide or call the Florida Medicaid fiscal agent's Provider Enrollment Unit at 1-800-289-7799, Option 4.

Instructions>Identifying Information>Contact Information>Owners and Operators>Applicant History

Applicant History

Answer all questions and upload any required documentation.

Click here for a list of required documentation for each question

Have you, or any owner(s)/operator(s) ever:

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?

(●) No ( ) Yes. If yes, please submit supporting documentation.

Name

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?

( ) No (●) Yes.

Against Whom? PALM BEACH COUNTY FIRE-RESCUE

What Date? 06/15/2011

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?

(●) No ( ) Yes. If yes, please submit supporting documentation.

Name

Provider Number

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?

(●) No ( ) Yes. If yes, please submit supporting documentation.

Name

Provider Number

Owes money to Medicaid or Medicare that has not been paid?

(●) No ( ) Yes. If yes, please submit supporting documentation.

Name

Provider Number

Have ownership in any other Medicaid enrolled business?

	◉ No ○ Yes.
Name of Other Business	
Provider Number	

Upload Other Documentation	Browse...

Renewal Enrollment Application

If you have questions about completing the online provider enrollment application, please review the Medicaid Provider Renewal Application Guide or call the Florida Medicaid fiscal agent's Provider Enrollment Unit at 1-800-289-7799, Option 4.

Instructions>Identifying Information>Contact Information>Owners and Operators>Applicant History>Certification

Certification

MEDICAID PROGRAM PROVIDER RENEWAL AGREEMENT

Before your application can be considered for review, please upload a copy of the Florida Medicaid Provider Agreement with the appropriate signatures.

This is to certify that

Name of Provider or Registered Agent* COLLINS, JEFFREY P

Title FIRE RESCUE ADMINISTRATOR

Date*

"For the purpose 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), Florida Statutes, knowingly submitting false or misleading information or statements to the Medicaid program for the purpose of being accepted as a Medicaid provider is a 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 from the date it is effective per Section 409.907 (11), Florida Statutes.

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

☑ **I accept the terms of the Renewal Agreement**

☐ **I do not accept the terms of the Renewal Agreement**

Upload Medicaid Provider Agreement Browse...

Upload

previous | submit | exit

APPROVED AS TO FORM AND
LEGAL SUFFICIENCY

By: _____
County Attorney

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

MEDICAID PROVIDER RENEWAL APPLICATION GUIDE

The Agency for Health Care Administration (Agency) must revalidate the enrollment of all providers regardless of provider type at least every 5 years per 42 CFR § 455.414.

Medicaid providers must complete a separate renewal for each Medicaid provider agreement they hold with the Agency. Each Medicaid provider agreement covers a seven-digit base Medicaid provider ID plus any two-digit service location codes associated with the base ID. One online renewal application covers all active locations associated with a single Medicaid base ID. Providers do not need to renew each individual service location separately.

Renewal notices are mailed to providers approximately 90 days before the expiration date of their current provider agreement. Providers with multiple base IDs will receive a separate renewal notice for each base ID approximately 90 days before the expiration of the associated agreement.

The renewal notice states the expiration date of the current agreement which is the deadline for completing the renewal. The notice also directs providers to access the renewal application available online in the secure **Florida Medicaid Web Portal** under the **Quick Links** dialog box. Through the online renewal process providers may verify the information currently on their provider file, submit any necessary corrections and upload any supporting documentation including a signed Medicaid Provider Agreement and proof of a current, Medicaid eligible background screening.

Providers will upload supporting documentation including

- Florida Medicaid Provider Agreement with appropriate signatures.
- Proof of current, Medicaid eligible background screening or proof of exemption from fingerprinting.
- Documentation of any adverse history associated with the applicant.
- Supporting documentation for any requested changes to information on the provider record such as name, tax id, address, national provider identifier, electronic funds transfer account, electronic remittance or data interchange configuration.

Incomplete or incorrectly completed renewal applications will trigger a deficiency letter to the applicant. The letter will detail the actions to be taken by the applicant to correct the application. The application will not be processed until all deficiencies are resolved.

If the fiscal agent for Florida Medicaid does not receive an accurately completed application and finish all processing tasks before the expiration date for the provider agreement, claims for dates of service after the provider agreement expiration date will suspend. Upon successful renewal of the provider, any suspended claims will be released to process.

Medicaid Provider Agreement – The agreement must be signed by the provider or by the provider's registered agent. Registered agents are those individuals authorized to transact business on behalf of the provider in the provider's Articles of Incorporation filed with the Florida Department of State. If a registered agent signs the agreement, the organization and its owners will be held accountable for the contents of the agreement just as if they had signed it themselves. If a registered agent signs the agreement, a copy of the Articles of Incorporation must be included with the Agreement to document the registered agent's status.

A CEO or president of an organization may sign the agreement in lieu of all owners, principals, partners, and financial custodians. If a CEO or president signs the agreement, the organization and its owners will be held accountable for the contents of the agreement just as if they had signed it themselves.

Criminal History Screening – Florida Medicaid requires criminal background screening for enrolling and renewing Medicaid providers. All persons with direct or indirect ownership of, a partnership interest in, and/or managing control of the provider are required to be disclosed on the application and to submit fingerprints for purposes of obtaining a criminal history record check.

Person with an ownership or control interest means a person or corporation that—

- Has an ownership interest totaling 5 percent or more in a disclosing entity;
- Has an indirect ownership interest equal to 5 percent or more in a disclosing entity;
- Has a combination of direct and indirect ownership interests equal to 5 percent or more in a disclosing entity;
- Owns an interest of 5 percent or more in any mortgage, deed of trust, note, or other obligation secured by the disclosing entity if that interest equals at least 5 percent of the value of the property or assets of the disclosing entity;
- Is an officer or director of a disclosing entity that is organized as a corporation; or
- Is a partner in a disclosing entity that is organized as a partnership.

Managing employee means a general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts the day-to-day operation of an institution, organization, or agency.

Managing employees include the medical and financial records custodian, pharmacy managers, billing agents who are employees of the provider, and individuals authorized to sign on the depository account.

If any individual has more than one relationship to the provider, for example, an officer who is the financial records custodian, only one criminal history is required.

Submitting Fingerprints – All fingerprints must be submitted electronically. For more information on the screening process, please visit our Background Screening web page at www.mymedicaid-florida.com. Select **Public Information for Providers**, then **Enrollment**, then **Background Screening**.

Exemptions to Submission of Fingerprints – Subsection 409.907 (8)(a), F.S. exempts certain applicants from fingerprinting.

- Board members of a not-for-profit corporation or organization may submit a completed *Organization Affidavit for Exemption from Medicaid Criminal History Check* including the name, address, date of birth, and Social Security Number for each director if they meet all of the following criteria:
  - Serve solely in a voluntary capacity;
  - Do not take part in the day-to-day operational decisions of the corporation or organization
  - Receive no remuneration from the corporation or organization for their service on the board of directors
  - Have no financial interest in the corporation or organization; and
  - Have no family members with financial interest in the corporation or organization,
- Units of local government may submit a completed *FDLE Criminal History Check and Fingerprinting Exemption Request*
- Any business that derives more than 50 percent of its revenue from the sale of goods to the final consumer, **AND** either the business or its controlling parent is required to file a form 10-K or similar statement with the Securities and Exchange Commission or the business has a net worth of $50 million or more may submit a completed *FDLE Criminal History Check and Fingerprinting Exemption Request.*

Accuracy of statements contained in any exemption request will be subject to verification by Medicaid.

Notice Regarding Use of Social Security Number – All individuals disclosed on the application are required to provide their name, address, date of birth, and Social Security Number to the Agency pursuant to 42 CFR § 455.104. This requirement applies even to individuals who are exempt from fingerprinting under Subsection 409.907 (8)(a), F.S.

FAQs

Q. Where do I find the online renewal application?

A. Log in to the Medicaid secure portal using your Medicaid ID and PIN. The renewal application is accessed through the Quick Links on the right hand side of the screen.

Q. What do I do if my password has expired?

A.

Q. What do I do if I can't access my secure portal?

A.

Q. I am having difficulty navigating through the renewal application. What do I do?

A. For assistance with completing the renewal application, please contact the Provider Enrollment Call Center at 1-800-289-7799, Option 4.

Q. I submitted my renewal application and want to check the status of my application. How do I do that?

A. The Renewal Application link from the Quick Links menu will automatically redirect users to the Renewal Status page once their application has been submitted. Users can view the current status of their renewal application, upload documents, and print a copy of their renewal application.

Q. I submitted my renewal application but need to make a correction. How do I do that?

A. The Renewal Application link from the Quick Links menu will automatically redirect users to the Renewal Status page once their application has been submitted. Users can upload documents, view the current status of their renewal application, and print a copy of their renewal application.

Q. What is considered proof of a current, Medicaid eligible background screening?

A. Upload a printout from the Care Provider Background Screening Clearinghouse or a receipt from a Livescan vendor showing a submission of fingerprints for a Level 2 screening.

See http://ahca.myflorida.com/MCHQ/Central_Services/Background_Screening/index.shtml for information on the clearinghouse.

Q. I already submitted my renewal application but received another notice. What do I do?

A. Call Provider Enrollment at 1-800-289-7799, Option 4 to verify the status of your renewal application and to discuss any possible deficiencies requiring submission of corrected forms or additional supporting documentation.

Q. My claims are suspending because renewal was not completed before the deadline. What do I do?

A. Call Provider Enrollment at 1-800-289-7799, Option 4 to verify the status of your renewal application and to discuss any possible deficiencies requiring submission of corrected forms or additional supporting documentation.

Q. When will my suspended claims be released?

A. Upon completion of the renewal process. Call Provider Enrollment at 1-800-289-7799, Option 4 to verify the status of your renewal application and to discuss any possible deficiencies requiring submission of corrected forms or additional supporting documentation.

Q. I received a notice to renew but the location in question has closed or otherwise ceased operations. What do I do?

A. If any of the service locations associated with the base number has closed, the provider must report the closure to the Medicaid fiscal agent. The request must contain the full nine-digit Medicaid ID for the closed service location and the effective date of the closure.

Q. Where do I find Medicaid forms such as the Medicaid Provider Agreements and EFT?

A. Most Medicaid forms are available on the Medicaid public portal at www.mymedicaid-florida.com. Select "Public Information for Providers", then select "Enrollment".

NON-INSTITUTIONAL MEDICAID PROVIDER AGREEMENT

FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

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 (agency) may make payments for medical assistance and related services rendered to Medicaid recipients only to an individual or entity who has a provider agreement in effect with the agency, 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, or 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 the agency.

(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 the agency. 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 fully with all state and federal laws, rules, regulations, and statements of policy applicable to the Medicaid program, including the Medicaid Provider Handbooks issued by the agency, as well as all federal, state, and local laws pertaining to licensure, if required, and the practice of any of the healing arts.

(4) Term and signatures. The parties agree that this is a voluntary agreement between the agency 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 five (5) years from the effective date of the provider's eligibility for initial enrollment unless otherwise terminated. With respect to reenrolling providers, the agreement shall remain in effect for five (5) years from either the date the most recent agreement expires or the date the provider signs the renewal agreement, which ever date is earlier, unless otherwise terminated. This agreement shall be renewable only by mutual consent. The provider understands and agrees that no agency signature is required to make this agreement valid and enforceable.

(5) Provider Responsibilities. The Medicaid provider shall:

(a) Possess at the time of 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 pertinent to the services or goods being provided, as required by the state or locality in which the provider is located, and the Federal Government, if applicable.

(b) Maintain in a systematic and orderly manner all medical and Medicaid-related records the agency requires and determines are relevant to the services or goods being provided.

(c) Retain all medical and Medicaid-related records for a period of five (5) years to satisfy all necessary inquiries by the agency.

(d) Safeguard the use and disclosure of information pertaining to current or former Medicaid recipients and comply with all state and federal laws pertaining to confidentiality of patient information.

(e) Send, at the provider's expense, all Medicaid-related information, which may be in the form of records, logs, documents, or computer files, and other information pertaining to services or goods billed to the Medicaid program, including access to all patient records and other provider information if the provider cannot easily separate records for Medicaid patients from other records to the Attorney General, the Federal Government, and the authorized agents of each of these entities.

(f) 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 and comply with all other state and federal requirements in this regard.

(g) Report and refund any moneys received in error or in excess of the amount to which the provider is entitled from the Medicaid program within 90 days of receipt.

(h) Be liable for and indemnify, defend, and hold the agency 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 to the extent allowed by in and accordance with section 768.28, F.S. (2001), and any successor legislation.

(i) Provide proof of liability insurance at the option of the agency and maintain such insurance in effect for any period during which services of goods are furnished to Medicaid recipients.

(j) 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 the agency 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 policy.

(k) Comply with all of the requirements of Section 6032 (Employee Education About False Claims Recovery) of the Deficit Reduction Act of 2005, if the provider receives or earns five million dollars or greater annually under the State plan.

(l) Submit, within 35 days of the date on a request by the Secretary or the Medicaid agency, full and complete information about the ownership of any subcontractor with whom the provider has had business transactions totaling more than $25,000 during the 12-month period ending on the date of the request; and any significant business transactions between the provider and any wholly owned supplier, or between the provider and any subcontractor, during the 5-year period ending on the date of the request.

(m) Employ only individuals who may legally work in the United States, either U.S. citizens or foreign citizens who are authorized to work in the U.S, in compliance with the Immigration Reform and Control Act of 1986 which prohibits employers from knowingly hiring illegal workers.

(n) Utilize the U.S. Department of Homeland Security's E-Verify Employment Eligibility Verification system to verify the employment eligibility of all persons employed by the provider during the term of this Contract to perform employment duties within Florida and all persons (including subcontractors) assigned by the provider to perform work pursuant to this Contract. The provider shall include this provision in all subcontracts it enters into for the performance of work under this Contract.

(o) Attest that 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 the agency and is sufficient cause for immediate termination of the provider from the Medicaid program and/or revocation of the provider number.

(p) Agree to notify the agency of any changes to the information furnished on the Florida Medicaid Provider Enrollment Application, including but not limited to changes of address, tax identification number, group affiliation, or depository bank account. The provider shall report a change in any principal of the provider, including any officer, director, agent, managing employee, or affiliated person, or any partner or shareholder who has an ownership interest equal to five (5) percent or more in the provider to the agency in writing within thirty (30) days after the change occurs. For a hospital licensed under chapter 395, F.S., or a nursing home licensed under part II of chapter 400, F.S., a principal of the provider is one who meets the definition of a controlling interest under s. 408.803, F.S.

(q) Agree to notify the agency within 5 business days after suspension or disenrollment from Medicare. Failure to notify may result in sanctions imposed pursuant s. 409.908 (24) and the provider may be required to return funds paid to the provider during the period of time that the provider was suspended or disenrolled as a Medicare provider.

(r) Search the List of Excluded Individuals/Entities (LEIE), located at http://www.oig.hhs.gov/fraud/exclusions.asp, and the Agency's final order database, located at http://apps.ahca.myflorida.com/dm_web, monthly to determine whether any employee or contractor has been excluded. Providers will notify the Agency immediately any exclusion information discovered. Civil monetary penalties may be imposed against Medicaid providers and managed care entities who employ or enter into contracts with excluded individuals or entities to provide items or services to Medicaid recipients.

(6) Agency Responsibilities. The agency shall:

(a) 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) Not seek repayment from the provider in any instance in which the Medicaid overpayment is attributable to error of the agency in the determination of eligibility of a recipient.

(7) Change of Ownership. A Medicaid provider agreement may be revoked, at the option of the agency, as the result of a change of ownership of any facility, association, partnership, or other entity named as the provider in the provider agreement.

(a) If the provider sells or transfers a business interest or practice that substantially constitutes the entity named as the provider in the provider agreement, or sells or transfers a facility that is of substantial importance to the entity named as the provider in the provider agreement, the provider is required to maintain and make available to the agency 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.

(b) If there is a change of ownership, the transferor remains liable for all outstanding overpayments, administrative fines, and any other moneys owed to the agency before the effective date of the change. The transferee is also liable to the agency for all outstanding overpayments identified by the agency on or before the effective date of the change of ownership. In the event of a change of ownership for a skilled nursing facility or intermediate care facility, the Medicaid provider agreement shall be assigned to the transferee if the transferee meets all other Medicaid provider qualifications. In the event of a change of ownership involving a skilled nursing facility licensed under part II of chapter 400, liability for all outstanding overpayments, administrative fines, and any moneys owed to the agency before the effective date of the change of ownership shall be determined in accordance with s. 400.179, F.S.

(c) At least 60 days before the anticipated date of the change of ownership, the transferor shall notify the agency of the intended change of ownership and the transferee shall submit to the agency a Medicaid provider enrollment application. If a change of ownership occurs without compliance with the notice requirements of this subsection, the transferor and transferee shall be jointly and severally liable for all overpayments, administrative fines, and other moneys due to the agency, regardless of whether the agency identified the overpayments, administrative fines, or other moneys before or after the effective date of the change of ownership. The agency may not approve a transferee's Medicaid provider enrollment application if the transferee or transferor has not paid or agreed in writing to a payment plan for all outstanding overpayments, administrative fines, and other moneys due to the agency. This subsection does not preclude the agency from seeking any other legal or equitable remedies available to the agency for the recovery of moneys owed to the Medicaid program. In the event of a change of ownership involving a skilled nursing facility licensed under part II of chapter 400, liability for all outstanding overpayments, administrative fines, and any moneys owed to the agency before the effective date of the change of ownership shall be determined in accordance with s. 400.179 if the Medicaid provider enrollment application for change of ownership is submitted before the change of ownership.

(d) As used in this subsection, the term:

(1.) "Administrative fines" includes any amount identified in a notice of a monetary penalty or fine which has been issued by the agency or other regulatory or licensing agency that governs the provider.

(2.) "Outstanding overpayment" includes any amount identified in a preliminary audit report issued to the transferor by the agency on or before the effective date of a change of ownership.

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

(9) Interpretation. When interpreting this agreement, it shall be neither construed against either party nor considered which party prepared the agreement.

(10) Governing Law. This agreement shall be governed by and construed in accordance with the laws of the State of Florida. Both parties concur that this agreement is a legal and binding document and is fully enforceable in a court of competent jurisdiction. Any legal action involving this agreement will be brought in the appropriate court in Leon County, Florida, and the parties submit to exclusive venue and personal jurisdiction in that court.

(11) Amendment. This agreement, application and supporting documents constitute the full and entire agreement and understanding between the parties with respect to their relationship. No amendment is effective unless it is in writing and signed by each party.

(12) 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.

(13) Agreement Retention. The parties agree that the agency 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.

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

(15) Assignability. The parties agree that neither may assign their rights under this agreement without the express written consent of the other.

The provider, or each principal of the provider if the provider is a corporation, partnership, association, or other entity, is required to sign this agreement. For this purpose, principals includes partners or shareholders of five (5) percent or more, officers, directors, managers, financial records custodian, medical records custodian, subcontractors, and individuals holding signing privileges on the depository account, and other affiliated person. A chief executive officer (CEO) or president may sign this agreement in lieu of all principals. Failure to sign the agreement will make the agreement and provider number voidable by the agency.

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 the agency of the submission of a materially incomplete, misleading or false provider application unless subsequently ratified or approved by the agency.

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

Jeffey P. Collins	Fire Rescue Administrator		
(legibly print name of signatory)	Title	Signature	Date
(legibly print name of signatory)	Title	Signature	Date

(ATTACH ADDITIONAL SIGNATURE PAGES IF NECESSARY)

Please complete the following information:

Provider's Name:	PBC FIRE RESCUE
DBA Name:	PBC FIRE RESCUE
Tax Identification Number:	596000785
National Provider Identifier:	1962412072
Florida Medicaid Identification Number:	400028500

(For new applicants, the Medicaid ID will be entered by the fiscal agent upon approval of the application.)

APPROVED AS TO FORM AND
LEGAL SUFFICIENCY

By: _____
County Attorney

Medicaid ID: _____
or, Application Tracking Number (ATN)

Special Exempt Entity Certification – Fingerprinting Exemption

Organization Business Name	Tax ID
PBC FIRE RESCUE	596000785
DBA Name	**NPI** *(if required to have an NPI)*
PBC FIRE RESCUE	1962412072

I, Jeffrey P. Collins, Fire Rescue Administrator , request exemption from the fingerprinting
(Print Name of CEO)
requirements under Chapter 409, Florida Statutes, and do hereby certify that the entity listed above meets one, or more, of the following conditions.

(check all that apply)

☑ This organization is a unit of local government. *(if the organization is a contractor with a unit of local government, this exemption does not apply.*

☐ This organization is a School District, and is exempt under Section 409.908, Florida Statutes.

☐ This organization derives more than 50% of its revenue from the sale of goods to final consumers **AND**
- ☐ Is required to file a form 10K with the Securities and Exchange Commission *(include copy of 10K form)*, **OR**
- ☐ Has a net worth of $50 million or more. *(include copy of annual report including audited financial statements)*.

Section 2: Certification Statement

"I certify that to the best of my knowledge and belief all of the information on this form is true, accurate, and complete. I understand that, under Section 409.920, Florida Statutes, the filing of materially incomplete or false information with this enrollment request is a 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. Furthermore, I understand that it is my responsibility to notify Medicaid's fiscal agent of any future changes to the information."

Signature of Person Submitting Certification

Printed Name of Person Submitting Certification	*Submission Date*
Jeffrey P. Collins, Fire Rescue Administrator	

- ***Enter the Application Tracking Number (ATN) or Medicaid ID at the top of the page.***
- ***Applicants can upload the completed form with their initial or renewal application via the Enrollment Wizard.***
- ***Enrolled providers can fax the completed form to HP Provider Enrollment at 1-866-270-1497.***

APPROVED AS TO FORM AND
LEGAL SUFFICIENCY

By: _____
County Attorney

Medicaid ID: _____
or, Application Tracking Number (ATN)

Special Exempt Entity Certification – Fingerprinting Exemption

Organization Business Name	Tax ID
PBC FIRE RESCUE	596000785
DBA Name	**NPI** *(if required to have an NPI)*
PBC FIRE RESCUE	1962412072

I, Michael Martz, Finance Director , request exemption from the fingerprinting
(Print Name of CEO)
requirements under Chapter 409, Florida Statutes, and do hereby certify that the entity listed above meets one, or more, of the following conditions.

(check all that apply)

☑ This organization is a unit of local government. *(if the organization is a contractor with a unit of local government, this exemption does not apply.*

☐ This organization is a School District, and is exempt under Section 409.908, Florida Statutes.

☐ This organization derives more than 50% of its revenue from the sale of goods to final consumers **AND**
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Signature of Person Submitting Certification

Printed Name of Person Submitting Certification	*Submission Date*
Michael Martz, Director of Finance & Planning	

- ***Enter the Application Tracking Number (ATN) or Medicaid ID at the top of the page.***
- ***Applicants can upload the completed form with their initial or renewal application via the Enrollment Wizard.***
- ***Enrolled providers can fax the completed form to HP Provider Enrollment at 1-866-270-1497.***

APPROVED AS TO FORM AND
LEGAL SUFFICIENCY

By: _____
County Attorney