Agenda Item #: 3E-2

PALM BEACH COUNTY
BOARD OF COUNTY COMMISSIONERS
AGENDA ITEM SUMMARY

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Meeting Date:	**February 7, 2017**	**[X]**	**Consent**	**[ ]**	**Regular**
		[ ]	**Ordinance**	**[ ]**	**Public Hearing**
Department Submitted By:	**Community Services**				
Submitted For:	**Division of Senior Services**				

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I. EXECUTIVE BRIEF

Motion and Title: Staff recommends motion to:

A) approve the Florida Medicaid Provider Renewal Enrollment Application;

B) approve the Special Exempt Entity Certification – Fingerprinting Exemption form;

C) approve the Non-Institutional Medicaid Provider Agreement; and

D) authorize the County Administrator, or designee, to execute and electronically submit the Florida Medicaid Provider Renewal Enrollment Application and any other necessary documents related to the renewal process.

Summary: The Agency for Health Care Administration (AHCA) revalidates the enrollment of all providers every five (5) years. The Division of Senior Services (DOSS) is a provider and the current enrollment will expire on February 20, 2017. Approval of the Florida Medicaid Provider Renewal Enrollment Application allows for the continued submission of DOSS invoices for Medicaid Long Term Care clients. (Division of Senior Services) Countywide (HH).

Background and Justification: 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. 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 the provider number.

Attachments:
1. Florida Medicaid Provider Renewal Enrollment Application
2. Special Exempt Entity Certification - Fingerprinting Exemption Form (2)
3. Non-Institutional Provider Agreement

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Recommended By: _____ 1/12/17
Department Director **Date**

Approved By: Nancy L Bolton 1/24/17
Assistant County Administrator **Date**

II. FISCAL IMPACT ANALYSIS

A. Five Year Summary of Fiscal Impact:

Fiscal Years	2017	2018	2019	2020	2021
Capital Expenditures					
Operating Costs					
External Revenue	17,191	17,191	17,191	17,191	17,191
Program Income					
In-Kind Match (County)					
NET FISCAL IMPACT	0	0	0	0	0

# ADDITIONAL FTE POSITIONS (Cumulative)					

Is Item Included in Current Budget? **Yes** X **No** _____

Budget Account No.:

Fund 1006 Dept 144 Unit 1445 Object Var. Program Code Var. Program Period Var.

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

Approval provides DOSS with the authority to submit invoices to Medicaid Long Term Care Programs. The fiscal impact is estimated.

C. Departmental Fiscal Review: _____

Julie Dowe, Director of Finance & Support Services

III. REVIEW COMMENTS

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

_____

OFMB 1/17

_____ 1/20/17

Contract Development and Control

1/19/17

B. Legal Sufficiency:

_____ 1-24-17

Assistant County Attorney

_____

C. Other Department Review:

_____

Department Director

This summary is not to be used as a basis for payment.

Attachment 1

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

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 DIV OF SENIOR SVS
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

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Instructions>Identifying Information>Contact Information>Owners and Operators

Contact Information

Contact Last Name*	Manfra
Contact First, MI*	Faith
Contact Phone, Ext.*	(561)355-4753
Email*	fmanfra@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

The following messages were generated:
Enter either Business name or Last and First name.

Owners and Operators

Business Name	Last Name	First Name	Title	Affiliation	Tax ID	Effective Date	End Date	BGS Exemption	% Owner	Date of Birth
PBC DIV OF	MANFRA	FAITH	DIRECTOR	AFFILIATED PERSON	061607702	08/30/2007	12/31/2299	Exempt from Background Screening	0%	01/11/1962

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 [redacted]
First Name, MI [redacted]
Affiliation* AFFILIATED PERSON
Title DIRECTOR
Lic. Source* ○ DOH ○ HQA ◉ OTHER
License
Tax ID Type ○ FEIN ◉ SSN
Tax ID* [redacted]
Date of Birth* [redacted]
Effective Date* 08/30/2007
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]
Address 2	
City*	[redacted]
State*	FL
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:

1. 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.

Name

2. 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. If yes, please submit supporting documentation.

Against Whom?

What Date?

3. 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

4. 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

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

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

Name

Provider Number

6. 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* MANFRA, FAITH

Title DIRECTOR

Date* 12/22/2016

"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.

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

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

Upload Medicaid Provider Agreement Browse...

AGENCY FOR HEALTH CARE ADMINISTRATION
PROVIDER ENROLLMENT CORRESPONDENCE COVER SHEET

This sheet must be mailed or faxed with all documents.

Name: PBC DIV OF SENIOR SVS

Date Submitted: 20161227

Provider ID: 670732700

Mail To: P.O Box 7070
Tallahassee, FL 32314-7070

Attention: Mailroom Supervisor

Fax Number: (866) 270-1497

NOTE: The fax machine receiving the fax requires that the image setting be set to FINE or SUPERFINE. If you cannot change the image settings on the fax machine, and the images are not viewable, it will be necessary to mail a copy of the required documentation, along with the appropriate cover sheet, to the address on the Fax Coversheet.

Also, the fax coversheet that is produced by the Web Portal should be the first page of the fax transmission. Proprietary coversheets slow the process and should not be used. If you do not have access to the coversheet created by the Web Portal, please include a coversheet that contains the nine-digit Medicaid Provider ID number.

WEB-0005-R 03/11b

0 1 2 2

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>

The provider renewal application for PBC DIV OF SENIOR SVS has been sent to Medicaid for review.

Renewal Provider ID is: 670732700

WHAT'S NEXT?

Florida Medicaid requires all owners and operators listed within the renewal application to undergo fingerprinting unless specific exemptions are met. Your application will not be processed until you complete background screening for the following individuals:

You have attached the following documents to your renewal application:

Document	Status
APPLICATION	RECEIVED
BACKGROUND SCREENING	RECEIVED
BACKGROUND SCREENING	RECEIVED
MEDICAID PROVIDER AGREEMENT	RECEIVED
MEDICAID PROVIDER AGREEMENT	RECEIVED
OTHER	RECEIVED
OTHER	RECEIVED
OTHER	RECEIVED

GENERAL INSTRUCTIONS

- Print a copy of the application for your records. *Print Application*
- *Enrollment forms* are available on this site.
- Required documents can be mailed, faxed, or uploaded:
  - A cover page is required for documents that are sent by mail or fax. Print Cover Page
- You can check the status of this application and upload document from the *Renewal Status*

State Of Florida

PROVIDER RENEWAL APPLICATION

Is this application based on a change of ownership (CHOW)? **NO**

PROVIDER IDENTIFYING INFORMATION
Name of Business or Individual **PBC DIV OF SENIOR SVS,**
Doing Business As (D/B/A)
Tax ID / Type **596000785 / FEIN**

CONTACT INFORMATION	
Contact Name **Manfra, Faith**	Contact Number **(561)355-4753**
Contact Email **fmanfra@pbcgov.org**	

OWNERS AND OPERATORS	
Owner Name **MANFRA, FAITH**	Title **DIRECTOR**
Tax ID / Type [redacted] / **SSN**	Relationship **AFFILIATED PERSON**
Lic. Source **NA**	Owner Percent **0%**
License Number	Date of Birth [redacted]
Address [redacted]	
City [redacted]	State **FL**
Zip [redacted]	

APPLICANT HISTORY
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**
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**
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**

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
Owes money to Medicaid or Medicare that has not been paid? NO
Have ownership in any other Medicaid enrolled business? NO
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**

Signature - Provider	Date Signed - Provider
MANFRA, FAITH	12/22/2016
For Official Use Only - Provider ID 670732700	

Approved As To Form
And Legal Sufficiency

By: _____
Assistant County Attorney

Attachment 2

Medicaid ID: 670732700
or, Application Tracking Number (ATN)

Special Exempt Entity Certification – Fingerprinting Exemption

Organization Business Name	Tax ID
Palm Beach County Division of Senior Services	59-6000785
DBA Name	**NPI** *(if required to have an NPI)*
Palm Beach County Division of Senior Services	1184962847

I, Paulette Burdick, Mayor, 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)

- [X] 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

Paulette Burdick, Mayor

Printed Name of Person Submitting Certification	*Submission Date*

- ***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.***

Attest: Sharon R. Bock
Clerk and Comptroller

By: _____
Deputy Clerk

Approved As To Form
And Legal Sufficiency

By: _____
Assistant County Attorney

NON-INSTITUTIONAL MEDICAID PROVIDER AGREEMENT

AHCA
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.

Paulette Burdick	Mayor		
(legibly print name of signatory)	Title	Signature	Date
N/A	—	—	—
(legibly print name of signatory)	Title	Signature	Date

(ATTACH ADDITIONAL SIGNATURE PAGES IF NECESSARY)

Please complete the following information:

Provider's Name: Palm Beach County Board of County Commissioners

DBA Name: Palm Beach County Division of Senior Services

Tax Identification Number: 59-6000785

National Provider Identifier: 1184962847

Florida Medicaid Identification Number: 670732700

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

Attest: Sharon R. Bock
Clerk and Comptroller

By: _____
Deputy Clerk

Approved As To Form
And Legal Sufficiency

By: _____
Assistant County Attorney