State of Illinois
Department of Healthcare and Family Services

LONG TERM CARE PROVIDER AGREEMENT
SUPPORTIVE LIVING FACILITY (PROVIDER TYPE 28)

☐ New Enrollment Date _____

☐ Name Change Date _____

☐ Change of _____ Date _____

☐ Re-Enrollment Date _____

INSTRUCTIONS: Please complete, sign and return this form within 10 working days from receipt to: Illinois Department of Healthcare and Family Services (HFS), Bureau of Long Term Care, 201 South Grand Avenue East, Springfield, Illinois 62763-0002. HFS staff will complete, sign and return a copy to the facility. If there are questions concerning this form contact HFS' Enrollment/Certification Unit at (217) 782-0545.

AGREEMENT FOR LONG TERM CARE NURSING SERVICES UNDER PROVISIONS OF TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID).

Facility Name: _____ agrees to each and every one of the following as conditions of participation under the Illinois Medicaid Program.

Address _____

City _____ State _____ Zip Code _____

Provider FEIN Number: _____

1. The Facility must be currently certified as a supportive living facility by HFS.

2. The Facility must, on a continuing basis, comply with: the current rules and regulations for supportive living facilities, all applicable Federal, State and local laws and regulations; including, but not limited to the requirement that facilities must maintain written policies, procedures and materials concerning advance directives and give written information to all adults concerning their rights under State law to make decisions about their medical care; requirements set forth in the Provider Handbook; and the policies and procedures of HFS.

3. The Facility must maintain and make available to HFS or its designee, on request, all records and signed Billing Certification(s) to disclose fully the nature and extent of services provided to residents as well as physician's reports. The Facility must maintain said records for not less than three (3) years from the date of service and maintain the Billing Certification for three (3) years from the voucher date to which it relates or for the time period required by applicable Federal and State laws, whichever is longer. If an HFS audit is initiated, the Facility shall retain all original records until the audit is completed and every audit issue has been resolved, even if the retention period extends beyond the required period

4. The Facility will cooperate at all times in making necessary information available to State and Federal personnel or their authorized representatives for such purposes as facility reviews, medical needs and service reviews, review of records and periodic review of resident care policies.

5. Pursuant to the Civil Rights Act of 1964, the Rehabilitation Act of 1973 and the Americans with Disabilities Act of 1990, the Facility will provide services equally to all persons without regard to race, color, religion, sex, national origin, or handicap.

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6. If HFS or its designee finds that there is noncompliance in violation of State regulations, HFS may terminate or suspend the Facility's Medicaid certification and this agreement will terminate subject to applicable notice and hearing requirements. If HFS finds that the Facility has failed to comply with any of the conditions or provisions of this agreement, participation in the Medicaid Program may be terminated, subject to applicable notice and hearing requirements.

7. This agreement and the current certification shall be binding on the new owner when the Facility is sold, leased, moved to a new location or when operations are discontinued. The Facility shall be responsible for repayment to HFS of any outstanding balances due HFS regardless of whether the outstanding balance was incurred by a current owner or operator or by a previous owner or operator. HFS may recover any such balance by recouping from amounts otherwise due the Facility.

8. The payment rate received by the Facility from HFS or the Illinois Department of Human Services (IDHS) shall constitute the full and complete charge for services rendered. Additional payment, other than room and board charges and patient credits authorized by HFS, may not be accepted. Payment of services under this agreement is made from Federal and State funds and any falsification or concealment of a material fact with regard to services provided or charges submitted may lead to prosecution or other appropriate legal action.

9. The facility agrees to comply with the disclosure requirements specified in 42 CFR Part 455 by filing with the Department upon the execution of this Agreement and within 35 days of a change occurring, a disclosure statement containing the following:

   a) The name and address of each person with an ownership or control interest in the Medicaid provider.

   b) The name and address of each person associated with any subcontractor providing services that the Medicaid provider has direct or indirect ownership of five percent or more.

   c) Whether any of the persons named in (a) and (b) above is related to another as spouse, parent, child or sibling.

   d) The name of any other health care entity that receives government funding in which a person with an ownership or control interest in the Medicaid provider also has an ownership or control interest.

   e) The ownership of any subcontractor providing services with whom the Medicaid provider has had business transactions totaling more than $25,000 during the 12-month period ending with the date of this request.

   f) Identify any significant business transaction between the Medicaid provider and any wholly owned supplier (total ownership, operator/licensee or person), or between the Medicaid provider and any subcontractor providing services during the five year period ending with the date of this request.

   g) Disclose the identity of any person who has ownership or control interest in the provider or is an agent or managing employee of the provider, and has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid or the Title XX services program since the inception of those programs.

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10. When changes in a Medicaid client's circumstances occur, including discharge due to death, facilities enrolled with a Recipient Eligibility Verification (REV) vendor agree to submit their notifications electronically within five working days to HFS. In reporting discharges due to death, facilities not enrolled with a REV vendor agree to fax the Form HFS 1156, Long Term Care Facility Notification, to the IDHS, Exception Processing Unit (EPU), within five working days of the client's death, maintaining the fax confirmation sheet as evidence of timely submission. Facilities not enrolled with a REV vendor also agree to submit the original Form HFS 1156 to the IDHS caseworker within five working days of any change in a client's circumstances.

11. In accepting HFS payments the Facility warrants that it shall review all remittance advices that accompany payments and shall certify that all services specified therein are a true, accurate and complete record of services rendered by the Facility. Furthermore, the Facility agrees to review, affix an original signature, and retain in its files the Billing Certification which is the last page of the remittance advice. After receipt of an incorrect or incomplete remittance advice, the Facility shall notify the IDHS local office of corrections that may affect HFS payment (in the case of temporary absences, notify HFS) within 30 working days of the date of receipt of the incorrect or incomplete remittance advice.

12. The Facility agrees to submit all claim issues to the Department within 12 months from the date of service as required under Federal regulations (42 CFR 447.45, Timely Claims Payment) and state regulations (89 Ill. Adm. Code 140.20, Payment of Claims, and 89 Ill. Adm. Code 140.24, Overpayment or Underpayment of Claims).

13. The Facility agrees to exhaust all other sources of reimbursement as required by Illinois Medical Assistance Program policy prior to seeking reimbursement from HFS.

14. The Facility agrees and understands that knowingly falsifying or willfully withholding information on the Provider Enrollment Application and/or the Provider Agreement may be cause for denial or termination of participation in the Illinois Medical Assistance Program. This agreement becomes effective upon acceptance by HFS.

I, representing said Facility, hereby certify that I have read and agree to abide by all terms of participation as stated in this agreement.

_____ _____

Facility Manager Signature Date

_____ _____

Approved By: Division of Medical Programs
Illinois Department of
Healthcare and Family Service

Date