Purchase of Service Agreement
Non-Recurrent Providers/Contractors/Businesses

This agreement between UPCAP Services and _____, hereinafter referred to as "Contractor" is designed to address the needs of program participants served by UPCAP Services through its "MI Choice" and "Care Management" programs.

The scope of service(s) to be provided by the Contractor is to correspond to the specific written work order developed by UPCAP Services staff on behalf of program participants. Contractor agrees to follow work orders as written and understands that services provided shall conform to establish service standards, and that services provided over and above the written authorization level are not reimbursable.

NOTE: If Contractor is a licensed provider with Medicare and/or Medicaid, contractor must first bill these payers and receive a written denial before UPCAP Services can pay.

UPCAP Services will reimburse Contractor at the agreed upon amount for services provided upon receipt of the appropriate monthly billing voucher. Vouchers must be received by the 4th day of the month following the month for which services were provided. Vouchers submitted more than ninety (90) days following the provision of service shall not be reimbursed unless specific arrangements are made and agreed to by UPCAP Services Administration before the beginning of service provision.

Unless otherwise indicated, the Contractor shall be responsible for providing necessary equipment to complete agreed upon tasks. Contractor shall maintain documentation (date of service, start and stop time, name of person for who service was provided, type(s) of service provided) to support monthly billing. Billing records must be maintained for six (6) years following the end of this agreement or ten (10) years of a licensed Medicare provider.

Contractor understands that neither UPCAP Services nor the individual(s) on whose behalf Contractor's service(s) is being purchased shall be responsible for personal injury or damage to equipment resulting from the performance of the service, and that Contractor is responsible for carrying any and all necessary personal insurance to cover such injury or damage.

For those contractors that will be entering the participant's home, the contractor shall submit a certificate of insurance for **Liability** and **Workman's Compensation** listing UPCAP Services as "Certificate Holder" (if applicable) and agree to a criminal background check. For those providers using their personal vehicles for snow removal, provider shall submit proof of insurance for their vehicle and a copy of their driver's license.

UPCAP Services will reimburse Contractor for services within thirty (30) days of receipt of approved billing vouchers at the rate agreed to through this agreement. Reimbursements will be mailed to the address provided as a part of this agreement.

Federal rules related to the provision of Home and Community Based Services require that any entity or individual who will be responsible for any part of a MI Choice or MI Health Link participant be included into the overall plan of care and further, that such entities or individuals acknowledge their acceptance of these responsibilities in writing. UPCAP utilizes a secure electronic process of service authorization notification known as "Vender View" which provides written authorization of the frequency and duration of service delivery negotiated between the service provider and UPCAP on behalf of program participants. This electronic authorization verifies the verbal service request by UPCAP staff on behalf of program participants. Service provider archival of each Vender View Service Authorization shall constitute written acknowledgement of the Service Provider's Care Plan responsibilities for the purpose of meeting the Federal Home and Community Base requirement. **Service Providers who do not utilize Vender View shall be provided a formal paper service order indicating the service to be provided, and the scope of service delivery. The provider's signature is required on this document with a copy returned to UPCAP with the Provider's initial service billing.**

This agreement shall become effective on the date of UPCAP's signature below. This agreement may be terminated by either party, for any reason, within thirty (30) days prior written notice.

Service(s) to be Provided:

A. _____ Bid per Unit: $_____
B. _____ Bid per Unit: $_____

Description of service:

_____
_____
_____
_____

By my signature below, I agree to the terms set forth in this purchase agreement and understand that UPCAP Services makes no guarantees to any service utilization or levels of reimbursement. All services are based on a specific provider selection process and based upon client need and approval. I also agree to maintain the confidentiality of the participants I serve.

SIGNATORIES

UPCAP Services	Contracting Agency
_____	_____
Signature	Signature
_____	_____
Typed Name	Typed Name
_____	_____
Date	Date

DIRECT PURCHASE APPLICATION – PART 3

HOME & COMMUNITY BASED SERVICES WAIVER FOR THE ELDERLY & DISABLED
SUBCONTRACTOR ENROLLMENT AGREEMENT
Michigan Department of Health & Human Services

This form is to be completed by all providers who wish to receive payment from the Medicaid-enrolled organized health care delivery system for services provided under the Home & Community Based Services Waiver for the Elderly & Disabled. An original payment agreement must be submitted for each business location and for each eligible provider.

COMPLETION INSTRUCTIONS **PLEASE TYPE OR PRINT CLEARLY**

Item #1: Individual providers must enter their last name, first name, and middle initial. All other applicants (e.g., a licensed business) must enter the complete business name as licensed/certified.
Item #3: If the applicant is employed/contracted by a business, or in partnership, enter the name of the business you are employed by, affiliated with, contracted with, or in partnership with.
Item #4: Proof of the EIN number (federal tax number) is REQUIRED.
Item #5: Providers must attach a copy of their licensure/certification, as applicable.
Item #6: The SSN is required for an individual and is confidential to be used for the administration of the program.

APPLICANT INFORMATION

1. PROVIDER'S NAME (SEE INSTRUCTIONS)	2. PROFESSIONAL TITLE, IF APPLICABLE
3. EMPLOYER'S NAME (SEE INSTRUCTIONS):	4. EIN NUMBER (SEE INSTRUCTIONS)
5. STATE LICENSE NUMBER (SEE INSTRUCTIONS)	6. APPLICANT'S SOCIAL SECURITY NUMBER
7. EMAIL ADDRESS:	8. NPI NUMBER:

BUSINESS LOCATION

8. MAILING ADDRESS (NO. & STREET)		P.O. BOX	
CITY	STATE	ZIP CODE	PHONE NUMBER ( )

MEDICAL ASSISTANCE (MEDICAID) PROVIDER PAYMENT AGREEMENT CONDITION

1. All information furnished on this payment agreement form is true and complete.

2. I consent that, upon request and at a reasonable time and place, I will permit authorized agents of the State of Michigan or the federal government to inspect, and copy, any records related to my delivery of goods or services to, or on behalf of, a participant under the Medicaid Program.

3. I am not currently suspended, terminated, or excluded from any state Medicaid Program or by the U.S. Department of Health and Human Services.

4. I agree to accept the Michigan Medicaid payment as payment in full for the services rendered. Except for participant liability as determined by the Michigan Medicaid Program including applicable co-payments, I will not seek nor accept additional or supplemental payment for the participant, his/her family or representative(s).

5. I may be prosecuted under applicable federal or state criminal and civil laws for submitting false claims, concealing material facts, misrepresentation, falsifying data, other acts of misrepresentation, or conspiracy to engage therein.

6. I agree to comply with the MDHHS's policies and procedures for the Medical Assistance Program and the Home and Community Based Services for the Elderly and Disabled contained in manuals, manual updates, provider bulletins, and other program notifications.

As a condition of receiving payment from the Michigan Medicaid Program for services provided to an eligible participant, I certify and/or agree to all of the conditions listed above. I certify that the undersigned has the authority to execute this agreement.

IMPORTANT: FACSIMILE SIGNATURES WILL NOT BE ACCEPTED

APPLICANT'S SIGNATURE	DATE	TITLE

The Michigan Department of Health & Human Services will not discriminate against any individual or group because of race, sex, religion, age, national origin, marital status, political beliefs, or disability.

MAIL THIS FORM TO PO BOX 606, ESCANABA MI 49829