HOME AND COMMUNITY-BASED ALTERNATIVES (HCBA) WAIVER PERSONAL CARE SERVICE (WPCS) PROVIDER AGREEMENT FORM

FOR _____

(Participant's name; please print or type)

Name of HCBA WPCS Provider (Please type or print)	
Address	
Telephone	Provider Number

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

The WPCS provider agrees, under penalty of perjury, that all claims for services provided to an HCBA Waiver participant have been rendered as prescribed by the attending physician, and in accordance with the Waiver participant's written Plan of Treatment. The WPCS provider shall also ensure that all information submitted to the HCBA Waiver Agency is accurate and complete, as it relates to the authorization of the requested service. The WPCS service provider understands that federal and state funding is used to pay for services rendered under the HCBA Waiver. Therefore, the provider is required to adhere to all federal Medicaid requirements pertaining to the provision of WPCS. **Any falsification or concealment of a material fact by the WPCS provider may result in the provider being prosecuted under federal and/or state laws.** The WPCS provider agrees to keep, for a minimum period of three years from the date of service, a printed, legible representation of all records that are necessary to disclose the full extent of services furnished to the Waiver participant. The WPCS provider agrees to furnish these records, and any information regarding payments claimed for rendering the services within the State of California, upon request, to: DHCS; the Medi-Cal Fraud Unit; the California Department of Justice; the Office of the State Controller; the U. S. Department of Health and Human Services; or any duly authorized representative. The WPCS provider also agrees that services are offered and provided without unlawful discrimination based on sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity or sexual orientation. DHCS does not unlawfully exclude people or treat them differently because of sex, race, color, religion, ancestry,

national origin, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity or sexual orientation.

THIS AGREEMENT MUST BE SIGNED, DATED, AND RETURNED TO San Ysidro Health BEFORE WPCS SERVICE HOURS WILL BE AUTHORIZED. For billing purposes, a start date must be included below and validated by the HCBA Waiver participant.

Start of Care Date: _____

HCBA Waiver Participant's Validation (Please Initial): _____

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

Signature of HCBA **WPCS Provider**	Date

Signature of HCBA **Waiver Agency Representative**	Date
Please print or type the name of the Waiver Agency Representative.	Title

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

HCBA Waiver Agency's Mailing Address:

ATTN: HCBA Waiver
San Ysidro Health
404 Euclid Ave Ste 351
San Diego, CA 92114

HCBA Waiver Agency's FAX number: **619-205-6323**

This form can also be emailed to: WPCS@SYHealth.org

Any question you may have about this form please call: **1-833-503-5910**