Individual's Name: Individual

OCHN CONID: CON ID

PROVIDER MEDICAID AGREEMENT

Medicaid Provider (42 CFR 431.107) Agreement

This Agreement is made Effective mm/dd/yy, by and between OCHN "herein referred to as the Host Agency and Employee or Agency "herein referred to as the provider**.** The purpose of this agreement is to define the roles and responsibilities of the above-named parties and to ensure compliance with federal Medicaid requirements. This agreement shall remain in effect until such time it must be terminated or modified. Any party can initiate a termination or modification by providing written notice to the other of the desire to terminate or modify this agreement. This agreement should not be finalized until the provider has met any additional requirements to provide Medicaid Services (i.e., background check, training). Should the provider fail to meet Medicaid requirements, the Host Agency may suspend or terminate this agreement.

The Host Agency agrees to the following:

1. Upon receipt of this agreement, to certify the Provider as available to provide services to individuals who receive services and supports through arrangements authorized by the Host Agency or one of its subcontractors, and financed through Michigan's Medicaid Specialty Pre-paid Mental Health Plan where the individual is seeking or requesting services and/or supports in accordance with their Individual Plan of Service.

The Provider agrees to the following:

1. To keep any records necessary to disclose the extent of services the provider furnishes to recipients of services.
2. On request, to furnish any information maintained under paragraph (1) of this section and any information regarding payments claimed for furnishing services under the person-centered plan to the Host Agency, the State Medicaid Agency, the Secretary of the Department of Health and Human Services, or the State Medicaid Fraud Control Unit.
3. To comply with the disclosure requirements specified in 42 CFR 455, Subpart B, as applicable which states that I must disclose if I own 5% or more of another provider entity.
4. To comply with the advance directive requirements specified in 42 CFR 489, Subpart I and 42 CFR 417.436 (d), as applicable. This regulation requires that the provider acknowledge the doctrine of informed consent whereby any and all forms of medical treatment, including life-sustaining treatment, may be declined by the consumer as specified.

Both parties expressly acknowledge that the sole purpose of this agreement is to assure compliance with 42 USC 1902 (a) 27. (The Social Security Act, that requires an agreement with each provider.) Further, both parties recognize and reaffirm that the Host Agency is not the employer of the provider of services and that the participant is the sole employer of the provider of services.

This agreement sets forth the entire understanding between parties with respect to the subject matters and supersedes any and all other agreements, either oral or in writing, between parties, pertaining to these matters. No change or modification of the terms of this agreement is valid unless it is in writing and signed by the parties.

The parties agree to the terms and conditions of this agreement as specified on the foregoing page and so signify by affixing their signatures below.

Employee/Agency Rep's Signature	Employee/Agency Rep's Name	mm/dd/yy
Medicaid Provider's Signature	Printed Name	Date
OCHN Representative's Signature	Printed Name	Date

Internal Review Only

MCA Reviewer Name	Review Date