



STATE OF WASHINGTON
DEPARTMENT OF HEALTH

EARLY INTERVENTION PROGRAM PROVIDER CONTRACT

Provider Contract #:N22040

Instructions for completing and returning your contract with Department of Health:

- Complete two copies of this provider contract and Appendix A, along with all supporting optional forms and return with a current copy of your W-9 and State Wide Payee Registration form. All sections must be completed. When your agreement is finalized by our contracts department, you will receive a signed copy of the contract in the mail.

RETURN THIS CONTRACT TO: Washington State Department of Health
 HIV Client Services, Early Intervention Program
 P.O. Box 47841
 Olympia, WA 98504-7841

AGREEMENT IS BETWEEN THE STATE OF WASHINGTON DEPARTMENT OF HEALTH, EARLY INTERVENTION PROGRAM, HERINAFTER KNOWN AS THE “DEPARTMENT” AND THE FOLLOWING HEALTH CARE PROVIDER OR CLINIC, HEREINAFTER KNOWN AS THE “PROVIDER”

PROVIDER/CLINIC INFORMATION

Legal name of provider (Last, first, middle initial):

Date of Birth:

Doing business as (DBA):

Federal Tax ID#:

Uniform Business Identifier (UBI) #:

Business Mailing Address:

Business Telephone #:

License #:

Is your license restricted in any way?: Yes No

If yes, please describe the restriction:

Provider Profession/Specialty:

- Medical Laboratory Radiologist Ophthalmologist/Optomtrist Dentist Oral Surgeon Denturist
 Endodontist Mental Health Chemical Dependency

If applicable, this Contract supersedes and cancels the previous agreements under Contract Number 2635, N09727, N15264, N15264, N16754, N17455, or N18154.

PURPOSE

The purpose of this Contract is to provide certain HIV early intervention medical care services by licensed providers to persons enrolled in the Early Intervention Program, and to provide the DEPARTMENT with clinical information on enrolled clients as requested.

DO NOT WRITE BELOW THIS LINE- DEPARTMENT OF HEALTH USE ONLY

Provider/Clinic Name: _____ Provider Agreement # **EIP** _____

TERMS AND CONDITIONS

Provider Services

The PROVIDER will provide HIV early intervention medical care services to clients enrolled in the DEPARTMENT'S Early Intervention Services Program. The services provided shall be within the PROVIDER'S authorized scope(s) of practice and must be listed in the DEPARTMENT'S APPROVED LIST OF SERVICES, available on the DEPARTMENTS website and through the DEPARTMENT'S listerv. The DEPARTMENT updates the approved list bi-annually (February and July). It is the PROVIDER'S responsibility to check the approved list monthly to ensure that she or she has the most up to date information.

Licensing, Accreditation and Registration

The PROVIDER shall comply with all applicable local, state, and federal licensing, accreditation and registration requirements necessary for the performance of this Agreement. The PROVIDER'S license, including all clinic providers' licenses, shall be current and unrestricted with regard to practice. The DEPARTMENT may exchange information with the Health Systems Quality Assurance Division regarding any provider's licensing status.

Billing and Payment

- (1) In accordance with WAC 246-130-030, the PROVIDER shall bill the DEPARTMENT according to the terms of this Agreement. The PROVIDER will use the DEPARTMENT'S billing guide for guidance regarding billing the DEPARTMENT, which is available on the DEPARTMENT'S website for viewing.
- (2) All billings to the DEPARTMENT shall identify the PROVIDER name and IRS tax ID number which shall be identical to those listed on this Agreement. Changes to any of the above stated forms of identity must be reported on an updated W-9 form and State Wide Payee form within 30 days of the change for payment to be issued.
- (3) The PROVIDER shall submit all billings within 180 days from date of service. The DEPARTMENT shall not be obligated to pay for services if the billing is not received within 180 days of service provision; however, the PROVIDER shall first bill the DEPARTMENT before billing the client or sending the client's bill to a collection agency. If the PROVIDER fails to bill the DEPARTMENT for services and reports the client to a collection agency, the PROVIDER agrees to remove client from collections.
- (4) The DEPARTMENT shall pay the PROVIDER in accordance with WAC 246-130-030. The DEPARTMENT shall pay only for covered, medically necessary services delivered to clients eligible for early intervention services under WAC 246-130-40.
- (5) The DEPARTMENT shall pay the PROVIDER in accordance with the fees published by the DEPARTMENT in the EARLY INTEVENTION PROGRAM SCHEDULE OF COVERAGE AND MAXIMUM ALLOWANCES or the PROVIDER'S usual and customary fees, whichever is less.
- (6) The DEPARTMENT shall make no payment to the PROVIDER under this Agreement for services provided to enrolled clients prior to the execution of this Agreement. The DEPARTMENT shall make no payment in advance or in anticipation of services.
- (7) The DEPARTMENT is payer of last resort. The PROVIDER shall seek reimbursement from all other third party payers before seeking reimbursement from the DEPARTMENT.
- (8) The PROVIDER may not bill, demand, collect or accept payment for a service covered under this agreement from a client or anyone on the client's behalf, other than the DEPARTMENT or third party payer. The PROVIDER agrees not to "balance bill" the client for these covered services. PROVIDER may not bill a client "interest" charges while waiting for payment from the DEPARTMENT.
- (9) The PROVIDER may not bill the client while waiting for a response from the DEPARTMENT.
- (10) The DEPARTMENT may deny payment for covered services if the PROVIDER fails to satisfy the conditions of payment set forth in this Agreement. In such instances, the PROVIDER shall not bill the client.

Assignment

Neither this Agreement nor any claim arising under this Agreement, shall be transferred or assigned by the PROVIDER without prior written consent of the DEPARTMENT.

Indemnification

The PROVIDER shall defend, protect, and hold harmless the State of Washington, the DEPARTMENT, or any employee thereof, from and against all claims, suits, or actions arising from negligent acts or omissions of the PROVIDER, employees, its agents, or subcontractors while performing under the terms of this agreement and shall hold the State of Washington harmless from any expenses connected with the defense settlement, or payment or monetary judgment from such claims, suits or actions, and duties in performance of the Agreement.

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Provider/Clinic Name: _____ Provider Agreement # **EIP** _____

Nondiscrimination

The PROVIDER shall, during the performance of this contract, comply with the Americans with Disability Act (42 U.S.C. Section 12101 et seq.), Washington State Law against Discrimination, Chapter 49.60 RCW, and shall not Discriminate on the grounds of race, color, sex, sexual orientation, religion, national origin, alien status, marital status, age, creed, Vietnam-era or disabled veterans status, or the presence of any sensory, mental or physical handicap. The PROVIDER shall not: 1) deny an individual any services or other benefits provided under this Agreement; 2) provide any service(s) or other benefits to an individual which are different, or are provided in a different manner from those provided to others under this Agreement, or 3) subject an individual to segregation or separate treatment in any manner related to the receipt of any services(s) or other benefits provided under this Agreement.

Overpayments

In the event that the DEPARTMENT overpays or makes erroneous payments to the PROVIDER under this Agreement, the PROVIDER shall repay the DEPARTMENT promptly. The DEPARTMENT will either secure repayment by a set-off against the next month’s billing or request reimbursement from the PROVIDER.

Right of Inspection

The PROVIDER shall provide right of access to its facilities to the DEPARTMENT, or any of its officers, or to any other authorized agent or official of the state of Washington or the federal government, at all reasonable times, in order to monitor and evaluate performance, compliance, and/or quality assurance under this Agreement.

Safeguarding of Client Information

The use or disclosure by any party of any information concerning a patient for any purpose not directly connected with the administration of the DEPARTMENT’S or the PROVIDER’S responsibilities with respect to services provided under this Agreement is prohibited except by written consent of the recipient or patient, or his/her responsible parent or guardian, or as provided by Washington State law.

Savings

In the event funding from state, federal, or other sources is withdrawn, reduced, or limited in any way after the effective date of the Agreement and prior to normal completion, either party may terminate the agreement under the “Termination for Convenience” clause.

Emergency Preparedness

Emergency messages may be distributed by the DEPARTMENT to the PROVIDER via email distribution lists, postings to the HIV client Services website, phone calls, postal service, and teleconferences.

Termination for default

In the event DEPARTMENT determines the PROVIDER has failed to comply with the conditions of this contract in a timely manner, DEPARTMENT has the right to suspend or terminate this contract. Further, DEPARTMENT may terminate this contract for default, in whole or in part, if DEPARTMENT has a reasonable basis to believe that the PROVIDER has:

- a) Failed to meet or maintain any requirement for contracting with DOH;
- b) Failed to ensure the health or safety of any client for whom services are being provided under this contract;
- c) Failed to perform under, or otherwise breached, any term or condition of this contract; and/or
- d) Violated any applicable law or regulation.

Before suspending or terminating the contract, DEPARTMENT shall notify the PROVIDER in writing of the need to take corrective action. If corrective action is not taken within thirty (30) days of notice, , the contract may be terminated or suspended. DEPARTMENT reserves the right to suspend all or part of the contract, withhold further payments, or prohibit the PROVIDER from incurring additional obligations of funds during investigation of the alleged compliance breach and pending corrective action by the PROVIDER or a decision by the DEPARTMENT to terminate the contract.

Termination for Convenience

Except as otherwise provided in this Agreement, either party may, by fourteen (14) days written notice, terminate this contract in whole or in part when it is in the best interest of either party. If the contract is so terminated, either party shall be liable only for payment in accordance with the terms of this contract for services provided prior to the effective date of termination.

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Provider/Clinic Name: _____ Provider Agreement # **EIP** _____

All Writings Contained Herein

This Agreement contains all the items and conditions agreed upon by the parties. No other understanding, oral or otherwise regarding the subject matter of this Agreement shall exist or bind any of the parties hereto.

Health Care Provider Signature _____ Date _____

Department of Health Contract Officer _____ Date _____

Date Effective _____ Until _____

Unless earlier termination under this Agreement's termination for default or convenience provisions.

Reviewed by Client Services Staff _____ Date _____

(Approved as to form by Assistant Attorney General)

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Provider/Clinic Name: _____ Provider Agreement # **EIP** _____

PLEASE
DO NOT
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Statewide Payee Registration Washington State

STEP 1: Is this a NEW registration or CHANGE to an existing registration (check one)?

NEW REGISTRATION

CHANGE to EXISTING REGISTRATION – complete the ENTIRE form and check below what is updated:

Name/DBA Address Contact Information Email Payment Options Direct Deposit Additional Information

If you know your Statewide Vendor Number, enter it here: _____

STEP 2: Enter information about the payee and contact person

Legal Name of Payee as it appears on federal tax forms (see W-9)

SSN OR EIN

Business Name, if different from Legal Name above – e.g. Doing Business As (DBA) Name

Contact Person

() - Ext.

Mailing Address

Contact Telephone Number

() -

City, ST and Zip Code

Contact Fax Number

3030 / RWCS / 0

Email to receive Statewide Vendor Number and payment notifications

DOH# / System / Ownership

Type of Business

STEP 3: Select Payment Option:

Direct Deposit to bank (recommended) or Check in US mail (terminates any previous banking information on file)

STEP 4: For Direct Deposit, complete all fields below and sign

Financial Institution Name – must be a US institution

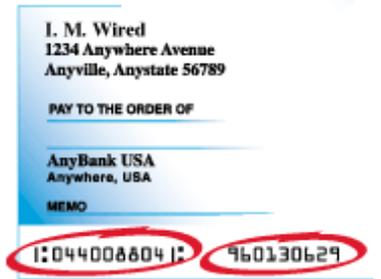
() -
Financial Institution Phone Number

Routing Number – see example at right

Account Number – see example at right

In addition to providing your banking information on this form, you may also attach a voided check.

Account Type: Checking or Savings (Checking will be used if neither box is marked.)



↑
routing number
(nine digits)

↑
account number
(can vary in length)

Authorization for Direct Deposit:

I hereby authorize and request Consolidated Technology Services (CTS) and the Office of the State Treasurer (OST) to initiate credit entries for payee payments to the account indicated above, and the financial institution named above is authorized to credit such account. I agree to abide by the National Automated Clearing House Association (NACHA) rules with regard to these entries. Pursuant to the NACHA rules, CTS and OST may initiate a reversing entry to recall a duplicate or erroneous entry that they previously initiated. I understand that, if a reversal action is required, CTS will notify this office of the error and the reason for the reversal. This authority will continue until such time CTS and OST have had a reasonable opportunity to act upon written request to terminate or change the direct deposit service initiated herein.

Authorized Representative (Please Print)

Title

SIGNATURE of Authorized Representative

Date

STEP 5: Complete and sign the Request for Taxpayer Identification Number (W-9)	
Substitute Form W-9	Request for Taxpayer Identification Number and Certification
1. Legal Name (as shown on your income tax return)	
2. Business Name, if different from Legal Name above – e.g. Doing Business As (DBA) Name	
3. Check ONLY ONE box below (see W-9 instructions for additional information)	
<input type="checkbox"/> Individual or Sole Proprietor <input type="checkbox"/> LLC filing as a sole proprietor <input type="checkbox"/> Partnership	<input type="checkbox"/> Corporation <input type="checkbox"/> S-Corp
<input type="checkbox"/> LLC filing as Corporation <input type="checkbox"/> LLC filing as Partnership <input type="checkbox"/> LLC filing as S-Corp	<input type="checkbox"/> Non Profit Organization <input type="checkbox"/> Volunteer <input type="checkbox"/> Board /Committee Member
<input type="checkbox"/> Local Government <input type="checkbox"/> State Government <input type="checkbox"/> Federal Government (including tribal)	<input type="checkbox"/> Tax-exempt organization <input type="checkbox"/> Trust/Estate
4. For Corporation, S-Corp, Partnership or LLC, check one box below if applicable: <input type="checkbox"/> Medical <input type="checkbox"/> Attorney/Legal	
5. If exempt from backup withholding, check here: <input type="checkbox"/> (See Instructions for W-9 to determine if you are exempt from backup withholding)	
6. Address (number, street, and apt. or suite no.)	For office use
7. City, state, and ZIP code	The Legal Name, Address and TIN must be filled in completely and the document signed for the forms to be accepted.
8. Taxpayer Identification Number (TIN)	
Enter your EIN <u>OR</u> SSN in the appropriate box to the right (do not enter both)	
For individuals, this is your social security number (SSN). For other entities, it is your employer identification number (EIN).	
OR	
<i>NOTE: The EIN or SSN must match the Legal Name as reported to the IRS. For a resident alien, sole proprietor, or disregarded entity, or to find out how to get a Taxpayer Identification Number, see the W9 Instructions. If the account is in more than one name, see the W9 Instructions for guidelines on whose number to enter.</i>	
9. Certification	
Under penalty of perjury, I certify that:	
<ul style="list-style-type: none"> • The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), and • I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding, and • I am a U.S. person (including a U.S. resident alien). 	
SIGNATURE of U.S. PERSON	Date

STEP 6: Submit to ONE of the Following:

For Fastest Service, PRINT, SIGN, SCAN and EMAIL to: eip.claimspayment@doh.wa.gov

If you do not have scanning ability, you may fax to **(360) 664-2216**
 Or Mail to: **Washington State Department of Health, Client Services**
PO Box 47841 Olympia, WA 98504-7841



STATE OF WASHINGTON
DEPARTMENT OF HEALTH

**EARLY INTERVENTION PROGRAM PROVIDER AGREEMENT
APPENDIX A**

All fields are required. If not applicable, please put "N/A"

CLINIC/PRACTICE INFORMATION				
Provider Name:		Federal Tax ID#:		
Facility Name:				
Facility Address:				
City:		State:		Zip:

BUSINESS INFORMATION				
Appointment phone number:		Fax Number:		
Mailing address:				
City:		State:		Zip:
Billing Address:				
City:		State:		Zip:

CONTACT INFORMATION			
Office Manager/Admin:		Phone Number:	
Email Address:			
Credentialing Manager:		Phone Number:	
Email Address:			
Please provide an email address for EIP updates: <i>(you may include multiple)</i>			
Website Address:			

ADDITIONAL INFORMATION

May we post your practice on our website? YES NO

Do you have multiple office locations? YES NO
(if yes, please fill out Appendix B for all locations)

Would you like to receive your remittance advices for payments electronically? YES NO
(if yes, please fill out the Secure FTP form)

For people with disabilities, this document is available on request in other formats. To submit a request, please call 1-800-525-0127 (TDD/TTY call 711)