Oregon Department of Human Services
OFFICE OF DEVELOPMENTAL DISABILITIES SERVICES

Foster Home Medicaid Provider Enrollment Agreement

For providers with foster homes for developmentally disabled children or child welfare foster homes, complete sections A and B only. For all other providers, complete all sections as applicable.

Section A — Foster home information

Foster home street address:	City:	State:	ZIP code + 4:
Mailing address *(if different):*	City:	State:	ZIP code + 4:
Foster home phone number*:*	Provider number:		Number of beds:

Name to be listed on license/certificate: _____

Applicant has applied for *(must choose **one**)*:

☐ **Initial license or certification** ☐ **Renewal license or certification**

To operate the following type of foster homes *(must choose **one**)*:

☐ **Adult foster home for older or physically disabled adults** governed by OARs 411-050-0600 through 411-050-0690.

☐ **Adult foster home for developmentally disabled adults** governed by OARs 411-360-0010 through 411-360-0310.

☐ **Child foster home for developmentally disabled children** governed by OARs 411-346-0100 through 411-346-0230.

☐ **Child welfare foster home** governed by OARs 413-200-0301 through 413-200-0396.

Section B — Provider information

Disclosure of Social Security numbers is required pursuant to 42 USC 405(c)(2)(C)(i) for the purpose of establishing identification, 42 CFR 455.104 for the purpose of exclusion verification, and 26 CFR 301.6109-1 for the purpose of reporting tax information.

Provider information

Last name *(as known by IRS)*:	First name *(as known by IRS)*:	MI:	Title: choose one
Street address:	City:	State:	Zip code + 4:
Social Security Number (SSN):	Date of birth:	Home phone number:	
Percentage of ownership: %	Officer title:		

Do you live in the foster home? ☐ Yes ☐ No
Do you provide care to residents? ☐ Yes ☐ No
Are you related to any other owner? ☐ Yes ☐ No
If yes, how are you related *(spouse, parent, child, sibling)*? _____
Have you been convicted of a criminal offense related to the person's involvement in any program under Medicare, Medicaid or Child Welfare? ☐ Yes ☐ No

Co-provider information *(if applicable)*

Last name *(as known by IRS)*:	First name *(as known by IRS)*:	MI:	Title: choose one
Street address:	City:	State:	Zip code + 4:
Social Security Number (SSN):	Date of birth:	Home phone number:	
Percentage of ownership: %	Officer title:		

Does this person live in the foster home? ☐ Yes ☐ No
Does this person provide care to residents? ☐ Yes ☐ No
Is this person related to any other owner? ☐ Yes ☐ No
If yes, how are they related *(spouse, parent, child, sibling)*? _____
Has this person been convicted of a criminal offense related to the person's involvement in any program under Medicare, Medicaid or Child Welfare? ☐ Yes ☐ No

Resident manager 1 information *(if applicable)*

Last name *(as known by IRS)*:	First name *(as known by IRS)*:	MI:	Title: choose one
Social Security Number (SSN):	Date of birth:	Home phone number:	

Resident manager 2 information *(if applicable)*

Last name *(as known by IRS)*:	First name *(as known by IRS)*:	MI:	Title: choose one
Social Security Number (SSN):	Date of birth:	Home phone number:	

Section C1 — Business information

The Department of Human Services (DHS) may report information to the Internal Revenue Service (IRS) and the Oregon Department of Revenue under the provider's name as listed in Section B or under the Taxpayer Identification Number (TIN) as chosen below.

Official business name as filed with the Oregon Secretary of State or IRS:

Type of business as filed with the Oregon Secretary of State or IRS:

☐ Sole proprietor ☐ Partnership ☐ Limited partnership
☐ Corporation (corp., Inc.) ☐ S corporation (SCORP) ☐ Limited liability corporation (LLC)

Employer Identification Number (EIN) or Tax Identification Number (TIN):

Do you want information reported to the IRS, when required, under your: ☐ SSN ☐ TIN/EIN

Section C2 — Information for other persons with ownership or controlling interest

Provide the following information for all managing employees, all corporate officers and all persons who have ownership or controlling interest in the foster home. Attach a separate paper for additional persons as necessary. **Do not include the applicant or co-applicant.** This information is required by 42 CFS 455.104 and 42 CFR455.106.

1. Name: | Date of birth:

Street address: | City: | State: | ZIP code + 4:

Phone number: | Social Security Number:

Percentage of ownership: % | Officer title:

Does this person live in the foster home? ☐ Yes ☐ No
Does this person provide care to residents? ☐ Yes ☐ No
Is this person related to any other owner? ☐ Yes ☐ No
If yes, how are they related *(spouse, parent, child, sibling)*?
Has this person been convicted of a criminal offense related to the person's involvement in any program under Medicare, Medicaid or Child Welfare? ☐ Yes ☐ No

2. Name: | Date of birth:

Street address: | City: | State: | ZIP code + 4:

Phone number: | Social Security number (SSN):

Percentage of ownership: % | Officer title:

Does this person live in the foster home? ☐ Yes ☐ No
Does this person provide care to residents? ☐ Yes ☐ No
Is this person related to any other owner? ☐ Yes ☐ No
If yes, how are they related *(spouse, parent, child, sibling)*?
Has this person been convicted of a criminal offense related to the person's involvement in any program under Medicare, Medicaid or Child Welfare? ☐ Yes ☐ No

Section C3 — Information on ownership or controlling interest related to outside entities

Provide the following information for all **other businesses** in which the persons or entities listed in Section B and Section C2 also have five percent (5%) or more ownership or controlling interest in any subcontractor of the foster home. Attach a separate paper for additional entities as necessary. This information is required by 42 CFR 455.104.

Business name:			
Business street address:	City:	State:	ZIP code + 4:
Phone number:	TIN/EIN:	Percentage of ownership: %	

Agreement

This Provider Enrollment Agreement, hereinafter referred to as the Agreement, sets forth the conditions for being enrolled as a Foster Home Provider with the State of Oregon Department of Human Services (DHS) and for receiving Medicaid payment for services provided within a foster home. This Agreement is valid for the term of provider's current license or certification and shall remain in effect during the term of the license or certification unless terminated earlier in writing in accordance with the terms of this Agreement.

1. Provider understands and agrees that all information submitted in the Agreement is true and accurate. Information disclosed by the provider is subject to verification. Any deliberate omission, misrepresentation or falsification of any information contained in this Agreement or contained in any communication supplying information to DHS, may be punished by administrative law, criminal law or both, including but not limited to revocation of the provider's license or certification to operate a foster home and receive payment for Medicaid services.
2. Provider must notify DHS of any changes to the information contained in this Agreement within thirty (30) days of the date of the change. Provider understands and agrees DHS may terminate this Agreement if it determines that the provider did not fully and accurately make any disclosure required in this Agreement or if the provider fails to notify DHS of any changes within thirty (30) days.
3. Provider agrees to comply with all applicable licensing, certification and regulatory requirements as set forth by federal and state statutes, regulations, and rules, and agrees to fully comply with all Oregon statutes and regulation applicable to the provider's scope of service as well as the program-specific rules for the type of home for which provider is licensed or certified.
4. Provider understands and agrees that prior authorization is required before placement of any client and that payment will not be issued if prior authorization was not granted.
5. Provider understands and agrees to comply with client specific regulations when admitting a client from a program other than the program under which the provider is licensed or certified.

   Client specific regulations are as follows:

   - Adults who are older or physically disabled — OARs 411-050-0655(1)(a)-(b), (4)(a) and (b)(A)-(E), (5)(m)(A)-(H) and (6)(f), (h), (i)(A-C) and (k).

- Adults who are developmentally disabled — OARs 411-360-0120(9); 411-360-0130(4)(f), and (6)(d); 411-360-0160(1)-(10); 411-360-0170(2)(b)-(c), (4)(a)(A)-(E), and (b)(A)-(F); 411-360-0180(5), (10), (16)(a)-(f), and (17); 407-045-260(1)(a)-(j) and (14); and 407-045-0300(1)-(5).

- Children who are developmentally disabled — OARs 411-346-0180(2)(a)-(j), (3)(h); 411-346-0190(1)(c), (e), and (g), (2)(b), (4)(c), and (e), (7)(a)-(h), (8)(a)-(j), (9)(a)-(n), (11)(e)-(j); and 411-346-0200(4)(d)-(f), (5)(a)-(d), and (g).

6. Provider agrees to provide the care and services necessary to ensure the health, safety and well-being of clients in the provider's home and to maximize clients' ability to function at the highest level of independence as possible. Provider understands and agrees payment may be denied or subject to recovery if care or services were not authorized or not provided in accordance with the requirements specified in this Agreement.

7. Provider will receive notification of individual client service rates. Provider agrees to accept the rate authorized by DHS as payment in full. Provider is not to charge the client or any person responsible for the client any additional amounts beyond the DHS determined client service contribution. Payment for ongoing services shall be processed after the end of the month in which service was provided. Payment for services that have ended shall be processed after the end of services. Provider understands and agrees payment cannot be made to any individual or entity that has been excluded from participation in federal or state programs, or that employs or is managed by excluded individuals or entities (ORS 443.004). As a condition of payment, provider must meet and maintain compliance with the Provider Rules, OAR 407-120-0300 through 407-120-0380 and 407-120-1505.

8. Provider may terminate this Agreement at any time by submitting a written notice in person or by certified mail with the specific date on which termination will take place. Notification must be submitted a minimum of sixty (60) days prior to the termination date. Termination by the Provider must be sent to the local office and to DHS. Provider must also submit appropriate and timely notice to all residents affected by this termination as outlined in the applicable program specific rules.

9. Department of Human Services (DHS) may terminate this Agreement at any time by submitting a notice in person or by certified mail with the specific date on which termination will take place.

10. Provider understands and agrees provider is not employed by any division of DHS or any Area Agency on Aging (AAA) and shall not for any purposes be deemed an employee of the State of Oregon or any AAA except as set forth in ORS 443.733 *(collective bargaining)*. Provider is responsible for its employees and for providing employment-related benefits and deductions that are required by law. Provider is solely responsible for its acts or omissions, including the acts or omissions of its own officers, employees or agents.

11. Provider shall indemnify and defend the State of Oregon, any Oregon county, Area Agency on Aging, Community Developmental Disability Program, their respective agencies and their officers, employees and agents from and against all claims, suits, actions, losses, damages, liabilities, costs and expenses of any nature whatsoever arising out of, or relating to the acts or omissions of provider or its officers, employees, subcontractors or agents under this Agreement.

12. Provider has fully read, understands and agrees to comply with the terms and conditions set forth in this Agreement. Payment of claims will be from federal and state funds. Any falsification in connection with the receipt of payment for services may be prosecuted under federal and state law.

By signing below, provider declares that he or she understands and agrees that violation of any of the terms and conditions of this Agreement constitute grounds for termination of this Agreement and may be grounds for administrative sanction as provided by Oregon statute or rule.

Provider signature _____ Date _____

Co-provider signature _____ Date _____

Local licensing authority use only

☐ OIG verified ☐ GSA (SAM) verified ☐ Approved Background Check
☐ OSBN verified ☐ CNA Registry verified ☐ Business Registry verified

License start date: _____ License end date: _____

DHS staff or designee signature and title: _____ Date: _____

Choose the type of license approved

☐ **DD – Adults with developmental disabilities:**
- ☐ Level one foster home
- ☐ Level 2B foster home
- ☐ Level 2M foster home
- ☐ Limited foster home

☐ **APD – Older adults and adults with physical disabilities:**
- ☐ Commercial adult foster home
- ☐ Limited foster home
- ☐ Ventilator-assisted care foster home

An AFH licensee can only live in one AFH. If this licensee has multiple AFH's, confirm that the system indicates this provider lives in no more than one AFH.

List the names of each person identified in Sections B and C2 who live in the home and provide care to residents. Check CNT – Controlling interest, COO-CO – Provider, OFF – Officer of business or PRI – Provider. If none, check N/A.

1. Licensee's name: _____ Date of birth: _____
   ☐ CNT ☐ COO – CO- ☐ OFF ☐ PRI ☐ N/A
2. Co-licensee's name: _____ Date of birth: _____
   ☐ CNT ☐ COO – CO- ☐ OFF ☐ PRI ☐ N/A
3. Other union member's name: _____ Date of birth: _____
   ☐ CNT ☐ COO – CO- ☐ OFF ☐ PRI ☐ N/A
4. Other union member's name: _____ Date of birth: _____
   ☐ CNT ☐ COO – CO- ☐ OFF ☐ PRI ☐ N/A
5. Other union member's name: _____ Date of birth: _____
   ☐ CNT ☐ COO – CO- ☐ OFF ☐ PRI ☐ N/A
6. Other union member's name: _____ Date of birth: _____
   ☐ CNT ☐ COO – CO- ☐ OFF ☐ PRI ☐ N/A