

**NURSING FACILITY (NF) AND NURSING FACILITY FOR MENTAL HEALTH  
(NF/MH)\*  
PROVIDER AGREEMENT  
(MEDICAID/MEDIKAN)**

**MS-2005  
REV. 12-92**

<b>1. Person/Business to receive payment</b>	<b>2. Address (Street, City, State, Zip)</b>
<b>3. Federal tax ID number</b>	<b>4. Facility name</b>
<b>5. Facility Address (Street, City, State, Zip)</b>	<b>6. Telephone number</b>
<b>7. List all owners with 5% or more interest in the nursing facility <u>premises</u>. If corporation(s), list states of incorporation. If unit(s) of government, specify the unit(s). If partnership(s), list all managing and general partners. Attach an additional sheet if necessary.</b>	
<b>8. List all owners with 5% or more interest in the nursing facility <u>business</u> if different from owners of the premises. If corporation(s), list state(s) of incorporation. If unit(s) of government, specify the units. If partnership(s), list all managing and general partner(s). Attach an additional sheet if necessary.</b>	
<b>9. List all lessee(s) and sublessee(s) of the nursing facility. (Place (X) <input type="checkbox"/> here if copies of executed leases and subleases are attached or have been submitted to the Division of Medical Services.)</b>	
<b>10. List the name and address of the management consultant or management services firm, (if applicable). (Place an "X" <input type="checkbox"/> here if a copy of the executed management agreement is attached or has been submitted to the Division of Medical Services.)</b>	
<b>11. Name(s) &amp; address(es) of premises Owner (s).</b>	
<b>12. Name(s) and address(es) of all other individuals who control the operation or management of the Nursing Facility.</b>	
<b>13. Building is financed by industrial revenue bonds: <input type="checkbox"/> YES <input type="checkbox"/> NO</b> Maturity date _____ Name & Address of govt. unit which issued the bonds:	

**\*Both Nursing Facility and Nursing Facility for Mental Health providers shall be referred to as Nursing Facility providers in this agreement.**

## **Terms and Requirements**

This nursing facility provider herein agrees to participate in the Kansas Medicaid/MediKan Program as administered by the Medical Services Division, State Department of Social and Rehabilitation Services. This nursing facility provider agrees to comply with all requirements for participation in the Kansas Medicaid/MediKan Program as required by Federal and State laws, with program requirements as published in the Medicaid/MediKan Provider Bulletins and Manuals, and with all terms and requirements of this agreement.

### **1. Disclosure of Ownership and Operating Information**

This nursing facility provider herein discloses all required ownership and operating information and certifies that all such information is true, accurate and appropriately entered or attached as of the effective date of this agreement. This nursing facility agrees and accepts that this provision constitutes a duty to report and disclose at the time of change the following ownership and operating information and that any reported or unreported changes may effect the operation of this provider agreement. This notice must include the identity of the new individual. This requirement is in accordance with 42 CFR 420.206 as amended by OBRA '87.

- \*individuals with ownership or control interest;
- \*Officers, directors, agents, or managing employees;
- \*The corporation, association or other company responsible for management of the facility; or
- \*The facility administrator or director of nursing.

### **2. Change of Ownership**

This nursing facility provider agrees that notice shall be given to the Department of Social and Rehabilitation Services at least sixty (60) days in advance of the closing transaction date for any change of provider. This provider is aware that failure to give such timely notification shall result in the new provider assuming responsibility for any overpayments made to the present provider before transfer.

### **3. Transfer of program receivables**

This nursing facility provider and its present ownership acknowledges and agrees that no receivables of this provider and its present ownership for any payment related to these programs shall be transferred to any successive provider unless copies of all documentation of any such purchase of rights is promptly furnished to the Department of Social and Rehabilitation services at the time of the closing transaction for such change of ownership.

**4. Assignment of provider agreement**

This provider agreement, if in effect, shall be assigned to the new owner of this nursing facility in a change of such ownership if applicable under the provisions of 42 CFR 483, and its recognized state requirements.

**5. License**

This nursing facility provider, if located in Kansas, agrees to maintain a licensed status with the State Department of Health and Environment of Kansas. This nursing facility provider, if located outside Kansas, agrees to maintain a licensed status with the appropriate licensing agency of the state in which it is located.

**6. Title XIX certification**

This nursing facility provider agrees to maintain standards of and to be at all times certified as being in compliance with all applicable requirements of Title XIX of the Social Security Act and all rules pursuant thereto by the Secretary of Health and Human Services.

**7. Court order compliance**

This nursing facility provider agrees to comply with all court orders as entered by any court of competent and applicable jurisdiction as affecting it and/or the Kansas Medicaid/MediKan Program.

**8. Provider survey disclosure**

This nursing facility provider is hereby informed that Section 1902 (a) (36) of the Social Security Act and 42 CFR 483, provide that the state survey agency will make public all provider surveys performed by it, the State Department of Health and Environment. Residents rights include examination of survey results. The results must be posted by the facility in a place readily accessible to residents.

**9. Provider agreement effective date**

This nursing facility provider is hereby informed that provider agreements are effective on the date of the onsite health and safety survey if all Federal and State requirements are met. If all such requirements are not met, the effective date on which all such requirements are met or the date the provider submits an acceptable response to HCFA Form 2567 or waiver request, whichever date is later, will be the effective date of the provider agreement. This provider agreement does not include a specific date of expiration.

**10. Resident Assessments required**

This nursing facility provider agrees to complete resident assessments of the residents in the provider's facility regardless of source of payment. The nursing facility provider agrees to accept as residents only those individuals, regardless of payment, who have received a preadmission assessment in accordance with P.L. 1992, Chapter 322, Sec. 5 subject to the exceptions therein.

**11. Advance Directives**

The nursing facility provider agrees to provide written information to each adult resident, or, in the case of an incapacitated individual the family of, surrogate for, or other concerned person of the incapacitated individual, outlining their options as provided under the Kansas Natural Death Act, K.S.A. 65-28, 106, et seq., the Kansas Durable Power of Attorney for Health Care Decisions Law, K.S.A. 58-625, et seq., and the Patient Self-Determination Act, Sections 4206 and 4751 of the Omnibus Budget Reconciliation Act of 1990, P.L. 101-508. The provider agrees to maintain written policies, procedures and materials about advance directives as required by the above laws and statutes.

**12. Record keeping and access**

This nursing facility provider agrees to give full cooperation to the Department of Social and Rehabilitation Services and its duly authorized agents in the administration of the program. Furthermore, this provider agrees to accurately maintain all records as required by Federal and State statutes and by Federal and State regulations and to allow and provide access to all such records as may be requested by the Department of Social and Rehabilitation Services, and agents and designees of that department, and the Department of Health and Human Services.

**13. Internal Revenue Services (IRS) reporting**

This nursing facility provider agrees that the Federal Employee Identification Number (FEIN) provided on the Provider Application Form is the correct number to report income to the IRS. This provider acknowledges that the Medicaid/MediKan Program will report income to the IRS using only the FEIN of the provider.

**14. Cost Reports**

The nursing facility provider agrees to retain responsibility for cost reports submitted to the Department of Social and Rehabilitation Services and for information contained therein. The nursing facility provider recognizes that the required cost reports will be used to determine the Medicaid rate of reimbursement and agrees to submit accurate, complete, and timely cost reports.

**15. Resident liability**

This nursing facility provider agrees that the program designated resident liability for a recipient is to be collected by the provider for authorized care, services, and goods. This provider agrees not to bill and not to otherwise attempt to collect payments from the recipient's representative, relative of the recipient, recipient's estate, or others for any amounts for any care, services, or goods in excess of the applicable resident liability. If the resident chooses, the facility must manage the resident's funds. In managing the funds, the facility must keep them in separate accounts, maintain a system that assures a full and complete and separate accounting, and affords the resident or legal representative reasonable access to the record.

**16. Payment**

This nursing facility provider agrees to accept as payment in full, subject to audit, the amount paid by the Medicaid/MediKan Program, with the exception of authorized co-payment and resident liability. This nursing facility provider acknowledges that if funds budgeted for the fiscal year prove inadequate to meet all Program costs, payments may be pended or reduced and a payment plan as determined by the Secretary of Social and Rehabilitation Services will be developed within federal and state guidelines.

**17. Billing for program services**

This nursing facility provider agrees to submit billings only for authorized care, services, and goods. Such billings shall be in accordance with form, contents, and amount as required by the Medicaid/MediKan Program. Provisions of the Medicaid/MediKan Program shall be in accordance with Federal statutes and regulations, State statutes and regulations, and from direct announcements, within the authorities of such statutes and regulations. Direct announcements of program and billing requirements shall be from the Department of Social and Rehabilitation Services or its designee and shall be communicated in writing to this provider.

**18. Timely filing of claims**

This nursing facility provider agrees that all claims must be received by the Division of Medical Services of the Department of Social and Rehabilitation Services' fiscal agent within six (6) months from the date the service was provided and that claims which are originally received within six (6) months from the date of service but are not received before the six (6) month limitation expires, may be corrected and resubmitted up to twelve (12) months from the date of service.

**19. Recovery of overpayment**

This nursing facility provider agrees that in any event that it receives payment for care, for service, for benefit, or for goods in an amount or amounts in excess of payment permitted by either Medicaid/MediKan provisions as applicable that such excessive payments may be deducted from future payments otherwise payable under such program to this provider. This provider acknowledges that such remedy is not the only or exclusive remedy available to the Department of Social and Rehabilitation Services in such instances. This provider acknowledges that it has rights to administrative review in such instances and that deductions from future payments begin fifteen (15) days following the notification of excess payment or immediately following the administrative review decision.

**20. Fraud**

This nursing facility provider agrees that payment of claims is from Federal and/or State funds and that any false claims, statements or documents or concealment of a material fact may be prosecuted under applicable Federal or State laws. This provider acknowledges that the submission of a false claim, cost report, document or other false information; charging the recipient for covered services except for authorized co-payment or resident liability; and giving or taking of a kickback or bribe in relationship to covered services are crimes which are prosecutable under applicable Federal and/or State laws.

**21. Civil Rights and 504 Compliance Assurances**

This nursing facility provider understands that the Department of Social and Rehabilitation Services' policy is to comply with the nondiscrimination, equal opportunity and affirmative action provisions of various Federal and State laws, regulations and executive orders, and to require individuals and firms with whom it does business to comply with these laws, regulations and orders. This provider understands that this compliance policy covers both employment policies and practices and service and benefit programs and activities. This provider understands that the Department will not do business with any individual or firm whose employment or service delivery practices discriminate against any person on the ground of race, color, national origin, ancestry, religion, age, sex, handicap or political affiliation.

This nursing facility provider agrees: (a) to observe the provisions of the Kansas Act Against Discrimination and shall not discriminate against any person in the performance of work under this agreement because of the race, religion, color, sex, physical handicap unrelated to such person's ability to engage in the particular work, national origin or ancestry; (b) in all solicitations or advertisement for employees, the contractor shall include the phrase, "equal opportunity employer," or a similar phrase to be approved by the Kansas Commission on Civil Rights; (c) if this provider fails to comply with the manner in which this provider reports to the commission in accordance with the provisions of K.S.A. 44-1031, this provider shall

be deemed to have breached the present contract and it may be cancelled, terminated or suspended, in whole or in part, by SRS Medical Services; (d) if this provider is found guilty of a violation of the Kansas Act Against Discrimination under a decision or order of the Kansas Commission on Civil Rights which has become final, this nursing facility provider shall be deemed to have breached this agreement and it may be cancelled, terminated or suspended, in whole or in part, by SRS Medical Services; and (e) this provider shall include the provisions of paragraphs (a) through (d) inclusively of this paragraph in every subcontract or purchase order so that such provisions will be binding upon such subcontractor or vendor. (The provisions of this paragraph shall not apply to an agreement with a provider: (a) who employs fewer than four (4) employees during the term of this agreement; or (b) whose contracts with SRS Medical Services cumulatively total five thousand dollars (\$5,000) or less during the fiscal year of SRS Medical Services.) (Specific regulations found at Kansas Statutes Annotated 44-1030 and Kansas Administrative Regulations, Agency 21, Articles 30 to 50.)

This nursing facility provider assures that all services will be provided in compliance with the provisions of Title VI of the Civil Rights Act of 1964 to the end that no person shall be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination on the ground of race, color, or national origin. This provider further assures that the United States has a right to seek judicial enforcement of this assurance. (Specific regulations found at 45 Code of Federal Regulations, Part 80.) The nursing facility provider assures that in facilities employing fifteen (15) or more employees, an affirmative action plan is completed and in effect.

This nursing facility provider assures that all services will be provided in compliance with the provisions of Section 504 of the Rehabilitation Act of 1973, which is designed to eliminate discrimination on the basis of handicap. (Specific regulations found at 45 Code of Federal Regulations, Part 84. This provider further assures that all services will be provided in compliance with the Americans with Disabilities Act of 1990, (Specific regulations found at 42 U.S.C. Section 12101, et seq.)

This nursing facility provider assures that all services will be provided in compliance with the provisions of the Age Discrimination Act of 1975, which is designed to prohibit discrimination on the basis of age. (Specific regulations found at 45 Code of Federal Regulations, Part 90.)

**22. Notice of termination of program participation**

This nursing facility provider and the Department of Social and Rehabilitation services mutually agree to give each other at least thirty (30) days (unless certification is terminated,

then payment terminates at that time) prior notice in the event of termination of participation in the Medicaid/MediKan Program. Such notice is required for cessation of business, election to no longer participate in the program, transfers of the ownership or ownership or operation of this Nursing Facility (this provision does not supersede the effects of requirements above), reduction in the types of care to be provided, and cancellation of this provider by the department.

This nursing facility provider agrees that any notice of intent to terminate participation in the program shall state the date for such termination. Agreement to these provisions must be signed by the individual or by the officer of the business to be receiving payments for approved services.

**23. Signature of Nursing Facility Provider**

Signature of Nursing Facility Provider (Owner or Lessee)	
Name (type or print)	Date

**24. Acceptance by the Secretary of Social and Rehabilitation Services**

This nursing facility agreement is for:

\_\_\_\_\_ Nursing Facility beds.

\_\_\_\_\_ Nursing Facility for Mental Health beds.

\_\_\_\_\_ Total

The assigned provider identification number is: \_\_\_\_\_

Signature	
Name and title (type or print):	Date: