

NEW YORK STATE
DEPARTMENT OF HEALTH

AIDS INSTITUTE

HIV UNINSURED CARE PROGRAMS

HOME CARE

AGREEMENT FORM

1-800-542-2437

EMPIRE STATION

P.O. BOX 2052

ALBANY, NY

12220-0052

Program Description

The New York State Department of Health, AIDS Institute, in cooperation with the HIV planning councils of New York City, Long Island, Lower Hudson Regions and Dutchess County has implemented a program to provide reimbursement to qualified primary care providers who provide services to uninsured persons with Human Immunodeficiency Virus (HIV).

General Program Requirements

The enrollment process requires the Home Care Agency to sign the Assurances and Agreement Form, and complete the Provider Enrollment Form. Make a copy for your records and return the originals to ADAP Plus:

**ADAP PLUS
EMPIRE STATION
P.O. BOX 2052
ALBANY, NY 12220-0052**

The HIV Home Care Program will reimburse all enrolled Home Care providers at the standard Medicaid reimbursement rates for any covered service; provided to an ADAP participant eligible for Home Care services.

Client Eligibility

The HIV Home Care Program serves HIV-Infected NYS residents who are chronically medically dependent due to HIV illness and meet the following criteria:

- | | | |
|---|-----------|--|
| 1 | Residency | New York State residency (US citizenship is not required) |
| 2 | Financial | Annual Income less than \$44,000 for a household of 1, \$59,200 for a household of 2 and \$74,400 for a household of 3 or more.
Liquid Assets less than \$25,000. |

There are no co-payment requirements.

HIV Home Care Program staff determines eligibility and issues enrolled participants an ID card.

Notification

An informational packet and enrollment acceptance notification will be sent to each Home Care Agency choosing to participate in the HIV Home Care Program. This packet will include a detailed list of covered services, the billing manual and claim processing instructions and format.

Questions

If additional information is required regarding the HIV Home Care Program, please call program staff at 1-800-542-2437.

NEW YORK STATE DEPARTMENT OF HEALTH, AIDS INSTITUTE
ADAP PLUS HOME CARE
ASSURANCES AND AGREEMENT FORM

This Agreement, signed this _____ day of _____, 20____ is intended to set forth the terms and conditions governing participation in the New York State Department of Health AIDS Institute Home Care Program (the "Program") administered by Health Research, Inc. (hereinafter referred to as HRI), in cooperation with the New York State Department of Health AIDS Institute (hereinafter referred to as the "AIDS Institute") and _____, (hereinafter referred to as Provider) agrees to be legally bound as to the following:

I. PROVIDER RESPONSIBILITIES:

- A.** The Provider agrees to participate in the Program and to comply with all Federal and New York State laws generally and specifically governing participation in the Medicaid Programs. The Provider agrees to be knowledgeable of and to comply with applicable rules, regulations, rates and fee schedules promulgated under such laws and any amendments thereto. The Provider further certifies that it has obtained all licenses, certifications and regulatory clearances required under State and Federal law and/or regulation to perform the services to be reimbursed hereunder, and that it is legally qualified in all aspects to perform such services.
- B.** The submission by or on behalf of the Provider of any claim for payment under the Program shall constitute certification by the Provider that:
 - 1. The services or items for which payment is claimed were actually provided by the Provider to the person (s) identified as the Home Health Care participant (s); and
 - 2. Claimed services have been confirmed by the Program to be covered services under the Program.
 - 3. The claim represents the applicable charge under Medicaid.
- C.** The Provider will accept payment from HRI as payment in full for all covered services billed under the Program. Any additional monies received from third party insurers in payment for services billed and paid for by the Program must be reimbursed to HRI within 30 days of receipt of such funds by Provider.
- D.** The Provider agrees to prepare and maintain contemporaneous records demonstrating its right to receive payment under the Program and to keep for a period of six years from the date of services or supplies were furnished, all information regarding claims for payment submitted by or on behalf of, the Provider

and to furnish such records and information, upon request, to HRI, and its agents and/or designees.

- E.** The Provider will not discriminate in the terms, conditions and privileges of employment or, against any employee, or against any applicant for employment because of race, creed, color, sex, national origin, age, disability, marital status, or sexual orientation. The Provider has an affirmative duty to take prompt, effective, investigative and remedial action where it has actual or constructive notice of discrimination in the terms, conditions or privileges of employment against (including harassment of) any of its employees by any of its other employees, including managerial personnel, based on any of the factors listed above. The Provider will not discriminate in its provision of services reimbursed under this Agreement because of race, creed, color, sex, national origin, age, disability, marital status, or sexual orientation. The Provider has an affirmative duty to take prompt, effective, investigative and remedial action where it has actual or constructive notice of discrimination in the terms, conditions or privileges of service provision hereunder based on the factors listed above.
- F.** The Provider will permit audits of all claims made under this Program. Such audits may be performed by the Federal Government, HRI, and/or their representatives.
- G.** The Provider will submit claims for payment on officially authorized claim forms or other acceptable methods approved by the Program. All such payments shall be subject to correction and adjustment upon audit under Paragraph I (F) above.
- H.** In full and complete consideration of Provider's provision of reimbursable services, as outlined in the Provider Enrollment Form, Provider shall accept compensation from HRI at approved Medicaid rates established for the Provider by the State for covered services approved during the Program application process. Provider agrees to pursue whatever steps necessary to assist clients in becoming Medicaid eligible.
- I.** The Provider certifies payment made by HRI under this Agreement shall not duplicate reimbursement of costs or services provided pursuant to this agreement which are received from other sources including, but not limited to client fees, private insurance, public donations, grant, or legislative funding from other units of government or any other source.
- J.** Provider represents that the information submitted in or with the application for enrollment to participate in the Program and from which this Agreement ensued is true, accurate and complete. The provider agrees further that such representation shall be a continuing one and that the Provider shall notify HRI in writing within fifteen (15) days of its occurrence, if any fact arises or is discovered subsequent to the date of the application which affects the truth, accuracy or completeness of such representation.
- K.** Provider will provide and seek reimbursement from the Program for covered AIDS-related services approved as part of the Program application process in the manner set forth in the Provider Enrollment Form, appended hereto and made a part hereof.

- L. Provider agrees that it shall not claim or assert any proprietary interest in any of the data or materials produced or delivered by Provider in the performance of the covered services reimbursed hereunder. Provider warrants that any such material produced by the Provider shall be original except for such portion from copyright works as may be included with the permission of the copyright owners thereof, that it shall contain no libelous or unlawful statements or materials, and will not infringe upon any copyright, trademark, patent, statutory or other proprietary rights of others and that it will hold harmless HRI, the New York State Department of Health and the State of New York from any costs, expenses and damages resulting from any breach of this warranty.
- M. Provider further agrees all written materials, pictorials, audiovisuals, questionnaires or survey instruments and proposed educational group session activities utilized, developed or distributed by the Provider in providing the services to be reimbursed hereunder must be reviewed and approved in writing by the NYS Department of Health AIDS Institute Program Review Panel prior to dissemination and/or publication. Such review will be conducted within a reasonable time frame. The Provider agrees to keep on file written notification of such approval.

Any such materials developed by the Provider will also include an attribution statement, which indicates the intended target audience and appropriate setting for distribution or presentation.

- N. Provider agrees to indemnify and hold harmless HRI, the New York State Department of Health and State of New York from and against any and all claims of any third parties for damages and expenses of whatsoever nature arising from, growing out of, or related to the Provider's performance or sole failure to perform any and all services reimbursed under this Agreement.
- O. The Provider, its officers, agents and employees and subcontractors shall treat all client/patient information, which is obtained by it through its performance under this Agreement, as confidential information to the extent required by the laws and regulations of the United States and laws and regulations of the State of New York, including Chapter 584 of the Laws of 1988, (the New York State HIV Confidentiality Law) and the appropriate portions of New York State Department of Health Regulation Part 63 (AIDS Testing and the Confidentiality of HIV related information).
- P. The Provider shall maintain or cause to be maintained, throughout the term of this Agreement, insurance of the types and in the amounts specified in the section hereof entitled Types of Insurance. Upon demand by HRI and/or Program evidence of such insurance in the form of Certificates of Insurance shall be submitted to HRI and/or program.

Types of Insurance

The types of insurance required to be maintained under this Agreement are as follows:

- Workers Compensation insurance for all employees of the Contractor and the Subcontractors engaged in performing this Agreement, as required by the laws of the State of New York.
- Disability insurance in accordance with the provisions of the NYS Compensation Law.
- Employer's liability or similar insurance for damages arising from bodily injury, by accident or disease, including death at any time resulting therefrom, sustained by employees of the Contractor, or subcontractors while engaged in performing this Agreement.
- Commercial General Liability insurance for bodily injury, sickness or disease, including death, property damage liability and personal injury liability with limits as follows:
 - Each occurrence - \$1,000,000
 - Personal and Advertising Injury - \$1,000,000
 - General Aggregate - \$2,000,000
- Automobile Liability Insurance covering any auto with a combined single limit of liability of \$1,000,000.
- Professional Liability Insurance with limits of liability of \$1,000,000 each occurrence and \$3,000,000 aggregate.

II. ADDITIONAL TERMS

- A.** The effective date of this Agreement shall be the date on which the Agreement is approved and dated by the Program and shall remain in effect until terminated in accordance with this Agreement. Termination of this contract shall not relieve the Provider of the obligation to retain records under Paragraph I (D) and to make restitution of overpayment for services or items made prior to termination in accordance with paragraphs I (C) and I (G).
- B.** It is understood that either the Provider or HRI, by giving 30 days written notice, may terminate this Agreement. It is understood and agreed, however, that in the event that the Provider is in default upon any of its obligations hereunder at the time of such termination, such right of termination on the part of HRI shall expressly be in addition to any other rights or remedies which HRI may have against the Provider by reason of such default.

- C. HRI may terminate this Agreement at any time. HRI may honor claims for services properly submitted within 90 days of such approved services, which in its judgement arose from services rendered by Provider prior to the date of termination by HRI.
- D. This Agreement shall not be construed to contain any authority, either express or implied, enabling the Provider to incur any expense or perform any act on behalf of HRI and/or Program.

Endorsed By: _____ Dated: _____

Print Name: _____ Title: _____

Please return this agreement to:

ADAP PLUS
EMPIRE STATION
P.O. BOX 2052
ALBANY, NY 12220-0052

STATE OF _____

CITY OF _____

COUNTY OF _____

On the _____ day of _____, 20____, before me personally came _____,
known to me to be the same person who executed the foregoing instrument for and on behalf of _____, and who, being by me duly sworn, did depose and say that s/he is the _____ of _____, and that s/he is the individual that executed the foregoing instrument.

Notary Public

Home Care Provider Enrollment Form

Please print clearly

MMIS Provider Number:

MMIS Locator Code:

NPI Number:

Tax ID Number: -

Agency Name: _____

Corporate Parent: _____

Address: _____

City: _____ State: Zip Code:

Main Phone: () - Ext:

Administrative Contact: _____ Title: _____

Counties Served: _____

Billing Address (if different from above):

Company Name: _____

Address: _____

City: _____ State: Zip Code:

Phone: () - Ext:

- Provider Type: (check all that apply)
- CHHA Operating Certificate #: _____
 - LTHHCP Operating Certificate #: _____
 - AHCP Operating Certificate #: _____
 - Licensed Home Care Service Agency Operating Certificate #: _____
 - Hospice Operating Certificate #: _____

- Services Provided: (check all that apply)
- Homemaker
 - Home Health Aide
 - Intravenous Prescription Drugs
 - Nursing
 - Personal Care Aide
 - Intravenous Therapy Supplies
 - Durable Medical Equipment
 - Routine Lab Work

Nutritional Assessment / Counseling: _____ Name of Nutritionist _____ License/Registration # _____