

Department of Health
Developmental Disabilities Supports Division
Developmental Disabilities (DD) Provider Information Sheet
(Form must be filled out completely)
PLEASE PRINT CLEARLY

Date: _____ New Applicant _____ Renewal Application _____

State Bureau of Revenue CRS# _____ Medicaid Billing # _____

Business Name (DBA) _____

Contact Person _____

Physical Address _____

City _____ State _____ Zip Code _____

Mailing Address _____

City _____ State _____ Zip Code _____

Phone # _____ Cell # _____ Fax # _____

E-mail address _____ Toll Free # _____

Do you plan on subcontracting services? Yes _____ (or) No _____

If yes, please provide subcontract forms for each subcontractor along with their Professional licensure (if applicable).

If more than ten (10) sub-contractors, please contact: Felicia Martinez at 505-476-8912 or email her at felicia.martinez2@state.nm.us for instructions on how to submit a spreadsheet.

Please answer the following questions regarding your organization:

1.) Does any other organization (including those who currently or previously provided service under the DDSD Medicaid Waiver program) control or influence your agency? Yes _____ (or) No _____

(If "YES" please provide name(s) and contact information below if necessary submit a separate sheet)

Contact _____ Phone # _____ Email _____

2.) Does your agency control or influence any other organization (including those who currently or previously provided service under the DDSD Medicaid Waiver program)? Yes _____ (or) No _____

(If "YES" please provide name(s) and contact information below if necessary submit a separate sheet)

Contact _____ Phone # _____ Email _____

1. Name and address of each person with an ownership or controlling interest in the entity.

Name:		
Address:	Telephone Number:	Relationship:
Name:		
Address:	Telephone Number:	Relationship:
Name:		
Address:	Telephone Number:	Relationship:

2. Name of any person, agent, managing employee or any other person who has ownership or controlling interest in the entity who has been convicted of a criminal offense or assessed a civil monetary penalty related to that person's involvement in any program under Medicaid, Medicare, other federal program or other state Medicaid programs.

Name:		
Address:	Telephone Number:	Relationship:
Name:		
Address:	Telephone Number:	Relationship:
Name:		
Address:	Telephone Number:	Relationship:

Name of Authorized Representative:	Title:
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**ATTACHMENT A - SCOPE OF WORK
DEPARTMENT OF HEALTH/DEVELOPMENTAL DISABILITIES SUPPORTS DIVISION
MEDICAID SERVICE SUMMARY FORM
(FORM MUST BE FILLED OUT COMPLETELY)**

NAME- PROVIDER/GROUP COMPANY

**MEDICAID COMMUNITY BASED WAIVER PROGRAMS
PLEASE REVIEW SERVICE STANDARDS & PROVIDER QUALIFICATIONS BEFORE
COMPLETING THIS SECTION**

DD WAIVER SERVICES

<input type="checkbox"/> CASE MANAGEMENT Case Management Agencies must provide services to all counties in an entire region. (see enclosed map) <input type="checkbox"/> METRO <input type="checkbox"/> NORTHWEST <input type="checkbox"/> NORTHEAST <input type="checkbox"/> SOUTHEAST <input type="checkbox"/> SOUTHWEST

DD WAIVER COMMUNITY INCLUSION SERVICES <input type="checkbox"/> Adult Habilitation <input type="checkbox"/> Community Access <input type="checkbox"/> Individual Supported Employment <input type="checkbox"/> Intensive Supported Employment <input type="checkbox"/> Group Supported Employment

DD WAIVER SERVICES <input type="checkbox"/> Environmental Modification <input type="checkbox"/> Goods and Services <input type="checkbox"/> Non-Medical Transportation <input type="checkbox"/> Nursing LPN <input type="checkbox"/> Nursing RN <input type="checkbox"/> Nutritional Counseling <input type="checkbox"/> Personal Plan Facilitation <input type="checkbox"/> Personal Support Companion <input type="checkbox"/> Respite <input type="checkbox"/> Supplemental Dental
--

DD WAIVER COMMUNITY LIVING SERVICES <input type="checkbox"/> Family Living <input type="checkbox"/> Independent Living <input type="checkbox"/> Supported Living
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DD WAIVER THERAPY SERVICES <input type="checkbox"/> Occupational Therapy <input type="checkbox"/> Physical Therapy <input type="checkbox"/> Speech Therapy <input type="checkbox"/> Behavioral Support Consultation <input type="checkbox"/> Tier III Crisis
--

PLEASE SUBMIT A SEPARATE FORM IF YOU ARE PROVIDING MULTIPLE SERVICES IN MULTIPLE REGIONS.

METRO	<input type="checkbox"/> BERNALILLO	<input type="checkbox"/> SANDOVAL	<input type="checkbox"/> TORRANCE	<input type="checkbox"/> VALENCIA					
NORTHWEST	<input type="checkbox"/> CIBOLA	<input type="checkbox"/> MCKINLEY	<input type="checkbox"/> SAN JUAN						
NORTHEAST	<input type="checkbox"/> COLFAX	<input type="checkbox"/> HARDING	<input type="checkbox"/> LOS ALAMOS	<input type="checkbox"/> MORA	<input type="checkbox"/> RIO ARRIBA	<input type="checkbox"/> SAN MIGUEL	<input type="checkbox"/> SANTA FE	<input type="checkbox"/> TAOS	<input type="checkbox"/> UNION
SOUTHEAST	<input type="checkbox"/> CHAVEZ	<input type="checkbox"/> CURRY	<input type="checkbox"/> DEBACA	<input type="checkbox"/> EDDY	<input type="checkbox"/> GUADALUPE	<input type="checkbox"/> LEA	<input type="checkbox"/> LINCOLN	<input type="checkbox"/> QUAY	<input type="checkbox"/> ROOSEVELT
SOUTHWEST	<input type="checkbox"/> CATRON	<input type="checkbox"/> DONA ANA	<input type="checkbox"/> GRANT	<input type="checkbox"/> HIDALGO	<input type="checkbox"/> LUNA	<input type="checkbox"/> OTERO	<input type="checkbox"/> SIERRA	<input type="checkbox"/> SOCORRO	

SIGNATURE:

Date:

Department of Health
Developmental Disabilities Supports Division
Medically Fragile (MF) Provider Information Sheet
(Form must be filled out completely)
PLEASE PRINT CLEARLY

Date: _____ New Applicant _____ Renewal Application _____

State Bureau of Revenue CRS# _____ Medicaid Billing # _____

Business Name (DBA) _____

Contact Person _____

Physical Address _____

City _____ State _____ Zip Code _____

Mailing Address _____

City _____ State _____ Zip Code _____

Phone # _____ Cell # _____ Fax # _____

E-mail address _____ Toll Free # _____

Do you plan on subcontracting services? Yes _____ (or) No _____

If yes, please provide subcontract forms for each subcontractor along with their Professional licensure (if applicable).

If more than ten (10) sub-contractors, please contact: Felicia Martinez at 505-476-8912 or email her at felicia.martinez2@state.nm.us for instructions on how to submit a spreadsheet.

Please answer the following questions regarding your organization:

1.) Does any other organization (including those who currently or previously provided service under the DDS Medicaid Waiver program) control or influence your agency? Yes _____ (or) No _____

(If "YES" please provide name(s) and contact information below if necessary submit a separate sheet)

Contact _____ Phone # _____ Email _____

2.) Does your agency control or influence any other organization (including those who currently or previously provided service under the DDS Medicaid Waiver program)? Yes _____ (or) No _____

(If "YES" please provide name(s) and contact information below if necessary submit a separate sheet)

Contact _____ Phone # _____ Email _____

1. Name and address of each person with an ownership or controlling interest in the entity.

Name:		
Address:	Telephone Number:	Relationship:
Name:		
Address:	Telephone Number:	Relationship:
Name:		
Address:	Telephone Number:	Relationship:

2. Name of any person, agent, managing employee or any other person who has ownership or controlling interest in the entity who has been convicted of a criminal offense or assessed a civil monetary penalty related to that person's involvement in any program under Medicaid, Medicare, other federal program or other state Medicaid programs.

Name:		
Address:	Telephone Number:	Relationship:
Name:		
Address:	Telephone Number:	Relationship:
Name:		
Address:	Telephone Number:	Relationship:

Name of Authorized Representative:	Title:
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**ATTACHMENT A - SCOPE OF WORK
DEPARTMENT OF HEALTH/DEVELOPMENTAL DISABILITIES SUPPORTS DIVISION
MEDICAID SERVICE SUMMARY FORM
(FORM MUST BE FILLED OUT COMPLETELY)**

NAME- PROVIDER/GROUP COMPANY

**MEDICAID COMMUNITY BASED WAIVER PROGRAMS
PLEASE REVIEW SERVICE STANDARDS & PROVIDER QUALIFICATIONS BEFORE
COMPLETING THIS SECTION**

MF WAIVER SERVICES

<input type="checkbox"/> CASE MANAGEMENT Case Management Agencies must provide services to all counties in an entire region. (see enclosed map) <input type="checkbox"/> METRO <input type="checkbox"/> NORTHWEST <input type="checkbox"/> NORTHEAST <input type="checkbox"/> SOUTHEAST <input type="checkbox"/> SOUTHWEST

MF WAIVER NURSING SERVICES <input type="checkbox"/> Private Duty Nursing (LPN) <input type="checkbox"/> Private Duty Nursing (RN) <input type="checkbox"/> Home Health Aide

MF WAIVER RESPITE SERVICES <input type="checkbox"/> Respite (LPN) <input type="checkbox"/> Respite (RN) <input type="checkbox"/> Respite (HHA) <input type="checkbox"/> Institutional Respite
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MF WAIVER SERVICES <input type="checkbox"/> Nutritional Counseling
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MF WAIVER THERAPY SERVICES <input type="checkbox"/> Occupational Therapy <input type="checkbox"/> Physical Therapy <input type="checkbox"/> Speech Therapy <input type="checkbox"/> Psychosocial Counseling
--

PLEASE SUBMIT A SEPARATE FORM IF YOU ARE PROVIDING MULTIPLE SERVICES IN MULTIPLE REGIONS.

METRO	<input type="checkbox"/>	BERNALILLO	<input type="checkbox"/>	SANDOVAL	<input type="checkbox"/>	TORRANCE	<input type="checkbox"/>	VALENCIA	<input type="checkbox"/>
NORTHWEST	<input type="checkbox"/>	CIBOLA	<input type="checkbox"/>	MCKINLEY	<input type="checkbox"/>	SAN JUAN	<input type="checkbox"/>		
NORTHEAST	<input type="checkbox"/>	COLFAX	<input type="checkbox"/>	HARDING	<input type="checkbox"/>	LOS ALAMOS	<input type="checkbox"/>	MORA	<input type="checkbox"/>
	<input type="checkbox"/>	RIO ARRIBA	<input type="checkbox"/>	SAN MIGUEL	<input type="checkbox"/>	SANTA FE	<input type="checkbox"/>	TAOS	<input type="checkbox"/>
SOUTHEAST	<input type="checkbox"/>	CHAVEZ	<input type="checkbox"/>	CURRY	<input type="checkbox"/>	DEBACA	<input type="checkbox"/>	EDDY	<input type="checkbox"/>
	<input type="checkbox"/>	GUADALUPE	<input type="checkbox"/>	LEA	<input type="checkbox"/>	LINCOLN	<input type="checkbox"/>	QUAY	<input type="checkbox"/>
SOUTHWEST	<input type="checkbox"/>	CATRON	<input type="checkbox"/>	DONA ANA	<input type="checkbox"/>	GRANT	<input type="checkbox"/>	HIDALGO	<input type="checkbox"/>
	<input type="checkbox"/>	LUNA	<input type="checkbox"/>	OTERO	<input type="checkbox"/>	SIERRA	<input type="checkbox"/>	SOCORRO	<input type="checkbox"/>

SIGNATURE:

Date:



New Mexico Medicaid Project
1720-A Randolph Road SE
Albuquerque, NM 87106
505-246-9988 505-246-8485 (fax)

Dear Medicaid Provider Applicant:

Thank you for your interest in becoming a New Mexico Medicaid provider. A provider participation agreement packet is enclosed. Please read the following instructions carefully before completing the agreement(s).

The application process takes 6-8 weeks from the date a properly completed provider participation agreement is received. When your agreement is approved, a unique provider identification number will be assigned to you. Do not provide services to New Mexico Medicaid clients until your Medicaid provider number has been assigned and you have received a copy of the New Mexico Medicaid Program Policy Manual and Billing Instructions.

In order for us to process your provider participation agreement in a timely manner, please follow these guidelines:

- The **MAD Form 312, PROVIDER PARTICIPATION AGREEMENT – INDIVIDUAL APPLICANT WITHIN A GROUP** should be completed by individual applicants who perform services within a group or organization. Payments will be made only to the group or organization. No payments will be made directly to the individual.
- The **MAD Form 335, PROVIDER PARTICIPATION AGREEMENT** should be completed by groups, organizations, or individual applicants to whom payment will be made.
- When applying for a group Medicaid provider number, include an agreement for the group (MAD 335) as well as individual agreements (MAD 312) for each practitioner who will be a member of the group if they do not already have a Medicaid number. For a group that already has an active Medicaid provider number that wishes to enroll an individual within their group, complete an agreement (MAD form 312) for the individual only. For practitioners who already have an assigned Medicaid number and who wish to be affiliated with a newly enrolling group, a signed letter must be submitted by the enrolled provider stating they wish to be affiliated with the group.
- **Please do not use “highlighter” or “whiteout” on the agreement(s) or on any of the attachments.** Agreements that are submitted with “highlighter” or “whiteout” will be returned without any further processing. To correct information on the agreement, make one line across the incorrect information and write in the corrected information. The person making the corrections should initial the changes.
- Review the enclosed *Type and Specialty List and Documentation Requirements* and select the **provider type** and **provider specialty (if applicable)** that best describes your practice, license and/or certification. If you are unsure which **provider type or specialty** to use, please contact the Provider Enrollment Unit at 1-800-299-7304 or 505-246-0710, option #3, then #5.
- If services have already been provided on an emergency basis, you may enter a requested effective date on the last page (signature page) of the Provider Participation Agreement. The date requested should be no more than 120 days prior to the date the completed agreement is being sent to ACS. **There is no guarantee that the requested effective date will be granted, as the Medical Assistance Division will make the final determination.**
- The enclosed W-9 form must be completed for applicants submitting a MAD 335, Provider Participation Agreement. The purpose of the W-9 is to assure that payments to providers are reported to the IRS with names and numbers that match IRS records. If you are a business, corporation, or sole proprietorship, enter the ID number assigned by the IRS. **Please attach a copy of the letter or other proof from the IRS assigning this tax identification number.**

- If you are enrolling as an individual, you must enter your Social Security number and date of birth on the agreement. Even if you are an individual who will be billing under a group number, you must enter your Social Security number and date of birth. You will bill your claims using the group provider number, which will be reported to the IRS with the group name and tax identification number.
- Tax exempt providers must submit a copy of their 501(c)3 tax-exempt letter.
- Every provider who completes a MAD 335 agreement and who renders services within New Mexico must provide their New Mexico Tax and Revenue identification number (box 19 of the agreement).
- The applicant's Medicare number and/or DEA number must be included on the agreement, if applicable. Also include a copy of the Medicare letter and/or DEA registration certification with the agreement. If the DEA number and/or Medicare number is/are pending at the time of application, please send ACS a copy of the certification when you receive this information.
- Applicants completing the MAD 335 form should also complete the enclosed Addendum form that requests information regarding Medicare carrier(s).
- New Mexico Medicaid project staff may need to obtain additional information from you in order to process your agreement. Please indicate a contact name and telephone number in the space provided on the last page of the Provider Participation Agreement.
- The applying provider must sign and date the agreement. **Please sign in blue ink only! Only an original signature with a date is acceptable. We cannot accept signature stamps or copies of signatures.** Applications with signatures that cannot easily be determined as original will be returned for correction. This standard is **strictly** enforced.
- Please be sure to include all required documentation as listed on the attached *Provider Participation Agreement, MAD 312 and 335 forms and Type and Specialty List and Documentation Requirements*. Required documentation may include:
 - ◆ Professional licensure
 - ◆ Agency licensure or certification
 - ◆ Business license
 - ◆ DEA registration certificate
 - ◆ New Mexico Non-Residential Pharmacy License (for certain out-of-state providers)
 - ◆ Proof of malpractice or liability insurance
 - ◆ Federal tax identification letter
 - ◆ CLIA certificate
 - ◆ Physician board specialty certification
 - ◆ Medicare certification letter
 - ◆ JCAHO accreditation letter
 - ◆ FQHC certification and interim rates
 - ◆ Medicare letter setting reimbursement rates for Rural Health Clinics (RHCs)
 - ◆ Renal dialysis Medicare composite rate letter
- If you plan to submit claims electronically, please review the *HIPAA Claims Submission Instructions* information that is attached to this packet.

If you have ANY questions at all, please do not hesitate to contact ACS's Provider Enrollment Unit at 1-800-299-7304 or 505-246-0710, option #3, then #5.

Sincerely,

Provider Enrollment
ACS



For Medicaid Use Only - Provider Number

STATE OF NEW MEXICO HUMAN SERVICES DEPARTMENT
MEDICAL ASSISTANCE DIVISION
PROVIDER PARTICIPATION AGREEMENT



THIS AGREEMENT IS FOR GROUPS, ORGANIZATIONS, OR INDIVIDUAL APPLICANTS TO WHOM PAYMENTS WILL BE MADE. IF THE APPLICANT IS AN INDIVIDUAL APPLYING FOR A PROVIDER NUMBER ONLY FOR IDENTIFYING SERVICES BILLED THROUGH A GROUP PRACTICE OR OTHER ORGANIZATION AND PAYMENTS WILL BE MADE TO THAT GROUP OR ORGANIZATION, THIS FORM SHOULD NOT BE USED. USE FORM MAD 312 INSTEAD.

RETURN completed application to:
New Mexico Medicaid Project
c/o ACS
1720 - A Randolph Rd.
Albuquerque, NM 87106

TO BE COMPLETED BY ALL APPLICANTS:

Form with fields for Name of Applicant, Professional Title, Physical Location, Billing Address, Mailing Address, State License Number, License Issued By, License Expiration Date, Provider Type, Provider Specialty, Social Security Number, Birth Date For Individuals.

IF PAYMENTS ARE MADE DIRECTLY TO THE APPLICANT, THE FOLLOWING MUST BE COMPLETED.

Form with checkboxes for entity type (individual, non-corporate business entity, partnership, sole proprietorship, corporation, governmental entity or public school), Federal Tax Number, Federal Tax Name, Doing Business As, NM Tax & Revenue ID Number.

COMPLETE IF APPLICABLE:

Form with fields for New Mexico Medicaid Number, HMO Affiliation, Name of plans, CLIA Number, National Provider I.D. (NPI) or UPIN Number, DEA Number, NABP #.

To be completed by physicians only. Are you board certified? If not board certified, attach specialty certification from residency program or letter from the chairperson of your residency program stating that you received training in your specialty area.

CERTIFIED UNDER TITLE XVIII MEDICARE? JCAHO CERTIFIED? If yes, attach copy of letter/certification letter.

Fiscal Year End Date

Medicare Provider Number(s) Medicare Carrier or Intermediary

Identify individuals who will be providing services for which payments will be made directly to your group or organization.

Table with columns: Individual's Name, Title, License Number, Provider Type, Provider Specialty, New Mexico Medicaid Number, For Medicaid Project Office Use Only.

Please attach a separate page if additional space is needed.

IF THE APPLICANT IS AN INDIVIDUAL, IDENTIFY ANY OTHER ORGANIZATION(S) THAT YOU WILL BILL UNDER:

Form with fields for Organization or Group Name, Organization or Group Medicaid Number, Organization or Group Medicare Number.

Please attach a separate page if additional space is needed.

Form with questions (a) Have you ever had a license revoked... (b) Have you or any of the owners or principals ever been convicted... (c) Have you or any of the owners or principals ever been excluded or suspended...

OWNERSHIP INFORMATION - The following information must be provided and updated, as applicable, if payments are to be remitted to a provider group, partnership, or association:

1. Name and address of each person with an ownership or controlling interest in the entity or any subcontractors in which the entity has or had direct or indirect ownership totaling five percent (5%) or more and whether any of these person(s) named is related to another as spouse, child, or sibling.

Name		Social Security Number
Address	Telephone Number	Relationship
Name		Social Security Number
Address	Telephone Number	Relationship
Name		Social Security Number
Address	Telephone Number	Relationship
Name		Social Security Number
Address	Telephone Number	Relationship

2. Name and address of any other entity in which a person with an ownership or controlling interest in the entity also has an ownership or controlling interest.

Name of Entity	Address	Telephone Number	Name of Person with Interest

3. Name of any person, agent, managing employee, or any other person who has ownership or controlling interest equal to five percent (5%) or greater in the entity who has been convicted of a criminal offense or assessed a civil monetary penalty related to that person's involvement in any program under Medicaid, Medicare, other federal program, or other state Medicaid program.

Name		Social Security Number
Address	Telephone Number	Program Violation
Name		Social Security Number
Address	Telephone Number	Program Violation
Name		Social Security Number
Address	Telephone Number	Program Violation
Name		Social Security Number
Address	Telephone Number	Program Violation

This Agreement, between the New Mexico Human Services Department (HSD) and the applicant as provider, specifies the terms and conditions for the provision of medical services to Medicaid clients. The Agreement shall be effective when completed in full with all required documentation attached and when signed by the provider and HSD, and shall remain in effect until terminated pursuant to the terms set out below.

**ARTICLE I -
OBLIGATIONS OF THE PROVIDER**
The Medicaid provider shall:

- 1.1. Abide by all federal, state, and local laws, rules, and regulations, including but not limited to, those laws, regulations, and policies applicable to providers of medical services under Title XIX (Medicaid) and Title XXI (SCHIP) of the Social Security Act and other health care programs administered by HSD.
- 1.2. Furnish services, bill for services, and receive payment for services only upon approval of this Agreement by the MAD Director or his/her designee.
- 1.3. Comply with all billing instructions, reimbursement, audit, recoupment, and withholding provisions distributed by HSD. All rates, policies, procedures, or rules of any kind relating to billing instructions, reimbursement, audit, recoupment, and withholding provisions furnished to providers must be specifically approved in writing by the MAD Director or his/her designee to be effective.
- 1.4. Maintain and keep updated program policies, instructions on billing and utilization review, and other pertinent material distributed by HSD.
- 1.5. Furnish and update complete information on provider address, licensing, certification, board specialties, corporate names, and parties with direct or indirect ownership or controlling interest and information on the conviction of delineated criminal or civil offenses by providers or parties with direct or indirect ownership or controlling interest at least sixty (60) days prior to the contemplated change or within ten (10) days after the conviction. Any payment by HSD on the basis of erroneous or outdated information is the responsibility of the provider and is subject to recoupment, criminal investigative costs, and/or civil penalties.
- 1.6. Comply with all federal, state, and local laws and regulations regarding the provider's authority to operate a business in New Mexico including, but not limited to, licensure, registration to pay gross receipts tax, permit requirements, and employee tax filing requirements.
- 1.7. Assume sole responsibility for all applicable taxes, insurance, licensing, and other costs of doing business.
- 1.8. Verify that an individual is eligible for a specified medical program administered by HSD.
- 1.9. Maintain the confidentiality of client information and records in accordance with state and federal laws, including 42 C.F.R. § 431.305, 8.100.100.13 and .14 NMAC, and regulations promulgated pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA).
- 1.10. Render covered services to eligible clients in the same scope, quality, and manner as provided to the general public; comply with all federal and state civil rights laws; and not discriminate on the basis of age, race, religion, color, sex, handicap, national origin, marital status, political belief, disability, or source of payment as per 45 C.F.R. § 80.3(a) and (b), 45 C.F.R. § 84.52, and 42 C.F.R. § 447.20.
- 1.11. Assume responsibility for any and all claims submitted on behalf of the provider and under the provider's number. Submission of false claims or fraudulent representation may subject the provider to termination, criminal investigations and charges, and other sanctions specified in the MAD Provider Program Manual.
- 1.12. Retain any and all original medical or business records as are necessary to verify the treatment or care of any client for which the provider received payment from HSD to provide that benefit or service, services or goods provided to any client for which the provider received payment from HSD, amounts paid by HSD on behalf of any client, and other records required by HSD for at least six (6) years from the date of creation or until ongoing audits are settled, whichever is longer. Services that have been billed to HSD which are not substantiated in the provider's record are subject to recoupment.
- 1.13. Upon closure of office or facility, inform HSD where records pertaining to Medicaid recipients will be located.
- 1.14. Furnish immediately to the Medicaid Agency, the Secretary of Health and Human Services, or the Medicaid Fraud Control Unit, at no cost, access to records in any format requested as described above and any information regarding payments claimed by the provider for furnishing services to clients. Permit the inspection of facilities used in the provision of services to clients by the U.S. Secretary of Health and Human Services, HSD, the Medicaid Fraud Control Unit, or HSD designees. Failure to comply with this provision constitutes a violation of federal and state Medicaid law and may result in immediate withholding of any pending or future payments. If records are requested by mail, the provider shall furnish the records within five (5) working days of the receipt of the request or as provided for in the request.
- 1.15. Accept as payment in full the amount paid by HSD for services furnished to clients in accord with the reimbursement structure in effect for the period during which services were provided as per the HSD reimbursement policy. No exceptions to, or waiver, of standard reimbursements will be permitted without the express written consent of the MAD Director or his/her designee.
- 1.16. Not collect payments from the client or any financially-responsible relative or representative of that client for services furnished to the client, except as allowed and specifically delineated by HSD.
- 1.17. Seek payment from any other payor or insurer before seeking payment from HSD, in the event the client is covered by an insurance policy or health plan, including Medicare. Refund to HSD the lesser of the payment received from a liable third party or the amount payable under medical programs administered by HSD and not bill HSD the difference between the payment received from the third party based on a "preferred patient care agreement" or "discount" arrangement and the provider's billed charge.
- 1.18. Not refuse to furnish services to an eligible client because of a third party's potential liability for payment for the services, except in instances in which a client who is covered by an HMO plan is seeking services from a provider who does not participate in the HMO plan network and would not be paid for services by the HMO plan.
- 1.19. Inform HSD immediately when an attorney or other party requests information related to the services rendered to a client that were paid by HSD and upon receipt of any knowledge of pending or active legal proceedings involving clients.
- 1.20. When furnishing services to clients who sustained injury in an accident or another action that may be subject to a legal proceeding, agree to the following:
 - (A) Hospital providers must either file a claim with HSD within 120 days of the date of hospital discharge or impose a hospital lien on the potential recovery from the liable third party. If the hospital provider elects to impose a lien, the provider is prohibited from filing a claim with HSD for payment of any unpaid balance resulting from the third party recovery or from seeking payment from the client.
 - (B) Non-hospital providers must accept the payment made by HSD as payment in full. A non-hospital provider may not seek additional payment for those services from the client even if the client

subsequently received a monetary award or settlement from the liable party.

1.21. When entering into contracts with the Medicaid managed care organizations (MCOs) contracting with HSD for the provision of managed care services to the Medicaid population, agree to be paid by the MCOs at any amount mutually-agreed between the provider or provider group and the MCOs, or failing that, the then current and "applicable reimbursement rate" based on the provider type. The "applicable reimbursement rate" is defined as the rate paid by HSD to providers participating in Medicaid or other medical programs administered by HSD and excludes disproportionate share hospital and medical education payments.

ARTICLE II - OBLIGATION OF THE HUMAN SERVICES DEPARTMENT HSD shall:

2.1. Distribute information necessary to participate in medical programs administered by HSD, including program policies, billing instructions, utilization review instructions, and other pertinent materials. The provider must contact HSD to request any additional program policy manuals, billing and utilization review instructions, and other pertinent materials.

2.2. Process payments in a manner delineated by federal guidelines either internally or through a delineated fiscal agent contractor.

2.3. Reimburse providers for furnishing covered services or procedures to eligible clients. Reimbursement is based on the HSD fee schedule, reimbursement rate, or reimbursement methodology in place at the time services are furnished by the provider. No exception to, or waiver of, standard reimbursement will be permitted without the express written consent of the MAD Director or his/her designee.

2.4. Conduct administrative investigations and administrative proceedings to ensure that providers comply with the terms of this Agreement and federal and state law pertaining to the administration of the health care programs administered by HSD, including the Medicaid Provider Act.

ARTICLE III - PATIENT SELF-DETERMINATION ACT

Nursing facility, intermediate care facility, hospital, home health agency, and hospice providers shall:

3.1. Furnish written information to all adult clients receiving medical care concerning their right to make decisions about medical care; accept or refuse medical or surgical treatment; and formulate arrangements for a living will or durable power of attorney.

3.2. Document in the client's medical record whether he/she has executed an advance directive which complies with New Mexico law on advance directives. The provision of care shall not be based on whether the client has executed an advance directive.

3.3. Inform each adult client, orally and in writing, at the time of facility admission or initiation of treatment, of the client's legal rights during his/her facility stay or course of treatment

ARTICLE IV - SUBMISSION OF COST REPORTS

4.1. Providers delineated by HSD who are reimbursed on a cost basis shall furnish HSD or its designee with such financial reports, audited or certified cost statements, and other substantiating data as necessary to establish a basis for reimbursement.

4.2. Cost statements or other data are to be furnished no later than 150 days following the closure of the provider's fiscal accounting period. Failure to comply with this provision will result in suspension of payment until the required statements and other data are provided.

ARTICLE V - STATUS OF PROVIDER

The provider, its agents, and employees are independent contractors who perform professional services for clients served through health care programs administered by HSD and are not employees of HSD. The provider shall not purport to bind HSD nor the State of New Mexico to any obligation not expressly authorized herein unless HSD has given the provider express written permission to do so.

ARTICLE VI - CHANGE IN OWNERSHIP

6.1. As soon as possible, but at least sixty (60) days prior to a change in ownership or status, any provider must notify HSD of the proposed change in ownership. Upon completion of the transfer of ownership, the initial provider participation agreement is terminated. The new owner must complete and receive approval of a new Medical Assistance Provider Participation Agreement before submitting any claims to HSD. Any payment by HSD on the basis of erroneous information due to the lack of notice is the responsibility of the previous provider and is subject to recoupment.

6.2. The previous owner shall be responsible for any overpayments and is entitled to receive payments from HSD up to the date of ownership transfer, unless otherwise specified in the contract for transfer of ownership.

6.3. The new owner shall furnish to HSD, upon receipt of a written request, the contract or other applicable documents specifying the terms of the change in ownership and responsibilities delineated in this Agreement.

6.4. HSD reserves the right to withhold all pending and other claims until the right to payments and/or recoupment is determined, unless the new owner agrees in writing to be liable for any recoupment or overpayment amounts.

6.5. For providers who are reimbursed on a cost basis and subject to cost settlements, HSD shall impose a lien and/or a penalty of up to ten percent (10%) of the purchase price against the previous owner until such time as the final cost settlement is completed and amounts owed, if applicable, are remitted to HSD.

ARTICLE VII - TERMINATION OF PROVIDER AGREEMENT

7.1. Provider status may be terminated without cause if the provider or HSD gives the other written notice of termination at least sixty (60) days prior to the effective date of the termination.

7.2. HSD will terminate this Agreement for cause, with thirty (30) days notice, if a provider, his/her agent, a managing employee, or any person having an ownership interest equal to five percent or greater in the health care provider:

(A) Misrepresents, by commission or omission, any information on the provider agreement enrollment form.

(B) Has previous or current exclusion, suspension, termination from, or the involuntary withdrawal from participation in a health care program administered by HSD, any other state's Medicaid program, Medicare, or any other public or private health or health insurance program.

(C) Is convicted under federal or state law of a criminal offense relating to the delivery of the goods, services, or supplies, under a health care program administered by HSD, any other state's Medicaid Program, Medicare, or any other public or private health or health insurance program.

(D) Is convicted under federal or state law of a criminal offense relating to the neglect or abuse of a patient in connection with the delivery of any goods, services, or supplies.

(E) Is convicted under federal or state law of a criminal offense relating to the unlawful manufacture, distribution, prescription or dispensing of a controlled substance.

(F) Is convicted under federal or state law of a criminal offense relating to fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct.

(G) Is convicted under federal or state law of a criminal offense punishable by imprisonment of a year or more which involved moral turpitude or acts against the elderly, children, or infirm.

(H) Is sanctioned pursuant to a violation of federal or state laws or rules relative to a health care program administered by HSD, any other state's Medicaid Program, Medicare, or any other public health care or health insurance program.

(I) Is convicted under federal or state law of a criminal offense in connection with the interference or obstruction of any investigation into any criminal offense listed in Paragraphs (C) through (H) of this subsection.

(J) Violates licensing or certification conditions or professional standards relating to the licensure or certification of health care providers or the required quality of goods, services, or supplies provided.

(K) Fails to pay recovery properly assessed or pursuant to an approved repayment schedule under a health care program administered by HSD.

7.3. Provider status may be terminated immediately, without notice, in instances in which the health and safety of clients in institutions are deemed to be in immediate jeopardy; are subject to an immediate or serious threat; or when it has been demonstrated, on the basis of reliable evidence, that a provider has committed fraud, abuse, or other illegal or sanctionable action. For purposes of this provision, institutional providers include nursing facilities, intermediate care facilities for the mentally retarded, all residential psychiatric treatment facilities, group homes, and other facility-based residential treatment programs.

7.4. HSD reserves the right to terminate this Agreement for cause as summarized in this Agreement and as delineated in Section MAD-960, SANCTIONS AND REMEDIES of the Medical Assistance Division Provider Policy Manual.

ARTICLE VIII - IMPOSITION OF SANCTIONS FOR FRAUD OR MISCONDUCT

8.1. If the provider obtains an excess payment or benefit willfully, by means of false statement, representation, concealment of any material fact, or other fraudulent scheme or devise with intent to defraud, criminal sentences and fines and/or civil monetary penalties shall be imposed pursuant to, but not limited to, the Medicaid Fraud Act, NMSA 1978, §§ 30-44-1 et seq., 42 U.S.C. § 1320a-7b, and 42 C.F.R. § 455.23.

8.2. In addition to the above criminal civil penalties, HSD may impose monetary

or non-monetary sanctions, including civil monetary penalties for provider misconduct or breach of any of the terms of this Agreement.

8.3. HSD may take any or a combination of the following actions against a provider for violation of the Medicaid Provider Act, NMSA 1978 §§ 27-11-1 et seq.:

(A) Imposition of an administrative penalty of not more than \$5,000 for engaging in any practice that violates the Act; each separate occurrence of such practice constitutes a separate offense;

(B) Issue an administrative order requiring the provider to (1) cease or modify any specified conduct or practices engaged in by it or its employees, subcontractors, or agents; (2) fulfill its contractual obligations in the manner specified in the order; (3) provide any service that has been denied; (4) take steps to provide or arrange for any services that it has agreed or is otherwise obligated to make available; or (5) enter into and abide by the terms of binding or nonbinding arbitration proceeding, if agreed to by any opposing parties; or

(C) Suspend or revoke this Agreement.

8.4. HSD may elect to pursue one or a combination of all the delineated sanctions, as applicable.

ARTICLE IX - REFUSAL TO EXECUTE AN AGREEMENT

HSD will not execute an Agreement with a provider if the provider, his/her agent, managing employee, or any person having an ownership interest equal to five percent (5%) or greater in the health care provider commits or has committed any of the violations listed in Article 7.2. of this Agreement or other provisions delineated in Section MAD-960, REMEDIES AND SANCTIONS of the MAD Provider Policy Manual.

ARTICLE X - RECIPIENT FUND ACCOUNT

Nursing facilities, swing bed hospitals, and intermediate care facilities for the mentally retarded shall establish and maintain an acceptable system of accounting for recipients' personal funds, in the manner prescribed by HSD, in those cases in which clients entrust their personal funds to the facility.

ARTICLE XI - PRECONDITION FOR PARTICIPATION

The provider understands that signing this Agreement is a precondition for participating in health care programs administered by HSD. A provider understands that the provision of services, billing of services, and receipt of payments for services

cannot occur until this Agreement is completed by the provider and approved for execution by HSD.

ARTICLE XII - NO WAIVERS

No terms or provisions of this Agreement shall be deemed waived and no breach excused, unless such waiver or consent shall be in writing and executed by the party claiming to have waived or consented.

ARTICLE XIII - APPLICABLE LAW

This Agreement shall be governed by the laws of the State of New Mexico. All legal proceedings arising from unresolved disputes under this Agreement are subject to administrative and judicial review as provided for in MAD-980, PROVIDER HEARING, of the MAD Provider Policy Manual.

ARTICLE XIV - ASSIGNMENT

The provider shall not assign or transfer any obligation, duty, or other interest in this Agreement, nor assign any claim for monies due under this Agreement without authorization of HSD. Any assignment or transfer which is not authorized by HSD shall be void.

ARTICLE XV - INDEMNIFICATION

The provider shall indemnify, defend, and hold harmless the State, HSD, its agents, and employees from any and all actions, proceedings, claims, demands, costs, damages, and attorney's fees, from all liabilities or expenses of any kind from any sources accruing to or resulting from the provider or its employees in connection with the performance of this Agreement and from all claims of any person or entity that may be directly or indirectly injured or damaged by the provider or its employees in the performance of this Agreement.

ARTICLE XVI - ENTIRE AGREEMENT

This Agreement incorporates all the agreements, covenants, and understandings between the parties hereto concerning the subject matter contained in this Agreement, and all such covenants, agreements, and understandings have been merged into this Agreement. No prior agreements, covenants, or understandings, either verbal or otherwise, of the parties or their agents shall be valid or enforceable unless contained in this Agreement.

This Agreement shall not be altered, changed, revised, or amended except by written instrument executed by the parties in the same manner as in this Agreement. Amendments shall contain an

effective date. Any amendments to this Agreement shall not be binding upon either party until approved in writing by HSD.

New Mexico Medicaid project staff may need to contact you regarding the completion of this form. Please list contact person and telephone number.

Contact Person:

Telephone Number:

BY SIGNATURE, THE PROVIDER AGREES TO ABIDE BY AND BE HELD TO ALL FEDERAL, STATE, AND LOCAL LAWS, RULES, AND REGULATIONS, INCLUDING, BUT NOT LIMITED TO THOSE PERTAINING TO MEDICAID AND THOSE STATED HEREIN. BY SIGNATURE, THE PROVIDER SOLEMNLY SWEARS UNDER PENALTY OF PERJURY THAT THE INFORMATION GIVEN IS TRUE AND ACCURATE.

Provider Name	Title - (If applicable)	
Signature (Original - Blue ink)		Date

HUMAN SERVICES DEPARTMENT APPROVAL

APPROVED NOT APPROVED

Reasons Not Approved:

.....

Dates of Agreement: From _____ To: _____

Authorized Signature		
Title		Date
ENTER QUANTITIES:	SNF / NF Beds	NF Beds
		ICF Beds
Subject to Automatic Cancellation - Based upon revisit and correction of deficiencies		Date

FOR HUMAN SERVICES DEPARTMENT USE ONLY

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Request for Taxpayer Identification Number and Certification

**Give Form to the
requester. Do not
send to the IRS.**

Print or type See Specific Instructions on page 2.	Name (as shown on your income tax return)	
	Business name/disregarded entity name, if different from above	
	Check appropriate box for federal tax classification (required): <input type="checkbox"/> Individual/sole proprietor <input type="checkbox"/> C Corporation <input type="checkbox"/> S Corporation <input type="checkbox"/> Partnership <input type="checkbox"/> Trust/estate	
	<input type="checkbox"/> Limited liability company. Enter the tax classification (C=C corporation, S=S corporation, P=partnership) ▶ _____	
	<input type="checkbox"/> Other (see instructions) ▶ _____	
Address (number, street, and apt. or suite no.)		Requester's name and address (optional)
City, state, and ZIP code		
List account number(s) here (optional)		

Part I Taxpayer Identification Number (TIN)	Social security number																							
Enter your TIN in the appropriate box. The TIN provided must match the name given on the "Name" line to avoid backup withholding. For individuals, this is your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the Part I instructions on page 3. For other entities, it is your employer identification number (EIN). If you do not have a number, see <i>How to get a TIN</i> on page 3.	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> </tr> <tr> <td colspan="3"></td> <td style="text-align: center;">-</td> <td colspan="3"></td> <td style="text-align: center;">-</td> <td colspan="3"></td> </tr> </table>																-				-			
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Part II Certification
Under penalties of perjury, I certify that:
1. 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 2. 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 3. I am a U.S. citizen or other U.S. person (defined below).
Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the certification, but you must provide your correct TIN. See the instructions on page 4.

Sign Here	Signature of U.S. person ▶	Date ▶
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General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

Purpose of Form

A person who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) to report, for example, income paid to you, real estate transactions, mortgage interest you paid, acquisition or abandonment of secured property, cancellation of debt, or contributions you made to an IRA.

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN to the person requesting it (the requester) and, when applicable, to:

1. Certify that the TIN you are giving is correct (or you are waiting for a number to be issued),
2. Certify that you are not subject to backup withholding, or
3. Claim exemption from backup withholding if you are a U.S. exempt payee. If applicable, you are also certifying that as a U.S. person, your allocable share of any partnership income from a U.S. trade or business is not subject to the withholding tax on foreign partners' share of effectively connected income.

Note. If a requester gives you a form other than Form W-9 to request your TIN, you must use the requester's form if it is substantially similar to this Form W-9.

Definition of a U.S. person. For federal tax purposes, you are considered a U.S. person if you are:

- An individual who is a U.S. citizen or U.S. resident alien,
- A partnership, corporation, company, or association created or organized in the United States or under the laws of the United States,
- An estate (other than a foreign estate), or
- A domestic trust (as defined in Regulations section 301.7701-7).

Special rules for partnerships. Partnerships that conduct a trade or business in the United States are generally required to pay a withholding tax on any foreign partners' share of income from such business. Further, in certain cases where a Form W-9 has not been received, a partnership is required to presume that a partner is a foreign person, and pay the withholding tax. Therefore, if you are a U.S. person that is a partner in a partnership conducting a trade or business in the United States, provide Form W-9 to the partnership to establish your U.S. status and avoid withholding on your share of partnership income.

The person who gives Form W-9 to the partnership for purposes of establishing its U.S. status and avoiding withholding on its allocable share of net income from the partnership conducting a trade or business in the United States is in the following cases:

- The U.S. owner of a disregarded entity and not the entity,
- The U.S. grantor or other owner of a grantor trust and not the trust, and
- The U.S. trust (other than a grantor trust) and not the beneficiaries of the trust.

Foreign person. If you are a foreign person, do not use Form W-9. Instead, use the appropriate Form W-8 (see Publication 515, Withholding of Tax on Nonresident Aliens and Foreign Entities).

Nonresident alien who becomes a resident alien. Generally, only a nonresident alien individual may use the terms of a tax treaty to reduce or eliminate U.S. tax on certain types of income. However, most tax treaties contain a provision known as a "saving clause." Exceptions specified in the saving clause may permit an exemption from tax to continue for certain types of income even after the payee has otherwise become a U.S. resident alien for tax purposes.

If you are a U.S. resident alien who is relying on an exception contained in the saving clause of a tax treaty to claim an exemption from U.S. tax on certain types of income, you must attach a statement to Form W-9 that specifies the following five items:

1. The treaty country. Generally, this must be the same treaty under which you claimed exemption from tax as a nonresident alien.
2. The treaty article addressing the income.
3. The article number (or location) in the tax treaty that contains the saving clause and its exceptions.
4. The type and amount of income that qualifies for the exemption from tax.
5. Sufficient facts to justify the exemption from tax under the terms of the treaty article.

Example. Article 20 of the U.S.-China income tax treaty allows an exemption from tax for scholarship income received by a Chinese student temporarily present in the United States. Under U.S. law, this student will become a resident alien for tax purposes if his or her stay in the United States exceeds 5 calendar years. However, paragraph 2 of the first Protocol to the U.S.-China treaty (dated April 30, 1984) allows the provisions of Article 20 to continue to apply even after the Chinese student becomes a resident alien of the United States. A Chinese student who qualifies for this exception (under paragraph 2 of the first protocol) and is relying on this exception to claim an exemption from tax on his or her scholarship or fellowship income would attach to Form W-9 a statement that includes the information described above to support that exemption.

If you are a nonresident alien or a foreign entity not subject to backup withholding, give the requester the appropriate completed Form W-8.

What is backup withholding? Persons making certain payments to you must under certain conditions withhold and pay to the IRS a percentage of such payments. This is called "backup withholding." Payments that may be subject to backup withholding include interest, tax-exempt interest, dividends, broker and barter exchange transactions, rents, royalties, nonemployee pay, and certain payments from fishing boat operators. Real estate transactions are not subject to backup withholding.

You will not be subject to backup withholding on payments you receive if you give the requester your correct TIN, make the proper certifications, and report all your taxable interest and dividends on your tax return.

Payments you receive will be subject to backup withholding if:

1. You do not furnish your TIN to the requester,
2. You do not certify your TIN when required (see the Part II instructions on page 3 for details),
3. The IRS tells the requester that you furnished an incorrect TIN,
4. The IRS tells you that you are subject to backup withholding because you did not report all your interest and dividends on your tax return (for reportable interest and dividends only), or
5. You do not certify to the requester that you are not subject to backup withholding under 4 above (for reportable interest and dividend accounts opened after 1983 only).

Certain payees and payments are exempt from backup withholding. See the instructions below and the separate Instructions for the Requester of Form W-9.

Also see *Special rules for partnerships* on page 1.

Updating Your Information

You must provide updated information to any person to whom you claimed to be an exempt payee if you are no longer an exempt payee and anticipate receiving reportable payments in the future from this person. For example, you may need to provide updated information if you are a C corporation that elects to be an S corporation, or if you no longer are tax exempt. In addition, you must furnish a new Form W-9 if the name or TIN changes for the account, for example, if the grantor of a grantor trust dies.

Penalties

Failure to furnish TIN. If you fail to furnish your correct TIN to a requester, you are subject to a penalty of \$50 for each such failure unless your failure is due to reasonable cause and not to willful neglect.

Civil penalty for false information with respect to withholding. If you make a false statement with no reasonable basis that results in no backup withholding, you are subject to a \$500 penalty.

Criminal penalty for falsifying information. Willfully falsifying certifications or affirmations may subject you to criminal penalties including fines and/or imprisonment.

Misuse of TINs. If the requester discloses or uses TINs in violation of federal law, the requester may be subject to civil and criminal penalties.

Specific Instructions

Name

If you are an individual, you must generally enter the name shown on your income tax return. However, if you have changed your last name, for instance, due to marriage without informing the Social Security Administration of the name change, enter your first name, the last name shown on your social security card, and your new last name.

If the account is in joint names, list first, and then circle, the name of the person or entity whose number you entered in Part I of the form.

Sole proprietor. Enter your individual name as shown on your income tax return on the "Name" line. You may enter your business, trade, or "doing business as (DBA)" name on the "Business name/disregarded entity name" line.

Partnership, C Corporation, or S Corporation. Enter the entity's name on the "Name" line and any business, trade, or "doing business as (DBA) name" on the "Business name/disregarded entity name" line.

Disregarded entity. Enter the owner's name on the "Name" line. The name of the entity entered on the "Name" line should never be a disregarded entity. The name on the "Name" line must be the name shown on the income tax return on which the income will be reported. For example, if a foreign LLC that is treated as a disregarded entity for U.S. federal tax purposes has a domestic owner, the domestic owner's name is required to be provided on the "Name" line. If the direct owner of the entity is also a disregarded entity, enter the first owner that is not disregarded for federal tax purposes. Enter the disregarded entity's name on the "Business name/disregarded entity name" line. If the owner of the disregarded entity is a foreign person, you must complete an appropriate Form W-8.

Note. Check the appropriate box for the federal tax classification of the person whose name is entered on the "Name" line (Individual/sole proprietor, Partnership, C Corporation, S Corporation, Trust/estate).

Limited Liability Company (LLC). If the person identified on the "Name" line is an LLC, check the "Limited liability company" box only and enter the appropriate code for the tax classification in the space provided. If you are an LLC that is treated as a partnership for federal tax purposes, enter "P" for partnership. If you are an LLC that has filed a Form 8832 or a Form 2553 to be taxed as a corporation, enter "C" for C corporation or "S" for S corporation. If you are an LLC that is disregarded as an entity separate from its owner under Regulation section 301.7701-3 (except for employment and excise tax), do not check the LLC box unless the owner of the LLC (required to be identified on the "Name" line) is another LLC that is not disregarded for federal tax purposes. If the LLC is disregarded as an entity separate from its owner, enter the appropriate tax classification of the owner identified on the "Name" line.

Other entities. Enter your business name as shown on required federal tax documents on the "Name" line. This name should match the name shown on the charter or other legal document creating the entity. You may enter any business, trade, or DBA name on the "Business name/disregarded entity name" line.

Exempt Payee

If you are exempt from backup withholding, enter your name as described above and check the appropriate box for your status, then check the "Exempt payee" box in the line following the "Business name/disregarded entity name," sign and date the form.

Generally, individuals (including sole proprietors) are not exempt from backup withholding. Corporations are exempt from backup withholding for certain payments, such as interest and dividends.

Note. If you are exempt from backup withholding, you should still complete this form to avoid possible erroneous backup withholding.

The following payees are exempt from backup withholding:

1. An organization exempt from tax under section 501(a), any IRA, or a custodial account under section 403(b)(7) if the account satisfies the requirements of section 401(f)(2),
 2. The United States or any of its agencies or instrumentalities,
 3. A state, the District of Columbia, a possession of the United States, or any of their political subdivisions or instrumentalities,
 4. A foreign government or any of its political subdivisions, agencies, or instrumentalities, or
 5. An international organization or any of its agencies or instrumentalities.
- Other payees that may be exempt from backup withholding include:
6. A corporation,
 7. A foreign central bank of issue,
 8. A dealer in securities or commodities required to register in the United States, the District of Columbia, or a possession of the United States,
 9. A futures commission merchant registered with the Commodity Futures Trading Commission,
 10. A real estate investment trust,
 11. An entity registered at all times during the tax year under the Investment Company Act of 1940,
 12. A common trust fund operated by a bank under section 584(a),
 13. A financial institution,
 14. A middleman known in the investment community as a nominee or custodian, or
 15. A trust exempt from tax under section 664 or described in section 4947.

The following chart shows types of payments that may be exempt from backup withholding. The chart applies to the exempt payees listed above, 1 through 15.

IF the payment is for . . .	THEN the payment is exempt for . . .
Interest and dividend payments	All exempt payees except for 9
Broker transactions	Exempt payees 1 through 5 and 7 through 13. Also, C corporations.
Barter exchange transactions and patronage dividends	Exempt payees 1 through 5
Payments over \$600 required to be reported and direct sales over \$5,000 ¹	Generally, exempt payees 1 through 7 ²

¹ See Form 1099-MISC, Miscellaneous Income, and its instructions.
² However, the following payments made to a corporation and reportable on Form 1099-MISC are not exempt from backup withholding: medical and health care payments, attorneys' fees, gross proceeds paid to an attorney, and payments for services paid by a federal executive agency.

Part I. Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. If you are a resident alien and you do not have and are not eligible to get an SSN, your TIN is your IRS individual taxpayer identification number (ITIN). Enter it in the social security number box. If you do not have an ITIN, see *How to get a TIN* below.

If you are a sole proprietor and you have an EIN, you may enter either your SSN or EIN. However, the IRS prefers that you use your SSN.

If you are a single-member LLC that is disregarded as an entity separate from its owner (see *Limited Liability Company (LLC)* on page 2), enter the owner's SSN (or EIN, if the owner has one). Do not enter the disregarded entity's EIN. If the LLC is classified as a corporation or partnership, enter the entity's EIN.

Note. See the chart on page 4 for further clarification of name and TIN combinations.

How to get a TIN. If you do not have a TIN, apply for one immediately. To apply for an SSN, get Form SS-5, Application for a Social Security Card, from your local Social Security Administration office or get this form online at www.ssa.gov. You may also get this form by calling 1-800-772-1213. Use Form W-7, Application for IRS Individual Taxpayer Identification Number, to apply for an ITIN, or Form SS-4, Application for Employer Identification Number, to apply for an EIN. You can apply for an EIN online by accessing the IRS website at www.irs.gov/businesses and clicking on Employer Identification Number (EIN) under Starting a Business. You can get Forms W-7 and SS-4 from the IRS by visiting IRS.gov or by calling 1-800-TAX-FORM (1-800-829-3676).

If you are asked to complete Form W-9 but do not have a TIN, write "Applied For" in the space for the TIN, sign and date the form, and give it to the requester. For interest and dividend payments, and certain payments made with respect to readily tradable instruments, generally you will have 60 days to get a TIN and give it to the requester before you are subject to backup withholding on payments. The 60-day rule does not apply to other types of payments. You will be subject to backup withholding on all such payments until you provide your TIN to the requester.

Note. Entering "Applied For" means that you have already applied for a TIN or that you intend to apply for one soon.

Caution: A disregarded domestic entity that has a foreign owner must use the appropriate Form W-8.

Part II. Certification

To establish to the withholding agent that you are a U.S. person, or resident alien, sign Form W-9. You may be requested to sign by the withholding agent even if Item 1, below, and items 4 and 5 on page 4 indicate otherwise.

For a joint account, only the person whose TIN is shown in Part I should sign (when required). In the case of a disregarded entity, the person identified on the "Name" line must sign. Exempt payees, see *Exempt Payee* on page 3.

Signature requirements. Complete the certification as indicated in items 1 through 3, below, and items 4 and 5 on page 4.

- 1. Interest, dividend, and barter exchange accounts opened before 1984 and broker accounts considered active during 1983.** You must give your correct TIN, but you do not have to sign the certification.
- 2. Interest, dividend, broker, and barter exchange accounts opened after 1983 and broker accounts considered inactive during 1983.** You must sign the certification or backup withholding will apply. If you are subject to backup withholding and you are merely providing your correct TIN to the requester, you must cross out item 2 in the certification before signing the form.
- 3. Real estate transactions.** You must sign the certification. You may cross out item 2 of the certification.

4. Other payments. You must give your correct TIN, but you do not have to sign the certification unless you have been notified that you have previously given an incorrect TIN. "Other payments" include payments made in the course of the requester's trade or business for rents, royalties, goods (other than bills for merchandise), medical and health care services (including payments to corporations), payments to a nonemployee for services, payments to certain fishing boat crew members and fishermen, and gross proceeds paid to attorneys (including payments to corporations).

5. Mortgage interest paid by you, acquisition or abandonment of secured property, cancellation of debt, qualified tuition program payments (under section 529), IRA, Coverdell ESA, Archer MSA or HSA contributions or distributions, and pension distributions. You must give your correct TIN, but you do not have to sign the certification.

Note. If no name is circled when more than one name is listed, the number will be considered to be that of the first name listed.

Secure Your Tax Records from Identity Theft

Identity theft occurs when someone uses your personal information such as your name, social security number (SSN), or other identifying information, without your permission, to commit fraud or other crimes. An identity thief may use your SSN to get a job or may file a tax return using your SSN to receive a refund.

To reduce your risk:

- Protect your SSN,
- Ensure your employer is protecting your SSN, and
- Be careful when choosing a tax preparer.

If your tax records are affected by identity theft and you receive a notice from the IRS, respond right away to the name and phone number printed on the IRS notice or letter.

If your tax records are not currently affected by identity theft but you think you are at risk due to a lost or stolen purse or wallet, questionable credit card activity or credit report, contact the IRS Identity Theft Hotline at 1-800-908-4490 or submit Form 14039.

For more information, see Publication 4535, Identity Theft Prevention and Victim Assistance.

Victims of identity theft who are experiencing economic harm or a system problem, or are seeking help in resolving tax problems that have not been resolved through normal channels, may be eligible for Taxpayer Advocate Service (TAS) assistance. You can reach TAS by calling the TAS toll-free case intake line at 1-877-777-4778 or TTY/TDD 1-800-829-4059.

Protect yourself from suspicious emails or phishing schemes. Phishing is the creation and use of email and websites designed to mimic legitimate business emails and websites. The most common act is sending an email to a user falsely claiming to be an established legitimate enterprise in an attempt to scam the user into surrendering private information that will be used for identity theft.

The IRS does not initiate contacts with taxpayers via emails. Also, the IRS does not request personal detailed information through email or ask taxpayers for the PIN numbers, passwords, or similar secret access information for their credit card, bank, or other financial accounts.

If you receive an unsolicited email claiming to be from the IRS, forward this message to phishing@irs.gov. You may also report misuse of the IRS name, logo, or other IRS property to the Treasury Inspector General for Tax Administration at 1-800-366-4484. You can forward suspicious emails to the Federal Trade Commission at: spam@uce.gov or contact them at www.ftc.gov/idtheft or 1-877-IDTHEFT (1-877-438-4338).

Visit IRS.gov to learn more about identity theft and how to reduce your risk.

What Name and Number To Give the Requester

For this type of account:	Give name and SSN of:
1. Individual	The individual
2. Two or more individuals (joint account)	The actual owner of the account or, if combined funds, the first individual on the account ¹
3. Custodian account of a minor (Uniform Gift to Minors Act)	The minor ²
4. a. The usual revocable savings trust (grantor is also trustee)	The grantor-trustee ¹
b. So-called trust account that is not a legal or valid trust under state law	The actual owner ¹
5. Sole proprietorship or disregarded entity owned by an individual	The owner ³
6. Grantor trust filing under Optional Form 1099 Filing Method 1 (see Regulation section 1.671-4(b)(2)(i)(A))	The grantor*
For this type of account:	Give name and EIN of:
7. Disregarded entity not owned by an individual	The owner
8. A valid trust, estate, or pension trust	Legal entity ⁴
9. Corporation or LLC electing corporate status on Form 8832 or Form 2553	The corporation
10. Association, club, religious, charitable, educational, or other tax-exempt organization	The organization
11. Partnership or multi-member LLC	The partnership
12. A broker or registered nominee	The broker or nominee
13. Account with the Department of Agriculture in the name of a public entity (such as a state or local government, school district, or prison) that receives agricultural program payments	The public entity
14. Grantor trust filing under the Form 1041 Filing Method or the Optional Form 1099 Filing Method 2 (see Regulation section 1.671-4(b)(2)(i)(B))	The trust

¹ List first and circle the name of the person whose number you furnish. If only one person on a joint account has an SSN, that person's number must be furnished.

² Circle the minor's name and furnish the minor's SSN.

³ You must show your individual name and you may also enter your business or "DBA" name on the "Business name/disregarded entity" name line. You may use either your SSN or EIN (if you have one), but the IRS encourages you to use your SSN.

⁴ List first and circle the name of the trust, estate, or pension trust. (Do not furnish the TIN of the personal representative or trustee unless the legal entity itself is not designated in the account title.) Also see *Special rules for partnerships* on page 1.

*Note. Grantor also must provide a Form W-9 to trustee of trust.

Privacy Act Notice

Section 6109 of the Internal Revenue Code requires you to provide your correct TIN to persons (including federal agencies) who are required to file information returns with the IRS to report interest, dividends, or certain other income paid to you; mortgage interest you paid; the acquisition or abandonment of secured property; the cancellation of debt; or contributions you made to an IRA, Archer MSA, or HSA. The person collecting this form uses the information on the form to file information returns with the IRS, reporting the above information. Routine uses of this information include giving it to the Department of Justice for civil and criminal litigation and to cities, states, the District of Columbia, and U.S. possessions for use in administering their laws. The information also may be disclosed to other countries under a treaty, to federal and state agencies to enforce civil and criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism. You must provide your TIN whether or not you are required to file a tax return. Under section 3406, payers must generally withhold a percentage of taxable interest, dividend, and certain other payments to a payee who does not give a TIN to the payer. Certain penalties may also apply for providing false or fraudulent information.

New Request Renewal Request

DDSD REQUEST FOR SUBCONTRACT APPROVAL FORM

(If this form is being filled out by hand please **PRINT** clearly, those not legible will be sent back)

1. Requesting Agency:

Address Contact Person

City State Zip Code Phone Number Fax Number

DATE SUBMITTED TO DDSD **Section 3 (below) must be completed and this form must be returned to DDSD once Subcontractor is no longer employed with your agency .**

2. Name of Proposed Subcontractor:

Address Phone Number SSN

City State Zip Code (last 4-digits)

Employee Start Date (for new hires) Other DD or MF Provider Agency(ies) this Subcontractor is employed or Subcontracting with:

Does this Subcontractor have Professional Licensure/Certification: YES NO

License # Licensing Agency

License Expiration Date

3. Employment End Date Would you Rehire/Subcontract with this person Yes No

If not please include reason below:

Complete the information below. It is the sole responsibility of the provider to ensure the subcontractor is in compliance with all licensing , Medicaid & DDSD requirements including but not limited to, insurance requirements, professional licensure, degree, qualifications, experience, caregiver's criminal screening clearance, financial requirements , experience, resume & transcripts.

Program <input checked="" type="checkbox"/> Mark service below	Service	Justification: Describe why the provider agency is unable to perform the Scope of Work with existing staff.	Effective Dates		Amount \$
			Start	End	
<input type="checkbox"/> DD	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="checkbox"/> MF	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

5. **BT Only- Please place an (x) on the training(s) that the proposed or renewing BT subcontractor has attended.** For those training(s) not checked, please fill in date when training(s) will be completed or scheduled.

1). Positive Team Approach to the Development of Behavioral Supports Date Attended/Date Scheduled

2). Sexuality Training Date Attended/Date Scheduled

Authorized Provider Signature

INFORMATION BELOW IS COMPLETED BY DDSD (FOR OFFICIAL USE ONLY):

Date of Review: _____ APPROVED Comments: _____

DOH Signature: _____ DENIED _____

DDSD STATEMENT OF ASSURANCES

(Failure to comply with all DDSD Statement of Assurances may result in Department of Health sanctions, up to and including a reduction in the term of the provider agreement and/or termination of the provider agreement.)

This form must be completed and signed (**in blue ink**) by the applicant. If any portion does not apply to your agency, please mark non-applicable and state reason why.

The applicant is required to assure DDSD that:

	INITIAL	DATE	N/A REASON
The provider agency will comply with the regulations for Caregivers Criminal History Screening for all employees and subcontractors of the agency. The agency must ensure that all employees and subcontractors that provide community living, adult habilitation, respite, case management, home health service, community access, non medical transportation, personal support and supported employment services must submit an application to Caregivers Criminal History Screening Program (CCHSP), no later than 20 calendar days from the first day of employment. The CCHSP can be reached at (505) 476-0801 or http://dhi.health.state.nm.us/ .			
The provider agency will ensure that all employees and subcontractors hired on or after 1/1/06, do not appear on the Employee Abuse Registry, prior to the first day of their employment. This applies to all employees except for licensed professionals practicing within the scope of their license. To obtain an access code and user name, please contact the Division of Health Improvement at (505) 476-0801.			
The provider agency will maintain current annual financial reports as required in Article 13 of the provider agreement.			
The provider agency will maintain current professional licensure of all professional staff at the provider agency as required in Article 14 of the provider agreement.			
The provider agency will comply with DDSD Training requirements.			
The provider agency will ensure that all agency staff participate and coordinate in IDT meetings for individuals receiving services by the Agency in accordance with DDSD Service Standards.			
The provider agency will ensure that all Individual Service Plan (ISP) will be implemented in accordance with the DDSD Service Standards,			
The provider agency will comply with all required regulations, service standards and policy and procedures.			
The provider agency will comply with the DDSD CST-150 Policy.			
The provider agency will maintain current insurance policies at the provider location with DOH named as an additional insured as required in the provider agreement.			
The provider agency will submit a current list of each Board Member's name, home address, phone number and email address to the Provider Enrollment Unit (PEU) annually.			
If applicable, the MF waiver provider will maintain current certificates for licensed health facilities.			

COMMUNITY INCLUSION PROVIDERS			
1. Promote and encourage the Employment First principle as stated in the Employment First Principle of the 2007 DD Waiver Service Standards page 59, Chapter 5, III A.			
2. Encourage and promote a uniquely meaningful day for each individual served			
3. Will promote competitive community jobs or self-employment, which would pay at least minimum wage or higher.			
4. Will ensure each individual is respected, offered age appropriate and non-stigmatizing opportunities.			
5. Will recruit and retain qualified employees.			
6. Will make timely referrals and use of Division of Vocational Rehabilitation Services as specified in the Developmental Disabilities Waiver Service Standards.			
COMMUNITY LIVING PROVIDERS			
1. Will ensure completion of an approved home study and training prior to placement of individuals.			
2. Complete all DDS requirements for approval of each direct support provider.			
3. Will notify DDS/PEU if there is a change in nursing staff.			
4. As applicable, ensure that all health related assessments are completed and updated for all individuals served as required in the DDS service standards.			
5. Will maintain a Residence Case File as required by the DDS services standards			
ENVIRONMENTAL MODIFICATION PROVIDERS			
The provider agency will take responsibility for any subcontractors hired by the Environmental Modification Provider to complete jobs.			

IMPORTANT (Failure to comply with all DDS Statement of Assurances may result in Department of Health sanctions, up to and including a reduction in the term of the provider agreement and/or termination of the provider agreement.)

Provider Signature and Title

Date

PROVIDER AGENCY STATUS SHEET

Please tell us how many individuals you serve in each service, in each region you are approved to provide services in. (You may attach a separate sheet if needed)

What was the date of your last QMB Audit? _____

What was your last QMB audit rating and what were the major issues?

Has your Agency been referred to the Internal Review Committee?
Yes or No If so, when and why?

Has your Agency ever been placed on a State Imposed Moratorium?
Yes or No If so, when and why?

Has the Regional Office placed your Agency on a Performance Improvement Plan?
Yes or No If so, when and why?

How would you rate your Agencies current your financial position?
