MISSOURI DEPARTMENT OF SOCIAL SERVICES
MISSOURI MEDICAID AUDIT AND COMPLIANCE
ADULT DAY CARE ASSURANCES

Questions #1, #2 and #3 must be answered. Disclose all associations with any currently enrolled provider(s) under #1 and previous enrolled provider(s) under #2. If the question does apply write N/A; if disclosing - include the individuals names, provider(s) name and type of service

LEGAL PROVIDER NAME AS FILED WITH THE IRS AND SECRETARY OF STATE, INCLUDING DBA NAME (SOLE PROPRIETORS, INCLUDE NAME AND DBA NAME)
1. Disclose all persons, individuals or business entities identified within the application or involved with the applying provider that **are currently enrolled** with the Missouri Medicaid Audit and Compliance Unit (MMAC) or Department of Health and Senior Services (DHSS), Division of Senior and Disability Services (DSDS) (hereafter state agencies) to provide any other service. List the type of service and the name of the company. If revalidating - disclose current enrollment here
2. Disclose all persons, individuals or business entities identified within the application or involved with the business entity that **have been previously (no longer) enrolled** with the state agencies. List the name of the company and the position held.
3. Disclose all persons, individuals or business entities identified within the application or involved with the business entity that have been sanctioned, suspended, terminated from participation, or denied enrollment in Medicaid, Medicare, SSBG/GR, or any other government public assistance program.
4. Applying provider understands and agrees to notify MMAC Provider Enrollment Unit via the Change Request form (http://mmac.mo.gov/providers/provider-enrollment/home-and-community-based-services/provider-contracts-forms/) of changes in the exact street address, telephone number or business hours in compliance with 2.3 of the Program Requirements.
5. Applying provider understands and agrees to maintain an e-mail account that is known to MMAC in order to communicate with the state agencies. Applying provider further understands and agrees to check the e-mail account periodically throughout each business day.
6. Applying provider understands and agrees to comply with all applicable federal and state laws including laws authorizing or governing the use of federal funds paid to the adult day care through the adult day care program.
7. Applying provider understands and agrees to comply with all applicable rules and laws administered by the Occupational Safety and Health Administration (OSHA), including the provision of medical supplies to ensure universal precautions, including, but not limited to, gloves.
8. Applying provider understands and agrees to comply with all applicable Health Insurance Portability and Accountability Act of 1996 (HIPAA) regulations and all amendments thereafter.
9. Applying provider understands and agrees to comply with requirements of the E-Verify federal work authorization program. Information regarding E-Verify is available at http://www.dhs.gov/files/programs/gc_1185221678150.shtm
10. The applying vendor understands and agrees that denial of Medicaid enrollment is the sole decision of MMAC. Decisions are made based on a variety of information including the application, site visit, past contractual performance, etc. and are not appealable to the Administrative Hearing Commission.

Affirmation	
On behalf of the applying provider, I affirm the applying provider will comply with all requirements outlined in this document (Adult Day Care Assurances). I further affirm that all documents and information submitted pursuant to this application are true and correct to the best of my knowledge and belief and that all required documents are included with this application. I further affirm I am an individual or the representative of the applying provider and am the duly authorized agent to execute this document on behalf of the applying provider under authority granted by said applying provider.	
LEGAL PROVIDER NAME AS FILED WITH THE IRS AND SECRETARY OF STATE, INCLUDING DBA NAME (SOLE PROPRIETORS, INCLUDE NAME AND DBA NAME)	
FEDERAL EMPLOYER IDENTIFICATION NUMBER (FEIN)	TELEPHONE NUMBER
SIGNATURE OF AUTHORIZED REPRESENTATIVE	TITLE OF AUTHORIZED REPRESENTATIVE
TYPED OR PRINTED NAME OF AUTHORIZED REPRESENTATIVE	DATE

Missouri Medicaid Audit and Compliance
Provider Enrollment Unit
3418 Knipp Drive, Suite F
Jefferson City, MO 65109

mmac.ihscontracts@dss.mo.gov

FAX: 573-634-3105