603-PA#_____

State of Alaska
Department of Health and Social Services
Division of Behavioral Health
Grants & Contracts Support Team
P.O. Box 110650, Juneau, AK 99811-0650
(Attachment #2 to FY16-18 RFP)

INDIVIDUALIZED SERVICE AND RESIDENTIAL CARE FOR CHILDREN AND YOUTH PROVIDER AGREEMENT

_____, (Provider) enters into a Provider Agreement with the State of Alaska, Department of Health & Social Services (the Department) for the purpose of providing Individualized Services for referred clients of the Division of Behavioral Health (DBH), Office of Children's Services (OCS), the Division of Juvenile Justice (DJJ) and self-referred individuals for the State of Alaska's Residential Care for Children and Youth (RCCY) Program. By entering into this Provider Agreement, the Provider agrees to maintain, in good standing, the Core Services Grant Agreement required for the provision of services under this Provider Agreement, as well as the following requirements, including all applicable provisions of the following Appendices:

APPENDICES:

A. 7 AAC 81, Grant Services for Individuals, Revised 6/23/06
B. AS 47.05 (Administration of Welfare, Social Services and Institutions); AS 47.07 (Medical Assistance for Needy Persons); AS 47.10 (Children in Need of Aid); AS 47.12 (Delinquent Minors); AS 47.14 (Juvenile Programs and Institutions); 7 AAC 43 (Medical Assistance, Behavioral Rehabilitation Services (BRS); 7 AAC 50 (Community Care Licensing); and 7 AAC 53 (Social Services), appended by reference. Current Alaska Statute and Regulation can be found online in the State's Document Library and Legal Resources at: http://www.law.state.ak.us/doclibrary/doclib.html.
C. Privacy & Security Procedures for Providers
D. Resolution for Alaska Native Entities (if applicable).

ATTACHMENTS:

The Alaska Department of Health and Social Services' BRS Handbook: http://dhss.alaska.gov/dbh/Documents/TreatmentRecovery/RBRS%20Documents/BRS%20Handbook%2010-28-13.pdf

Residential Care Forms available at: http://dhss.alaska.gov/dbh/Pages/Residentialcare

I. PROVIDER ELIGIBILITY

The Provider agrees to the provisions of 7 AAC 81(Grant Services for Individuals), and all other applicable State and Federal laws; and declares and represents that it meets the eligibility requirements for a services provider for this Agreement by meeting and maintaining these established criteria:

A. Proof of a Federal Tax ID Number;
B. A current State of Alaska Business License;
C. A current Residential Child Care License in good standing for each facility associated with this Provider Agreement;
D. Alaska Native entities entering into a Provider Agreement with the Department agree to provide a waiver of immunity from suit for claims arising out of the activities of the Provider related to this Agreement using Attachment 2 to this Request for Proposals.
F. Providers agree to the provisions of the Privacy & Security Procedures (Appendix C).
G. Eligibility to receive funds under this Provider Agreement is dependent upon the Provider maintaining the core services grant under 7 AAC 78 (Grant Programs) in good standing.

The Provider further agrees they will provide care for Department clients who are referred for placement and will maintain compliance with the laws governing services provided under this agreement which include citations referenced in Appendices A and B of this Agreement.

II. DESCRIPTION OF SERVICES

The purpose of the Provider Agreement is to provide care for RCCY clients in situations where State General Funds (rather than BRS Medicaid funds) are used to provide services for referred children and youth.

BRS Medicaid eligible services will be direct billed by RCCY grantees, not by or to the Department.

The funding provided under this Agreement targets:

1. children and youth in, or in need of, potential residential care (see Section IV, Billing, subsection A);
2. children who are five years or younger (not diagnosed using the DC (Diagnostic Criteria)0-3;
3. additional staffing expenses (see Section IV, Billing, subsection B); and
4. non-Medicaid payments for beds to maintain the placement when a child/youth is away for an allowable reason.

III. CLIENT ELIGIBILITY

Clients eligible for this Agreement are those who meet the criteria for the level of service being provided by the facility in which they reside, or who can use the services to attempt to avoid residential placement, or for assistance with discharge or step-down service costs. The clients may be in the custody of the State; however non-custody children may also be eligible if they meet the criteria outlined in the BRS Handbook, qualify for diversion or step-down with a referral from DBH, custody agency personnel, or a community reference. Funds under this Provider Agreement do not cover services that Medicaid or other insurance will pay for. The RCCY Provider Agreement is a payer of last resort.

IV. BILLING

A. Individual Service Agreements.

Individual Service Agreements (ISA's) for children in, or at risk of, behavioral health residential treatment can use ISA funds to address service gaps that would otherwise prevent them from returning to and/or remaining in a community-based setting. ISA funds may also be used to assist in step-down from residential levels of care. ISA's are a payment mechanism of last resort to be used only when other funding sources have been exhausted. ISA funds reimburse expenses incurred for individual youth when approved. ISA's require pre-approval by the RCCY Program Manager, or designee, on an Individualized Service Agreement form (available at: http://dhss.alaska.gov/dbh/Pages/Residentialcare).

B. Request for Additional Funds for Children Placed in Resident Care.

When a child placed in the facility has specific needs the program cannot provide under its regular program, the RCCY Program Manager may approve, on a case-by-case basis, funding requests from grantees for temporary additional funding for staffing costs. Approval for additional funds may be provided when the request is submitted on a form provided by DBH to the OCS Residential Child Care Coordinator. Funding will not be approved for administrative expenditures. Services will be reimbursed for actual services provided. (Request for Additional Funds form available at: http://dhss.alaska.gov/dbh/Pages/Residentialcare).

Following is a description of all service fees billable through this Provider Agreement. Subject to the limitation of appropriations (7 AAC 81.220), the Division of Behavioral Health will reimburse the Provider at the daily rates found in the FY16 RCCY RFP and BRS Manual for the following services:

1. children and youth in, or in need of, potential residential care;
2. children aged five and younger (not diagnosed using Diagnostic Criteria (DC: 0-3);
3. additional staffing expenses; and
4. payments for beds to maintain the placement when a child/youth is away for an allowable reason.

In order to receive payment for services 1, 2 and 4, the Provider must submit a billing in the form of the Monthly Attendance Report (available at http://dhss.alaska.gov/dbh/Pages/Residentialcare) detailing the total number of days for each service described and the number of clients who received services to the address stated in this section. This form is due to the DBH State Office (see contact list at the end of this Provider Agreement) within five (5) days after the end of the month in which services were provided.

The form for service #3, Additional Staffing Expenses, is located at: http://dhss.alaska.gov/ocs/Documents/ResidentialCare/docs/RequestAdd%27lFunds_ChildreninResidentCare.pdf

As indicated below, each attendance category has a limit on the number of days when the full daily rate will be paid.

Providers must complete their respective Monthly Attendance Reports for all clients, including BRS Medicaid, and submit them by the fifth day of the month following the month in which the services were provided. Monthly Attendance Reports are submitted to the RCCY Program Manager or designee (see contact list). Attendance reports will be submitted for all RCCY grant facilities, and will indicate on the attendance report all client attendance, or that there were no clients if that is the case.

The following populations will be grouped and represented on their own attendance report: children in custody, community (non-custody) placements, and children ages five and younger (indicate those diagnosed through the DC 0-3 Diagnostic Criteria). Names of the children should be alphabetized on each attendance report. The attendance sheets must clearly indicate the total number of children in attendance each day and each child's status using the following codes:

[P] Present at facility and receiving BRS
[R] Runaway (up to five (5) days per incident are payable)
[V] Home Visit (up to fifteen (15) days are payable through the entire placement)
[F] Youth Facility (up to fifteen (15) days are payable through the entire placement)
[O] Other "temporary placement out of RCCY for alternative treatment" for up to fifteen (15) days per episode (in order to be reimbursed for these days, documentation of this event and its effect on the child's course of treatment is required)
[D] Discharged
[M] Medical Hospitalization - acute psychiatric or other hospital care (up to fifteen (15) days) are payable through the entire placement
[H] Hold (up to seven (7) days are payable) – when a child has been accepted for placement in the program and has an anticipated placement date

A. Hold [H] days can only be requested if the facility is at 80% capacity (80% utilization) at the time of the request. [H] days will be paid at half of the BRS daily rate if the bed was held but the child was not placed, and at the full BRS daily rate if the child was placed at the facility. All [H] days should be requested using the Authorization to Hold a Residential Childcare Facility Bed form (available at: http://dhss.alaska.gov/dbh/Pages/Residentialcare). The first seven (7) days may be approved by the corresponding regional DBH, Office of Children's Services (OCS) or Division of Juvenile Justice (DJJ) supervisor, and up to seven (7) additional days can be requested from the DBH Residential Care Program Manager. It is the responsibility of the DBH, OCS or DJJ worker to submit the request to their regional supervisor. It is the Provider's responsibility to follow up with the DBH, OCS or DJJ regional supervisor to make sure these days have been approved and submitted to DBH.

B. Fifteen (15) days maximum for combined categories of Medical Hospitalization [M], Youth Facility [F], and Home Visit [V] are payable per placement. Full payment will not be allowed when attendance categories are sequentially linked. In instances when leave from the facility is sequentially linked, the category with the maximum number of payable days will determine the total number of days full payment can be made for each category code. There must be an episode of at least one day "Present" between absence categories in order for full payment to be made. In the instance that multiple attendance categories are "run together" on an attendance report to exceed 15 days total, written

approval must be sought at the time the absence occurs from the DBH Residential Care Program Manager. When there is a need evaluate a specific child's combination of attendance and absences due to repeated patterns, the grantee should record the attendance and absences on the attendance sheet and provide the child's treatment plan. The DBH Residential Care Program Manager will review and make final approval of the number of days that will be paid. In order for a provider to receive payment for the full daily BRS rate, the child must be in one of the preceding "attendance categories", EXCEPT for Hold days, [H], which will be paid at half the BRS rate; and Discharge days, [D], which will not be reimbursed. If a youth residing in the facility does not return to the facility for any reason after inpatient treatment, detention at a facility, or after having run from placement, the Provider will not be paid for those specially coded days directly prior to the discharge.

C. If the individual treatment plan supports additional absent days in the medical, hospitalization, and youth facility categories, the program may apply for additional approved days using the Authorization for Additional Absent Days in a Residential Childcare Facility Bed form (available at http://dhss.alaska.gov/dbh/Pages/Residentialcare). Up to seven (7) days can be requested of the DBH Residential Care Program Manager. These days should be requested through the DBH Residential Care Program Manager as soon as the Provider is aware they may be necessary.

D. If services for a youth require additional staff for the safety of themselves or others, the Provider must obtain prior approval from the DBH Residential Care Program Manager for these services whenever possible. If prior approval is not reasonable, the Provider must submit the request within 48 hours of the service being initiated. The Request for Additional Funds for Children Placed in Residential Care form (available at http://dhss.alaska.gov/dbh/Pages/Residentialcare) should be used, and up to two weeks of additional funding may be granted. This type of service should not be reflected on the Monthly Attendance Report.

E. A Level II Emergency Shelter facility may not maintain a child/youth in care for longer than thirty (30) *days unless there is documentation that continued care is necessary* (7 AAC 50.610 (k) - Emergency Shelter Care in Full Time Care Facilities).

Children/youth may not be maintained in care beyond sixty (60) days unless approved by the Residential Care Program Manager prior to exceeding sixty (60) days. It is the goal of the Department not to allow youth to remain in the facility more than ninety (90) days, with sixty (60) days as the preferred outer limit.

If the Provider anticipates the child will remain at the facility past sixty (60) days, an extension must be requested of the Residential Care Program Manager. Before approval of an extension, facility staff will call the treatment team together before the forty-fifth (45^{th}) day of treatment to inform the team that the allowable length of stay (sixty (60) days) is coming to an end and to help facilitate timely discharge. The facility will

provide the Residential Care Program Manager with the discharge plan resulting from this meeting with the extension request, if needed.

For children/youth who are not in custody and occupying a BRS funded bed, the Residential Care Program Manager will review and approve or deny extension requests for approval beyond sixty (60) days.

If a determination is made that the child/youth is difficult to place and may need long-term residential treatment, a referral must be made to the Department for review.

A request for an extension includes the following steps:
1) The RCCY facility provides to the Residential Care Program Manager a copy of the youth's initial and any updated assessments, the most current treatment plan, and a brief summary of progress in the youth's major life domains while residing at the facility; and
2) the RCCY facility requests the appropriate DBH, OCS or DJJ worker or other person provide the youth's barriers to alternative placements, what has been accomplished to overcome those barriers, permanency, concurrent, and placement plans, tribal involvement (if applicable), and an anticipated discharge date. Without authorization, the Department reserves the right to withhold payment for days not approved.

The Department is the payer of last resort. Clients with a primary payer source such as private insurance or Medicaid are eligible to be enrolled in the services described in this agreement if they meet the client eligibility requirements. The Provider must bill the primary source first, and submit an Explanation of Benefits noting denial of payment for approved services if payment is being sought from the Department for clients with a primary payer source. If the Department pays for a service, and a primary payment source subsequently submits payment for the same service, the Provider shall credit back to the Department payments received by the Provider.

Providers submitting claims to the Department for services provided to a client shall include itemized charges describing only Department approved services as outlined in the BRS Handbook. Claims submitted for a client with primary payer source must include an attached Explanation of Benefits denying the payment by the primary source.

Endorsement of a Department payment warrant constitutes certification that the claim for which the warrant was issued was true and accurate, unless written notice of an error is sent by the Provider to the Department within 30 days after the date that the warrant is cashed.

Clients seen through Department-funded services will not be charged any sliding-scale fee, deductible, co-pay or administrative fee for covered services.

Except when good cause for delay is shown, the Department will not pay for services unless the Provider submits a claim within 30 days of the date the service was provided. Again, the Department is the payer of last resort; therefore, determination of payment by a primary payer source (private insurance, Medicaid, etc.) constitutes good cause for delay.

For questions regarding secure transmissions of information, call the Administrative Contact person listed in the signature block of this Agreement. Refer to Section VI of this document for explicit instructions about the submission of confidential or other sensitive information. Providers will be responsible for using appropriate safeguards to maintain and insure the confidentiality, privacy, and security of information transmitted to the Department until such information is received by the Department.

V. SUBCONTRACTS

Subcontracts are not allowed under the terms of this Provider Agreement.

VI. CONFIDENTIALITY AND SECURITY OF CLIENT INFORMATION

The Provider will ensure compliance with the Health Insurance Portability & Accountability Act of 1996 (HIPAA), the Health Information Technology for Economical and Clinical Health Act of 2009 (HITECH), and 45 C.F.R. 160 and 164, if applicable, and other federal and state requirements for the privacy and security of protected health information the Provider receives, maintains, or transmits, whether in electronic or paper format. Client information is confidential and cannot be released without the HIPAA-compliant written authorization of the client and DHSS, except as permitted by other state or federal law.

By entering into this Agreement, the Provider acknowledges and agrees to comply with the Privacy and Security Procedures for Providers as set forth in Appendix C to this Agreement.

Confidential Reporting Instructions

Before transmitting personally identifiable client information reported under the terms of this Agreement, the Provider must call or email the Department's Program Contact. To protect confidentiality, the Provider must first establish the mechanism for a secure electronic file transfer. Or, the Provider may fax the information to the Program Coordinator, after clearly identifying it as "confidential" on the cover page of the fax transmission.

Alternatively, the Provider may submit hard copy information in a sealed envelope, stamped "confidential" placed inside another envelope. This information must be sent by certified, registered, or express mail, or by courier service, with a requested return receipt to verify that it was received by the appropriate individual or office.

VII. REPORTING AND EVALUATION

The Provider agrees to comply with 7 AAC 81.120 (Confidentiality) and 7 AAC 81.150 (Reports), and other applicable State or Federal laws regarding the submission of information including the provisions of Section VI of this Agreement. The Provider agrees to submit any reporting information required under this Agreement and to make available information deemed necessary by the Department to evaluate the efficacy of service delivery or compliance with applicable state or federal statutes or regulations.

The Provider agrees to provide State officials and their representative(s) access to facilities, systems, books and records, for the purpose of monitoring compliance with this Agreement and evaluating services provided under this Agreement.

On-site Quality Assurance Site Reviews may be conducted by Department staff to ensure compliance with service protocols. The Provider will ensure that Department staff has access to program files for the purposes of follow-up, quality assurance monitoring and fiscal administration of the program.

VIII. RECORD RETENTION

The Provider will retain financial, administrative, and confidential client records in accordance with 7 AAC 81.180 (Retention of Records) and with Appendix C to this Agreement. Upon request, the Provider agrees to provide copies of the Provider's records created under this Agreement to the Department of Health and Social Services, under the health oversight agency exception of HIPAA. The Provider will seek approval and instruction from the Department before destroying those records in a manner approved by the Department. In the event a Provider organization or business closes or ceases to exist as a Provider, the Provider must notify the Department in a manner of compliance with 7 AAC 81.185 (Transfer of Records) and Appendix C (Privacy & Security) to this Agreement.

IX. ADMINISTRATIVE POLICIES

A. The Provider must have established written administrative policies and apply these policies consistently in the administration of the Provider Agreement without regard to the source of the money used for the purposes to which the policies relate. These policies include: employee salaries and overtime, employee leave, employee relocation costs, use of consultants and consultant fees, training, criminal background checks (if necessary for the protection of vulnerable or dependent recipients of services), and conflicts of interest, as well as the following:

1. Compliance with OSHA regulations requiring protection of employees from blood-borne pathogens and that the Alaska Department of Labor must be contacted directly with any questions;
2. Compliance with AS 47.05.300-390 and 7 AAC 10.900-990. Compliance includes ensuring that each individual associated with the Provider in a manner described under 7 AAC 10.900(b) has a valid criminal history check from the Department of Health and Social Services, Division of Health Services, Background Check Program ("BCP") before employment or other service, unless a provisional valid criminal history check has been granted under 7 AAC 10.920 or a variance has been granted under 7 AAC 10.935. Specific information about how to apply for and receive a valid criminal history check may be obtained from: http://dhss.alaska.gov/dhcs/Pages/cl/default.aspx or call (907) 334- 4475 or (888) 362-4228 (intra-state toll free);

3. Compliance with AS 47.17 (Child Protection), and AS 47.24.010 (Reports of Harm) including notification to employees of their responsibilities under that section to report harm to children and vulnerable adults;
4. If providing residential and/or critical care services to clients of the Department, the Provider shall have an emergency response and recovery plan, providing for safe evacuation, housing and continuing services in the event of flood, fire, earthquake, severe weather, prolonged loss of utilities, or other emergency that presents a threat to the health, life or safety of clients in their care.

B. The Provider agrees to maintain appropriate levels of insurance necessary to the responsible delivery of services under this Agreement, which will include items 1 and 2 below, and may include all the following that apply to the circumstances of the services provided:

1. Worker's Compensation Insurance for all staff employed in the provision of services under this Agreement, as required by AS 23.30.045. The policy must waive subrogation against the State.
2. Commercial General Liability Insurance - covering all business premises and operations used by the Provider in the performance of services under this Agreement with minimum coverage limits of $300,000 combined single limit per occurrence.
3. Commercial General Automobile Liability Insurance - covering all vehicles used by the Provider in the performance of services under this Agreement with minimum coverage limits of $300,000 combined single limit per occurrence.
4. Professional Liability Insurance - covering all errors, omissions, or negligent acts in the performance of professional services under this Agreement. This insurance is required for all providers of clinical or residential services, or for any other provider for whom a mistake in judgment, information, or procedures may affect the welfare of clients served under the Provider Agreement.

X. EQUAL EMPLOYMENT OPPORTUNITY

The Provider shall adhere to Alaska Statutes regarding equal employment opportunities for all persons without regard to race, religion, color, national origin, age, physical or mental disability, gender or any other condition or status described in AS 18.80.220(a)(1) (Unlawful Employment Practices) and 7 AAC 81.100 (Equal Employment Opportunity). Notice to this effect must be conspicuously posted and made available to employees or applicants for employment at each location where services are provided under this Provider Agreement; and sent to each labor union with which the Provider has a collective bargaining agreement. The Provider must include the requirements for equal opportunity employment for contracts and subcontracts paid in whole or in part with funds earned through this Agreement. Further, the Provider shall comply with Federal and State statutes and regulations relating to the prevention of discriminatory employment practices.

XI. CIVIL RIGHTS

The Provider shall comply with the requirements of 7 AAC 81.110 and all other applicable state or federal laws preventing discrimination, including the following federal statutes:

A. The Civil Rights Act of 1964 (42 U.S.C.2000d)
B. Drug Free Workplace Act of 1988 (41 U.S.C. 701-707)
C. Americans with Disabilities Act of 1990 (41 U.S.C. 12101 – 12213)

In compliance with 7 AAC 81.110(c) (Civil Rights of Recipients of Services) the Provider may not exclude an eligible individual from receiving services but, with concurrence from the Department, may offer alternative services to an individual if the health or safety of staff or other individuals may be endangered by inclusion of that individual.

The Provider will establish procedures for processing complaints alleging discrimination on the basis of race, religion, national origin, age, gender, physical or mental disability or other status or condition described in AS 18.80.220(a)(1) (Unlawful Employment Practices) and 7 AAC 81.110(b) (Civil Rights of Recipients of Services).

XII. ACCOUNTING AND AUDIT REQUIREMENTS

The Provider shall maintain the financial records and accounts for the Provider Agreement using generally accepted accounting principles. The Provider will also ensure that grant income is used in a way that meets accepted standards of fiscal accountability for public money as defined in 7 AAC 78.210 (Grant Income).

The Department may conduct an audit of a Provider's operations at any time the Department determines that an audit is needed. The auditor may be a representative of the Department; or a representative of the Federal or municipal government, if the Agreement is provided in part by the federal or municipal government; or an independent certified public accountant. The Provider will afford an auditor representing the Department or other agency funding the agreement, reasonable access to the Provider's books, documents, papers, and records if requested. Audits must be conducted in accordance with the requirements of 7 AAC 81.160 (Audit Requirements) including the requirement for a Provider to refund money paid on a questioned cost or other audit exception, if they fail to furnish the Department with a response that adequately justifies a discovery of questioned costs or other audit exceptions.

XIII. LIMITATION OF APPROPRIATIONS

The Department is funded with state and federal funds, which are awarded on an annual basis. During each State fiscal year, the Department may authorize payment of costs under a provider agreement only to the extent of money allocated to that fiscal year. Because there is a fixed amount of funding on an annual basis, it may at times be necessary for the Department to prioritize the client population served under this Agreement. Limitations may include but are not limited to a moratorium on types of services, or a moratorium by geographic region served, or a restriction of services to

clients with defined needs. The decision to limit billable services shall be based solely on available funding.

XIV. INDEMNIFICATION AND HOLD HARMLESS OBLIGATION

The Provider shall indemnify, hold harmless, and defend the Department from and against any claim of, or liability for error, omission, or negligent act of the Provider under this Agreement. The Provider shall not be required to indemnify the Department for a claim of, or liability for, the joint negligent error or omission of the Provider and the independent negligence of the Department. If there is a claim of, or liability for, the joint negligent error or omission of the Provider and the independent negligence of the Department, the indemnification and hold harmless obligation shall be apportioned on a comparative fault basis.

"Provider" and "the Department," as used within this section include the employees, agents, or Providers who are directly responsible, respectively, to each. The term "independent negligence" is negligence other than in the Department's selection, administration, monitoring, or controlling of the Provider and in approving or accepting the Provider's work.

XV. AMENDMENT

The Provider acknowledges that state and federal laws relating to information privacy and security, protection against discriminatory practices, and other provisions included in this Agreement may be evolving and that further amendment to this Agreement may be necessary to ensure compliance with applicable law. Upon receipt of notification from the Department that change in law affecting this Agreement has occurred, the Provider will promptly agree to enter into negotiations with the Department to amend this Agreement to ensure compliance with those changes.

XVI. TERMINATION OF AGREEMENT AND APPEALS

The Provider agrees to notify the Department immediately if it is no longer eligible to provide services based on applicable Provider eligibility requirements set out in Section I of this Agreement. Notification of non-eligibility will result in automatic termination of this Agreement. Failure to comply with the terms of this Agreement and/or standards outlined in the Agreement and its appendices may result in non-payment and automatic termination of the Agreement by the Department.

A Provider may appeal the decision to terminate a provider agreement under 7 AAC 81.200 (Request for Appeal). All appeals will be conducted in accordance with Section 7AAC 81.200-210 of the Alaska Administrative Code.

Except as noted above, the Department may terminate this Agreement with 30 days' notice. A provider may also terminate the Agreement with 30 days' notice, but must provide assistance in making arrangements for safe and orderly transfer of clients and information to other providers, as directed by the Department.

This Agreement remains in force until the Provider or the Department terminates the Agreement or a material term of the Agreement is changed.

RESIDENTIAL CARE FOR CHILDREN & YOUTH (RCCY)
ISA PROVIDER AGREEMENT
SIGNATURE PAGE

PROVIDER / AGENCY INFORMATION

Provider Name:_____ Grant # _____

Provider Address: _____
Street / PO City State Zip

Provider Federal Tax ID #:

_____

Provider Phone #: _____ Provider Fax # _____

I certify that I am authorized to negotiate, execute and administer this Agreement on behalf of the Provider agency named in this Agreement, and hereby consent to the terms and conditions of this Agreement, and its appendices and attachments.

PROVIDER:

_____ _____
Signature of Provider's Authorized Representative Printed Name/Authorized Provider Representative

_____ _____
Title of Authorized Provider Representative Date

Providers must identify the business entity type under which they are legally eligible to provide services and intend to enter into this Provider Agreement.
Check Entity Type: ☐ Private For-profit Business, licensed to do business in the State of Alaska ☐ Nonprofit Organization Incorporated in the State of Alaska, or tax exempt under 26 U.S.C. 501(c)(3) ☐ Alaska Native Entity, as defined in 7 AAC 78.950(1) All applicants under this provision must submit with their signed Agreement, a Waiver of Sovereign Immunity, using the form provided as Appendix D to this Provider Agreement. ☐ Political Subdivision of the State (City, Borough or REAA)

DEPARTMENT OF HEALTH & SOCIAL SERVICES:

_____	Darla Madden
Signature of DHSS Authorized Representative	Printed Name of Authorized DHSS Representative
Grants & Contracts Manager	_____
Title of Authorized DHSS Representative	Date

DHSS CONTACTS:

DHSS Grants Administration Contact: Diane LoRusso, Grants Administrator Grants & Contracts Support Team PO Box 110650 Juneau, AK 99811-0650 Phone: (907) 465-6148 Fax: (907) 465-8678 diane.lorusso@alaska.gov	***DBH Residential Care Program Manager Program Contact:*** Steve Krall, Program Manager Division of Behavioral Health PO Box 110620 Juneau, AK 99811-0620 Phone: (907) 465-2315 Steve.Krall@alaska.gov
Certification and Licensing Contact: Craig Baxter Residential Licensing Program Manager Division of Health Care Services 4501 Business Park Blvd, Bldg L Anchorage, Alaska 99503 Phone: (907) 334-2526 Craig.Baxter@alaska.gov	***Billing Forms / Attendance Report Contact:*** Dave Nugent, Accounting Technician Division of Behavioral Health PO Box 110620 Juneau, AK 99811-0620 Phone: (907) 465-5280 Dave.Nugent@alaska.gov