DHS
Oregon Department
of Human Services

185550

PROVIDER ENROLLMENT AGREEMENT

(Revised 7/1/2012)

This Agreement sets forth the conditions for being enrolled as a Provider with the Department of Human Services (DHS), to receive provider number(s) in order to submit payment claims, and to receive payment for Community Service Programs. Community Program Services are provided to persons with developmental disabilities. Payments for services are made using federal Medicaid or state of Oregon funds or a combination of both state and federal funds.

Portland Parks & Recreation
(Provider Name)

7/1/2012
(Date)

As a condition for participation as a Provider with DHS for Community Service Programs for persons with developmental disabilities (Recipients), Provider agrees to comply with all provisions of OAR Chapter 411, Division 370, OAR Chapter 411 Division 323 and the following conditions:

1. Provider understands and agrees that all information submitted in and in support of this Agreement is true and accurate. Information disclosed by the Provider may be subject to verification. Provider must notify DHS of any changes to the information contained in this Agreement within 30 days of the date of the change. Provider understands DHS may terminate this Agreement if it determines that the Provider did not fully and accurately make any disclosure required in this Agreement or if the Provider fails to notify DHS of any changes within 30 days. Any deliberate omission, misrepresentation or falsification of any information contained in this Agreement or contained in any communication supplying information to DHS may be punished by administrative or criminal law or both, including but not limited to revocation of the Provider's license or certification required to deliver Community Service Program services and receive payment for Medicaid services.

2. Provider agrees to comply with all applicable licensing, certification and regulatory requirements as set forth by federal and state statutes, regulations, and rules, necessary to provide Community Service Program services. **Effective 7/1/2012, the requirements for insurance have been updated, per Exhibit A, to comply with State requirements. The required insurance amount is based upon your agency's state revenue from ODDS. DHS must receive proof of this insurance in our office no later than August 1, 2012.**

3. Provider understands that prior authorization is required before placement of, or service to, any Recipient and that payment will not be issued if prior authorization was not granted.

4. Provider agrees to provide the care and services necessary to ensure the health, safety and well-being of recipients and to promote their independence, community integration and productivity. Provider agrees payment may be denied or subject to recovery if care or services were not authorized or not provided in accordance with the program-specific rules.

5. Provider agrees to accept the rate authorized by DHS as payment in full and will not charge the recipient or any person responsible for the recipient any additional amounts for these services,

other than the permissible charges authorized or required by administrative rule. Payment cannot be made to any individual or entity that has been excluded from participation in federal or state programs or that employs or is managed by excluded individuals or entities. As a condition of payment, Provider must meet and maintain compliance with the Provider Rules, OAR 407-120-0300 through 407-120-0380 and 407-120-1505. **In accordance the form included in Exhibit B, must be completed and returned to DHS no later than August 1, 2012. This information must be updated to our office as changes occur.**

6. Provider agrees to participate in and cooperate with the approaches used by the DHS and its representatives to promote the integrity and quality of the Community Services Program. Provider agrees to respond to the actions or improvements required as a result of program integrity and quality assurance activities.

7. Provider agrees that by signature of the Provider or designee, including electronic signatures on a claim form or transmittal document, that the services claimed were actually provided and appropriate, were documented, and were provided in accordance with the standards of services, applicable DHS Rules and this Agreement. The Provider is solely responsible for the accuracy of claims submitted, and the use of a billing entity does not change the Provider's responsibility for the claims submitted on Provider's behalf. Any overpayment made to Provider by DHS may be recouped by DHS including withholding of future payments or other process as authorized by law.

8. Provider may terminate this Agreement at any time by submitting a written notice in person or by certified mail with the specific date on which termination will take place to the local CDDP and DHS. Notification must be submitted a minimum of 90 days prior to the termination date unless otherwise provided by OAR Chapter 411, Division 370, program-specific rules, or other DHS rule or with the agreement of DHS. Provider must also submit appropriate and timely notice to all Recipients affected by this termination as outlined in the applicable program specific rules.

9. DHS may terminate this Agreement at any time by submitting a written notice in person or by certified mail with the specific date on which termination will take place.

10. Provider understands and agrees provider is not employed by any division of DHS or any Community Developmental Disability Program (CDDP) and shall not for any purposes be deemed an employee of the State of Oregon or any CDDP. Provider is responsible for its employees and for providing employment-related benefits and deductions that are required by law. Provider is solely responsible for its acts or omissions, including the acts or omissions of its own officers, employees or agents.

11. Provider has fully read and understands this Agreement. This Agreement becomes effective upon the date of signature and will terminate five years from that date unless terminated earlier in accordance with this Agreement.

Signature of Provider or Authorized Business Representative

Date

Title of Provider or Business Representative

APPROVED AS TO FORM
James H. Van Dyke
CITY ATTORNEY 7/24/12

Reference Links:

OAR Division 411, Chapter 370
OAR Division 407, Division 120
http://www.oregon.gov/DHS/spd/provtools/index.shtml#CDDP

EXHIBIT A

PROVIDER INSURANCE REQUIREMENTS

TYPES AND AMOUNTS.

1. **WORKERS COMPENSATION**. Insurance in compliance with ORS 656.017, which requires all employers that employ subject workers, as defined in ORS 656.027, to provide workers' compensation coverage for those workers, unless they meet the requirement for an exemption under ORS 656.126(2). Employers Liability insurance with coverage limits of not less than $500,000 must be included.

2. **PROFESSIONAL LIABILITY:** Covers any damages caused by an error, omission or negligent act related to the Services to be provided under the agreement, with limits not less than the following, as determined by DHS, or such lesser amount as DHS approves in writing:

☒ Per occurrence for all claimants for claims arising out of a single accident or occurrence:

Agency not-to-exceed amount:	Required Insurance Amount:
Not over $1,000,000.	$1,000,000.
Over $1,000,000, but not over $2,000,000.	$2,000,000.
Over $2,000,000 but not over $3,000,000.	$3,000,000.
Over $3,000,000.	$4,000,000.

Professional liability insurance is required for professionals or entities that provide professional Services for which professional liability insurance is available for the profession.

3. **COMMERCIAL GENERAL LIABILITY:**

Covers bodily injury, death, and property damage in a form and with coverages that are satisfactory to DHS. This insurance shall include personal injury liability, products and completed operations. Coverage shall be written on an occurrence form basis, with not less than the following amounts as determined by DHS, or such lesser amount as DHS approves in writing:

Bodily Injury, Death and Property Damage:

☒ Per occurrence for all claimants for claims arising out of a single accident or occurrence:

Agency not-to-exceed amount:	Required Insurance Amount:
Not over $1,000,000.	$1,000,000.
Over $1,000,000, but not over $2,000,000.	$2,000,000.
Over $2,000,000 but not over $3,000,000.	$3,000,000.
Over $3,000,000.	$4,000,000.

4. **AUTOMOBILE LIABILITY INSURANCE:** Required for Contractors when the scope of work includes transportation. Covers all owned, non-owned and hired vehicles. This coverage may be written in combination with the Commercial General Liability Insurance (with separate limits for "Commercial General Liability" and "Automobile Liability"). Automobile Liability Insurance must be in not less than the following amounts as determined by DHS, or such lesser amount as DHS approves in writing:

Bodily Injury, Death and Property Damage:

☒ Per occurrence for all claimants for claims arising out of a single accident or occurrence:

Agency not-to-exceed amount:	Required Insurance Amount:
Not over $1,000,000.	$1,000,000.
Over $1,000,000, but not over $2,000,000.	$2,000,000.
Over $2,000,000 but not over $3,000,000.	$3,000,000.
Over $3,000,000.	$4,000,000.

5. **ADDITIONAL INSURED.** The Commercial General Liability insurance and Automobile Liability insurance must include the State of Oregon, its officers, employees and agents as Additional Insureds but only with respect to the Contractor's activities to be performed under the agreement. Coverage must be primary and non-contributory with any other insurance and self-insurance.

6. **"TAIL" COVERAGE.** If any of the required insurance policies is on a "claims made" basis, such as professional liability insurance, the Contractor shall maintain either "tail" coverage or continuous "claims made" liability coverage, provided the effective date of the continuous "claims made" coverage is on or before the effective date of the Agreement, for a minimum of 24 months following the later of : (i) the Contractor's completion and DHS 's acceptance of all Services required under the Agreement or, (ii) the expiration of all warranty periods provided under the Agreement. Notwithstanding the foregoing 24-month requirement, if the Contractor elects to maintain "tail" coverage and if the maximum time period "tail" coverage reasonably available in the marketplace is less than the 24-month period described above, then the Contractor may request and DHS may grant approval of the maximum "tail " coverage period reasonably available in the marketplace. If DHS approval is granted, the Contractor shall maintain "tail" coverage for the maximum time period that "tail" coverage is reasonably available in the marketplace.

7 **NOTICE OF CANCELLATION OR CHANGE.** The Contractor or its insurer must provide 30 days' written notice to DHS before cancellation of, material change to, potential exhaustion of aggregate limits of, or non-renewal of the required insurance coverage(s).

8. **CERTIFICATE(S) OF INSURANCE.** DHS shall obtain from the Contractor a certificate(s) of insurance for all required insurance before the Contractor performs under the Agreement. The certificate(s) or an attached endorsement must specify: i) all entities and individuals who are endorsed on the policy as Additional Insured and ii) for insurance on a "claims made" basis, the extended reporting period applicable to "tail" or continuous "claims made" coverage.

EXHIBIT B

DHS
Oregon Department of Human Services
Seniors and People with Disabilities

Purpose and Instructions for Completing

Provider Ownership and Control

Interest Statement

Purpose

The primary use of the Disclosure of Ownership and Controlling Interest Statement is to comply with screening requirements related to the Patient Protection and Affordable Care Act, http://www.gpo.gov/fdsys/pkg/FR-2011-02-02/pdf/2011-1686.pdf and 42 CFR 455.104; to facilitate monitoring of providers sanctioned by the U.S. Department of Health and Human Services (DHHS) Centers for Medicare and Medicaid Services (CMS), DHHS Office of Inspector General, and/or the Oregon Department of Human Services (DHS).

Completion and submission of this form is a condition of certification or recertification under any of the programs established by titles XVIII (Medicare) or XIX (Medicaid) or as a condition of approval or renewal of a contractor agreement between the disclosing entity and DHS.

Payment will not be made for any services furnished by the provider, on or after the effective date of exclusion. Failure to submit requested information may result in a refusal by DHS to enter into a provider agreement or contract with any such disclosing entity.

Instructions

The following instructions are designed to clarify certain questions on the form. Instructions are listed in order of question for easy reference. See 42 CFR 455.101 for additional definitions. No instructions have been given for questions considered self-explanatory.

It is essential that all applicable questions be answered accurately and that all information is current. Answer ***all*** questions as of the current date. If additional space is needed, attach a sheet referencing the part and question being completed.

Part 1 - Identifying information

A. Specify the name of the facility licensee/owner submitting this statement of ownership and control. **Note:** If the facility licensee/owner is not the operator/manager please submit an additional form for the operator.

B. Specify the doing business as/assumed business name (DBA/ABN) of the facility. This name must be registered with the Oregon Secretary of State Corporate Division.

C. List the applicant's Employer Identification number (EIN) as issued by the IRS. For more information about an EIN, please check https://www.irs.gov for "Employer Identification numbers" or "EIN". Whenever this Disclosure Statement requests an Employer Identification number (EIN) about an individual or entity, it has the same meaning.

D. Check the entity type that best describes the structure of the applicant's organization.

Part 2 - Ownership and control interests – Definitions- Use the following definitions to identify the individuals you should enter in parts **A, B and D** of this section.
(See 42 CFR 455.101 for additional definitions.)

- **Managing employee** means a general manager, business manager, administrator, director or other individual who exercises operational or managerial control over or who directly or indirectly conducts the day-to-day operation of an institution.

- **Employer Identification Number (EIN)** - also known as a Federal Tax Identification Number means the number used to identify a business entity. http://www.irs.gov/businesses

- **"Direct ownership interest"** is defined as the possession of stock, equity in capital or any interest in the profits of the disclosing entity. *See* 42 CFR 455.102 to calculate ownership or control percentages.
- **"Disclosing entity"** the applicant is the disclosing entity, defined as the entity requesting certification or recertification under any of the programs established by titles XVIII (Medicare), XIX (Medicaid) or as a condition of approval or renewal of a Medicaid Contractor agreement.
- **"Indirect ownership interest"** is defined as ownership interest in an entity that has direct or indirect ownership interest in the disclosing entity. The amount of indirect ownership in the disclosing entity that is held by any other entity is determined by multiplying the percentage of ownership interest at each level. For example, if A owns 10 percent of the stock in a corporation that owns 80 percent of the stock of the disclosing entity, A's interest equates to an 8 percent indirect ownership and must be reported. Conversely, if B owns 80 percent of the stock of a corporation that owns 5 percent of the stock of the disclosing entity, B's interest equates to a 4 percent indirect ownership interest in the disclosing entity and need not be reported.
- **"Controlling interest"** is defined as the operational direction or management of a disclosing entity which may be maintained by any or all of the following devices; the ability or authority, expressed or reserved to amend or change the corporate identity (i.e. joint venture agreement, unincorporated business status) of the disclosing entity; the ability or authority to nominate or name members of the Board of Directors or Trustees of the disclosing entity; the ability or authority, expressed or reserved to amend or change the by-laws, constitution or other operating or management direction of the disclosing entity; the right to control any or all of the assets or other property of the disclosing entity upon the sale or dissolution of that entity; the ability or authority, expressed or reserved to control the sale of any or all of the assets to encumber such assets by way of mortgage or other indebtedness, to dissolve the entity or to arrange for the sale or transfer of the disclosing entity to new ownership or control. In order to determine percentage of ownership, mortgage, deed of trust, note, or other obligation, the percentage of interest owned in the obligation is multiplied by the percentage of the disclosing entity's assets used to secure the obligation. For example, if A owns 10 percent of a note secured by 60 percent of the provider's assets, A's interest in the provider's assets equates to 6 percent of the provider's assets, B's interest in the provider's assets equates to 4 percent and need not be reported. An indirect ownership interest must be reported if it equates to an ownership interest of 5% or more in the disclosing entity
- **"Other disclosing entity"** means any other Medicaid disclosing entity and any entity that does not participate in Medicaid, but is required to disclose certain ownership and control information because of participation in any title XVIII (Medicare) or XIX (Medicaid). This includes any entity that provides health related services for which it claims payment under any plan or program established under titles XVIII (Medicare) or XIX (Medicaid) of the Act.

"Subcontractor" means an individual, agency, or organization to which a disclosing entity

has contracted or delegated part of its management functions or responsibilities of providing medical care to its patients; or an individual, agency, or organization with which a fiscal agent has entered into a contract, agreement, purchase order, or lease (or lease of real property) to obtain space, supplies, equipment, or services provided under the Medicaid agreement.

Part 3 - Criminal offenses. This section asks about criminal offenses and exclusions. Complete this section for any of the individuals listed in part 2 of this form.

Part 4 - Board of Directors: For organizations that are corporations, this section asks for information about each person on the Board of Directors.

185550

DHS
Oregon Department of Human Services
Seniors and People with Disabilities

Provider

Ownership and Control Interest Statement

1- Identifying information

A. Applicant name: Portland Parks & Recreation
Street address: 426 NE 12th
Phone: 503-823-4328 Email: Jane.doyle@portland.gov
☐ Facility business owner/licensee ☐ Facility operator/manager

B. ABN/DBA name registered with Oregon Secretary of State:

C. Federal Employer Identification number (EIN): 93-6002236
For initial certification, initial Medicaid enrollment and for change of ownership (CHOW), Attach a copy of the IRS confirmation letter showing your EIN.

D. Check the entity type that best describes the structure of the licensee/owner.
Check **only one** box.
☐ For profit corporation ☐ Non-profit corporation ☐ Partnership
☒ Government owned ☐ Sole proprietorship ☐ Limited liability company

2 - Ownership or control interests – complete the following for each individual or entity with five percent (5%) or greater.

A. Direct or indirect ownership or controlling interest in the disclosing entity *(see instructions for definition of ownership and controlling interest).*
Attach additional pages as necessary to list all individuals and entities.

Name	Title or entity type	Address	EIN or SSN	Date of birth (if applicable)	Percentage
City of Portland	5	426 NE 12 Portland, Or 97232			

* **Entity type:** In the "entity type" field, enter one of the codes listed below for each individual listed.

1 = Sole proprietorship	**2 = Partnership**	**3 = Limited liability company**
4 = Corporation	**5 = Government or tribal**	**6 = Other** *(Specify)*

B. List the name, address and EIN or SSN of each person or entity with an ownership or controlling interest **in any subcontractor** in which the provider entity has direct or indirect ownership of five percent (5%)or more.

Name	Title	Address	EIN/SSN	Percentage

C. List those persons named in **A** or **B** that are related to each other (spouse, parent, child, sibling, or other family members by marriage or otherwise).

Name	Relationship

D. List the name, address and EIN of any other disclosing entity in which a person or entity named in A. or B. also has an ownership or control interest of at least 5% or more.
For example, do any owners of the disclosing entity also have ownership interest in health care facilities or services that receive Medicare or Medicaid payment? *(Example, sole proprietor, partnership or members of Board of Directors.)*

Name of other disclosing entity	Address	EIN	Percentage

E. List the name, address, SSN and date of birth of each person with a five percent (5%) or greater ownership interest in the disclosing entity ever held ownership or disclosure interest in a facility providing services to the elderly, disabled or ill individuals for which license, registration or certification was either denied or involuntarily terminated or terminated voluntarily during a state or federal termination process.

Name	Address	SSN/DOB

F. List the name, address, SSN and date of birth for any managing employee of the disclosing entity;

Name	Address	SSN	Date of birth

3 – Debarment and suspension

A. List the name, title, and address for any person or entity with an ownership or control interest in the disclosing entity, or is an agent or managing employee of the disclosing entity that has been convicted of a criminal offense related to that person's or entity's involvement in any program under Medicare or Medicaid.

Name	Title	Address

B. List the name, title, and address of any individual or entity with an ownership or controlling interest in the disclosing entity that has been suspended or debarred from participation in Medicare or Medicaid.

Name	Title	Address

4 – Board of Directors

If the disclosing entity is a corporation (for example, for profit, non-profit, limited liability, or other corporate form), list the name, title, address SSN and date of birth of the directors.

Name	Title	Address	SSN	Date of birth