**Instructions**

After reviewing this document in its entirety, print out this document, initial each page and sign the provider qualification attestation. Send this signed form with the required documentation to the [appropriate AAA](https://www.dshs.wa.gov/sites/default/files/ALTSA/hcs/documents/AAA/AAA%20Medicaid%20Intake%20Contacts.docx) based on the counties in which you wish to provide services.

**General Description**

Skilled nursing services are medically necessary services that a licensed nurse acting within the scope of her/his practice can provide or supervise. Authorizing practitioner orders must be obtained when required by applicable state practice laws for licensed nurses. An authorizing practitioner order is notnecessary to start the client referral to adult day health.

**Long-Term Services and Supports: Laws, Rules, and Policies**

Below is a list of some of the laws, rules, and policies that may be helpful to review prior to completing an application. This may not be a comprehensive list of all laws, rules, and policies that apply.

* [Chapter 74.39A RCW: Long-Term Care Services Options](http://app.leg.wa.gov/RCW/default.aspx?cite=74.39A)
* [Chapter 43.43.830 RCW through 43.43.845 RCW: Washington State Patrol Background Checks](http://apps.leg.wa.gov/RCW/default.aspx?cite=43.43)
* [Chapter 388-71 WAC: Home and Community Services and Programs](http://app.leg.wa.gov/WAC/default.aspx?cite=388-71)
* [Chapter 70.127 RCW: In-Home Services Agencies](http://apps.leg.wa.gov/RCW/default.aspx?cite=70.127)
* [WAC 182-551-2100 Home health services - Covered skilled nursing services](http://apps.leg.wa.gov/WAC/default.aspx?cite=182-551-2100WAC%20388-551-2100)
* [Aging and Disability Services Long-Term Care Manual Chapter 7: CORE LTC Programs](https://www.dshs.wa.gov/altsa/aging-and-disability-services-long-term-care-manual)
* Registered Nurse licensed under [Chapter 18.79 RCW](http://apps.leg.wa.gov/RCW/default.aspx?cite=18.79) and [Chapter 246-840 WAC](http://apps.leg.wa.gov/wac/default.aspx?cite=246-840)
* Licensed Practical Nurse licensed under [Chapter 18.79 RCW](http://apps.leg.wa.gov/RCW/default.aspx?cite=18.79)

**Provider Contract**

The DSHS contract provided is for informational purposes only. This information is available to review to ensure all contract terms can be met prior to application.



**Minimum Qualifications**

In order to receive a contract to serve DSHS clients, the AAA must consider an applicant’s ability to perform successfully under the terms and conditions of the contract. This includes contractor integrity, compliance with public policy, record of past performance, and financial and technical resources. Providers must meet the following minimum qualifications:

1. At least one year of demonstrated experience and ability to provide services per the specifications in the contract unless more experience is required in the specific provider qualifications listed below.
2. Current Washington State Business License or an explanation of why you are exempt from registering your business with the state of Washington.
3. Demonstrated capacity to ensure adequate administrative and accounting procedures and controls necessary to safeguard all funds and meet program expenses in advance of reimbursement, determined through evaluation of the agency’s most recent audit report or financial review. A waiver of this requirement may be available for businesses that have been in operation for less than one year or for self-employed contractors who will only provide a direct service with no employees and no fiduciary responsibility.
4. Owners, managing employees, and anyone with a controlling interest (board of directors) of the agency have not been convicted of a criminal offense related to that person’s involvement in any program under Medicare, Medicaid, or Title XVII, XIX, or XX, nor have they been placed on a Federal exclusion list or otherwise suspended or debarred from participation in these programs.
5. Insurance requirements listed in the DSHS contract. Local areas may require higher minimum coverage. Subcontractors, or any agency that is paid to carry out any of the duties of the contract, must maintain insurance with the same types and limits of coverage as required under the contract.
6. The agency owner/contract signatory must [pass a DSHS criminal history background check](http://apps.leg.wa.gov/WAC/default.aspx?cite=388-113-0020).
7. All employees, volunteers, and subcontractors who may have unsupervised contact with vulnerable adults must have passed a criminal history background check, which must be conducted by the contractor every two years and kept in personnel or subcontractor files. The criminal history background check must at least include Washington State Patrol criminal conviction records.
8. No history of significant deficiencies as evidenced by monitoring, licensing reports or surveys, including Area Agency on Aging monitoring reports, if applicable.
9. Have sufficient staff qualified to provide services per the DSHS contract terms as evidenced by a current organizational chart or staffing plan indicating position titles and credentials, as applicable. This also includes any outside agency, person, or organization that will do any part of the work defined in the DSHS contract.
10. Current staff, including those with unsupervised access to clients and those with a controlling interest in the organization, have no findings of abuse, neglect, exploitation, abandonment nor has the agency had any government issued license revoked or denied related to the care of medically frail and/or functionally disabled persons suspended or revoked in any state.
11. Have no multiple cases of lost litigation related to service provision to medically frail and/or functionally disabled persons.
12. Provide services throughout the defined service area. The service area is defined by the contracting Area Agency on Aging.

**Specific Provider Qualifications**

1. Registered Nurse licensed under [Chapter 18.79 RCW](http://apps.leg.wa.gov/RCW/default.aspx?cite=18.79) and [Chapter 246-840 WAC](http://apps.leg.wa.gov/wac/default.aspx?cite=246-840) or;
2. Licensed Practical Nurse licensed under [Chapter 18.79 RCW](http://apps.leg.wa.gov/RCW/default.aspx?cite=18.79) or;
	* Must be working under the supervision of an RN per state law
3. Home Health Agency licensed under [Chapter 70.127 RCW](http://apps.leg.wa.gov/RCW/default.aspx?cite=70.127).
4. Providers must submit evidence of a current core provider agreement with the Health Care Authority.

**Required Documentation to Send to the AAA**

1. Completed [Contractor Intake Form and Required Attachments](http://www.dshs.wa.gov/sites/default/files/FSA/forms/word/27-043.doc)
2. Current rates
3. Record of past performance, including copies of all site visits or program review reports received from any monitoring entities (i.e., federal, local or state government) that occurred within the last 24 months. If the monitoring report has not yet been provided to your organization, indicate the date of the site visit or program review and the name of the monitoring agency which completed the review.
4. Most Recent Audit Report or Financial Review
5. [Medicaid Provider Disclosure Statement](https://www.dshs.wa.gov/sites/default/files/FSA/forms/word/27-094.docx)
6. Completed [Background Check Authorization Form](https://www.dshs.wa.gov/sites/default/files/FSA/forms/pdf/09-653.pdf) for the owner/contract signatory
7. Policies and Procedures meeting the requirements of mandatory reporting procedures as describe in Chapter 74.34 RCW, relating to the protection of vulnerable adults
8. Organizational chart or staffing plan, including applicable credentials and a list of any subcontractors
9. Evidence that specific provider qualifications are met including copies of Washington specialty licenses, certifications or credentials as appropriate to the documentation listed in specific provider qualifications.
10. Core Provider Agreement
11. Current insurance certificate

Business Name and Address:

Application Contact Name/Phone/Email:

By signing this form, I attest that I have reviewed the requirements and understand the requirements for the Medicaid program for which my organization is applying and that the organization meets all of the qualifications and requirements listed in the application packet. I further attest that the organization has submitted all documents requested.

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Signature Title Date