**Instructions**

After reviewing this document in its entirety, print it and sign the provider qualification attestation. Send this signed and dated form, including all of the additional required documentation, to the Department of Social and Health Services (DSHS) headquarters office at [adshqcontracts@dshs.wa.gov](mailto:adshqcontracts@dshs.wa.gov).

**General Description**

This contract is intended for contractors who provide non-medical equipment and supplies, such as waterproof mattress covers, handheld showers, reachers, adaptive utensils, plates, cups, and assistive technology devices.

**Specialized Equipment and Supplies** means equipment and supplies provided to a DSHS client that are:

1. Necessary to increase the client’s ability to perform activities of daily living; or
2. Necessary for the client to perceive, control, or communicate with the environment in which the client lives; and
3. Of direct remedial benefit to the client; and
4. In addition to any medical equipment and supplies provided under the Medicaid State Plan, Medicare or other insurance.

**CFC Assistive Technology (CFC AT)** means devices that:

1. Enhance independence or substitute for human assistance with ADLs, IADLs, or health related tasks.
2. Are not covered by any other funding source such as Medicare, Apple Health, or a private insurance carrier.

**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 388-106 WAC: Long-Term Care Services](http://app.leg.wa.gov/WAC/default.aspx?cite=388-106)
* [Chapter 388-71 WAC: Home and Community Services and Programs](http://app.leg.wa.gov/WAC/default.aspx?cite=388-71)
* [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) and Chapter 7B Community First Choice

**Provider Contract**

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

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**Minimum Qualifications**

In order to receive a contract to serve DSHS clients, DSHS 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.
2. Current Washington State Business License or an explanation of why you are exempt from registering your business with the state of Washington.
3. 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.
4. 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.
5. If any employee, volunteer, or sub-contractor of the company may have unsupervised contact with vulnerable adults, 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).
6. All employees, volunteers, and subcontractors who may have unsupervised contact with vulnerable adults must have passed a criminal history background check. Background checks must be conducted by the company every two years and kept in personnel or subcontractor files.
7. No history of significant deficiencies as evidenced by monitoring, licensing reports or surveys, including Area Agency on Aging monitoring reports, if applicable.
8. 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.
9. Have no multiple cases of lost litigation related to service provision to medically frail and/or functionally disabled persons.
10. Provide services throughout the state of Washington.

**Specific Provider Qualifications**

1. The contractor must be a legal business entity and legitimately engaged in the business of the provision of assistive technology and/or specialized equipment and supplies.
2. Contractors located in the State of Washington must have a Universal Business Identifier and Master Business License, as issued by the State Department of Revenue.
3. Out-of-state contractors must possess a Universal Business Identifier and Master Business License only when it is required by Washington State law.

**Required Documentation to Send to DSHS**

1. Completed [Contractor Intake Form and Required Attachments](https://www.dshs.wa.gov/sites/default/files/FSA/forms/word/27-043.docx)
2. Copies of all specialty licenses (in addition to general business license), if applicable
3. [Medicaid Provider Disclosure Statement](https://www.dshs.wa.gov/sites/default/files/FSA/forms/word/27-094.docx)
4. Completed [Background Check Authorization Form](https://www.dshs.wa.gov/sites/default/files/FSA/forms/pdf/09-653.pdf) for the owner/contract signatory, if required.

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