**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**

A vehicle modification is an adaptation or alterations to a vehicle that is the Client’s primary means of transportation in order to accommodate the unique needs of the individual, enable full integration into the community, and ensure the health, welfare and safety of the Client. Such adaptation includes, but is not limited to, devices and provisions for entering and leaving a motor vehicle, for operating the vehicle or components of the vehicle, and for restraint of drivers and passengers with disabilities and equipment associated with those persons, such as wheelchairs, canes, walkers, etc. This service includes the adaption or alteration of a vehicle designed to meet a Client’s specific needs. The vehicle modification must be designed to enhance the individual’s ability to live and function in the community and to increase, maintain, or improve the Client’s functional capabilities. Contractor must ensure:

1. Safety of persons using automotive adaptive equipment and vehicles that have been modified shall be the primary design consideration. Any installation of equipment or modification of the motor vehicle shall not introduce new single-point failures of the associated vehicle subsystem which otherwise did not exist in that subsystem and which compromise user safety, or safety of the motoring public.
2. All modifications and adaptations are based on an assessment and recommendations by an occupational therapist or other professional and are included in the Client’s plan of care.
3. Modifications allow safe handling and driving of the vehicle in all driving conditions.
4. Workmanship of any adaptive equipment and its installation in a motor vehicle shall be comparable to the best commercial practice. Where applicable, all installations shall be designed to be permanent, and shall use hardware, fastenings, and connectors consistent with permanent installation.
5. The minimum warranty period for both labor and parts for any automotive adaptive equipment or vehicle modification shall be specified by the manufacturer, but not less than one year from date of delivery to the consumer.
6. The manufacturer, supplier or installer shall furnish the Client a user manual with each adaptive device which contains information on the proper use and operation of the device, including how to recognize and what to do in case of malfunction, and maintenance information, including schedule.
7. Modification does not impede routine local and state safety and emissions inspections, as required by law.
8. Excluded are:
9. Purchase or lease of a vehicle.
10. Upkeep and maintenance of the vehicle except the modification/adaption and associated equipment during its warranty period.
11. Assistance with vehicle registration and licensing.
12. Modifications that are of general utility without direct medical or remedial benefit to the client.

Area Agencies on Aging contract with providers of Specialized Transition Goods and Services for Vehicle Modification to assure that services are provided within health and safety standards established by statute and rule.

**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)
* [WAC 246.335 In-Home Services Agencies](http://app.leg.wa.gov/WAC/default.aspx?cite=246-335)

**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.
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 have passed a criminal history background check, which must be conducted 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**

Contractor must be ASE (Automotive Service Excellence) certified and/or received training from an Accrediting Commission of Career Schools and Colleges certified (ACCSC) program or other equivalent training (including being National Mobility Equipment Quality Assurance Program (QAP) Accredited or other equivalents).

Services must be performed within the scope of practice of the contractor’s license and in compliance with professional rules, as defined by law or regulation, and are provided in a manner consistent with protecting and promoting the client’s health and welfare, and appropriate to the client’s physical and psychological needs. Contractor must have a minimum of three years of experience providing services to disabled populations.

**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. Mission statement, articles of incorporate, and bylaws, as applicable
3. Current rates
4. Total program operating budget, including all anticipated revenue sources and any fees generated
5. 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 applicable. 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.
6. Most Recent Audit Report or Financial Review
7. [Medicaid Provider Disclosure Statement](https://www.dshs.wa.gov/sites/default/files/FSA/forms/word/27-094.docx)
8. Completed [Background Check Authorization Form](https://www.dshs.wa.gov/sites/default/files/FSA/forms/pdf/09-653.pdf) for the owner/contract signatory
9. Policies and Procedures meeting the requirements of mandatory reporting procedures as describe in Chapter 74.34 RCW, relating to the protection of vulnerable adults
10. Organizational chart or staffing plan, including applicable credentials and a list of any subcontractors
11. Evidence that specific provider qualifications are met
12. 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