STATEMENT OF AGREEMENT FOR PROVIDERS

I certify that:

Initials

___ I am not currently excluded, suspended or otherwise barred from participation in the Medicare or Medicaid programs or any other federal or federally assisted program;

___ My license is current and active. My license is not currently revoked, suspended or sanctioned by any State licensing authority for any reason; and, I understand that a credentials check will be done initially and periodically by the Economic Services Administration (ESA)/Community Services Division (CSD);

___ I have not surrendered my license pending disciplinary procedures involving professional misconduct;

___ I will immediately notify CSD if any investigation or disciplinary action is initiated against my license. I understand failure to do so could result in adverse action, including but not limited to, suspension of referrals or services, termination of my contract, and/or legal action;

___ All support staff, including subcontractors or vendors, used in the performance of mental incapacity evaluation services must be approved in advanced in writing by CSD; meet the appropriate licensing and certification requirements of the state; are not currently excluded, suspended or otherwise barred from participation in the Medicare or Medicaid programs or any other federal or federally assisted programs; and have completed the DSHS Notice of Nondisclosure form;

___ I provide equal access and quality of service to people with disabilities, from diverse ethnic backgrounds, and to members of sexual minority groups;

___ I have been provided with a copy of the administrative rules relevant to mental incapacity evaluations and understand the evidence requirements;

___ I understand I must be knowledgeable about and comply with federal and state regulations concerning the privacy and confidentiality of information about individuals referred to me by CSD; and the medical information and records I obtain from those individuals; and unauthorized disclosure of such records is prohibited;

___ I understand all requests for copies of reports, including subpoenas, be referred to the designated CSD Contact upon receipt of such requests;

___ I understand I can voluntarily stop performing services or request termination of my contract after providing CSD sufficient advance notice in writing; and

___ I understand that false certification will be grounds for termination of my contract.

SIGNATURE:_____ DATE:_____