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 Department of Social and Health Services (DSHS);

___ I am not under any investigation nor have I surrendered my license pending disciplinary procedures involving professional misconduct;

___ I will immediately notify DSHS if there is any pending disciplinary action against my license. Failure to do so could result in termination of an agreement to perform services and/or legal action;

___ I understand that I will respond to accepted referrals by evaluating the medical evidence, completing the DSHS Review of Medical Evidence form (13-899) by computer or word processor, and sending the complete form (13-899) to the Community Services Office (CSO) by website, fax, or by mail (when website is not available) within five (5) days of the referral;

___ I will notify the DSHS contact when I receive a referral for a client that I have examined or treated previously so that the referral can be reassigned;

___ I will notify the DSHS contact when I am unavailable to accept referrals at least seven (7) days in advanced for planned absences;

___ I understand all requests for copies of reports, including subpoenas, be referred to the DSHS Public Disclosure Office;

___ I understand I can voluntarily terminate my contract for convenience at any time, and equally, involuntary termination is at the discretion of the DSHS contact/staff; and

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

SIGNATURE:_____ DATE:_____