Iowa Department of Human Services

State Payment Program Provider Enrollment

Providers of services to adults with MR/DD under an approved County Management Plan should complete this form to register services to MR/DD members in the State Payment Program. Complete this page, attach a written verification of your service unit-rates signed by the County CPC, and send to:

Iowa Dept. of Human Services
State Payment Program Manager
Division of BDPSFAC 5th Fl
1305 E Walnut
Des Moines IA 50319-0114

Provider Name		Tax ID Number	
Street	City	State	Zip
Payee Name (if different than above)	Telephone Number	Fax Number	
Name of County or Counties Approved for County Management Plan(s)			

Service Description	5-digit County Chart of Accounts Code	SPP Service Code	Unit Type*	Service Rate per Unit

***Unit Types:** 1=Half hour 2=Hour 3=Half day 4=Day 5=Month 6=Session/Event 7=Trip 8=Mile

Photocopy and attach separate pages if you need to add more services.

By my signature below, I certify that I have read the information on the back of this document and that I agree to the conditions and statements there.

Print Name of Contact Person for Information	Contact Person Signature	Date

DO NOT WRITE IN THE SHADED BOX BELOW. Allow 30 business days for the SPP Manager to assign a provider number and notify you of approval. This notification will include your provider number, billing and contract management instructions. Use the provider number assigned to bill for services to persons with MR/DD enrolled in the SPP. Notify the DHS worker for the SPP member (at the local DHS office) to change or add service lines on the member's SRS to correspond to this billing number, service codes, and effective date.

SPP Provider Number 15 -			-				SPP Mgr. Approval
Special MH-MR Agreement		County #		Vendor #			

In signing this agreement:

The provider certifies that all licenses or certifications required by state or federal law to provide this service are maintained in good standing and that the Department will be notified within 24 hours of any change in the provider's licensure or certification standing.

The provider agrees that the service unit rate being charged the Department is not greater than the rate charged to any other payor funding the same service with the provider and that payment for the service is not available from any other source.

The provider agrees to bill using form 470-0020, *Purchase of Service Provider Invoice*, and only for services actually provided to an enrolled person from the effective date of State Payment Program eligibility.

The provider agrees to provide notification to the Department within 30 days of any change in an enrolled person's circumstances that would affect the person's eligibility or the cost of services.

The provider agrees to maintain, for a period of five years from date of service, clinical and financial records adequate to support the need for and the provision of the services purchased under this agreement and that the Department, or its authorized agent, will have access to these records to perform any clinical or fiscal audits the Department deems necessary.

The provider agrees to provide, at a minimum, quarterly reports on the enrolled person's progress to the state or county worker assigned responsibility for the case.

The provider agrees to cooperate in providing the Department with any information the provider has that is necessary to determine initial or continuing eligibility of a person for whom funding is sought.

The provider agrees to comply with 441 Iowa Administrative Code Chapter 153, Division IV, State Payment Program for Services to Adults With Mental Illness, Mental Retardation, and Developmental Disabilities.

The provider agrees to comply with all applicable state and federal confidentiality laws and applicable rules in the Iowa Administrative Code.

The provider agrees to be in compliance with all federal, state and local laws and regulations with respect to civil rights, equal employment opportunity, and affirmative action.

The Department reserves the right to terminate this agreement for any reason by giving the provider 30 days notice.

The provider may request a review of any Department decision adversely affecting the provider by submitting a written request for a review to the administrator of the Division of Behavioral, Development and Protective Services for Families, Adults and Children (BDPSFAC) within 10 days of receipt of the Department's decision. Within 30 days of receipt of the request, the administrator will provide a response to the request in writing. When dissatisfied with the division administrator's response, the provider may submit a written request for review to the Director of the Department within 10 days of receipt of the administrator's decision. Within 14 working days, the Director will issue a decision. The decision of the Director is final.