Assertive Community Services (ACT)
Provider Agreement Addendum

The undersigned is part of an organization that has submitted an application to the Iowa Department of Human Services Iowa Medicaid program to be a provider of services under the Assertive Community Services (ACT) program.

By signing this Declaration Form, the provider agrees to furnish data to the State of Iowa Medicaid program on an annual basis regarding the utilization of all services paid under the ACT bundled rate. This must include cost information broken down by practitioner category and type of service.

_____

Provider Name

_____

Tax ID

_____

NPI

_____

Name and title of person signing this form

_____

Signature

Please return this completed form to:

Provider Services Unit
Iowa Medicaid Enterprise
P.O. Box 36450
Des Moines, IA 50315