INTERMEDIATE CARE FACILITY FOR THE DEVELOPMENTALLY DISABLED/INTELLECTUALLY DISABLED INDIVIDUALS (ICF-DD/ID) ATTACHMENT

SCOPE OF SERVICES

(a) The FACILITY shall provide intermediate care facility services for the developmentally disabled/intellectually disabled individuals in conformance with and as described in Title 17, Subtitle 12, Subchapter 4, Chapter 17-1737, Hawaii Administrative Rules (HAR), and the applicable sections under C.F.R. 42, Part 483, Subpart I to those patients who have been determined by the Department of Human Services (DHS) to be Medicaid eligible.

(b) The FACILITY, its employees and agents, shall comply with retaliatory acts provisions of §349-14, Hawaii Revised Statutes, in assuring that no patient seeking advocacy assistance or who makes a complaint concerning the FACILITY, its employees or agents is subject to retaliation by the FACILITY, its employees or agents.

REIMBURSEMENT

(a) DHS shall reimburse the FACILITY for authorized ICF-DD/ID services provided to residents. Reimbursements shall be limited to services rendered in the areas of the FACILITY, which are licensed by the State Department of Health as a nursing facility (NF) under C.F.R. 42 Part 483, Subpart I.

(b) DHS and the FACILITY mutually agree that for the purposes of this Agreement, a "resident day" shall include the day of admission or the day of discharge from the FACILITY, but not both.

(c) DHS shall make payments through its fiscal agent in accordance with time limits specified in HAR§§17-1739.1-15 and 17-1739.1-16. DHS reserves the right not to make any payments for claims which are submitted more than twelve (12) months after the month in which services were rendered.

(d) The FACILITY shall submit its statement of services for each Medicaid patient to the DHS fiscal agent no later than the thirtieth (30th) calendar day following discharge of the patient. In the event that the resident's care continues for a full calendar month, the FACILITY shall then bill the fiscal agent within (30) days from the end of each month of service.

PENALTIES

The DHS shall allocate to the FACILITY any and all Federal financial penalties (FFP) assessed by the Centers for Medicare & Medicaid Services (CMS) for the FACILITY's failure to meet requirements set forth in this Agreement. The penalties shall be assumed and paid by the FACILITY upon notification from DHS.

REPORTS

(a) The FACILITY shall prepare and submit all required monthly and quarterly reports on the DHS 1137 Census Report Medicaid Resident Movement form. The reports include, but are not limited to all Medicaid admissions, discharges, including deaths, and periods of absence from the FACILITY due to deaths, hospitalization and overnight passes. The DHS 1137 form shall be submitted to the Med- QUEST Division's Administration by the fifteenth (15th) of the month following the reporting period.

(b) The FACILITY shall make available, at the request of DHS, a listing of all residents who were approved for temporary absences from the FACILITY, including information on the destination, number of days of absence, and specific dates absent by the resident.

I/We have read all of the above and fully understand and agree to its terms.

(Print Name of Provider/Authorized Business Agent)	(Name of Health Care Facility)
(Signature of Provider/Authorized Business Agent)	(Date Signed)

Provider First Name and Last Name or DBA: _____
Be sure to include this identification at the bottom of every page.