NEW YORK STATE
DEPARTMENT OF HEALTH

AIDS INSTITUTE

HIV UNINSURED CARE PROGRAMS

HOME CARE

ADDENDUM TO THE HOME CARE AGREEMENT FORM

MEDICAID SPENDDOWN/SURPLUS

1-800-542-2437

EMPIRE STATION
P.O. BOX 2052
ALBANY, NEW YORK
12220-0052

NEW YORK STATE DEPARTMENT OF HEALTH, AIDS INSTITUTE
HOME CARE - MEDICAID SPENDDOWN/SURPLUS

ADDENDUM TO HOME CARE PROVIDER AGREEMENT

This Agreement, signed this _______ day of __________________, 20_____ is intended to set forth the terms and conditions governing participation in the New York State Department of Health AIDS Institute Home Care Medicaid Spenddown Direct Billing administered by Health Research, Inc. (hereinafter referred to as HRI), in cooperation with the New York State Department of Health AIDS Institute and ____,

located at ____.

Hereinafter referred to as Provider, agrees to be legally bound as to the following:

PROVIDER RESPONSIBILITIES:

A. The Provider agrees to participate in the Program and to comply with all Federal and New York State laws generally and specifically governing participation in the Medicaid Programs. The Provider agrees to be knowledgeable of and to comply with applicable rules, regulations, rates and fee schedules promulgated under such laws and any amendments thereto. The Provider further certifies that it has obtained all licenses, certifications and regulatory clearances required under State and Federal law and/or regulation to perform the services to be reimbursed hereunder, and that it is legally qualified in all aspects to perform such services.

B. The submission by or on behalf of the Provider of any claim for payment under the Program shall constitute certification by the Provider that:

1.) The participant is receiving home care services from the provider that will be billed to New York State Medicaid.
2.) The Provider agrees to accept receipts from the participant which would be provided to Medicaid on the participant's behalf, and reduce the amount billed to the Program.
3.) The services provided to the participant through the Home Care Agency are services, which would be reimbursed by the Program.
4.) The value of the Home Care Services provided to the participant exceeds the amount of the monthly Spenddown/Surplus.
5.) Billing/Claims submission will be for one month only, and occur by the 15th of each month. All claims submitted are for current month services only.

PROVIDER COMMITMENT:

Signature: ____ Date: _______________

Print Name: ______________________________________ Title: ______________________________________

CITY OF ____________________________ COUNTY OF ________________________ STATE OF ____________

On the ______ day of _______________, 20____, before me personally came ______________________________, known to me to be the same person who executed the foregoing instrument for and on behalf of _______________________________, and who, being by me duly sworn, did depose and say that s/he is the _____________________________________ of _________________________________, and that s/he is the individual that executed the foregoing instrument.

____
Notary Public

RETURN THIS AGREEMENT TO **- EMPIRE STATION, PO BOX 2052, ALBANY NY, 12220-0052**