

MEDI-CAL PARTICIPATION AGREEMENT

As a condition of providing **Adult Day Health Care** services under the California Medi-Cal Program,

 (Provider Legal Name)

hereinafter called the "Provider," providing services at

 (Center Name)

located at

 (Center Address)

hereby agrees:

- (A) To provide care appropriate to the above-designated service category in accordance with Medi-Cal regulations (Title 22, Division 3, Chapter 5, and Division 5, Chapter 10, California Code of Regulations) and the Adult Day Health Care statutes (Welfare and Institutions Code, Division 9, Chapter 7, and Health and Safety Code, Division 2, Chapter 3.3) as amended from time to time.
- (B) To meet the standards for certification as a provider pursuant to Welfare and Institutions Code Section 14552:
- Meet all other requirements of licensure as an Adult Day Health Care center pursuant to Chapter 3.3 (commencing with Section 1570) of Division 2 of the Health and Safety Code.
 - Comply with requirements of this chapter (Welfare and Institutions Code, Division 9, Chapter 7) regarding program and scope of services.
 - Have appropriate licensed personnel.
 - Employ required personnel for furnishing of required services pursuant to Section 14550 consistent with commonly accepted professional standards.
 - Afford to each participant all rights, including the right to be free from harm and abuse, identified in the rules and regulations adopted pursuant to Section 1580 of the Health and Safety Code.
 - When serving a substantial number of participant of a particular racial or ethnic group, or participants whose primary language is not English, shall employ staff who can meet the cultural and linguistic needs of the participant population.
 - Have organizational and administrative capacity to provide services under the provision of this chapter.
- (C) To comply with Title VI, Civil Rights Act of 1964, and Title 22, California Code of Regulations, prohibiting discrimination against any beneficiary on the basis of race, color, creed, national origin, sex, age or physical or mental disability.
- (D) To keep and maintain for a period of seven years and three years from the date of service such health records and financial records, respectively, as are necessary to fully disclose the extent of services provided to individuals under the Medi-Cal Program, regardless of termination of this Agreement by either the Provider or the California Department of Aging (hereinafter called the Department); to furnish the Department, the Department of Health Care Services or the Secretary of Health and Human Services or their duly authorized representatives with such information, regarding any payments claimed for providing such services as the Department, the Department of Health Care Services, or the Secretary of Health and Human Services or their duly authorized representatives may, from time to time, request.
- (E) That the Department may terminate this Agreement upon decertification or suspension of the Provider in accordance with regulations contained in Article 6 (commencing with Section 51451) of Chapter 3, and in Article 4 (commencing with Section 54301) of Chapter 5, in Division 3, Title 22, California Code of Regulations, as amended from time to time.
- (F) That this Agreement is not assignable by the Provider either in whole or in part without the written consent of the Department.
- (G) That the Provider shall not be entitled to payment from the Medi-Cal Program for services rendered to Medi-Cal beneficiaries during any period that a Medi-Cal Participation Agreement is not in effect.

**MEDI-CAL PARTICIPATION AGREEMENT
(Continued)**

(H) To provide the following services, as designated, during the term of this Agreement:

- | | |
|--|--|
| <input type="checkbox"/> Physical Therapy | <input type="checkbox"/> Mental Health Services |
| <input type="checkbox"/> Occupational Therapy | <input type="checkbox"/> Psychiatrist |
| <input type="checkbox"/> Speech Therapy | <input type="checkbox"/> Psychologist |
| <input type="checkbox"/> Medical Services | <input type="checkbox"/> Licensed Clinical Social Worker |
| <input type="checkbox"/> Staff Physician | <input type="checkbox"/> Psychiatric Nurse |
| <input type="checkbox"/> Participant Physician | <input type="checkbox"/> Social Services |
| <input type="checkbox"/> Nursing | <input type="checkbox"/> Therapeutic Activities |
| <input type="checkbox"/> Nutrition | <input type="checkbox"/> Pharmacist |
| <input type="checkbox"/> Purchase Meals | <input type="checkbox"/> Transportation |
| <input type="checkbox"/> Prepares Meals | <input type="checkbox"/> Purchase rides |
| <input type="checkbox"/> Dietary Counseling | <input type="checkbox"/> Provide vehicle and driver |

(I) To notify the Department immediately in writing when any change occurs in the provision of services designated in (H).

(J) That this Medi-Cal Participation Agreement shall be valid only for the facility and address designated above.

The Department hereby agrees:

(A) To certify the Provider for participation in the Medi-Cal Program for purposes of providing the services designated in (H), effective _____.
(State Use Only)

(B) That the Provider may terminate this Agreement by submitting a written notice to the Department indicating that the Provider is voluntarily withdrawing from participation in the Program.

The parties mutually agree that this Medi-Cal Participation Agreement shall terminate on _____ unless terminated sooner, as described in this Agreement. (State Use Only)

Provider Name: _____ State of California _____

_____ California Department of Aging _____

By: _____ By: _____
(Signature of Provider or Legal Representative)

(Printed Name)

Title: _____ Title: _____

Date: _____ Date: _____