

ATTESTATION FORM

By completing & signing this form you are attesting that the information provided reflects policies & procedures currently in place for your organization.

All information in this attestation is subject to validation. Additional supporting documentation may be required & requested at any time.

Provider Name: _____

Owner/Operator* Name: _____

*Owner/Operator is considered to be an employee & must have a staff file for themselves.

*Owner/Operator must have a file that contains the current information for all staff including volunteers.

Initial Training/ Competency:

- 1) Provider has a Job Description for each staff. Yes No
- 2) Provider has training plans for staff including documentation of completed trainings. Yes No
- 3) Provider ensures staff is able to demonstrate the necessary skills to perform their specific duties prior to initial performance. Yes No
- 4) Provider ensures and documents qualifications of each staff member including academic preparation and relevant experience, verification of current license, certifications or registrations to practice in the State as applicable. Yes No
- 5) Provider ensures staff working with frail elders or disabled populations have documented experience with population staff will work with or provider has plans to ensure staff is adequately trained.
(This may include personal or professional experience) Yes No
- 6) Provider will maintain documentation staff is trained annually on Compliance and Fraud, Waste and Abuse Yes No

Resources if needed:

<https://www.cms.gov/Outreach-and-Education/MLN/WBT/MedicareFraudandAbuse/FraudandAbuse/story.html>

<https://www.cms.gov/Outreach-and-Education/MLN/WBT/MLN3995723-MLNPartsCD/FWA/story.html>

- 7) Provider ensures staff having contact with members is screened for communicable diseases and provider has protocols in place when staff tests positive for communicable diseases. Yes No

Resources if needed:

<https://www.dhs.wisconsin.gov/library/collection/f-01679>

If "No" please explain:

Initial and On-Going Validation of Credentials

8) Provider documents pre-employment and every four years thereafter, any staff who has experience as a nursing assistant, home health aide or hospice aide, as defined under DHS 12 has not had a substantial finding listed on the Nurse Aid Registry indicating they have abused or neglected a client or misappropriated the funds or property of a client. Yes No

Website: <https://wi.tmuniverse.com/search>

9a) Provider completes Wisconsin Department of Justice (DOJ) Criminal & Caregiver background checks for each staff, including transportation staff, prior to employment and updated every four years thereafter. Yes No Website: <https://recordcheck.doj.wi.gov/>

9b) Provider has policy/procedure in place for hiring which includes review of DOJ results and BID completion. Provider has documented protocol of action to take based on results.

Yes No

10) Does owner/operator have any criminal charges pending against them or were they ever convicted of any crime anywhere, including in federal, state, local, military and tribal courts?

Yes No If yes, please explain:

11) Providers who transport members will maintain corporate auto insurance. Yes No N/A

12) For providers who receive funding for travel time OR transport members, provider completes the driver's record check and validates and documents auto insurance at pre-employment and at least annually for all staff. (Community Care, Inc. includes funding for travel time in the rates for Supportive Home Care Providers & Residential Providers; Personal Care Agencies are reimbursed for travel time) Yes No N/A

Website: <https://trust.dot.state.wi.us/occsin/occsinservlet?whoami=statuspl>

Excluded Individuals and Entities

13) Provider acknowledges that Community Care, Inc. will not pay for any goods or services provided by an individual (i.e., employee) or entity that has been excluded from participation in government programs, and will recover any payments previously made for goods or services provided by an excluded individual or entity. Community Care, Inc. will not make payment to an individual – directly or indirectly – or entity while that individual or entity is under a government imposed payment suspension. Yes No

14) Provider will immediately notify Community Care, Inc. of any exclusion or suspension – including a payment suspension - involving the provider's operation. Yes No

15) Provider understands that the US Department of Justice may impose civil monetary penalties (CMP) on anyone who hires an excluded individual or entity. Yes No

Providers are encouraged to regularly check employees and other associated individuals and entities (e.g., vendors, volunteers, board members, etc.) to verify that exclusions have not been imposed. To verify employees and other associated individuals have not been excluded, providers should check government exclusion databases which can be found at <https://exclusions.oig.hhs.gov/>

Transportation Providers

- 16) Providers who transport individuals must have a communication system in place on all transportation vehicles which would allow contact with Community Care. Yes No N/A
- 17) Providers who transport individuals attest they have a mechanism in place to ensure all vehicles are maintained in accordance with manufacturer’s recommendations and undergo regularly documented safety checks to ensure vehicles are safe, accessible and equipped to meet the needs of those being transported (including staff’s own vehicles if they are used for transport of individuals) Yes No N/A

Contract

- 18) Provider has reviewed and attests to meeting all service definitions and standards for services for which they are applying/contracted with Community Care as listed in ADDENDUM VIII. Benefit Package Service Definitions of the MCO Family Care Contract which can be viewed at <https://www.dhs.wisconsin.gov/familycare/mcos/contract.htm> Yes No
- 19) Providers who are Supportive Home Care Providers (including Yard Work & Snow Removal, Daily Living Skills Training, Prevocational and Supported Employment Providers who provide personal care services) and In-Home Respite Providers must comply with the *Family Care Training and Documentation Standards for Supportive Home Care and in-Home Respite* found at: www.dhs.wisconsin.gov/publications/p01602.pdf. Provider attests and has submitted proof of compliance with this attestation. Yes No N/A
- 20) Provider will make the Community Care, Inc. contract available to staff working with Community Care members. The provider must also make available to staff all related documents such as: Model of Care, the Benefit Grid, Communication Requirements (at time of contract) and Practice Guidelines. (all documents are available on CCI website at communitycareinc.org). Yes No
- 21) Provider attests that it is in compliance with DHS requirements for Civil Rights/Affirmative Action and has provided Community Care with a Letter of Assurance <https://www.dhs.wisconsin.gov/library/F-00165.htm>. In addition, providers with more than 50 employees or receiving more than \$50,000 in government funding must complete a Civil Right Compliance Plan <https://www.dhs.wisconsin.gov/civil-rights/index.htm> Yes No

Provider Information

- 22) Provider has a back-up plan in place when there are staff shortages. Yes No
Briefly define or attach additional forms/ policy as necessary.

- 23) Provider has a plan in place for regular and emergency medical needs. Yes No
Briefly define or attach additional forms/policy as necessary.

24) Provider has a policy to prevent any member from being left in a vehicle. Yes No
Briefly describe or attach transportation policy or practices. Include any forms that staff must document on who is in the vehicle at start and end of trips.

25) Provider has an emergency preparedness plan. Yes No

26) Provider and/or Owner has ever been licensed or certified Yes No
(If yes, please answer the questions below)

a) What type of license or certification? _____

b) Who issued the license or certification? _____

c) What dates were you licensed or certified? _____

27) Provider and/or Owner had a license or certification revoked Yes No

If yes, please explain including name of licensed or certified entity:

28) Provider has had a contract terminated or requested a termination with any entity including but not limited to other MCO's; County; etc. Yes No

If yes, please attach letter or supporting information regarding the decision.

29) Provider has had a contract application denied through CCI or another entity Yes No

If so, list legal entity name & individual name associated with the denial:

Date denied:

Reason for denial:

30) Provider is under or has been under either a corrective action in the last 12 months and/or increased oversight with another MCO, IRIS, DQA, DHS or other entity. Yes No

Contracting Requirement

All providers must check the following box stating that they have read & understand the following statement.

Community Care, Inc. will not contract directly with a program member’s relative or guardian for the purpose of providing care to the member. (*“Relative” means a spouse, parent, step-parent, child, step-child, sibling, grandchild, grandparent, aunt, uncle, niece or nephew*)

Exceptions may be considered where relatives and legal guardians may be paid to perform or provide only the following services: personal care, supportive home care, specialized transportation, certified 1-2 bed adult family home services, education (daily living skills training), respite care, skilled nursing, and supported employment. All conflicts of interest must be reviewed and all MCO qualifications/standards must be met.

I have read and understand.

Falsification and/or omission of information on this application may lead to contract denial and/or contract termination. Community Care, Inc. reserves the right to deny or end a contract at any time based on information Community Care, Inc. may receive that is inconsistent with provider submission. Please ensure accuracy on all application materials to avoid further action.

If any requirements are missing during the application process or subsequent Community Care, Inc. provider contract review, it may result in Community Care, Inc. decision to deny an application or, if provider is already contracted, take action up to and including contract termination.

Print Name of Person
Completing Form:

Title of Person Completing
Form:

Phone Number:

Signature**:

Date:

** By signing, I attest I am authorized to sign on the provider’s behalf and the information in this document is true and accurate.

- Electronic signature is considered valid only when document is submitted by e-mail from the signer’s e-mail address.
- If mailing or faxing application, signature must be handwritten.