ENROLLMENT PROCESS

Provider EFT/Direct Deposit Information

Service Provider Name (Vendor name)	Service Provider Number(s) - List all
Bank Name (Primary Account)	Bank Name (P&I Account)*
Bank Routing Number (Primary Account)	Bank Routing Number (P&I Account)
Account Number (Primary Account)	Account Number (P&I Account)
Account Type (Checking or Savings: Primary)	Account Type (Checking or Savings: P&I)
Mail Check Remittance? Y/N - Primary	Mail Check Remittance? Y/N - P&I
Starting Date for EFT Processing	

*Second Bank Account, for P&I, should be used by Residential Facilities for the purpose of receiving Personal & Incidental funds for the consumers.

**If you want a printed copy of your detail EFT transactions, answer yes to Mail Check Remittance.

Please submit a voided check and a W-9 form with this request.

ENROLLMENT PROCESS

Provider EFT/Direct Deposit Information

1. CLAIMS ACCEPTANCE AND PROCESSING

The regional center agrees to accept from the enrolled Provider electronic invoices. The Provider hereby acknowledges that he or she has received and read and understands and agrees to abide by the EB provider manual and its contents, and agrees to read and comply with all EB provider manual updates and provider bulletins relating to electronic billing.

2. CLAIMS CERTIFICATION

The Provider agrees and shall certify under penalty of perjury that all claims for services provided to regional center consumers have been provided to the consumers by the Provider. The services were, to the best of Provider's knowledge, provided in accordance with the consumer's written Individual Program Plan. The Provider shall certify that all information submitted to the regional center is accurate and complete. The Provider understands that payment of these claims will be from federal and/or state funds, and falsification or concealment of a material fact may be prosecuted under federal and/or state laws. The Provider agrees to keep for a minimum period of five years from the date of service a printed representation of all records which are necessary to disclose fully the extent of services furnished to the consumer. The Provider agrees to furnish these records and any information regarding payments claimed for providing the services, within the State of California, to the California Department of Health Services; the Medi-Cal Fraud Unit; California Department of Developmental Services; California Department of Justice; Office of the State Controller; U.S. Department of Health and Human Services, or their duly authorized representatives. The Provider also agrees that services are offered and provided without discrimination based on race, religion, color, national or ethnic origin, sex, age, or physical or mental disability.

I certify that the consumer(s) submitted through the electronic process were provided the services as authorized for the stated periods, and that no additional charges were made to other parties. These claims are submitted under penalty of perjury in accordance with the Medi-Cal program Provider Agreement Claim Certification.

3. VERIFICATION OF CLAIMS WITH SOURCE DOCUMENTS

The Provider agrees to retain personal responsibility for the development, transcription, data entry, and transmittal of all invoice information for payment. The Provider shall also assume personal responsibility for verification of submitted invoices with source documents. The Provider agrees that no invoice shall be submitted until the required source documentation is completed and made readily retrievable in accordance with Medi-Cal statutes and regulations. Failure to make, maintain, or produce source documents shall be cause for immediate termination of electronic billing privileges.

4. CHANGE IN ELECTRONIC BILLING STATUS

The Provider and the Regional Center agree that any changes in Provider status which might affect eligibility to participate in electronic billing pursuant to federal and state law shall be promptly communicated to each party.

5. PROVIDER REVIEWS

The Provider agrees that agents of the Regional Center, the Department of Developmental Services, the Department of Health Services, the Office of the State Controller, the Department of Justice, or any other authorized agent or representative of the State of California or any authorized representative of the U.S. Department of Health and Human Services may, from time to time, conduct such reviews as are necessary to ensure compliance with state and federal law and with this agreement. In particular, the Provider agrees to make available to such agent or representative all source documents necessary to verify the accuracy and completeness of invoices submitted electronically.

6. EFFECTIVE DATE

This agreement shall become effective upon approval of the Regional Center.

7. TERMINATION

The Department, Regional Center or Provider may terminate this agreement with or without cause by giving seven days prior written notice of intent to terminate, and the Provider has no right to appeal such termination by the Department or Regional Center. The Department or Regional Center may, however, terminate this agreement immediately upon determination that the Provider has failed or refused to produce or retain source documents in accordance with federal and state laws or this agreement or has violated other provisions of the provider agreement.

8. PROVIDER TO HOLD REGIONAL CENTER AND STATE OF CALIFORNIA HARMLESS

The provider agrees to hold the Regional Center and the State of California harmless for any and all failures performed by billing software, or other features of electronic billing which do not occur with (hard copy) paper billing. The provider agrees that the provider is assuming any and all risks that accompany electronic billing and that the provider is not relying upon the evaluation, if any, that the State of California or Regional Center has made of the electronic billing system or software the provider is using.

9. CONFIDENTIALITY OF RECORD

The Provider agrees to provide adequate precautions to protect the confidentiality of Consumer information in accordance with Welfare and Institutions Code section 4514, Health Insurance Portability and Accountability Act (HIPAA), and all other applicable state and federal statutes and regulations regarding confidentiality of consumer information.

Provider Signature Information

Full Printed Name E-mail address (please print clearly)

Provider Signature Telephone Date

Upon completion, this form needs to be emailed to your vendor liaison and to the Accounting department (erica.rosales@kernrc.org, ruben.fernandez@kernrc.org and fbesnard@kernrc.org).