

Appendix N

Scope of Services, Provider Service Expectations and/or Service Manuals

As indicated in the Subcontract Agreement entered into on January 1, 2018 Provider acknowledges receipt and understanding of Scope of Services, Provider Service Expectations and/or Service Manuals for the following services;

SPC Service
 Description

10710	Transportation- Medical Zone 1A, no co-pay
10710	Transportation- Medical Zone 1B, no co-pay
10720	Transportation- Non- Medical Zone 1A, no co- pay
10720	Transportation- Non- Medical Zone 1B, no co- pay

Provider agrees to follow the above Scope of Services and/or Service Manuals and disseminate all pertinent expectations material to Provider's staff and ensure expectations are followed.



Authorized Provider Signature
La Crosse MTU

7-13-18

Date



Appendix H
Caregiver Background
Checks Attestation Form



APPENDIX H

Caregiver Background Checks Attestation Form

- A. Provider shall comply with the provisions of HFS 12, Wis. Admin Code.
- B. Provider shall conduct background checks at its own expense of all employees assigned to do work for the Purchaser under this contract.
- C. Provider shall retain in its Personnel Files all pertinent information, to include a Background Information Disclosure Form and/or search results from the Department of Justice, the Department of Health Services, and the Department of Regulation and Licensing, as well as out of State Records, tribal court proceedings and military records.
- D. Provider shall not assign any individual to conduct work under this contract who does not meet with requirement of this law.
- E. Provider shall train its staff to immediately report all allegations of misconduct to their immediate supervisor, including abuse and neglect of a member or misappropriation of member's property. Staff shall also report to their immediate supervisor, as soon as possible, but no later than the next working day, when they have been convicted of any crime or have been, or are being investigated by any government agency for any act or offense (HFS 12.07 (1)).
- F. The Provider shall notify the Purchaser in writing via certified mail within one (1) business day if an employee has been charged with or convicted of any crime specified in HFS 12.07(2).
- G. Provider shall maintain the results of background checks on its own premises for at least the duration of the contract. Purchaser may audit Provider Personnel files to assure compliance with State of Wisconsin Caregiver Background Check Policy.
- H. After the initial background check at the time of employment, licensure or contracting, the Provider must conduct a new Caregiver Background Check every (4) years, or at any time within that period, if the Provider has reason to believe a new check should be obtained.

Provider signature certifies that it meets all applicable requirements for Caregiver Background Checks.



Signature

7-13-18

Date



Appendix G Incident Reporting Attestation Form

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Inclusa and contracted providers must comply with all applicable state statutes and rules including, but not limited to, HFS 132.33 and 132.60, HFS 82.10, HFS 83.21, HFS 88.10, ch.51.61 (1) (i) Stats and s. HFS 94.10 Wis. Adm. Code, in the use of isolation, seclusion, physical, and chemical restraints. Inclusa Restrictive Measures Policy covers the approval process as directed by ch.51.61 (1) (i) Stats and s. HFS 94.10 Wis. Adm. Code.

By signing this Attestation form; Provider attests that they have reviewed the Provider Incident Reporting PowerPoint Training located on the Inclusa.org website in the Provider Resources section. Provider also attests that they understand the contractual requirements of the training and will also educate all applicable staff working directly with Inclusa members.

A handwritten signature in black ink, appearing to be "D. Jones", written over a horizontal line.

Signature

A handwritten date "7-13-18" in black ink, written over a horizontal line.

Date

Inclusa, Inc.

APPENDIX C- Provider Insurance Coverage Minimums

Non-Residential Services:		Professional Liability Requirements	General Liability Requirements	Auto Liability **Required when transportation of member is part of service**	Workers Comp- must follow state law
Works directly with Inclusa Members	No Employees/ Self-Employed	\$1 Million	\$1 Million	\$1 Million / occurrence	Not Required
	Fewer than 25 Employees	\$1 Million	\$1 Million	\$1 Million / occurrence	Required
	25 or More Employees	\$1 Million + \$1 Million Umbrella	\$1 Million + \$1 Million Umbrella	\$1 Million / occurrence	Required
Does NOT have direct contact/care with Inclusa Members	No Employees/ Self-Employed	Not Required	\$1 Million	\$100,000 per person \$300,000 per occurrence \$100,000 property	Not Required
	Fewer than 25 Employees	Not Required	\$1 Million	\$100,000 per person \$300,000 per occurrence \$100,000 property	Required
	25 or More Employees	Not Required	\$1 Million + \$1 Million Umbrella	\$100,000 per person \$300,000 per occurrence \$100,000 property	Required

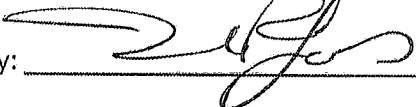
Residential Services:		Professional Liability Requirements	General Liability Requirements	Auto Liability **Required when transportation of member is part of service**	Workers Comp- must follow state law
Owner-Occupied 1-2 bed Adult Family Home and Respite Homes	Owner lives in the Adult Family Home	Inclusa strongly recommends providers obtain professional liability coverage if not caring for a related family member	Inclusa strongly recommends providers obtain general liability coverage if not caring for a related family member	\$100,000 per person/ \$300,000 per occurrence / \$100,000 property	Not Required
	Homeowners/Renters: \$300,000 Combined single limit (bodily injury and property damage) Required				
Corp 1-2 Bed and Licensed Adult Family Homes	AFH with owner/staff working in the home or Licensed 3-4 Bed	\$1 Million per occurrence	Homeowners/Renters: \$300,000 Combined single limit (bodily injury and property damage)	\$100,000 per person/ \$300,000 per occurrence / \$100,000 property	Required per applicable state laws based on number of employees
CBRF, RCAC, Corporate Adult Family Homes	Fewer than 100 Beds (all facilities combined)	\$1 Million per occurrence \$2 Million general aggregate \$1 Million Umbrella liability	\$1 Million per occurrence \$2 Million general aggregate \$1 Million Umbrella liability	\$1 Million / occurrence	Required
	100 Beds or More (all facilities combined)	\$1 Million/\$2 Million + \$5 Million Umbrella	\$1 Million/\$2 Million + \$5 Million Umbrella	\$1 Million / occurrence	Required

APPENDIX A Signatures: La Crosse MTU

202069-2018-00

REIMBURSEMENT FOR AUTHORIZED SERVICES

PROVIDER's Authorized Representative,

By: 

Printed Name: Mark R. Jones

Title: President

Date: 7-13-18

City of La Crosse Authorized Representative,

By: _____

Printed Name: _____

Title: _____

Date: _____

PURCHASER's Authorized Representative,

Purchaser's Authorized Representative
Inclusa, Inc.
Chief Executive Officer

Date

***PROVIDER: Provide a copy of this Appendix to your Billing Department**

Remit Invoices to: Wisconsin Physicians Service Insurance Corporation (WPS)

*10710	Transportation- Medical Zone 1B, no co-pay	T2003-RD	Medical non-emergency transportation; per encounter/trip	1/1/2018	\$27.96	Each
*10720	Transportation- Non-Medical Zone 1B, no co-pay	T2003-RI	Non-medical transportation; encounter/trip.	1/1/2018	\$27.96	Each

APPENDIX A : La Crosse MTU

202069-2018-00

REIMBURSEMENT FOR AUTHORIZED SERVICES

PURCHASER AND PROVIDER AGREE:

1. Reimbursement for authorized services provided to eligible members will be determined in accordance with this Appendix and the Agreement between PROVIDER and Inclusa, Inc. (PURCHASER).
2. This Appendix A shall be the controlling Appendix A and supersede any and all previous Appendix A documents and/or Services, Rates, Special Provisions (SRSP) documents.

METHOD OF PAYMENT:

1. PURCHASER will reimburse PROVIDER based upon billed authorized units of service delivered at the agreed upon unit rate as indicated below.
2. When 'MA Rate' is indicated in Rate column, PURCHASER will reimburse PROVIDER based on current Medical Assistance (MA) designated procedure codes and rates as published by the Wisconsin Medical Assistance Program.

TOTAL COST:

1. PURCHASER will only reimburse for services or goods listed and authorized by PURCHASER at the agreed upon rates listed below.
2. PROVIDER understands that the total amount to be paid pursuant to the Agreement shall not exceed an amount equal to the number of PURCHASER authorized actual units of service or goods delivered by the PROVIDER.

SPECIFIC TO EXPANSION COUNTIES AS OF 7/1/2017

1. Non-residential PROVIDERS – Current rates are specific to transitioning waiver participants. Rates for new referrals will be determined through collaboration with Inclusa, Inc. Community Resources/Provider Relations Contracting Staff.
2. Residential PROVIDERS – Current rates are specific to transitioning waiver participants. Rates for new referrals will be determined through utilization of Inclusa, Inc.'s Residential Rate Setting Methodology.

*Services with a * indicates service is new or changed*

SPC	Service Description	Procedure Code/Modifier	Procedure Code Description	Effective Date of Rates	Rate	Unit Type
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La Crosse MTU

Abby Vans/Zone 1A

*10710	Transportation- Medical Zone 1A, no co-pay	T2003-RD	Medical non-emergency transportation; per encounter/trip	1/1/2018	\$23.71	Each
*10720	Transportation- Non-Medical Zone 1A, no co-pay	T2003-RI	Non-medical transportation; encounter/trip.	1/1/2018	\$23.71	Each

Abby Vans/Zone 1B



2018 Provider Subcontract Renewal Addendum

Inclusa, Inc. agrees to renew the Inclusa Provider Subcontract Agreement between Purchaser (Inclusa) and Provider for the period beginning January 1, 2018. Provisions of the Subcontract Agreement remain the same for this renewal period, unless indicated below in bold font;

Section VII Payment for Services and Goods

Added Language

F. PROVIDER agrees to bill PURCHASER's third party claims administrator in a timely manner, but no later than ninety (90) calendar days from the date of service if there is not third party payor and 90 days from the date of the EOB with claims of a third party payor. **When a claim consists of multiple dates of service, the 90 calendar day submission timeframe will begin with the last date of service.**

N. PROVIDER will follow the process below for situations where overpayment for services is received.

- a. Report the overpayment to PURCHASER when identified.
- b. Return the overpayment to Third Party Claims Administrator (WPS) within sixty (60) calendar days of the date on which the overpayment was identified.
- c. Notify PURCHASER and Third Party Claims Administrator (WPS) in writing of the reason for the overpayment.