



*The Department of Services
for Children, Youth and
Their Families*

Division of Management Support Services

RE: Cost Recovery Documentation

Dear Colleague:

Please complete the three forms listed below and make copies of current licenses and/or certificates. Please also send a copy of any accreditation you may have. For JCAHO accreditation, send a copy of the JCAHO certificate and also the JCAHO letter that gives the effective month, day and year. If you are a clinician in private practice, please send a copy of your current professional license.

The completed, signed forms (originals) and copies of licenses and/or certificates may be returned in one of two ways. They may be sent separately to my attention at the address listed below or they may be sent back with the signed contract. **Please send these forms to Cost Recovery Unit, Attn: Vicky Varga, 1825 Faulkland Rd., Wilmington, DE 19805.**

Any additional program or rate information you are able to include would be appreciated. If you have rate information already prepared and do not want to hand write your rates in the Rate Certification form, attach your rate information to the signed Rate Certification Form. The Rate Certification Form, CMS Sanctions Certification Form, and Accreditation Status Form are standard forms required to be completed every year. In order for the Delaware Children's Department to pursue Delaware Medicaid reimbursement for services we provide to Delaware children through a third party, such as your organization, we are required to obtain information and signatures on the enclosed forms yearly and maintain copies of current licenses and accreditations. In your contract or agreement with us you agreed to provide this information. The funds we recover from Medicaid allow us to provide more services to the children of Delaware.

If you have any questions, please contact Victoria Varga at (302) 892-4565 or at victoria.varga@state.de.us. Please contact Ms. Varga if you expect a delay in your response greater than two weeks.

Thank you for your assistance in this matter.

Victoria Varga, Management Analyst II
Delaware Children's Department, DMSS, CRU
1825 Faulkland Road
Wilmington, DE 19805
Phone (302)892-4565, Fax (302)633-5113
victoria.varga@state.de.us

STATE OF DELAWARE
DEPARTMENT OF SERVICES FOR CHILDREN, YOUTH, AND THEIR
Department of Services
for Children, Youth, and
Their Families
FAMILIES

ACCREDITATION STATUS FORM

- This organization is not accredited.
 This organization is accredited.

Accrediting Organization(s)

From: _____ To: _____
Period of Accreditation
Beginning (MM/DD/YY) to Ending (MM/DD/YY)

Please detail which parts of your organization are covered by the accreditation standards (If your entire organization is accredited, it is only necessary to indicate "All" instead of providing a comprehensive list). In addition please specify facility or campus names included in the survey (if applicable) within each service area.

PLEASE PROVIDE A COPY OF THE ACCREDITATION CERTIFICATE FOR OUR FILE

Date

Name of person completing form (please print)

Phone number (for any questions on this topic)

Agency

Email address

STATE OF DELAWARE
DEPARTMENT OF SERVICES FOR CHILDREN, YOUTH, AND THEIR
FAMILIES

CMS SANCTIONS CERTIFICATION FORM

Per the “SOCIAL SECURITY ACT, SEC. 1128, 42 USC Sec. 1320a-7. Exclusion of certain individuals and entities from participation in Medicare and State health care programs,” the Secretary of U.S. Department of Health and Human Services, may exclude individuals and entities from participation in any Federal health care program, including Medicaid and Medicare or any State health care program.

I, the undersigned, as an authorized representative of this agency, certify that this agency has never been sanctioned by Centers for Medicare & Medicaid Services (CMS) formerly HCFA or had a license revoked.

(Date)

(Authorized Signature)

(Printed Name)

(Title)

(Agency Name)

(Street Address)

(City, State, Zip)

If your agency has ever been sanctioned please provide details including date of reinstatement.

SEND ORIGINAL SIGNATURE ONLY -- DO NOT SEND A COPY OF THIS DOCUMENT.

STATE OF DELAWARE DEPARTMENT OF SERVICES
FOR CHILDREN, YOUTH AND THEIR FAMILIES (DSCYF)

RATE CERTIFICATION FORM - Charges to the General Public

DSCYF may bill services which we have purchased from your agency to Delaware Medicaid under an agreement between DSCYF and Medicaid, whereby DSCYF is the exclusive provider of Medicaid behavioral health services to children in Delaware. Per 42 CFR 447.271 (Upper limits based on customary charges), Medicaid will not reimburse DSCYF more than the provider's usual and customary charges to the general public for the services.

To assist us in remaining compliant with the above regulation, we ask that you complete this form and return it to us.

- Please list your usual and customary per unit charges to the general public for all behavioral health services which are contracted by DSCYF. If you operate a school program as part of the therapeutic program, show the education costs as a separate rate. If children in the program attend public school, it is not necessary to list the education cost.
- Please complete a separate form for each location for which services are contracted by DSCYF. (NOTE: a campus consisting of closely located cottages is considered one location)
- **Please do not write the rate agreed upon with DSCYF, unless it is also your usual and customary charge to the general public. If a service is program funded and there is no rate, please write "program funded."**

Please indicate the 4-digit DSCYF Contract ID number on your DSCYF contract): _____

Please indicate the period for which the rates below apply (fiscal or calendar year): _____

<u>Service type</u> (include HCPC and CPT codes)	<u>Rate / Unit of Service</u>	<u>Education Cost Per Unit</u>
_____	/	_____
_____	/	_____
_____	/	_____
_____	/	_____

If your facility is not located in Delaware, please indicate whether you are enrolled with the Medicaid program in the state in which the facility that provides the MA behavioral health services purchased by DSCYF is located.

No, agency is not enrolled with MA in another state: _____

Yes, agency is enrolled with MA in the following states: _____

(If agency is enrolled with MA in its home state (that state in which agency is located), please include a listing of your State Medicaid rates for the services for which you are contracting with DSCYF.)

<u>Return ORIGINAL SIGNATURE</u>	Authorized Representative Name _____ (Please print)
	Authorized Signature _____
	Title _____
	Date _____
	Agency Name (Please print) _____
	Phone Number _____ (for any questions on this topic)
	Email address _____