Dear Service Provider:

Under an agreement between DSCYF and Delaware Medicaid, DSCYF is the exclusive provider of Medicaid behavioral health and substance abuse services to children in Delaware.

In order for DSCYF's Cost Recovery Unit to pursue reimbursement from Medicaid for services provided to Delaware children through a third party such as your organization, we must annually obtain documentation from you. In your Contract or Statement of Agreement (Article I, Section B.5) with DSCYF you agreed to provide this information.

Completing these forms and supplying the below requested information will not enroll you in Medicaid. It will simply enable the State of Delaware to lower its cost by requesting partial compensation from Medicaid. We are requesting the following:

- ☐ 1. Rate Certification Form (enclosed)
- ☐ 2. Usual and Customary Rate Schedule showing your rates for services like the services in this contract
- ☐ 3. CMS Sanctions Certification Form (enclosed)
- ☐ 4. Accreditation Status Form (enclosed)
- ☐ 5. Letters of Accreditation, such as JCAHO (copy)
- ☐ 6. State issued licenses (copy)
- ☐ 7. National Provider ID (NPI) Number (copy of NPI letter or printout from NPI Registry)
- ☐ 8. State issued Medicaid Letter, showing your Medicaid enrollment and rates (copy)
- ☐ 9. Provider Disclosure Statement (attached as separate document)

Please return the completed forms and other documents via email, fax, or mail:

You can scan and email to:	brian.calio@state.de.us This is the preferred method
You can fax to: *(Must use all 10 digits)*	302.661.7224 (This is a shared fax number, so include a cover page to Brian Calio's attention)
You can mail to	STATE OF DELAWARE DSCYF-DMSS-N301 COST RECOVERY UNIT (ATTN: BRIAN CALIO) 1825 FAULKLAND ROAD, WILMINGTON, DE 19805

If you expect a delay of more than two weeks in your response or if you have any questions, please contact me. The funds we recover from Medicaid allow us to provide more services, through service providers like you, to the children of Delaware. Once you send these documents, you may call the number below to confirm receipt.

Brian Calio
Fiscal Management Analyst
DSCYF Cost Recovery Unit
Phone: 302.892.4570

RATE CERTIFICATION FORM – Day Treatment

Usual and Customary Charges to the Public

Complete a separate form for each location for which services are contracted by DSCYF. If a service is program funded, not per diem, please check "Yes" for "Program Funded." Please list both your "usual and customary rate" and the DSCYF contracted rate for all services. If you operate an education program as part of the treatment program, please show the education cost as a separate rate. If children in the program attend public school, it is not necessary to list the public education cost.

Contract ID # (found on your DSCYF Contract)		
Contract Period	**From:**	**To:**
Program Funded	☐ YES ☐ NO	

Facility/Program Name	Service Description	Procedure Billing Code	Procedure Modifier	DSCYF Contract Rate	Usual & Customary Education Rate	Usual & Customary Total Rate	Medicaid Rate
e.g. Location name	*Day Treatment Substance Abuse program that operates more than X hours/day 5 days/week*	*H0035*		*$219.30*		*$225.00*	

Is your agency enrolled with Medicaid?	☐ YES ☐ NO
If yes, in which States?	

Signature of Authorized Representative	
Title of Authorized Representative	
Printed Name of Authorized Representative	
Agency Name	
Date	
Phone	
Email	

Please provide a copy of your State's Medicaid letter showing your enrollment and your rate(s).

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.

As an authorized representative of this agency, I certify that the following is true regarding sanctions by the Centers for Medicare & Medicaid Services (CMS), formerly HCFA.

☐ This agency or individuals working for it have never been sanctioned by CMS.

☐ This agency or individuals working for it were sanctioned by CMS. The agency or individuals were sanctioned on (date) _____. Please select one option below.

- ☐ The sanctions have not been removed.
- ☐ The sanctions were removed on (date) _____. Please provide supporting documentation.

Signature of Authorized representative	
Printed Name	
Date	
Title	
Phone Number	
Email Address	
Agency Name	
Agency Address	
Agency City, State, Zip	

You may attach supporting documentation if necessary.

ACCREDITATION STATUS FORM

☐ This agency is not accredited.

☐ This agency is accredited. Documents confirming accreditation such as certificates are attached.

Agency Name	
Accrediting Organization(s), i.e. JCAHO, CARF, COA, etc.	
Period of Accreditation START Date	
Period of Accreditation END Date	

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, if applicable, included in the survey within each service area.

Signature of Person Completing Form	
Printed Name of Person Completing Form	
Date	
Phone Number	
Email address	

Please provide copies of accreditation certificate(s).