HOME AND COMMUNITY BASED-SERVICES PROVIDER AGREEMENT

Name of Service Provider *(Please type or print)*

Address

Telephone	Vendor Number	Service Code

CERTIFICATION STATEMENT

The Provider agrees and shall certify under penalty of perjury that all claims for services provided to regional center clients have been provided to the clients by the Provider. The services were, to the best of the Provider's knowledge, provided in accordance with the client's written Individual Program Plan. The Provider shall also 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 any 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 three 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 client. The Provider agrees to furnish these records and any information regarding payments claimed for providing the services, on request, 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.

THE PROVIDER AGREES TO INCLUDE WITH EACH CLAIM SUBMITTED TO THE REGIONAL CENTER A CERTIFICATION STATEMENT TO THE ABOVE TERMS AND CONDITIONS WHICH SHALL BE PRINTED ON THE REVERSE SIDE OF EACH PROVIDER OF CARE CLAIM FORM.

I certify that the undersigned will be A PARTICIPATING provider of Medi-Cal home and community-based services upon SUBMISSION OF THIS AGREEMENT TO THE REGIONAL CENTER and satisfaction of all vendorization requirements pursuant to Title 17, California Code of Regulations, and compliance with the requirements for providers of service set out in Welfare and Institutions Code, Division 9, Part 3, and in California Code of Regulations, Title 22.

Department of Health Services

Signature of Service Provider	Date

(Rev. 6/99)

HOME AND COMMUNITY BASED-SERVICES PROVIDER AGREEMENT

Name of Service Provider *(Please type or print)*

John Smith LLC

Address

123 Sunny Ln. Sunnyville, CA 123456

Telephone	Vendor Number	Service Code
555-555-5555		099

You will not have a vendor number the first time completing this form. You can leave this blank.

CERTIFICATION STATEMENT

The Provider agrees and shall certify under penalty of perjury that all claims for services pro r clients have been provided to the clients by the Provider. The services were, to the best of the P rovided in accordance with the client's written Individual Program Plan. The Provider shall also 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 any 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 three 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 client. The Provider agrees to furnish these records and any information regarding payments claimed for providing the services, on request, 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.

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Department of Health Services

Signature of Service Provider	Date
John Smith	01-01-2023

(Rev. 6/99).