**MEDICAID CREDENTIALING AGREEMENT**

This contract is made effective this \_\_\_\_ day of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, 20\_\_\_\_, by and between [COMPANY NAME] Services (herein after the “Company”), and \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (herein after “Provider Enrollee”). This contract constitutes a provider agreement between these two parties and is governed by the laws of Florida.

WHEREAS the company intends to enroll the Provider Enrollee as a member of the Company’s behavior analysis Medicaid group provider on the conditions set forth in this contract.

**LEGAL STATUS**

The Provider Enrollee agrees that he or she is fully authorized to seek employment in the United States of America and provides proof of eligible legal status (i.e., unrestricted social security card and/or permanent resident card/US passport card). Per Medicaid enrollment policy for all BA39 provider types, Provider Enrollees are required to submit a copy of their social security card as proof of tax ID. The Company will maintain confidential documents in a secure location.

**The RED text can be removed from the final template, it only serves as a reminder.**

**[SOME PROVIDER ENROLLEES MAY BE NON-US CITIZENS OR PERMANENT RESIDENTS OR HAS RESTRICTED SOCIAL SECURITY CARD WITH ONLY WORK AUTHORIZATION; THOSE ENROLLEES WILL NEED TO SUBMIT ADDITIONAL DOCUMENTS SUPPORTING THEIR AUTHORIZATION STATUS TO LEGALLY WORK IN THIS COUNTRY.]**

**CERTIFICATION**

The Provider Enrollee must maintain an active status in the Behavior Analysis Certification Board (BACB®) Certificant Registry to be a Medicaid provider applicant. The Provider Enrollee’s certification must also not be within the expiration date during the enrollment period, a certification renewal must be conducted prior to the initiation of the provider application. If the Provider Enrollee is shown to be inactive due to not having a supervisor, if applicable, then the Company will assign the Provider Enrollee a supervisor to practice under. The selected supervisor will be the anticipated BCBA/BCaBA that the Provider Enrollee will be assigned to practice under with potential cases.

**[PLEASE NOTE: PROVIDER ENROLLEES FOR THE LEAD ANALYST PROVIDER TYPE DO NOT REQUIRE SUPERVISION, THE ABOVE INFORMATION REGARDING SUPERVISION WILL NOT APPLY TO THEM AND CAN BE OMITTED].**

**BACKGROUND SCREENING**

The Provider Enrollee’s background screening results must be shown with an eligible status for Medicaid provider enrollment. If the screening results discloses an ineligible status for provider enrollment, then the Provider Enrollee will not be allowed to enroll as a member of the Company’s group.

**NON-COMPETE TENURE CLAUSE**

The Provider Enrollee acknowledges that for the first [#] months following the approval of a Medicaid provider enrollment application, the Provider Enrollee is required to be contracted as a member of the Company’s group. During the tenure period, the Provider Enrollee is allowed to be employed with a competing group provider, however, he or she must maintain a client with the Company for the specified timeframe.

**[THE NON-COMPETE TENURE CLAUSE CAN BE OMITTED FROM THIS AGREEMENT, IT IS OPTIONAL. ADJUSTMENTS CAN ALSO BE MADE TO BEST FIT YOUR COMPANY’S POLICIES. FOR EXAMPLE, YOU MAY SUBSTITUTE OR ADD A NON-SOLICITATION CLAUSE.]**

**ACKNOWLEDGEMENT**

The Provider Enrollee acknowledges that the Company’s decision to enroll him or her as a Medicaid provider under their group is due to the lack of Provider Enrollee availability in the geographical area to service the Medicaid recipients in the Company. If approved, the Provider Enrollee will undergo a new hire onboarding process to ensure duties and responsibilities are understood prior to the start date of employment. The Provider Enrollee also acknowledges that the Company is not responsible for the Florida Medicaid’s program determination for their enrollment application.

IN WITNESS WHEREOF, the Company and the Provider Enrollee have executed and delivered this agreement as of the date written below.

**Authorized Company Representative Provider Enrollee**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Title: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_