

**PROVIDER AGREEMENT
BETWEEN THE NEW YORK STATE DEPARTMENT OF HEALTH
AND
THE SERVICE PROVIDERS UNDER CONTRACT WITH THE SCHOOL DISTRICT
WHICH IS ENROLLED IN THE NEW YORK STATE MEDICAID
SCHOOL SUPPORTIVE HEALTH SERVICES PROGRAM (SSHSP)**

Based upon a request by the school district to participate in the New York State Medicaid SSHSP Program under Title XIX of the Social Security Act,

(Organization/Contracted Provider's Name)

will hereinafter be called the (outside contracted) Provider, agrees as follows to:

- A)
- 1) Keep any record necessary to disclose the extent of services the Provider furnishes to recipients receiving assistance under the New York State Plan for Medicaid Assistance.
 - 2) On request, furnish the New York State Department of Health, or its designee and the Secretary of the United States Department of Health and Human Services, and the New York State Medicaid Fraud Control Unit any information maintained under paragraph (A)(1), and any information regarding any Medicaid claims reassigned by the Provider.
 - 3) Comply with the disclosure requirements specified in 42 CFR Part 455, Subpart B.
- B) Comply with Title VI of the Civil Rights Act of 1964, Section 504 of the Federal Rehabilitation Act of 1973, and all other State and Federal statutory and constitutional non-discrimination provisions which prohibit discrimination on the basis of race, color, national origin, handicap, age, sex, religion and/or marital status.
- C) Abide by all applicable Federal and State laws and regulations, including the Social Security Act, the New York State Social Services Law, Part 42 of the Code of Federal Regulations and Title 18 of the Codes, Rules and Regulations of the State of New York.

(Outside Contract) Provider's Authorized Signature: _____

Printed Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone: _____ Date Signed: _____

Please list the School District(s) under contract with on the back of this form.

