DXC Technology
P.O. Box 242577
301 Technacenter Dr.
Montgomery, AL 36124-2577

December 01, 2017

ESCAMBIA COUNTY EMERGENCY
6575 NORTH W STREET
PENSACOLA, FL 32505-0000

Re: Re-Enrollment of Existing Alabama Medicaid Provider Number

Medicaid ID: 210040403
NPI: 1518960426

Dear Provider:

In accordance with federal and state rules, the Alabama Medicaid Agency requires some providers to have a site visit in addition to completing re-enrollment verification. If a visit has been conducted by Alabama Medicaid or another approved entity within the required time constraints, this letter is being mailed to your office as a notice of the need to re-enroll with Alabama Medicaid. If a visit has not been conducted within the required time constraints, this provider reenrollment notification is being hand delivered to you by your Alabama Medicaid Provider Representative. Any issues discovered during the visit may impact your status as a Medicaid provider.

Federal Law now requires all Medicaid providers to verify their enrollment information and/or submit any changes in order to receive payment. To expedite this process, providers are asked to do the following for the service location sited below:

1. Go to www.medicaid.alabama.gov and click on Providers, then Provider Home and then Secure Portal Login.
2. Download the Provider Reenrollment Facsimile (PRV-A035-M).
3. Review entire document for accuracy.
4. If information is correct, print, sign and mail the form along with any required supplemental documents.
5. If changes are needed, follow directions for each specific section, then print, sign and mail the form along with any required supplemental documents. (Note: Contact information, as well as some addresses, fax, e-mail and phone data may be updated online via the Provider Web Portal.)
6. All documentation must be received by the Provider Enrollment Unit within 35 days of delivery of this letter. Failure to submit this information will cause your provider number to be deactivated.

Physical Location Address:
6575 N W STREET
PENSACOLA, FL 32505-1714

Re-Enrollment Facsimile Download Instructions can be found at the following link: http://www.medicaid.alabama.gov/content/10.0_Contact/10.3_Provider_Contacts/10.3.4_Provider_Enrollment.aspx Under Re-Enrollment - Downloading Provider Reenrollment Facsimile.

Information should be submitted to:

DXC Technology
ATTN: Provider Enrollment
P.O. Box 242577
301 Technacenter Dr.
Montgomery, AL 36124

If you have questions regarding this letter, please call 1-888-223-3630 (nationwide).

We appreciate your participation in the Alabama Medicaid program and thank you for helping us ensure the accuracy of your contact and billing information.

Sincerely,

Provider Enrollment

ALABAMA MEDICAID AGENCY
MEDICAID MANAGEMENT INFORMATION SYSTEM
PROVIDER REENROLLMENT FACSIMILE
REPORT PERIOD: 12/01/2017

NPI	MCD ID	NAME
1518960426	210040403	ESCAMBIA COUNTY EMERGENCY

Below is the information Alabama Medicaid currently has on file for the above named provider. As an Alabama Medicaid provider you MUST review this information to determine the accuracy. If all information is accurate, please print and sign this report and submit along with any required supplemental documentation. If this information is not accurate, take action as needed based on directions below. All providers MUST take action in order for the provider number shown below to remain active.

ALL REPORTS, WHETHER CHANGED OR NOT, MUST BE SIGNED AND SUBMITTED WITH SUPPLEMENTAL DOCUMENTATION TO DXC,
ATTN: PROVIDER ENROLLMENT AT: PO BOX 242577, MONTGOMERY, AL 36124

ALL DOCUMENTS/FORMS/LISTS MENTIONED IN THIS DOCUMENT THAT YOU MAY NEED TO COMPLETE OR REFER TO FOR GUIDANCE CAN BE FOUND AT:
http://www.medicaid.alabama.gov/content/10.0_Contact/10.3_Provider_Contacts/10.3.4_Provider_Enrollment.aspx

A change to data in this section constitutes the need for a new enrollment application and closure of this provider number. To close this provider number, indicate the reason for closure and the date (mm/dd/ccyy) on this form prior to submission. To complete a new enrollment application visit: https://www.medicaidhcp.alabamaservices.org/ProviderEnrollment

TAX ID 596000598

PROVIDER TYPE
26 Transportation Provider

Changes are not allowed for the data in this section. This information is displayed for validation purposes only. If this information is not accurate please contact DXC Provider Enrollment Staff at (888) 223-3630 (nationwide):

GROUP NAME
GROUP NPI
GROUP MCD ID

Changes to data in this section require the provider to print this report, notate corrections and supply any additionally required supporting documentation to DXC Provider Enrollment Staff:

SERVICE LOCATION INFORMATION:
ADDRESS 1 6575 N W STREET
ADDRESS 2
CITY PENSACOLA
STATE FL
ZIP 32505-1714

TAX NAME ESCAMBIA COUNTY EMERGENCY
Service Location and/or Tax Name changes require a completed W-9.
Corporate Board of Directors Resolution is required for physician groups that operate as a corporation.

DEA #

CLIA #

NPI	MCD ID	NAME
1518960426	210040403	ESCAMBIA COUNTY EMERGENCY

CLIA and/or DEA changes require a copy of the certificate.

MEDICARE # 1518960426
Medicare Number changes require a copy of the Medicare Letter for this provider at this location.

PROVIDER SPECIALTY
260 Ground Ambulance

Specialties you may indicate must be appropriate for your provider type. Refer to the Type Specialty Chart and/or forms (as needed) on the website mentioned below.

EPSDT specialty requires submission of a new EPSDT Agreement. Plan First specialty requires submission of a new Plan First Agreement. Certification of Mammography Systems is required if adding the Mammography specialty.

EFT INDICATOR
If the EFT indicator immediately above is 'Y', you must complete an Electronic Funds Transfer (EFT) Enrollment and submit along with a copy of a voided check or letter from the bank.

Providers who have been assigned trading partner ID, to receive Electronic Remittance Advices (ERAs)/835 transactions, must complete and submit along with this document an updated Electronic Remittance Advice (ERA) Authorization Agreement. For providers already enrolled to receive Electronic Remittance Advice (ERAs/835) transactions, the data will be verified and/or updated based on the updated form submitted. For providers NOT already enrolled to receive Electronic Remittance Advice (ERAs/835) transactions, qualified providers will be enrolled based on the updated form submitted.

EFT and ERA enrollment may be accomplished via the electronic enrollment functionality available on the Electronic Provider Enrollment Portal at https://medicaidhcp.alabamaservices.org/provider/ OR via the Forms available at: http://www.medicaid.alabama.gov/content/10.0_Contact/10.3_Provider_Contacts/10.3.4_Provider_Enrollment.aspx

License data is displayed as is stored by Alabama Medicaid. With the required additions of information such as state abbreviations, the entire license may not reflect the exact information on your license. Please verify only the numeric values shown below as they must be the same as is reflected on your professional license. If an update is required please be sure to print this report, notate changes and submit to DXC Provider Enrollment Staff.

LICENSE # 009105680 LICENSE STATE FL LICENSE EFFECTIVE DATE 12/14/2017 LICENSE END DATE 12/14/2018
221 AL 6/12/2017 6/30/2018

Collaborating/Supervising Physician information must be verified. For Nurse Practitioners who have a Collaborating/Supervising Physician not displayed below OR different from that displayed must indicate the Collaborating/Supervising Physician Name and NPI.

COLLABORATING/SUPERVISING PHYSICIAN NPI:
COLLABORATING/SUPERVISING PHYSICIAN NAME:

Information provided must match the Collaborating/Supervising Physician information on the Approval for Collaborative Practice license that is signed by the CRNP and collaborating physician. A copy of the Approval for Collaborative Practice license must accompany this form.

NPI	MCD ID	NAME
1518960426	210040403	ESCAMBIA COUNTY EMERGENCY

ALL GROUP and FACILITY providers must complete and submit FACILITY/GROUP DISCLOSURE FORMS for all parties who fill at least one of the following positions:

Agent	Director	Managing Employee
Officer	Owner	Shareholder (with 5% or more controlling interest)

Listed below are the parties currently on file as filling a position listed above. If listed or additional parties are still filling such positions, a Facility/Group Disclosure Form must be submitted for each party. If any of the parties listed below no longer fill such a position please provide an end date for the segment listed below:

NAME	EFFECTIVE DATE	END DATE

Changes to data in this section should be made via the Web Portal panels located under the Provider menu. Upon doing so, indicate in this section that changes were applied via the Web Portal:

CONTACT INFORMATION:

NAME	JOE SCIALDONE		E-MAIL	JAScialdone@MyEscambia.com
PHONE	(850)471-6507	EXT	FAX	(850)471-6518

If contact information above is not provided, the name and phone number of the person signing this facsimile will be entered on provider file as the contact.

SERVICE LOCATION INFORMATION:

E-MAIL	JAScialdone@MyEscambia.com	
PHONE	(850)471-6500	EXT
FAX	(850)471-6518	
TOLL FREE		EXT

PAY TO INFORMATION:

E-MAIL			
ADDRESS 1	6575 NORTH W STREET	PHONE	EXT
ADDRESS 2		FAX	
CITY	PENSACOLA	TOLL FREE	EXT
STATE	FL		
ZIP	32505-		

MAIL TO INFORMATION:

E-MAIL			
ADDRESS 1	6575 NORTH W STREET	PHONE	EXT
ADDRESS 2		FAX	
CITY	PENSACOLA		
STATE	FL		
ZIP	32505-1714		

ALL required supplemental documentation, in addition to the items listed below, must also be received along with this document.

NPI	MCD ID	NAME
1518960426	210040403	ESCAMBIA COUNTY EMERGENCY

ALL providers must sign and submit a new Provider Agreement.

ALL INDIVIDUAL providers must complete and submit an INDIVIDUAL DISCLOSURE FORM for themselves.

ALL GROUP and FACILITY providers must complete and submit FACILITY/GROUP DISCLOSURE FORMS for all parties who fill at least one of the following positions:

Agent	Director	Managing Employee
Officer	Owner	Shareholder (with 5% or more controlling interest)

Please be aware that an application fee may be required prior to your enrollment as an Alabama Medicaid provider. If an application fee has been paid to Medicare or another state or you are currently enrolled in Medicare, another State's Medicaid Program, or CHIP, proof of such is required to be submitted as part of the supplemental documentation for this enrollment application. If you do not meet one of the above mentioned conditions, you may be required to pay an application fee. Please refer to the Alabama Medicaid Participation Requirements to determine if your provider type is required to submit an application fee. Alabama Medicaid Participation Requirements can be found via the following link:
http://www.medicaid.alabama.gov/content/10.0_Contact/10.3_Provider_Contacts/10.3.4_Provider_Enrollment.aspx

ALL DOCUMENTS/FORMS/LISTS MENTIONED IN THIS DOCUMENT THAT YOU MAY NEED TO COMPLETE OR REFER TO FOR GUIDANCE CAN BE FOUND AT:
http://www.medicaid.alabama.gov/content/10.0_Contact/10.3_Provider_Contacts/10.3.4_Provider_Enrollment.aspx

ALL REPORTS, WHETHER CHANGED OR NOT, MUST BE SIGNED AND SUBMITTED WITH SUPPLEMENTAL DOCUMENTATION TO DXC,
ATTN: PROVIDER ENROLLMENT AT: PO BOX 242577, MONTGOMERY, AL 36124 - OR - FOR COURIERS WHO REQUIRE A PHYSICAL ADDRESS FOR DELIVERY:
ATTN: PROVIDER ENROLLMENT AT: 301 TECHNACENTER DRIVE, MONTGOMERY, AL 36117-6008

Signature _____ Date _____

Signature must be that of the individual enrolled. For groups/facilities the signature must be that of an authorized representative.

Jeff Bergosh	Chairman	850-595-4910
Printed Name	Position/Title	Phone

ATTEST: PAM CHILDERS
CLERK OF THE CIRCUIT COURT

BY: _____
DEPUTY CLERK

Approved as to form and legal sufficiency.

By/Title: _____

Date: 1/9/18

Select purpose of form below:

☐ Initial Enrollment
ATN #_____

☒ Reenrollment
NPI # 1518960426

MCD # 210040403

PROVIDER AGREEMENT

Name of Provider: Escambia County Board of County Commissioners / Escambia County EMS

NPI: 1518960426 Medicaid ID: 210040403

As a condition for participation as a provider under the Alabama Medicaid Program (MEDICAID), the provider (Provider) agrees to comply with all terms and conditions of this Agreement.

I. ALL PROVIDERS

1.1 Agreement and Documents Constituting Agreement.

A copy of the current *Alabama Medicaid Provider Manual* and the *Alabama Medicaid Administrative Code* has been or will be furnished to the Provider. This Agreement is deemed to include the applicable provisions of the State Plan, *Alabama Medicaid Administrative Code*, and *Alabama Medicaid Provider Manual*, as amended, and all State and Federal laws and regulations. If this Agreement is deemed to be in violation of any of said provisions, then this Agreement is deemed amended so as to comply therewith. Invalidity of any portion of this Agreement shall not affect the validity, effectiveness, or enforceability of any other provision. Provider agrees to comply with all of the requirements of the above authorities governing or regulating MEDICAID. Provider is responsible for ensuring that employees or agents acting on behalf of the Provider comply with all of the requirements of the above authorities.

1.2 State and Federal Regulatory Requirements.

1.2.1 Provider has not been excluded or debarred from participation in any program under Title XVIII (Medicare) or any program under Title XIX (Medicaid) under any of the provisions of Section 1128(A) or (B) of the Social Security Act (42 U.S.C. § 1320a-7), or Executive Order 12549. Provider also has not been excluded or debarred from participation in any other state or federal health-care program. Provider must notify MEDICAID or its agent within ten (10) business days of the time it receives notice that any action is being taken against Provider or any person defined under the provisions of Section 1128(A) or (B), which could result in exclusion from the Medicaid program

1.2.2 Provider agrees to disclose information on ownership and control, information related to business transactions, and information on persons convicted of crimes in accordance with 42 C.F.R. Part 455, Subpart B, and provide such information on request to MEDICAID, the Alabama Attorney General's Medicaid Fraud Control Unit, and/or the United States Department of Health and Human Services. Provider agrees to keep its application for participation in the Medicaid program current by informing MEDICAID or its agent in writing of any changes to the information contained in its application, including, but not limited to, changes in ownership or control, federal tax identification number, or provider business addresses, at least thirty (30) business days prior to making such changes. Provider also agrees to notify MEDICAID or its agent within ten (10) business days of any restriction placed on or suspension of the Provider's license or certificate to provide medical services, and Provider must provide to MEDICAID complete information related to any such suspension or restriction.

1.2.3 This Agreement is subject to all state and federal laws and regulations relating to fraud and abuse in health care and the Medicaid program. As required by 42 C.F.R. §431.107, Provider agrees to keep any and all records necessary to disclose the extent of services provided by the Provider to individuals in the Medicaid program and any information relating to payments claimed by the Provider for furnishing Medicaid services. Provider also agrees to provide, on request, access to records required to be maintained under 42 C.F.R. §431.107 and copies of those records free of charge to MEDICAID, its agent, the Alabama Attorney General's Medicaid Fraud Control Unit,

1.2.4 and/or the United States Department of Health and Human Services. All such records shall be maintained for a period of at least three years plus the current year. However, if audit, litigation, or other action by or on behalf of the State of Alabama or the Federal Government has begun but is not completed at the end of the above time period, or if audit findings, litigation, or other action has not been resolved at the end of the above time period, said records shall be retained until resolution and finality thereof.

1.2.5 The Alabama Attorney General's Medicaid Fraud Control Unit, Alabama Medicaid Investigators, and internal and external auditors for the state/federal government and/or MEDICAID may conduct interviews of Provider employees, subcontractors and its employees, witnesses, and recipients without the Provider's representative or Provider's legal counsel present unless the person voluntarily requests that the representative be present. Provider's employees, subcontractors and its employees, witnesses, and recipients must not be coerced by Provider or Provider's representative to accept representation by the Provider, and Provider agrees that no retaliation will occur to a person who denies the Provider's offer of representation. Nothing in this agreement limits a person's right to counsel of his or her choice. Requests for interviews are to be complied with, in the form and the manner requested. Provider will ensure by contract or other means that its employees and subcontractors over whom the Provider has control cooperate fully in any investigation conducted by the Alabama Attorney General's Medicaid Fraud Control Unit and/or MEDICAID. Subcontractors are those persons or entities who provide medical goods or services for which the Provider bills the Medicaid program or who provide billing, administrative, or management services in connection with Medicaid-covered services.

1.2.6 Provider must not exclude or deny aid, care, service or other benefits available under MEDICAID or in any other way discriminate against a person because of that person's race, color, national origin, gender, age, disability, political or religious affiliation or belief. Provider must provide services to Medicaid recipients in the same manner, by the same methods, and at the same level and quality as provided to the general public.

1.2.7 Provider agrees to comply with all state and federal laws relating to the preparation and filing of cost reports, audit requirements, and inspection and monitoring of facilities, quality, utilization, and records.

1.2.8 Under no circumstances shall any commitments by MEDICAID constitute a debt of the State of Alabama as prohibited by Article XI, Section 213, Constitution of Alabama of 1901, as amended by Amendment 26. It is further agreed that if any provision of this Agreement shall contravene any statute or Constitutional provision or amendment, whether now in effect or which may, during the course of the Agreement, be enacted, then that conflicting provision in the Agreement shall be deemed null and void. The Provider's sole remedy for the settlement of any and all disputes arising under the terms of this Agreement shall be limited to the filing of a claim against Medicaid with the Board of Adjustment for the State of Alabama.

1.2.9 In the event litigation is had concerning any part of this Agreement, whether initiated by Provider or MEDICAID, it is agreed that such litigation shall be had and conducted in either the Circuit Court of Montgomery County, Alabama, or the United States District Court for the Middle District of Alabama, Northern Division, according to the jurisdiction of those respective courts. This provision is not intended to, nor shall it operate to, enlarge the jurisdiction of either of said courts, but is merely an agreement and stipulation as to venue.

1.3 Claims and Encounter Data

1.3.1 Provider agrees to submit claims for payment in accordance with billing guidelines and procedures promulgated by MEDICAID, including electronic claims. Provider certifies that information submitted regarding claims or encounter data will be true, accurate, complete, and that such information can be verified by source documents from which data entry is made by the Provider. Further, Provider understands that any falsification or concealment of a material fact may be prosecuted under state and/or federal laws.

1.3.2 Provider must submit encounter data required by MEDICAID or any managed care organization to document services provided, even if the Provider is paid under a capitated fee arrangement.

1.3.3 All claims or encounters submitted by Provider must be for services actually rendered by Provider. Physician providers must submit claims for services rendered by another in accordance with MEDICAID rules regarding providers practicing under physician supervision. Claims must be submitted in the manner and in the form set forth in the *Alabama Medicaid Provider Manual*, and within the time limits established by MEDICAID for submission of claims. Claims for payment or encounter data submitted by the provider to a managed care entity or MEDICAID are governed by the Provider's contract with the managed care entity. Provider understands and agrees that MEDICAID is not liable or responsible for payment for any Medicaid-covered services provided under the managed care Provider contract, or any agreement other than this Medicaid Provider Agreement.

1.3.4 Federal and state law prohibits Provider from charging a recipient or any financially responsible relative or representative of the recipient for Medicaid-covered services, except where a copayment is authorized under the Medicaid State Plan. (42 C.F.R. §447.20). The provider (or its staff) must advise each recipient when MEDICAID payment will not be accepted prior to services being rendered, and the recipient must be notified of responsibility for the bill. The fact that Medicaid payment will not be accepted must be recorded in the recipient's medical record.

1.3.5 As a condition for eligibility for Medicaid benefits, a recipient assigns all rights to recover from any third party or any other source of payment to MEDICAID (42 C.F.R. §433.145 and §22-6-6.1, Code of Alabama 1975). Except as provided by MEDICAID's third-party recovery rules *(Alabama Medicaid Administrative Code*, Chapter 20), Provider agrees to accept the amounts paid under MEDICAID as payment in full for all covered services. (42 C.F.R. §447.15).

1.3.6 Provider must refund to MEDICAID any overpayments, duplicate payments, and erroneous payments which are paid to Provider by MEDICAID as soon as the payment error is discovered.

1.3.7 Provider has an affirmative duty to verify that claims and encounters are received by MEDICAID or its agent and implement an effective method to track submitted claims against payments made by MEDICAID.

1.3.8 MEDICAID'S obligation to make payments hereunder is subject to the availability of State and Federal funds appropriated for MEDICAID purposes. Further, MEDICAID'S obligation to make payments hereunder is and shall be governed by all applicable State and Federal laws and regulations. In no event shall the MEDICAID payment exceed the amount charged to the general public for the same service.

1.3.9 Provider shall not charge MEDICAID for services rendered on a no-cost basis to the general public.

1.3.10 Provider is prohibited from offering incentives (such as discounts, rebates, refunds, or other similar unearned gratuity or gratuities) other than an improvement(s) in the quality of service(s), for the purpose of soliciting the patronage of MEDICAID recipients. Should the Provider give a discount or rebate to the general public, a like amount shall be adjusted to the credit of MEDICAID on the MEDICAID claim form, or such other method as MEDICAID may prescribe. Failure to make a voluntary adjustment by the Provider shall authorize MEDICAID to recover same by then existing administrative recoupment procedures or legal proceedings.

1.3.11 Provider agrees and hereby acknowledges that payments made under this agreement are subject to review, audit adjustment and recoupment action. In the event that Provider acquires or has acquired ownership of another MEDICAID provider through transfer, sale, assignment, merger, replacement or any other method, whether or not a new Agreement is required, Provider shall be responsible for any unrecovered improper MEDICAID payments made to the previous provider. An indemnification agreement between Provider and the previous provider shall not affect MEDICAID'S right to recovery.

1.3.12 Provider agrees to comply with the provisions of the *Alabama Medicaid Provider Manual* regarding the transmission and receipt of electronic claims and eligibility verification data. Provider must verify that all claims submitted to MEDICAID or its agent are received and accepted. Provider is responsible for tracking claims transmissions against claims payments and detection and correcting all claims errors. If Provider contracts with third parties to provide claims and/or eligibility verification data from MEDICAID, the Provider remains responsible for verifying and validating all transactions and claims, and ensuring that the third party adheres to all client data confidentiality requirements.

II. RECIPIENT RIGHTS

2.1. Provider must maintain the recipient's state and federal right of privacy and confidentiality to the medical and personal information contained in Provider's records.

2.2. The recipient must have the right to choose providers unless that right has been restricted by MEDICAID or by waiver of this requirement from CMS. The recipient's acceptance of any service must be voluntary.

2.2.1 The recipient must have the right to choose any qualified provider of family planning services.

III. ADVANCE DIRECTIVES - HOSPITAL, HOME HEALTH, HOSPICE, AND NURSING HOME PROVIDERS

3.1 The provider shall comply with the requirements of §1902(w) of the Social Security Act (42 USC §1396a(w)) as described below:

3.1.1 Maintain written policies and procedures in respect to all adult individuals receiving medical care by or through the provider about patient rights under applicable state law to make decisions concerning medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate advance directives;

3.1.2 Provide written information to all adult individuals on patient policies concerning implementation of such rights;

3.1.3 Document in the patient's medical record whether or not the individual has executed an advance directive;

3.1.4 Not condition the provision of care or otherwise discriminate against a patient based on whether or not he/she has executed an advance directive;

3.1.5 Ensure compliance with requirements of state law (whether statutory or recognized by the courts) concerning advance directives;

3.1.6 Provide (individually or with others) for education for staff and the community on issues concerning advance directives; and

3.1.7 Furnish the written information described above to adult individuals as required by law.

IV. TERM, AMENDMENT, AND TERMINATION

This Agreement will be effective from the date all enrollment documentation has been received and verified until the date the Agreement is terminated by either party. This Agreement may be amended as required, provided such amendment is in writing and signed by both parties concerned. Either party may terminate this Agreement by providing the other party with fifteen (15) days written notice. MEDICAID may immediately terminate the Agreement for cause if the Provider is excluded from the Medicare or Medicaid programs for any reason, loses its licenses or certificates, becomes ineligible for participation in the Medicaid program, fails to comply with the provisions of this Agreement, or if the Provider is or may be placing the health and safety of recipients at risk. MEDICAID may terminate this Agreement without notice if the Provider has not provided services to Medicaid recipients in excess of five (5) claims or $100.00 during the last fiscal year.

V. CIVIL RIGHTS COMPLIANCE

Assurance is hereby given that in accordance with Title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000d et seq.), Section 504 of the Rehabilitation Act of 1973 (29 U.S.C. 70b), the Age Discrimination Act of 1975 (42 U.S.C. 6101, et seq.), the Americans with Disabilities Act of 1990, Section 1557 of the Patient Protection and Affordable Care Act of 2010, and the Regulations issued thereunder by the Department of

Health and Human Services (45 CFR Parts 80, 84, and 90) no individual shall, on the ground of race, sex, color, creed, national origin, age, or handicap be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or services by this institution.

VI. SIGNATURE AUTHENTICATION STATEMENT

To the best of my knowledge, the information supplied on this document is accurate and complete and is hereby released to HP and the Alabama Medicaid Agency for the purpose of enrolling with Alabama Medicaid.

I hereby authorize, consent to, and request the release to the Alabama Medicaid Agency of any and all records concerning me, including, but not limited to, employment records, government records, and professional licensing records, and any other information requested by the Alabama Medicaid Agency for purposes of acting on my application to be an enrolled provider under the Alabama Medicaid program.

Signature of applicant (or an authorized representative if you are enrolling as a provider group/supplier)

1. 18 U.S.C. § 1001 authorizes criminal penalties against an individual who in any matter within jurisdiction of any depart or agency of the United States knowingly and willfully falsifies, conceals or covers up by any trick, scheme or device a material fact, or make any false, fictitious or fraudulent statements or representations, or makes any false writing or document knowing the same to contain any false, fictitious of fraudulent statement or entry.

Individual offenders are subject to fines of up to $250,000 and imprisonment for up to five years. Offenders that are organizations are subject to fines of up to $500,000. 18 U.S.C. § 3571 Section 3571(d) also authorizes fines of up to twice the gross gain derived by the offender if it is greater than the amount specifically authorized by the sentencing statute.

2. Section 1128B(a)(1) of the Social Security Act authorizes criminal penalties against an individual who "knowingly and willfully makes or causes to be made any false statement or representation of a material fact in any application for any benefit or payment under a program under a Federal health care program. **The offender is subject to fines of up to $25,000 and/or imprisonment for up to five years.**

3. The Civil False Claims Act, 31 U.S.C. § 3729 imposes civil liability, in part, on any person who:
a) knowingly presents, or causes to be presented, to an officer or an employee of the United States Government a false or fraudulent claim for payment or approval;
b) knowingly makes, uses, or causes to be made or used, a false record or statement to get a false or fraudulent claim paid or approved by the Government; or
c) conspire to defraud the Government by getting a false or fraudulent claim allowed or paid.

4. Section 1128B(a)(1) of the Social Security Act imposes civil liability, in part, on any person (including an organization, agency or other entity) that knowingly presents or causes to be presented to an officer, employee, or agent of the United States, or of any department or agency thereof, or of any State agency.

A claim that the Secretary determines is for a medical or other item or service that the person knows or should know:
a) was not provided as claimed; and/or
b) the claim is false or fraudulent.

This provision authorizes a civil monetary penalty of up to $10,000 per each item or service, an assessment of up to 3 times the amount claimed, and exclusion from participation in the Medicare program and State health care programs.

5. The Government may assert common law claims such as "common law fraud," "money paid by mistake," and "unjust enrichment." **Remedies include compensatory and punitive damages, restitution and recovery of the amount of the unjust profit.**

Provider Signature _____
(Must be an original signature)

Date _____

Name of Provider: _____

BOARD OF COUNTY COMMISSIONERS
ESCAMBIA COUNTY, FLORIDA
Jeff Bergosh, Chairman

Approved as to form and legal sufficiency.

By/Title: _____

Date: 1/8/18

ATTEST: PAM CHILDERS
CLERK OF THE CIRCUIT COURT

BY: _____
DEPUTY CLERK

Select purpose of form below: DISCLOSURE FORM Revised 12/09/16

☐ Initial Enrollment ATN #_____

☐ Reenrollment NPI # 1518960426 MCD # 210040403

☐ Update NPI #_____ MCD #_____

PROVIDER DISCLOSURE FORM

Providers who operate as a corporation, organization, institution, agency, partnership, professional association, or similar entity must complete the following information for each of the following individuals: (Print/Make additional copies as necessary)

Owners Officers Shareholders with 5% or more controlling interest
Agents Directors Managing Employees

This form must be completed for anyone who holds one of the above listed positions. Completion of this form requires that a valid answer be provided to EVERY question. Incomplete forms will be returned for the missing information.

Submit with bar coded cover sheet to HPES' Provider Enrollment Department at:
P O Box 241685, Montgomery, AL 36124-1685

The completion of this form is required to establish a new group or payee or update an enrolled group or payee. Please note that the address for corporate entities must include as applicable primary business address, every business location, and P.O. Box address. Attach additional sheets if necessary.

Name: Escambia County Board of County Commissioners / Escambia County EMS	Title: NA
Home Address: NA	Business Address: 6575 North W St Pensacola, FL 32505-1714
Social Security Number: NA	Employer's Tax ID: 59-6000598
Driver's License Number & Issuer: NA	Driver's License Expiration Date: NA
Date of Birth: NA	Sex: ☐ Male ☐ Female NA
Previous Home Address: NA	Previous Business Address: NA

List the name and address of each person with an ownership or controlling interest in the disclosing entity or in any subcontractor in which the disclosing entity has direct or indirect ownership of 5% or more. This includes relatives.

Name	Address
Jeff Bergosh, Chairman	Escambia County Board of County Commissioners
	Escambia County, Florida

List the names of **any other disclosing** entity in which person with an ownership or control interest in the disclosing entity also has an ownership or control interest of at least 5% or more.

NOTE: Other disclosing entity means any other Medicaid disclosing entity and any entity that does not participate in Medicaid, but is required to disclose certain ownership and control information because of participation in any of the programs established under the title V, XVIII, or XX of the Act.

Name	Address	Tax ID	%
NA			

Are you related as spouse, parent, child, or sibling to any other owner, officer, agent, managing employee, director or shareholder? ☐ Yes ☒ No If yes, please give names and relationships (Attach additional sheets if necessary):

Name	Relationship

Select purpose of form below:

DISCLOSURE FORM Revised 12/09/16

☐ Initial Enrollment
ATN #_____

☒ Reenrollment
NPI # 1518960426
MCD # 210040403

☐ Update
NPI #_____
MCD #_____

PROVIDER DISCLOSURE FORM (cont.)

List any business transactions with wholly owned suppliers or any subcontractors totaling more than $25,000, during the last 12 months.

FULL LEGAL NAME	ADDRESS	AMOUNT OF BUSINESS TRANSACTION	RELATIONSHIP
NA	NA	NA	NA

Have you ever been excluded, debarred, or sanctioned from any state or federal program? ☐Yes ☐ No
If yes, please fully explain the details including dates, the state where the incident occurred, and any adverse action against your license: (attach additional sheets if necessary)

No

Is your license currently suspended or restricted? ☐Yes ☐ No

If yes, please fully explain the details including dates, the state where the incident occurred, and any adverse action against your license: (attach additional sheets if necessary)

No

Have you ever been convicted of a crime? (excluding minor traffic citations) ☐Yes ☐ No

Convicted means that:

1. A judgement of conviction has been entered against an individual or entity by a Federal, State or local court, regardless of whether:
   a) There is a post-trial motion or appeal pending, or
   b) The judgement of conviction or other record related to the criminal conduct has been expunged or otherwise removed;
2. A Federal, State or local court has made a finding of guilt against an individual or entity;
3. A Federal, State or local court has accepted a plea of guilty or *nolo contendere* by an individual or entity; or
4. An individual or entity has entered into participation in a first offender, deferred adjudication, or other program or arrangement where judgement of conviction has been withheld.

If yes, please fully explain the details including dates, the state where the incident occurred, and any adverse action against your license:

NA

Do you have any outstanding criminal fines, restitution orders, or overpayments identified in this state or any other state? ☐ Yes ☒ No

STATE OF FLORIDA
DEPARTMENT OF HEALTH
BUREAU OF EMERGENCY MEDICAL OVERSIGHT

ADVANCED LIFE SUPPORT SERVICE LICENSE

This is to certify that: ESCAMBIA COUNTY PUBLIC SAFETY DEPARTMENT Provider Number # 1703
Name of Provider

1000 WEST MORENO STREET, PENSACOLA, FLORIDA 32501
Address

has complied with Chapter 401, Florida Statutes, and Chapter 64J-1, Florida Administrative Code, and is authorized to operate as an Advanced Life Support Service subject to any and all limitations specified in the applicable Certificate(s) of Public Convenience and Necessity and/or Mutual Aid Agreements for the County(s) listed below:

☐ INTER-FACILITY ☒ TRANSPORT ☐ NON-TRANSPORT

ESCAMBIA
County (s)

Steve A. McCoy
Emergency Medical Services Administrator
Florida Department of Health

THIS CERTIFICATE EXPIRES ON: 12/14/2018

This certificate shall be posted in the above mentioned establishment

PUBLIC SAFETY BUREAU
CERTIFICATE OF PUBLIC CONVENIENCE AND NECESSITY

WHEREAS, the Escambia County Public Safety Department has requested authorization to provide Advanced Life Support services to the citizens of Escambia County; and
(Advanced Life or Basic Life Support)

WHEREAS, there has been demonstrated there is a need to provide these essential services to the citizens of this county; and,

WHEREAS, the above named service affirms that it will maintain compliance with the requirements of the Emergency Medical Services Act (Chapter 401, F.S.) and rules (Chapter 10D-66, F.A.C.).

THEREFORE, the Board of County Commissioners of Escambia County hereby issues a Certificate of Public Convenience and Necessity to said Company to provide ALS Non Transport and ALS Transport services with limitations as prescribed on this certificate.
(BLS, ALS-transport, ALS non-transport)

In issuing this certificate, the governing body of Escambia County has considered recommendations of affected municipalities.

Date Issued January 1, 2018

Date of Expiration December 31, 2018
(Unless certificate is sooner revoked or suspended)

Limitations: JURISDICTION: Entire County

SPECIAL CONDITIONS: To include all ALS and BLS transfers

ATTEST: Pam Childers
Clerk of the Circuit Court

Deputy Clerk

Board of County Commissioners
D.B. Underhill, Chairman

BCC Approved: 9/21/2017

Alabama State Board of Health
Office of Emergency Medical Services

THIS IS TO CERTIFY that a license is hereby granted by the STATE BOARD OF HEALTH

To ESCAMBIA COUNTY EMS

To conduct and maintain an EMERGENCY MEDICAL SERVICE in **Out of State** County,

at Address: **6575 NORTH "W" STREET**
PENSACOLA, FL 32505

In EMS Region: **Out of State**

is authorized to Supply/Resupply Fluids/Medications at the **ALS Level 1.**
This license Shall Expire **06/30/2018**, and is subject to the provisions of the Code of Alabama, 1975, §22-18-1, et seq.

This license shall not be Assignable or Transferable and shall be subject to revocation as specified in the STATE BOARD OF HEALTH EMERGENCY MEDICAL SERVICES RULES .

IN WITNESS WHEREOF, I have hereunto set my hand this day, **June 12 2017.**

State Health Officer

License Number **221**

Certificate No. **7515**

ADPH-EMS-26/Rev. 11-01-15