Ohio Department of Medicaid

ADDENDUM TO ODM PROVIDER AGREEMENT NURSING FACILITY VENTILATOR PROGRAM

SECTION I: PROVIDER INFORMATION			
Facility Name: *(DBA)*			
Facility Street Address:			
City:	**State:**	**Zip Code:**	**Medicaid Provider Number:**
Room/Bed Numbers in Vent Unit:			

SECTION II: ADDITIONAL PROVIDER REQUIREMENTS

In addition to the requirements specified in the Nursing Facility Provider Agreement, the Nursing Facility (NF) shall comply with all of the requirements included in Ohio Administrative Code 5160-3-18 Nursing Facilities (NFs): Ventilator Program. The facility must also comply with Paragraph (E) Ventilator weaning if they are authorized to provide ventilator weaning services under this program as designated below.

SECTION III: PROVIDER SIGNATURE

(OPTION A) By my signature below, I certify that I am the owner, officer, chief executive officer, general partner, or board member of the business organization entering into this provider agreement to operate this ventilator services unit under the Medicaid program. I agree to be bound by this agreement and all applicable laws. I certify the information submitted on the request and the information as it appears on this provider agreement is accurate and complete. I agree that our business organization will notify the Ohio Department of Medicaid in writing of any subsequent changes to the information contained in the request or in this agreement.

Provider Representative Name *(print or type)*	**Title** *(print or type)*
Provider Representative Signature	**Date**

(OPTION B) By my signature below, I certify that I am signing with agent authority from and on behalf of,

Name *(print or type)* _____ ***Title*** *(print or type)* _____

who is the owner, officer, chief executive officer, general partner, or board member of the business organization entering into this provider agreement to operate this ventilator services unit in the Medicaid program, and that **I have been given the authority** to bind the business organization to this agreement and all applicable laws. I certify on the organization's behalf that the information submitted on the request and the information as it appears in this provider agreement is accurate and complete. Further, by my signature, I am binding the business organization to notify the Ohio Department of Medicaid in writing of any subsequent changes to the information contained in the request or in this agreement.

Name of Authorized Agent for Provider *(print or type)*	**Title** *(print or type)*
Authorized Agent Signature	**Date**

SECTION IV: AUTHORIZATION GRANTED BY ODM	Effective Date	Approval
Basic Ventilator Services Only		
Basic Ventilator Services and Ventilator Weaning Services		

SECTION V: SIGNATURE OF AUTHORIZED DEPARTMENT OF MEDICAID (ODM) REPRESENTATIVE	
Name of Authorized ODM Representative *(print or type)*	**Title** *(print or type)*
Signature	**Date**