Client Services

Washington's HIV Care, Treatment & Prevention Services

The Washington State Department of Health (DOH) offers two healthcare programs aimed at treating and preventing HIV. Client Services houses The Early Intervention Programs (EIP) for HIV Care and the Pre-Exposure Prophylaxis Drug Assistance Program (PrEP DAP) for HIV prevention.

Important Information for Providers:

DOH contracts directly with provider offices to deliver specific healthcare services to people who qualify.

- Providers must be contracted with the Client Services Program EIP, PrEP DAP or both to be eligible for reimbursement.
- Patients must be enrolled in either the EIP or PrEP DAP program for the services provided by the provider's office to be eligible for reimbursement.
- Services are limited, a comprehensive list of services is available on our website listed below.

Learn more by visiting our website at: **https://doh.wa.gov/you-and-your-family/illness-and-disease-z/hiv/hiv-care-client-services/early-intervention-program/resources-contracted-providers**

Or by scanning the QR code

CLIENT SERVICES PROGRAM OVERVIEW

EIP

HIV Treatment & Care

The Early Intervention Program (EIP) **serves people living with HIV.**

Patients must be enrolled in the EIP program to be eligible for assistance.

EIP assists enrolled clients with the costs of the following services (see covered services list):

- Medical & Labs
- Dental
- Monthly Insurance Premiums
- Pharmacy
- Mental Health

WHO QUALIFIES for EIP?
People who:

- Are HIV-positive
- Are a Washington State Resident
- Have family* income 500% or Less Federal Poverty Level

HOW DO PATIENTS BECOME ELIGIBLE?

Interested patients must apply. The EIP/ADAP application and information are available online at: https://doh.wa.gov/you-and-your-family/illness-and-disease-z/hiv/hiv-care-client-services/early- intervention-program/application-and-eligibility

For more information, e-mail us at: EIP.ClaimsPayments@doh.wa.gov

*Family Includes: Legally married spouse or registered domestic partner and/or dependent children age 18 and younger

PrEP DAP

HIV Prevention

The Pre-Exposure Prophylaxis Drug Assistance Program (PrEP DAP) **serves HIV-negative people who have risk factors that expose them to HIV.**

Patients must be enrolled in the PrEP DAP program to be eligible for assistance.

PrEP DAP assists enrolled clients with the costs of the following services (see covered service list):

- Medical & Labs
- Pharmacy

WHO QUALIFIES for PrEP DAP? People who:

- Are HIV-negative
- Are a Washington State Resident
- Are at high risk for HIV

HOW DO PATIENTS BECOME ELIGIBLE?

Interested patients must apply. The PrEP DAP application and information are available online at: https://doh.wa.gov/you-and-your-family/illness-and-disease-z/hiv/prevention/pre-exposure-prophylaxis-drug-assistance-program-prep-dap/how-do-i-apply-prep-dap

For more information, e-mail us at: EIP.ClaimsPayments@doh.wa.gov

PrEP is a biomedical HIV prevention method in which an HIV-negative person who is at high risk of becoming infected with HIV takes a pill daily to reduce that risk. Studies show PrEP is over 99% effective, if taken as prescribed.

Completing the Early Intervention Program Provider Contract

This document includes useful information for completing and submitting your contract.

Completing your Contract

Complete **ALL** fields and submit all required documents:

Required from all providers:

- Contract (4 pages)
- Appendix A (1 page)
- Statewide Payee Registration (must be completed on the Office of Financial Management website at OFM.WA.GOV/Payee). This form is necessary to receive payments for services rendered.

Additional Documentation:

If you have **more than one location,** you will need to submit additional documents.

- For locations using the **same Tax ID Number**, complete **Appendix B.**
- For locations using a **different Tax ID Number**, submit a separate contract, including **Appendix A** (and Appendix B, if necessary).

For dental and mental health providers, complete **Appendix C**

Submitting Your Contract

You may submit your contact by email, fax or mail.

Email: Send a PDF copy to EIP.ClaimsPayments@doh.wa.gov Subject: EIP Contract
Fax: Attn: HIV Client Services Contracts Fax number: (360) 664-2216
Mail: EIP Contracts PO Box 47841 Olympia, WA 98504-7841

We are here to help! Please contact us at EIP.ClaimsPayments@doh.wa.gov if you have questions.

STATE OF WASHINGTON

DEPARTMENT OF HEALTH

CLIENT SERVICES

EARLY INTERVENTION & PRE-EXPOSURE PROPHYLAXIS ASSISTANCE PROGRAM PROVIDER CONTRACT

Provider Contract #: _____ **System Reference #:** _____

Instructions for completing and returning your contract with Department of Health:
Complete this provider contract and Appendix A, (and Appendix B & C, if necessary) and return with a current copy of your W-9 and Statewide Vendor Payee Registration form. All sections must be completed. When your agreement is finalized by our contracts department, you will receive a digital copy of your contract with the option to have your contract mailed.

RETURN THIS CONTRACT TO: mail: Client Services, PO Box 47841 Olympia, WA 98504, or email: EIP.ClaimsPayments@doh.wa.gov or fax: 360-664-2216

AGREEMENT IS BETWEEN THE STATE OF WASHINGTON DEPARTMENT OF HEALTH, EARLY INTERVENTION PROGRAM, HERINAFTER KNOWN AS THE "DEPARTMENT" AND THE FOLLOWING HEALTH CARE PROVIDER OR CLINIC, HEREINAFTER KNOWN AS THE "PROVIDER"

PROVIDER/CLINIC INFORMATION
Legal name of provider (Last, first, middle initial):

Doing business as (DBA): _____ Federal Tax ID#: _____

Uniform Business Identifier (UBI) #: _____ License #: _____

Is your license restricted in any way? Yes ☐ No ☐

If yes, please describe the restriction: _____

Business Mailing Address: _____

Business Telephone #: _____

Are you applying to EIP, PrEP DAP or both?

Please Note: *If you want to add services later, you will have to request an amendment to your* contract.

☐ EIP (Care & Treatment) ☐ PrEP DAP (HIV Prevention) *Medical and Lab only ☐ Both

EIP Contract Category:
☐ Medical ☐ Dental

If applicable, this Contract supersedes and cancels the previous agreements under Contract Number 2635, N09727, N15264, N16754, N17455, N18154 or N22040.

DO NOT WRITE BELOW THIS LINE – DEPARTMENT OF HEALTH USE ONLY

Provider/ Clinic Name: _____ Provider Contract #: _____

PURPOSE

The purpose of this Contract is to provide certain HIV care and prevention services by licensed providers to persons enrolled in The Early Intervention Program and the PrEP DAP Program, and to provide the DEPARTMENT with clinical information on enrolled clients as requested.

TERMS AND CONDITIONS

Provider Services

The PROVIDER will provide HIV care and/or prevention services to clients enrolled in the DEPARTMENT'S Client Services Programs. The services provided shall be within the PROVIDER'S authorized scope(s) of practice and must be listed in the DEPARTMENT'S APPROVED LIST OF SERVICES, available on the DEPARTMENT'S website and through the DEPARTMENT'S listserv. The DEPARTMENT updates the approved list annually. It is the PROVIDER'S responsibility to check the approved list monthly to ensure that he or she has the most up-to-date information.

Licensing, Accreditation and Registration

The PROVIDER shall comply with all applicable local, state, and federal licensing, accreditation, and registration requirements necessary for the performance of this Agreement. The PROVIDER'S license, including all clinic providers' licenses, shall be current and unrestricted with regard to practice. The DEPARTMENT may exchange information with the Health Systems Quality Assurance Division regarding any provider's licensing status.

Billing and Payment (The WACs referenced below refer to the ADAP program; the PrEP DAP program does not have a specific WAC but will abide by the same rules regarding billing and payment as cited in this section)

1) In accordance with WAC 246-130-030, the PROVIDER shall bill the DEPARTMENT according to the terms of this Agreement. The PROVIDER will use the DEPARTMENT'S billing guide for guidance regarding billing the DEPARTMENT, which is available on the DEPARTMENT'S website for viewing.
2) All billings to the DEPARTMENT shall identify the PROVIDER name and IRS tax ID number which shall be identical to those listed on this Agreement. Changes to any of the above stated forms of identity must be reported on an updated W-9 form and Statewide Vendor Payee form within 30 days of the change for payment to be issued.
3) The PROVIDER shall submit all billings within 365 days from date of service. The DEPARTMENT shall not be obligated to pay for services if the billing is not received within 365 days of service provision; however, the PROVIDER shall first bill the DEPARTMENT before billing the client or sending the client's bill to a collection agency. If the PROVIDER fails to bill the DEPARTMENT for services and reports the client to a collection agency, the PROVIDER agrees to remove client from collections.
4) The DEPARTMENT shall pay the PROVIDER in accordance with WAC 246-130-030. The DEPARTMENT shall pay only for covered, medically necessary services delivered to clients eligible for early intervention services under WAC 246-130-40.
5) The DEPARTMENT shall pay the PROVIDER in accordance with the fees published by the DEPARTMENT in the CLIENT SERVICES PROGRAMS SCHEDULE OF COVERAGE AND MAXIMUM ALLOWANCES or the PROVIDER'S usual and customary fees, whichever is less.
6) The DEPARTMENT shall make no payment to the PROVIDER under this Agreement for services provided to enrolled clients prior to the execution of this Agreement. The DEPARTMENT shall make no payment in advance or in anticipation of services.
7) The DEPARTMENT is payer of last resort. The PROVIDER shall seek reimbursement from all other third-party payers before seeking reimbursement from the DEPARTMENT.
8) The PROVIDER may not bill, demand, collect or accept payment for a service covered under this agreement from a client or anyone on the client's behalf, other than the DEPARTMENT or third-party payer. The PROVIDER agrees not to "balance bill" the client for these covered services. PROVIDER may not bill a client "interest" charge while waiting for payment from the DEPARTMENT.
9) The PROVIDER may not bill the client while waiting for a response from the DEPARTMENT.
10) The DEPARTMENT may deny payment for covered services if the PROVIDER fails to satisfy the conditions of payment set forth in this Agreement. In such instances, the PROVIDER shall not bill the client.

Agreement
Neither this Agreement nor any claim arising under this Agreement, shall be transferred, or assigned by the PROVIDER without prior written consent of the DEPARTMENT.

Indemnification
The PROVIDER shall defend, protect, and hold harmless the State of Washington, the DEPARTMENT, or any employee thereof, from and against all claims, suits, or actions arising from negligent acts or omissions of the PROVIDER, employees, its agents, or subcontractors while performing under the terms of this agreement and shall hold the State of Washington harmless from any expenses connected with the defense settlement, or payment or monetary judgment from such claims, suits or actions, and duties in performance of the Agreement.
1)Subject to the limitations of the Oregon Tort Claims Act (ORS 30.260 through 30.300) and to the extent of liabilities arising out of the tortious acts of Oregon Health & Science University.

Nondiscrimination
The PROVIDER shall, during the performance of this contract, comply with the Americans with Disability Act (42 U.S.C. Section 12101 et seq.), Washington State Law against Discrimination, Chapter 49.60 RCW, and shall not Discriminate on the grounds of race, color, sex, sexual orientation, religion, national origin, alien status, marital status, age, creed, Vietnam-era or disabled veterans' status, or the presence of any sensory, mental, or physical handicap. The PROVIDER shall not: 1) deny an individual any services or other benefits provided under this Agreement; 2) provide any service(s) or other benefits to an individual which are different, or are provided in a different manner from those provided to others under this Agreement, or 3) subject an individual to segregation or separate treatment in any manner related to the receipt of any services(s) or other benefits provided under this Agreement.

Overpayments
In the event that the DEPARTMENT overpays or makes erroneous payments to the PROVIDER under this Agreement, the PROVIDER shall repay the DEPARTMENT promptly. The DEPARTMENT will either secure repayment by a set-off against the next month's billing or request reimbursement from the PROVIDER.

Right of Inspection
The PROVIDER shall provide right of access to its facilities to the DEPARTMENT, or any of its officers, or to any other authorized agent or official of the state of Washington or the federal government, at all reasonable times, in order to monitor and evaluate performance, compliance, and/or quality assurance under this Agreement.

Safeguarding of Client Information
The use or disclosure by any party of any information concerning a patient for any purpose not directly connected with the administration of the DEPARTMENT'S or the PROVIDER'S responsibilities with respect to services provided under this Agreement or with information contained in EIP's online client management site is prohibited except by written consent of the recipient or patient, or his/her responsible parent or guardian, or as provided by Washington State law or federal law. Unauthorized use or disclosure of confidential information in violation of state or federal law is subject to administrative, civil, and criminal penalties identified in law.

Savings
In the event funding from state, federal, or other sources is withdrawn, reduced, or limited in any way after the effective date of the Agreement and prior to normal completion, either party may terminate the agreement under the "Termination for Convenience" clause.

Emergency Preparedness
Emergency messages may be distributed by the DEPARTMENT to the PROVIDER via email distribution lists, postings to the HIV Client Services website, phone calls, postal service, and teleconferences.

Suspension Of Performance and Resumption of Performance
In the event contract funding from State, Federal, or other sources is withdrawn, reduced, or limited in any way after the effective date of this contract and prior to normal completion, the DEPARTMENT may give notice to the PROVIDER to suspend performance as an alternative to termination. The DEPARTMENT may elect to give written notice to the PROVIDER to suspend performance when the DEPARTMENT determines that there is a reasonable likelihood that the funding insufficiency may be resolved in a timeframe that would allow performance to be resumed prior to the end date of this contract. Notice may include notice by facsimile or email to the PROVIDER'S representative. The PROVIDER shall suspend performance on the date stated in the written notice to suspend. During the period of suspension of performance each party may inform the other of any conditions that may reasonably affect the potential for resumption of performance.
When the DEPARTMENT determines that the funding insufficiency is resolved, the DEPARTMENT may give the PROVIDER written notice to resume performance and a proposed date to resume performance. Upon receipt of written notice to resume performance, the PROVIDER will give written notice to the DEPARTMENT as to whether it can resume performance, and, if so,

DO NOT WRITE BELOW THIS LINE – DEPARTMENT OF HEALTH USE ONLY

Provider/ Clinic Name: _____ Provider Contract #: _____

the date upon which it agrees to resume performance. If the PROVIDER gives notice to the DEPARTMENT that it cannot resume performance, the parties agree that the contract will be terminated retroactive to the original date of termination.
If the date the PROVIDER gives notice it can resume performance is not acceptable to the DEPARTMENT, the parties agree to discuss an alternative acceptable date. If an alternative date is not acceptable to the DEPARTMENT, the parties agree that the contract will be terminated retroactive to the original date of termination.

Termination for Default

In the event DEPARTMENT determines the PROVIDER has failed to comply with the conditions of this contract in a timely manner, DEPARTMENT has the right to suspend or terminate this contract. Further, DEPARTMENT may terminate this contract for default, in whole or in part, if DEPARTMENT has a reasonable basis to believe that the PROVIDER has:

a) Failed to meet or maintain any requirement for contracting with DOH;
b) Failed to ensure the health or safety of any client for whom services are being provided under this contract;
c) Failed to perform under, or otherwise breached, any term or condition of this contract; and/or
d) Violated any applicable law or regulation.

Before suspending or terminating the contract, DEPARTMENT shall notify the PROVIDER in writing of the need to take corrective action. If corrective action is not taken within thirty (30) days of notice, the contract may be terminated or suspended. DEPARTMENT reserves the right to suspend all or part of the contract, withhold further payments, or prohibit the PROVIDER from incurring additional obligations of funds during investigation of the alleged compliance breach and pending corrective action by the PROVIDER or a decision by the DEPARTMENT to terminate the contract.

Termination for Convenience

Except as otherwise provided in this Agreement, either party may, by fourteen (14) days written notice, terminate this contract in whole or in part when it is in the best interest of either party. If the contract is so terminated, either party shall be liable only for payment in accordance with the terms of this contract for services provided prior to the effective date of termination.

All Writings Contained Herein

This Agreement contains all the items and conditions agreed upon by the parties. No other understanding, oral or otherwise regarding the subject matter of this Agreement shall exist or bind any of the parties hereto.

Health Care Provider Signature: Date:

Department of Health Contract Officer: Date:

Effective Date: Date:

Reviewed by Client Services: Date:

(Approved as to form by Assistant Attorney General)

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Provider/ Clinic Name: _____ Provider Contract #: _____

STATE OF WASHINGTON
DEPARTMENT OF HEALTH

CLIENT SERVICES
EARLY INTERVENTION & PRE-EXPOSURE PROPHYLAXIS PROGRAM

APPENDIX A

SELECT ENTITY TYPE	
☐ TRB –Tribal Entity	☐ GVS – Government State (EXCEPT Higher Ed)
☐ CBO – Community Based Organization/Non-Profits	☐ GVL – Government Local (EXCEPT Con-Con/LHJ)
☐ PRV – Private/For-Profit	☐ CLH – Local Health Jurisdiction
☐ HSP - Hospital	☐ HED – Higher Education
☐ EMS – EMS/Trauma Center	☐ GVF – Government Federal
☐ SCH – Schools, School Districts & Education Institutions (excluding Higher Ed)	

MAIN CLINIC/PRACTICE INFORMATION					
Provider Name:		Federal Tax ID#:			
Facility Name:		Appointment Phone:			
Facility Address:					
	☐ *Please check this box if your clinic offers* **VIRTUAL/ TELEHEALTH** *appointments*				
City:		State:		Zip:	
Services Offered: ☐Medical ☐Laboratory ☐Radiologist ☐Vision ☐Dentist ☐Oral Surgeon ☐Denturist ☐Endodontist ☐Mental Health					

BILLING & MAILING INFORMATION					
Mailing address:					
City:		State:		Zip:	

Billing Address:					
City:		State:		Zip:	

CONTACT INFORMATION (FOR EIP ONLY, NOT SHARED WITH CLIENTS)			
Contracts Manager Name:		Phone Number:	
Email Address:		Fax Number:	

Billing Manager Name:	☐ (*same as above)*	Phone Number:	
Email Address:		Fax Number:	

Office Manager Name:	☐ (*same as above)*	Phone Number:	
Email Address:		Fax Number:	

May we post your practice on our website? *(Please note – Email addresses will* ***NOT*** *be listed)* ☐ Yes ☐ No	**Do you have multiple clinic locations?** *(If yes, please fill out* ***Appendix B****)* ☐ Yes ☐ No
May we share your practice with case managers? ☐ Yes ☐ No	**How would you like to receive your remittances?** ☐ Mail ☐ Online ☐ Both

STATE OF WASHINGTON
DEPARTMENT OF HEALTH

CLIENT SERVICES
EARLY INTERVENTION & PRE-EXPOSURE PROPHYLAXIS PROGRAM

APPENDIX B

Please complete one box below for each additional clinic

ADDITIONAL CLINIC INFORMATION					
Facility Name:					
Facility Address:					
City:		State:		Zip:	
Main Contact Name:		Appointment Number:			
Email Address:		Clinic Fax Number:			
Services Offered at this Location:	☐Medical ☐Laboratory ☐Radiologist ☐Vision ☐Dentist ☐Oral Surgeon ☐Denturist ☐Endodontist ☐Mental Health				

ADDITIONAL CLINIC INFORMATION					
Facility Name:					
Facility Address:					
City:		State:		Zip:	
Main Contact Name:		Appointment Number:			
Email Address:		Clinic Fax Number:			
Services Offered at this Location:	☐Medical ☐Laboratory ☐Radiologist ☐Vision ☐Dentist ☐Oral Surgeon ☐Denturist ☐Endodontist ☐Mental Health				

ADDITIONAL CLINIC INFORMATION					
Facility Name:					
Facility Address:					
City:		State:		Zip:	
Main Contact Name:		Appointment Number:			
Email Address:		Clinic Fax Number:			
Services Offered at this Location:	☐Medical ☐Laboratory ☐Radiologist ☐Vision ☐Dentist ☐Oral Surgeon ☐Denturist ☐Endodontist ☐Mental Health				

ADDITIONAL CLINIC INFORMATION					
Facility Name:					
Facility Address:					
City:		State:		Zip:	
Main Contact Name:		Appointment Number:			
Email Address:		Clinic Fax Number:			
Services Offered at this Location:	☐Medical ☐Laboratory ☐Radiologist ☐Vision ☐Dentist ☐Oral Surgeon ☐Denturist ☐Endodontist ☐Mental Health				

STATE OF WASHINGTON
DEPARTMENT OF HEALTH

CLIENT SERVICES
EARLY INTERVENTION & PRE-EXPOSURE PROPHYLAXIS PROGRAM

APPENDIX B (additional contacts)

Please note that this information is not shared with clients, and it is only used by program staff for contacts.

ADDITIONAL CONTACT INFORMATION			
Additional Contact Name:		Contact Position/ Title:	
Phone Number:		Fax Number:	
Contact Email Address(s):			

Additional Contact Name:		Contact Position/ Title:	
Phone Number:		Fax Number:	
Contact Email Address(s):			

Additional Contact Name:		Contact Position/ Title:	
Phone Number:		Fax Number:	
Contact Email Address(s):			

Additional Contact Name:		Contact Position/ Title:	
Phone Number:		Fax Number:	
Contact Email Address(s):			

Additional Contact Name:		Contact Position/ Title:	
Phone Number:		Fax Number:	
Contact Email Address(s):			

Additional Contact Name:		Contact Position/ Title:	
Phone Number:		Fax Number:	
Contact Email Address(s):			

STATE OF WASHINGTON
DEPARTMENT OF HEALTH

CLIENT SERVICES
EARLY INTERVENTION & PRE-EXPOSURE PROPHYLAXIS PROGRAM

APPENDIX C

For Mental Health Care and Dental Providers Only

SELECT PROVIDER TYPE
☐ Mental Health Care ☐ Dental Care

1. Does your office have the ability to bill Medicaid (ProviderOne) or Apple Health?

   ☐ Yes ☐ No

2. Does your office bill Medicare?

   ☐ Yes ☐ No

3. Does your office accept Commercial Insurance?

   ☐ Yes ☐ No

If yes, what coverage does your office accept? (you may include an attachment)

4. If you are a Mental Health Care Provider, do you provide any specialized services?

   (Example: EMDR, DBT, Hypnotherapy, etc.) ☐ Yes ☐ No

If yes, what services do you provide?