

**CBAS TEMPORARY ALTERNATIVE SERVICES PROVIDER PARTICIPATION AGREEMENT**  
CDA 7013 (NEW 04/2020)

As a condition of providing Community-Based Adult Services (CBAS) Temporary Alternative Services (TAS) under the 1115(a) Waiver, 1135 Waiver, and subsequent guidance,

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(Licensee Name)

hereinafter called the “Provider,” providing services via

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(ADHC/CBAS Center Name)

hereby agrees to:

- (A) Temporarily reduce congregate day center activities and provide the following services telephonically or via telehealth; at the doorstep; individually in the center, and/or in participants’ homes, with appropriate safety precautions, as needed and as designated in the participants’ health records:

- |                            |                                  |
|----------------------------|----------------------------------|
| Nursing                    | Occupational Therapy             |
| Personal Care              | Speech Therapy                   |
| Social Services            | Therapeutic Activities           |
| Behavioral Health Services | Registered Dietitian – Nutrition |
| Physical Therapy           | Counseling                       |

**NOTE:** Providers must consider the participants’ most urgent needs and deliver services in the safest possible manner. Providers may serve participants in person **ONLY** when absolutely necessary and when using infection control measures to protect participants and staff to reduce exposure to, and transmission of, COVID-19.

- (B) Do all of the following:
- ✓ Maintain phone and email access for participant and family support, to be staffed a minimum of 6 hours during provider-defined hours of services, Monday through Friday.
  - ✓ Provide a minimum of one service to the participant or their caregiver for each authorized day billed. This service could include a telehealth (e.g., telephone, live video conferencing, written communication via text or email) contact, a service provided on behalf of the participant, or an in-person “door-step” brief well check conducted when the provider is delivering food, medicine, activity packets, etc. .
  - ✓ Conduct a COVID-19 wellness check and risk assessment for COVID-19 at least once a week, with greater frequency as needed.
  - ✓ Assess participants’ and caregivers’ current needs related to known health status and conditions, as well as emerging needs that the participant or caregiver is reporting.
  - ✓ Respond to needs and outcomes through targeted interventions and evaluate outcomes.

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- ✓ Communicate and coordinate with participants' networks of care supports based on identified and assessed need.
- ✓ Arrange for delivery or deliver supplies based on assessed need, including, but not limited to, food items, hygiene products, and medical supplies. If needs cannot be addressed, staff will document efforts and reasons why needs could not be addressed.

(C) Staff CBAS TAS with a 1) Program Director; 2) Registered Nurse(s); and 3) Social Worker(s) to carry out carry out CBAS TAS tasks.

Providers must have additional staff as needed to address the number of participants served and their identified needs and to assist in the delivery of services required for CBAS TAS participation, and as described in the provider's CDA approved *CBAS TAS Plan of Operation*. All staff must function within their scope of practice, qualifications, and abilities.

(D) Notify the Department immediately in writing when any change occurs in the provision of services designated in (A).

By: \_\_\_\_\_  
(Signature/Title of Provider or Legal Representative)

\_\_\_\_\_  
(Printed Name)

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

**Failure to provide CBAS TAS as described here and in the provider's Plan of Operation may result in adverse actions against the provider's certification and/or recoupment or cancellation of payment.**

**STATE USE ONLY**

The Department hereby agrees:

- (A) To certify the Provider for participation in CBAS TAS for purposes of providing the services designated in (A), effective \_\_\_\_\_.  
(State Use Only)
- (B) That the Provider may terminate this Agreement by submitting a written notice to the Department indicating that the Provider is voluntarily discontinuing Temporary Alternative Services.

By: \_\_\_\_\_  
(Signature/Title of CDA Representative)

\_\_\_\_\_  
(Printed Name)

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