Agency With Choice
Part of PathWays | Fulfilling Opportunity

Transportation Mile Instructions

- **General information**
  - The individual must be in the vehicle when transportation reimbursement is billed.
  - Each transporter must complete their own contract with PathWays.
  - Transportation can only be reimbursed for the approved locations.
  - A separate monthly calendar will be used for each location.
  - Reimbursement will be based on the shortest distance between the start and end points.
  - The transporter will be notified by the Regional Manager when they can begin.
  - If the individual **doesn't receive** PathWays services at this time, Pathways' HIPAA Privacy Notice Policy and the Privacy Notice Acknowledgement Form must be provided to the individual.
    - Only a signed Acknowledgement form needs returned

- **How to become a Transporter**
  - If the transporter is a **current employee of PathWays:**
    - The transporter won't be required to provide vehicle information, their driver's license, or a background check because this information is already on file.
    - The Agreement for Reimbursement document needs to be completed by the transporter.
      - If there are multiple locations, the transporter will need to complete this document for each location.
      - MapQuest/Google Maps results verifying the total distance for each location is needed.
        - An example has been provided in this packet
    - The Compliance Program Notification Acknowledgement form will need to be signed by transporter verifying that they have reviewed the information.

  - If the transporter **isn't a current PathWays employee**:
    - The Agreement for Reimbursement document needs to be completed by the transporter.
      - If there are multiple locations, the transporter will need to complete this document for each location.
      - MapQuest/Google Maps results verifying the total distance for each location is needed.
        - An example has been provided in this packet
    - The Compliance Program Notification Acknowledgement form will need to be signed by transporter verifying that they have reviewed the information.
    - The transporter will need to provide us with:
      - Driver's license
      - Vehicle Registration
      - Proof of inspection
      - Insurance card

- **Background Checks Required**
  - Background check results must be within 3 months of the date of submission to PathWays.
  - Transporters are responsible for paying any cost associated with the clearances.
  - All required background check results must be turned into the regional manager with the rest of the documents.
  - PA State Police Criminal Record Check required for **all transporters not currently employed by PathWays.**
    - This background check will be completed by the transporter using:
      - https://epatch.pa.gov/home
  - Child Abuse Clearance/Act 33
    - Only required if individual being transported is under the age of 18
    - This background check will be completed by the transporter using:
      - https://www.compass.state.pa.us/cwis/public/home
  - FBI Background Clearance/Act 73
    - Only required if individual being transported is under the age of 18 or the transporter hasn't lived in the state of PA for the past 5 years
    - Transporter will need to use this website to schedule an appointment to have their fingerprinting completed
      - https://uenroll.identogo.com/

- **How to Track and Submit for Reimbursement**
  - Each transporter will have their own calendar to record their trips.
    - A blank calendar has been included in the packet.
    - Each location will have a separate calendar.
  - Each time the transporter provides the transportation, they will initial on the correct date and location form showing that transportation was provided.
    - For example, if you are dropping the individual off at work on 7/14/22, then you would initial on the line for drop off on 7/14/22 on the calendar.
    - There is a sample calendar within the packet that you can refer to.
  - Calendars are used monthly.
    - At the end of each month, the completed calendars should be submitted using one of the following methods:
      - Email to: transportation@yourpathways.org
      - Fax to: 724-229-9252
        - Attn: Transportation
      - Mail to: PathWays Attn: Transportation, 95 W. Beau Street Suite 420, Washington Pa 15301
  - Reminder: All required vehicle information and driver's license must remain up to date at all times in order for the transporter to continue to receive reimbursement for transportation.
    - When new documents are obtained, they should be sent to credentials@yourpathways.org

Agency With Choice
Part of PathWays | Fulfilling Opportunity

- **Payment for Transportation**
  - The transporter has the option to have their reimbursement checks direct deposited into the account.
    - If interested, please complete the direct deposit form.
      - A voided check, verification of account information, or the signature of a bank personnel is needed with this form.
      - Current employees who have direct deposit through PathWays still need to complete this form if direct deposit is the desired method of payment.
    - If the transporter isn't interested in direct deposit, they will receive a reimbursement check in the mail.

Please feel free to reach out if you have any questions regarding this information or need assistance completing the packet.

Thank you,

Agency with Choice
724-225-8145 Option 1

Effective: September 23, 2013

PathWays of Southwestern Pennsylvania, Inc.

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires PathWays of Southwestern Pennsylvania to protect the privacy of your "protected health information" (PHI). PHI includes information that we have created, received, maintained, or transmitted regarding your health or payment for health care services you have received. It includes both your medical records and personal information such as your name, social security number, address, and phone number. PHI also includes genetic information about you or a family member such as genetic tests, manifestations of a disease or disorder, or requests for (or the receipt of) genetic services or participation in clinical research which includes genetic services.

HIPAA requires PathWays of Southwestern Pennsylvania to maintain the privacy of your PHI. This Notice is intended to inform you of PathWays of Southwestern Pennsylvania's legal obligations under HIPAA and related regulation to:

- Protect the privacy of your PHI;
- Provide you with this Notice explaining our duties and practices regarding your PHI;
- Comply with the terms of this Notice.

This Notice also informs you about how PathWays of Southwestern Pennsylvania uses and discloses your PHI and explains the rights that you have with regard to the PHI that PathWays of Southwestern Pennsylvania maintains about you.

In some situations, federal and state laws provide privacy protections to your PHI in addition to HIPAA. Examples of PHI that sometimes receives additional protection include PHI related to mental health, HIV/AIDS, reproductive health, or chemical dependency. PathWays of Southwestern Pennsylvania may refuse to disclose such PHI, or PathWays of Southwestern Pennsylvania may contact you to obtain an express written authorization before disclosing it.

PathWays of Southwestern Pennsylvania is required to abide by the terms of this Notice. However, PathWays of Southwestern Pennsylvania reserves the right to make changes to this Notice and to make such changes effective for all PHI PathWays of Southwestern Pennsylvania may already have about you. If and when a material change is made to this Notice, PathWays of Southwestern Pennsylvania will post the revised Notice on our public web site at www.yourpathways.org and at PathWays of Southwestern Pennsylvania branches.

PATHWAYS OF SOUTHWESTERN PENNSYLVANIA'S USES AND DISCLOSURES OF YOUR PHI

Uses and Disclosures for Treatment, Payment, and Health Care Operations

For Treatment: PathWays of Southwestern Pennsylvania may use or disclose your PHI for treatment without obtaining your authorization. For example, PathWays of Southwestern Pennsylvania may disclose your PHI to our physicians, nurses, counselors, and others involved in your care; our staff to coordinate such activities as referrals or appointments; or other health care providers treating you who are not on our staff such as emergency room staff and specialists.

For Payment: PathWays of Southwestern Pennsylvania may use or disclose PHI to obtain payment for the services we have provided to you without obtaining your authorization. For example,

PathWays of Southwestern Pennsylvania may use and disclose your PHI to bill your health insurer or you for the care we provide. PathWays of Southwestern Pennsylvania may also disclose your PHI to other organizations and providers for their payment activities without your authorization unless disclosure is prohibited by law.

For Health Care Operations: PathWays of Southwestern Pennsylvania may use and disclose your PHI to enable us to operate efficiently and in the best interests of our associates without obtaining your authorization. For example, PathWays of Southwestern Pennsylvania may use and disclose your PHI to review and improve the care you receive and to provide training for its staff. PathWays of Southwestern Pennsylvania may also disclose your PHI to other individuals, called "business associates," such as consultants and auditors, who help us with our business activities. (Note: If we share your PHI with business associates for this purpose, they must agree to protect your privacy.)

Other Permitted Uses and Disclosures Without Your Authorization. HIPAA authorizes PathWays of Southwestern Pennsylvania and its business associates, to use and/or disclose your PHI without your authorization in the following instances and for the following purposes.

1. When Required By Law. For example:
   - For judicial and administrative proceedings pursuant to court or administrative order, legal process and authority.
   - To report information related to victims of abuse, neglect, or domestic violence.
   - To assist law enforcement officials in their law enforcement duties.

2. For Health and Safety Purposes. For example:
   - To avert a serious threat to the health or safety of you or any other person.
   - To an authorized public health authority or individual to perform public health and safety activities, such as preventing or controlling disease, injury, or disability or to report vital statistics such as birth or death.
   - To meet the reporting and tracking requirements of governmental agencies, such as the Food and Drug Administration.

.

3. For Government Functions. For specialized government functions such as intelligence, national security activities, security clearance activities and protection of public officials; and to health oversight agencies for audits, examinations, investigations, inspections, and licensures.

4. For Active Members of the Military and Veterans. For example, to comply with the laws and regulations governing military services and veterans' affairs.

5. For Workers' Compensation. For example, to comply with the laws which provide benefits for work-related illnesses or injuries.

6. In Emergency Situations. For example, to a family member or close personal friend involved in your care in the event or an emergency or to a disaster relief entity in the event of a disaster.

7. To Others Involved in Your Care. Under limited circumstances, to a member of your family, a relative, a close friend, or other person you identify who is directly involved in your health care or payment of bills related to your health care. For example, if you are seriously injured and unable to make a health care decision for yourself, we may disclose your PHI to a family member if we determine that disclosure is in your best interest. If you do not want this information to be shared, you may request that these disclosures be restricted as outlined later in this notice.

8. For Appointment Reminders. To you to remind you that you have a health care appointment with us unless you specifically ask us to communicate with you through a different method as described later in this Notice.

9. To Personal Representatives. To people you have authorized to act on your behalf, or people who have a legal right to act on your behalf, such as parents for unemancipated minors and individuals who have Power of Attorney for adults.

10. For Treatment and Health-Related Alternatives Information Purposes. To communicate with you about treatment services, options, or alternatives, as well as health-related benefits or services that may be of interest to you, or to describe our providers to you.

11. For Research Purposes. But only to the extent that certain steps as required by law are taken to protect your privacy.

12. For Organ, Eye and Tissue Donation. If you are an organ donor, to an organ or procurement organization to facilitate an organ, eye, or tissue donation and transplantation.

13. Regarding Deceased Individuals. To coroners, medical examiners, and funeral directors so those professionals may perform their duties.

14. To Correctional Facilities. If you are an inmate in a correctional facility we may disclose your PHI to the correctional facility for certain purposes, such as providing health care to you or protecting your health and safety or that of others.

Any Other Uses and Disclosures Require Your Express Authorization. Except in the situations listed in the sections above, we will use and disclose your PHI only with your written authorization, including uses and disclosures for:

- Marketing. Marketing does **not** include our face-to-face interactions with you or refill reminders or other communications we might have with or send to you about a drug currently prescribed for you to the extent that any payment that we may receive for making that communication is reasonably related to our costs in making that communication. Marketing also does **not** include case management or care coordination for your treatment or to recommend alternative treatments, therapies, or health care providers for you as long as we do not receive any payment for making these communications with you.

- Receiving direct or indirect payment in exchange for providing the information. Such a "sale" of PHI does **not** include disclosing your information to a health insurer in order to receive payment for products or services we provide to you.

You may revoke your authorization, in writing, at any time. If you revoke your authorization, we will no longer use or disclose PHI except as described above (or as permitted by any other authorizations that have not been revoked). However, please understand that we cannot retrieve any PHI disclosed to a third party in reliance on your prior authorization. Once your PHI has been disclosed pursuant to your authorization, the protections HIPAA provides may no longer apply to the disclosed PHI, and the information may be re-disclosed by the recipient without your knowledge or authorization.

To obtain a form of authorization to request that we disclose your PHI other than as provided above, please contact a PathWays of Southwestern Pennsylvania representative at the office where you receive services.

YOUR RIGHTS REGARDING YOUR PROTECTED HEALTH INFORMATION

You have the following rights regarding your PHI that PathWays of Southwestern Pennsylvania creates, collects and maintains. If you are required to submit a written request related to these rights, as described below, you should submit the request to PathWays of Southwestern Pennsylvania 's Privacy Officer as follows:

Kimberly McBane
655 Jefferson Avenue
Washington PA 15301

Right to Request Restrictions: You have the right to request restrictions on your PHI that PathWays of Southwestern Pennsylvania uses or discloses to carry out treatment, payment, or health care operations. You may also ask that we limit the information we give to someone who is involved in your care, such as a family or friend. Please note that we are not required to agree to your request unless, and except as otherwise required by law, the disclosure you want to restrict pertains solely to a health care item or service for which you have paid for out of pocket in full. If we do or must agree, we will honor your limits unless it is an emergency situation. To request a restriction of your PHI, please submit your request in writing.

Right to Receive Confidential Communications or Communications by Alternative Means or at an Alternative Location: You have the right to ask that we communicate with you by another means or at a different address. For example, you may request that we contact you at home rather than at work. To request communications by another means or at an alternative location, please submit your request in writing. You should state the alternative means by, or location at which you would like to receive, your PHI. If appropriate, your request should state that the disclosure of all or part of the information by non-confidential communications could endanger you. Reasonable requests will be accommodated to the extent possible and you will be notified appropriately.

Right to Inspect and Copy: You have the right to inspect and receive a copy of your PHI that PathWays of Southwestern Pennsylvania or its business associates maintain in a designated record set. To request copies, please contact the Privacy Officer. We may ask you to make this request in writing, and we may charge a reasonable fee for the cost of producing and mailing the copies. In certain situations we may deny your request and will tell you why we are denying it. In some cases you may have the right to ask for a review of our denial.

Right to Amend: You have the right to request that PathWays of Southwestern Pennsylvania or its business associates amend your PHI that is maintained in a designated record set if you believe the information is incorrect or incomplete. To request an amendment, submit a detailed, written request to the PathWays of Southwestern Pennsylvania Privacy Officer. This request must provide the reason(s) that supports your request. PathWays of Southwestern Pennsylvania may deny your request if it is not in writing, if it does not provide a reason in support of the request, or if you have asked to amend information that:

- Was not created by or for PathWays of Southwestern Pennsylvania unless you provide PathWays of Southwestern Pennsylvania with information that the person or entity that created the information is no longer available to make the amendment;
- Is not part of the PHI maintained by or for PathWays of Southwestern Pennsylvania
- Is not part of the health record information that you would be permitted to inspect and copy; or
- Is accurate or complete.

PathWays of Southwestern Pennsylvania will notify you in writing as to whether it accepts or denies your request for an amendment to your PHI. If PathWays of Southwestern Pennsylvania denies your request, it will explain how you can continue to purse the denied amendment.

Right to Receive an Accounting of Disclosures: You have the right to request an “accounting” of certain disclosures of your PHI. The accounting lists instances where PathWays of Southwestern Pennsylvania or its business associates disclosed some portion of your PHI to others and to whom that disclosure was made. The accounting does not include disclosures for treatment, payment, and health care operations; disclosures made to or authorized by you; and certain other disclosures. You may request an accounting of the disclosures made up to six years before your request. If you want an accounting that covers a time period of less than six years, please state that in your written request for the accounting.

To request an accounting of disclosures, submit a written request to the PathWays of Southwestern Pennsylvania Privacy Officer. You may receive one list per year at no charge. If you request another list during the same year, we may charge you a reasonable fee; however, we will notify you of the cost involved before processing the accounting.

Right to Request a Paper Copy of this Notice: You have a right to receive a copy of this Notice at any time. To obtain it, submit a written request to the PathWays of Southwestern Pennsylvania Privacy Officer.

Right to Complain: You have the right to complain to PathWays of Southwestern Pennsylvania and to the Department of Health and Human Services if you believe your privacy rights have been violated. To file a complaint with PathWays of Southwestern Pennsylvania submit a written complaint to the PathWays of Southwestern Pennsylvania Privacy Officer. PathWays of Southwestern Pennsylvania will not retaliate or discriminate against you or otherwise withhold services, payment, or privileges from you because you file a complaint with PathWays of Southwestern Pennsylvania or with the Department of Health and Human Services.

Right to Receive A Notice of Certain Breaches: You have the right to receive notice in the event that we or one of our business associates create, receive, maintain or transmit your PHI in an unsecured manner (such as in paper form or if the PHI is in electronic form but is not secured) and a breach of our safeguards occurs.

Pathways of Southwestern PA, Inc.
Privacy Notice Acknowledgement Form

_____ _____
Consumer's Printed Name Date Provided to Consumer

_____ _____
Legible Signature of Personnel Providing HIPAA Information Title

Please return this form to: _____ by _____
Specify Pathways of SW PA Personnel Specify date

Pathways of SW PA respects all consumers' rights to privacy and confidentiality and is committed to upholding an environment worthy of your trust.

My signature below acknowledges receipt of Pathways of SW PA Privacy Notice which describes how my medical information may be used and disclosed, along with my rights.

_____ _____
Consumer's signature Date of Signature

_____ _____ _____
Consumer's Representative/Witness signature Relationship to consumer Date
(Provide only if Consumer is unable to sign)

Pathways of SW PA Personnel will complete information listed below:

Check one: Received signed document _____ witnessed signature/s _____

_____ _____ _____
Pathways of SW PA Personnel signature Title Date

Actual Service Start Date: _____

HIPAA Form #9aR
9/7/13 KM

Agency With Choice
Part of PathWays | Fulfilling Opportunity

Agreement for Reimbursement of Travel Costs

THIS AGREEMENT is made and entered into on this _____ day of _____ 20_____, by and between PathWays of Southwestern Pennsylvania, Inc., hereinafter referred to as "PathWays" and _____, hereafter referred to as "Participant."

WHEREAS, Participant has a demonstrated need for transportation as described in Participant's approved, current Office of Developmental Programs Individual Support Plan, hereinafter referred to as "ODP ISP.'

WHEREAS, _____, hereafter referred to as "Transporter," an individual 18 years of age of older, has agreed to provide said transportation.

WHEREAS the parties desire to put forth in writing their agreement for such reimbursement.

NOW THEREFORE, intending to be legally bound hereby, the parties hereto agree as follows:

1. Transporter will be solely responsible for providing the Participant's transportation.
2. Transporter will submit to PathWays complete and accurate monthly transportation reimbursement forms within 5 business days of the end of the month for the preceding month. Once received, PathWays will issue a check within a reasonable timeframe. The reimbursement rate will be the ODP currently established reimbursement rate. The cost of said services will not exceed the authorized transportation mile service subtotal in the Participant's ODP ISP.
3. The parties agree that the name and exact street address of the participant is: _____ _____.
   The parties agree that the name and exact street address of the location that the Participant is dropped off at and picked up from is: _____ _____.
   The parties agree upon the following mileage:
   _____ total miles from Participant's home/pick up location to program drop off/pick up location while the participant is physically in the vehicle **(include MapQuest/Google verification)**
   _____ total miles from drop off/pick up location to Participant's home/drop off location while the participant is physically in the vehicle (same as above) **(include MapQuest/Google verification)**
   *" Total round trip" should be rounded to the nearest full mile – if .5 or above round up, if .4 or below, round down.
   One trip mileage is the total mileage required to transport the individual (1) from home/pick up location to a service/resource location; (2) from a service/resource location to home/drop off point; or (3) from a service location/resource to another service location/resource, as specified in the ODP ISP, while the individual is physically in the vehicle. Mileage cannot be reimbursed when the individual is not in the vehicle for return trips.
4. The parties acknowledge that the Transporter is not an employee of PathWays, and that PathWays has no control over the Transporter's schedule or the Transporter's motor vehicle. The Transporter acknowledges at all times that they are acting solely on behalf of the Participant and not PathWays and that PathWays is acting only

Agency With Choice
Part of PathWays | Fulfilling Opportunity

as a conduit for providing reimbursement to the Participant per the ODP ISP. It is acknowledged that PathWays shall have no obligations to inspect or assure the safety of the Transporter's motor vehicle and that the Transporter is acting at all times as an independent contractor on behalf of the Participant. The parties acknowledge that PathWays assumes no responsibility for the inspection of the Transporter's vehicle or for the safety and welfare of the Participant or Transporter when in said vehicle. However, the Transporter understands that he/she is responsible to maintain a valid PA vehicle registration, valid PA Transporter's license, required insurance coverage of $100,000/$300,000 bodily injury, and a current vehicle inspection date. It is the Transporter's responsibility to maintain updated insurance, registration, driver's license, and inspection, submitting to use each time they are renewed. Copies of each will be provided prior to start of service, and at each time they are renewed. If there is a lapse in the submission of the renewed documents, reimbursement will not be made during the time period from expiration of document through receipt of renewed documents.

I acknowledge receipt of HIPAA Privacy Notice, Vendor Compliance Notification, and Monthly Transportation Reimbursement Forms. I also acknowledge that all services will be completed in accordance with the authorized ODP ISP.

MapQuest/Google verification included: _____

_____ _____
Participant or Representative's Signature Date

_____ _____
Transporter's Signature Date

Transporter's Address:

_____

_____

_____

Transporter's Phone Number:

_____

Transporter's Email:

_____

PathWays Use Only:

Start Date authorized by PathWays: _____

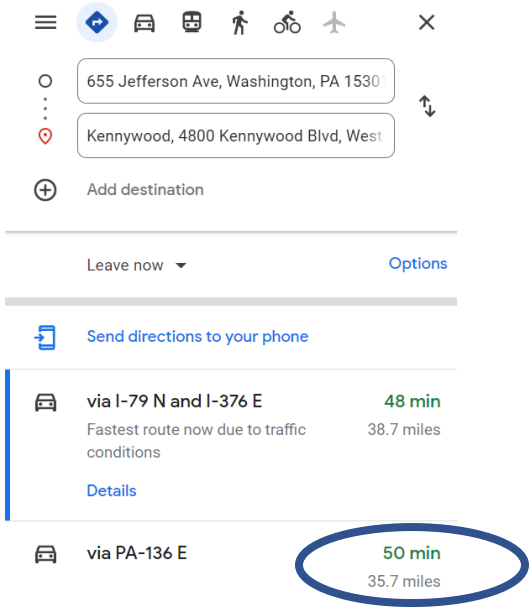
Date and initials of staff completing the verification of mileage (attached verification): _____

_____ _____
PathWays Representative's Signature Date

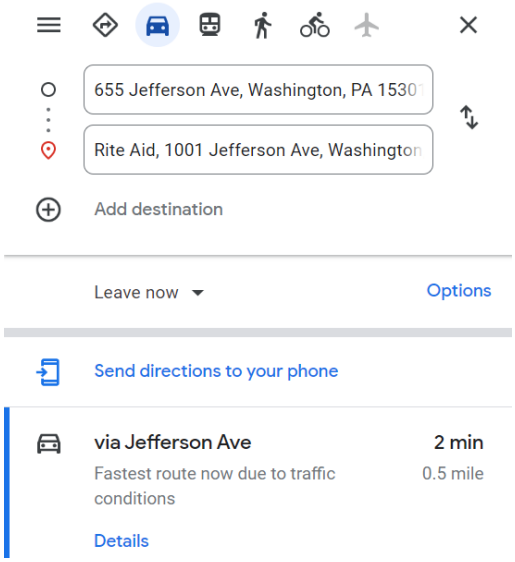
Agency With Choice
Part of PathWays | Fulfilling Opportunity

MapQuest/Google Map Example

In this example, there are two routines provided. Even though the first is shorter timewise, the transporter has to choose the second one because it is the shortest distance based on mileage.



In this example, there is only one route available and therefore will be the one used by the transporter.



PATHWAYS COMPLIANCE PROGRAM NOTIFICATION

It is the policy of Pathways of Southwestern Pennsylvania, Inc. and its affiliated corporations (the "Organization") to comply with all local, state, and federal laws governing its operations; to conduct its affairs in keeping with the moral, legal and ethical standards of our industry; and to support the government's efforts to reduce healthcare fraud and abuse. The Organization's Compliance Program establishes a culture within the Organization that promotes prevention, detection, and resolution of instances of conduct that do not conform to federal and state law, and federal, state, and private payor health care program requirements. All employees and certain agents, contractors, and consultants who furnish or authorize the furnishing of Medicaid supplies and services or are involved in the monitoring of services provided by the organization are expected to adhere to the Compliance Program. Employees, agents, and contractors shall be educated regarding the Compliance Program at hire or engagement.

Confidentiality:

Individuals receiving services from the Organization have the right to complete and total confidentiality regarding their receipt of services as well as the details of the services. Information designated as confidential should not be discussed with anyone other than on a "need to know" basis. In addition, employees, agents and contractors have a responsibility to avoid disclosure of non-confidential internal information about the Organization its employees, its individuals and its business associates unless specifically authorized by the Organization.

Direct Care Concerns:

Employees, agents and contractors are to treat individuals with dignity and respect for human rights, serving as positive role models, demonstrating professional and therapeutic attitudes and behavior, preventing abuse and neglect, and ensuring a safe environment. You have a responsibility to report any employee, agent or contractor you observe who is disrespectful, abusive, neglectful, or untherapeutic with any individual.

Business Information:

The Organization considers its pricing information, pricing policies, terms, market studies, business or strategic plans, and any other similar information to be confidential. The sharing of information with competitors is a highly sensitive matter, particularly where that information

could form the basis of a pricing agreement, express or implied. Although it is neither unusual nor improper to obtain information from individuals, trade publications, or other legitimate sources about the activities of competitors, it is never proper to communicate such information to, or to receive it from, a competitor. All bids or proposals should be accurate, complete and directly responsive to the prospective individual's/customer's request and may not contain any information that is false or intentionally misleading.

Conflict of Interest:

In accordance with the Organization's Conflict of Interest policy, a conflict of interest is defined as an activity or interest which is inconsistent with or opposed to the legitimate best interest of the Organization. It is the policy of the Organization that all directors, contractors/consultants, and employees will avoid personal transactions or situations in which their personal interest will or will appear to conflict with those of the Organization.

Gifts and Improper Use of Funds:

The Organization prohibits giving anything of value to government employees who work for individuals or potential individuals of the Organization. There are four permissible exceptions to this rule:

- Promotional items of nominal value ($20.00 or less), such as a calendar or coffee mug displaying the Organization logo;
- Modest refreshments, such as coffee and donuts in connection with a business discussion;
- A meal on-site to accommodate continuing business meeting with government employees;
- Food, refreshments, entertainment, instructional materials at a widely attended event provided the government employee's agency has properly authorized his/her attendance.

Non-governmental personnel may be provided with meals, refreshments, and entertainment with reasonable value, less than $50.00, in connection with business discussions, provided this does not violate the Code of Conduct of the recipient's Organization. To provide such items valued over $50.00 requires Organization approval by the Chief Executive Officer. Gifts or other considerations of more than a nominal value ($20.00 or less) or money of any amount may not be given to anyone in a position to influence individual referrals.

The Anti-Kickback Act of 1986 requires each prime contractor or subcontractor to promptly report a violation of the kickback laws to the appropriate Federal agency, Inspector General, or the Department of Justice if the contractor has reasonable grounds to believe that a violation

exists.

Business Records:

The Organization's records are maintained in a manner that provides for an accurate and auditable account of all financial transactions in conformity with generally accepted accounting principles. No false or deceptive entries may be made, and all entries must contain an appropriate description of the underlying transaction. All reports, vouchers, bills, invoices, payroll and service records, time worked, individual records, and other essential data must be prepared with care and honesty. Employees, agents or contractors having ethical responsibility requiring documentation in an individual record must be aware of the rules and regulations regarding record maintenance, record retention, and record confidentiality. Employees, agents and contractors have an obligation to ensure required documentation is maintained, kept confidential, and not falsified.

Deficit Reduction Act (DRA):

The Deficit Reduction Act of 2005 (PL109-171) became effective on January 1, 2007 and requires health care Organizations receiving five million dollars or more in annual Medicaid reimbursement to educate employees, contractors, and agents about fraud and abuse, false claims, and whistleblower protection laws and regulations. The Deficit Reduction Act requires investigation of all potential false claims and fraud/abuse; payment coordination; claims payment only for US citizens or qualified aliens; co-payment limits compliance; and electronic claims submission by large providers.

Billing Practices:

The Organization is committed to accurate billing and submitting claims for services that reflect the services and care provided to individuals and is justified by approved units of service and documentation of services rendered. The Organization's employees, agents and contractors are required to report any potential or suspected improper billing practices or violations of standard billing practices or of Organization policies and procedures.

False Claims:

Federal and state laws and regulations govern billing for services provided by the Organization, or its agents and procedures must be strictly followed. Failure to follow claims regulations can lead to exclusion from federal funding including payments from

Medicare and Medicaid, as well as criminal and civil liability. Submission of claims for reimbursement which are false, fraudulent, inaccurate, incomplete, duplicative, or for noncovered services is prohibited.

The Federal False Claims Act covers fraud involving any federally funded contract, including Medicare and Medicaid. Liability is established for any person who (1) knowingly presents, or causes to be presented, to an officer or employee of the United States Government or a member of the Armed Forces of the United States a false or fraudulent claim for payment or approval; (2) 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; (3) conspires to defraud the Government by getting a false or fraudulent claim paid or approved by the Government or (4) knowingly makes, uses, or causes to be made or used, a false record or statement to conceal, avoid, or decrease an obligation to pay or transmit money or property to the Government.

“Knowing” and “knowingly” mean that a person, with respect to information (1) has actual knowledge of the information; (2) acts in deliberate ignorance of the truth or falsity of the information; or (3) acts in reckless disregard of the truth or falsity of the information, and no proof of specific intent to defraud is required. In sum, the False Claims Act imposes liability on any person who submits a claim to the federal government that he or she knows (or should know) is false. The False Claims Act also imposes liability on an individual who may knowingly submit a false record in order to obtain payment from the government. Another area of liability includes those instances in which someone may obtain money from the federal government to which he may not be entitled, and then uses false statements or records in order to retain the money. Providers violating the Federal False Claims Act can be subject to civil monetary penalties ranging from $5,500 to $11,000 per false claim and three times the amount of the government's damages.

The Criminal Penalties for Acts Involving Federal Health Care Programs provides for felonious criminal penalties and a fine of not more than $25,000 and/or imprisonment for not more than five years for whomever makes false statements or submits false claims.

Administrative Remedies for False Claims and Statements states any person who makes, presents, or submits a claim that is false or fraudulent is subject to a civil penalty of not more than $5,000 for each claim and an assessment of not more than twice the amount of the claim.

Fraud and Abuse:

"Fraud" is defined as intentional deception or misrepresentation made by an entity or person with the knowledge that the deception could result in some unauthorized benefit to the entity or persons. “Abuse” is defined as practices that are inconsistent with sound fiscal, business, or medical practices and that result in an unnecessary cost to a government health care program or other health care plan.

The principal types of fraud and abuse are:

- Misrepresentation of material facts
- Concealment of material facts
- Bribery
- Conflict of Interest
- Theft of money or property
- Any dishonest or fraudulent act
- Forgery or alteration of any documents or account
- Forgery or alteration of a check, bank draft, billing source documents, such as but not limited to: timesheets; authorizations; documentation of care provided, etc. or any other financial document
- Misappropriation of funds, supplies, or other assets
- Impropriety in the handling or reporting of money or financial transactions
- Theft of trade secrets or intellectual property
- Breach of fiduciary duty
- Statutory offenses

Reporting Concerns:

Any employee, contractor, agent, contractor, or representative of the Organization is expected to take an active role to ensure that fraud and abuse is detected and reported. Any employee, contractor, agent, contractor, or representative of the Organization who is aware of or suspects any false report or document, false claim, improper billing practices, or violations of Organization policies and procedures must report their concern to: (1) immediate supervisor (if the reporter is an employee) or (2) manager or director (3) the Compliance Officer at 724-229-0851 ext.150 or (4) by leaving a voicemail on the Pathways’ Compliance Hotline at 800-997-7344 or (5) anonymously by written letter to the Compliance Officer: 95 W. Beau St., Suite 420; Washington, PA 15301.

Any employee, contractor, agent, contractor, or representative of the Organization should not report accusations that are known to be false. This does not mean that a person reporting fraud and abuse needs “proof” of a problem to initiate a report; merely that he or she must have a reasonable and honest basis for concern. Any violations will be investigated.

The Organization will ensure all potential fraud and abuse violations will be promptly investigated and actions taken to resolve the identified problem. Compliance Officer, or their delegate, will investigate the incident. The Compliance Officer will utilize internal compliance processes and involve outside counsel, auditors, or other experts to assist in an investigation as appropriate and necessary. The Organization requires that all employees and agency representatives fully cooperate in any such investigations. Any individual who reports a compliance concern in good faith will have the right to do so anonymously if he/she requests anonymity. The information provided by the individual will be treated as confidential and privileged to the extent feasible and permitted by applicable laws.

Whistleblowers:

The False Claims Act Whistleblower Employee Protection Act prohibits a Organization from discharging, demoting, suspending, threatening, harassing, or discriminating against any employee, contractor or agent if the individual reports or assists in the investigation of a false claim. The Organization will not tolerate retaliation or intimidation of any kind against any employee, contractor, agent, or contractor because they report a suspected violation of Federal or state laws and regulations. Anyone who attempts such retaliation will be subject to disciplinary action, up to and including termination of employment. However, if the individual who reports the compliance issue has participated in a violation of the law, or an Organizational policy, the Organization retains the right to take appropriate disciplinary or other action against the individual, including termination of employment or agency representation or in the case of a contractor, termination of the applicable contract.

Government Sanctioning:

The Organization does not contract with individuals or companies sanctioned under government programs.

All agents and contractors must:

- Notify the Organization of any known or suspected violations of law or regulations pertaining to the agent's or contractor's relationship with the Organization.
- Disclose to the Organization any government investigations in which the agent or contractor is, was or may become involved.
- Disclose to the Organization any persons affiliated with the agent or contractor, including any officer, director, owner, employee, or contractor who has been

disbarred or excluded from participation in any federal or state funded health care program.

- Immediately disclose to the Organization, any persons affiliated with the agent or contractor, including any officer, director, owner, employee or contractor of the agent or contractor, who has been convicted of or pleaded guilty to a felony or other serious offense and who remains in affiliation or employment relationship with the agent or contractor after the conviction or guilty plea.

Interrelationship of Providers:

In accordance with 55 Pa. C.S. § 1101.51, the Organization shall not engage in the following arrangements with other providers:

1. The referral of MA recipients directly or indirectly to other practitioners or providers for financial consideration or the solicitation of MA recipients from other providers.
2. The offering of, or paying, or the acceptance of remuneration to or from other providers for the referral of MA recipients for services or supplies under the MA Program.
3. A participating provider may not lease or rent space, shelves or equipment within a provider's office to another provider or allowing the placement of paid or unpaid staff of another provider in a provider's office. This does not preclude a provider from owning or investing in a building in which space is leased for adequate and fair consideration to other providers nor does it prohibit an ophthalmologist or optometrist from providing space to an optician in his office.
4. The solicitation or receipt or offer of a kickback, payment, gift, bribe or rebate for purchasing, leasing, ordering or arranging for or recommending purchasing, leasing, ordering or arranging for or recommending purchasing, leasing or ordering a good, facility, service or item for which payment is made under MA. This does not preclude discounts or other reductions in charges by a provider to a practitioner for services, that is, laboratory and x-ray, so long as the price is properly disclosed and appropriately reflected in the costs claimed or charges made by a practitioner.
5. A participating practitioner or professional corporation may not refer a MA recipient to an independent laboratory, pharmacy, radiology or other ancillary medical service in which the practitioner or professional corporation has an ownership interest.

PathWays
Life Long Fulfillment

TO:

FROM:

DATE:

RE: COMPLIANCE PROGRAM NOTIFICATION

Section 6032 of the **Deficit Reduction Act of 2005** requires entities receiving Medicaid payments in excess of $5,000,000 to establish and disseminate written policies to all employees, certain contractors and agents that provide detailed information about the entity's policies and procedures regarding efforts to prevent and detect fraud, waste, and abuse.

In accordance with this act, please find the enclosed "Compliance Program Notification" for your review. Please sign the enclosed acknowledgement confirming your receipt and review of this notification. A signed copy of this acknowledgement is required to be returned.

Thank you for your cooperation.

I, _____, independent
(First and Last name)

contractor and/or representative of Pathways of Southwestern Pennsylvania, Inc., hereby acknowledge my receipt and review of the Compliance Program Notification dated **_____.**

Signed: _____ Date: _____
(Signature)

TRANSPORTATION MILE (W7271) SERVICE NOTE MONTH/YEAR: ____________________ TOTAL MILES: _______ (# trips____ x miles/trip ____= total_____)

Individual: ____ Purpose of trip(s): ____________________________________

Transported from (address): ______________________________ Transported to (address): ______________________________

**Please initial each date that service (pickup and/or drop off) is provided. **Please submit only one form per place transported and per transporter.

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Date: Drop Off: ______ Pick Up: _______	Date: Drop Off: ______ Pick Up: _______	Date: Drop Off: ______ Pick Up: _______	Date: Drop Off: ______ Pick Up: _______	Date: Drop Off: ______ Pick Up: _______	Date: Drop Off: ______ Pick Up: _______	Date: Drop Off: ______ Pick Up: _______
Date: Drop Off: ______ Pick Up: _______	Date: Drop Off: ______ Pick Up: _______	Date: Drop Off: ______ Pick Up: _______	Date: Drop Off: ______ Pick Up: _______	Date: Drop Off: ______ Pick Up: _______	Date: Drop Off: ______ Pick Up: _______	Date: Drop Off: ______ Pick Up: _______
Date: Drop Off: ______ Pick Up: _______	Date: Drop Off: ______ Pick Up: _______	Date: Drop Off: ______ Pick Up: _______	Date: Drop Off: ______ Pick Up: _______	Date: Drop Off: ______ Pick Up: _______	Date: Drop Off: ______ Pick Up: _______	Date: Drop Off: ______ Pick Up: _______
Date: Drop Off: ______ Pick Up: _______	Date: Drop Off: ______ Pick Up: _______	Date: Drop Off: ______ Pick Up: _______	Date: Drop Off: ______ Pick Up: _______	Date: Drop Off: ______ Pick Up: _______	Date: Drop Off: ______ Pick Up: _______	Date: Drop Off: ______ Pick Up: _______
Date: Drop Off: ______ Pick Up: _______	Date: Drop Off: ______ Pick Up: _______	Date: Drop Off: ______ Pick Up: _______	Date: Drop Off: ______ Pick Up: _______	Date: Drop Off: ______ Pick Up: _______	Date: Drop Off: ______ Pick Up: _______	Date: Drop Off: ______ Pick Up: _______

I certify to the best of my knowledge that the above information is correct. I attest that my registration, license, insurance, and inspection information are not expired.
Attach renewed copies to this form.

______________________________ ____________ ______________________________ ________
Person providing service signature Date Program Staff's signature (from place transported to) Date

______________________________ ____________ ______________________________ ________
Person providing service printed name Date Individual's signature (for Community Employment) Date

PathWays
Life Long Fulfillment

TRANSPORTATION MILE (W7271) SERVICE NOTE MONTH/YEAR: July 2022 TOTAL MILES: _____ (# trips____ x miles/trip ____= total_____)

Individual: Jane Dow

Purpose of trip(s): employment transportation

Transported from (address): Jane's home address

Transported to (address): address of employment

**Please initial each date that service (pickup and/or drop off) is provided.

**Please submit only one form per place transported and per transporter.

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Date:	Date:	Date:	Date:	Date:	Date: 7/1	Date: 7/2
Drop Off: _____	Drop Off: _____	Drop Off: _____	Drop Off: _____	Drop Off: _____	Drop Off: _____	Drop Off: _____
Pick Up: _____	Pick Up: _____	Pick Up: _____	Pick Up: _____	Pick Up: _____	Pick Up: _____	Pick Up: _____
Date: 7/3	Date: 7/4	Date: 7/5	Date: 7/6	Date: 7/7	Date: 7/8	Date: 7/9
Drop Off: _____	Drop Off: _____	Drop Off: _____	Drop Off: _____	Drop Off: _____	Drop Off: _____	Drop Off: _____
Pick Up: _____	Pick Up: _____	Pick Up: _____	Pick Up: _____	Pick Up: _____	Pick Up: _____	Pick Up: _____
Date: 7/10	Date: 7/11	Date: 7/12	Date: 7/13	Date: 7/14	Date: 7/15	Date: 7/16
Drop Off: _____	Drop Off: _____	Drop Off: _____	Drop Off: _____	Drop Off: Transporter's initials	Drop Off: _____	Drop Off: _____
Pick Up: _____	Pick Up: _____	Pick Up: _____	Pick Up: _____	Pick Up: _____	Pick Up: _____	Pick Up: _____
Date:	Date:	Date:	Date:	Date:	Date:	Date:
Drop Off: _____	Drop Off: _____	Drop Off: _____	Drop Off: _____	Drop Off: _____	Drop Off: _____	Drop Off: _____
Pick Up: _____	Pick Up: _____	Pick Up: _____	Pick Up: _____	Pick Up: _____	Pick Up: _____	Pick Up: _____
Date:	Date:	Date:	Date:	Date:	Date:	Date:
Drop Off: _____	Drop Off: _____	Drop Off: _____	Drop Off: _____	Drop Off: _____	Drop Off: _____	Drop Off: _____
Pick Up: _____	Pick Up: _____	Pick Up: _____	Pick Up: _____	Pick Up: _____	Pick Up: _____	Pick Up: _____

I certify to the best of my knowledge that the above information is correct. I attest that my registration, license, insurance, and inspection information are not expired.
Attach renewed copies to this form.

Transporter's signature _____ _____
Person providing service signature Date

Transporter's printed name _____ _____
Person providing service printed name Date

Signature of Individual's Supervisor _____ _____
Program Staff's signature (from place transported to) Date

Signature of Individual receiving services _____ _____
Individual's signature (for Community Employment) Date

PathWays
Life Long Fulfillment

Vendor Electronic Deposit Authorization Form

Name:	
Address:	
Email Adress:	

New	
Change	
Cancellation	

Checking Account Information

Please attach a voided check. Payment information <u>will not</u> be processed without a voided check.

Bank Name:
Bank Address:
Bank Phone Number:
Routing Number:
Account Number:

I hereby authorize to have my payments electronically deposited into the bank account listed above. I understand that it is my responsibility to notify accounts payable of any changes to my account. Changes include but are *not limited to* : changing your name, changing financial institutions, changing accounts within the same institution, or closing accounts. Any changes made *without notifying accounts payable in advance will result in delay of payment.* I also understand that if accounts payable notifies my financial institution that I am not entitled to the funds deposited to my account, my bank is authorized to debit my account for the amount of the adjustment. I understand that in the event my financial institution is not able to deposit any electronic transfer into my account due to any action I take; that I am responsible for any resulting bank fees incurred, and that accounts payable cannot issue the funds to me until the funds are returned to Pathways of Southwestern Pennsylvania, Inc. by my financial institution.

As required by the Federal Office of Foreign Asset Control in support of U.S.C. Title 50, War and National Defense, I attest that the full amount of my electronic deposit is not being forwarded to a bank in another country and that if at any point I establish a standing order for my receiving bank to forward the full electronic deposit to a bank in another country, I will inform accounts payable immediately.

New setups and changes to electronic deposits may take up to two weeks to process after this form has been submitted. Paper checks will be provided during processing and where electronic payments are not possible.

Vendor Signature: **Date:**

01/21