STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
Home and Community Living Administration
Developmental Disabilities Administration

TIME SENSITIVE PROVIDER REVALIDATION NOTICE

[Date]

Dear **[Provider]**:

Your client social service contract(s) to provide **[insert service/contract name]** services to clients of the Home and Community Living Administration or the Developmental Disabilities Administration has been selected for an **out-of-cycle provider revalidation**. Please complete the attached paperwork and return to **ProviderRevalidationDSHS@dshs.wa.gov by [date].**

Complete and return the following:

- Medicaid Provider Disclosure Statement.
    - This is a federal and state requirement. **You must provide full and accurate disclosure of ownership as well as financial, managerial, and controlling interests**.
- IRS W-9 form.
- Copies of any applicable professional licenses or certifications as outlined in your contract.
- A copy of your current business license.
- Small business certification (**only if applicable**).
- Copy of current Washington State photo ID.

Thank you for your cooperation. We value your continued partnership in serving Washington state's DSHS Medicaid recipients. Please send any questions about this process to ProviderRevalidationDSHS@dshs.wa.gov.

Off-cycle provider revalidation FAQ