Provider toolkit | Frequently asked questions

For additional toolkit materials visit wacaresfund.wa.gov/providers/toolkit

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Providers must meet minimum qualifications and hold a WA Cares contract with the Department of Social and Health Services or an Area Agency on Aging to become a registered provider.

What are the covered services?

- Adaptive equipment and technology
- Adult day services, including adult day care and adult day health
- Care transition coordination
- Dementia and behavioral supports
- Education and consultation
- Environmental modifications
- Home-delivered meals
- Home safety evaluation
- In-home personal care (including paid family caregivers)
- Assisted living services (including memory care)
- Adult family home
- Nursing home services
- Personal emergency response system
- Professional nursing services
- Respite for family caregivers (in-home and in a facility)

- Services that assist paid and unpaid family members, specifically housework and errands, and yardwork and snow removal
- Transportation

What qualifications do I need to meet to become a registered provider?

Minimum qualifications for providers are established under Chapter 388-116 WAC. Additional information is in the sample contracts, which include detailed statements of work. Provider application detail documents are available for each of our covered services in our provider toolkit.

When can I start serving beneficiaries?

All registered providers can begin serving beneficiaries on July 1, 2026. Providers participating in the pilot in Lewis, Mason, Spokane and Thurston counties began serving beneficiaries on Jan. 6, 2026.

What is the difference between application, contracting and registration?

An application is the first step of the registration process. All applications must be submitted online. Before you apply, make sure you can do what is in the statement of work and meet minimum qualifications for the service(s) you are interested in providing.

Once your application is approved, you will begin the contracting process. Depending on the service and the area you serve, the Department of Social and Health Services or an Area Agency on Aging may be responsible for processing your application and contracting with you, which includes ongoing monitoring.

After contracting is complete, you will be issued a registration number and entered into the WA Cares Provider Network Directory.

Can a beneficiary have multiple providers?

Beneficiaries can have multiple providers and spend their benefit on any of the covered services.

Does WA Cares have case managers to assess needs and request services?

WA Cares does not have case managers. Since WA Cares is self-directed, beneficiaries are responsible for finding registered providers who offer services they want and contacting providers directly.

If I am a registered provider and I move my business, can I still provide services?

Registered providers will need to report any change of address to the WA Cares Team. Depending on your service, you may need to discontinue your registration and reapply with your new address to continue providing services.

If I am located out of state, can I still provide services?

All providers must meet minimum qualifications and legally be able to do business in the state of Washington.

How do I report the death of a beneficiary?

Contact the WA Cares team.

PAID FAMILY CAREGIVING

How can I become a paid family caregiver for a beneficiary?

If the person you're caring for, or want to care for, has earned WA Cares benefits, you can apply to become a paid caregiver, even if you're caring for your own spouse or registered domestic partner. You may be employed through a home care agency or through Consumer Direct Care Network Washington as an individual provider. See our caregiving comparison chart for more information about working for these employers.

CONSUMER DIRECT CARE NETWORK WASHINGTON

Where can I find information for individual providers?

Individual providers are employed by Consumer Direct Care Network Washington. Contact Consumer Direct Care Network Washington directly with any questions about becoming an individual provider or serving WA Cares beneficiaries as an individual provider.

APPLICATION

What are the application requirements?

- Verify you meet the minimum qualifications and gather all documentation needed to apply for your service type(s).
    - More information specific to the requirements for each service can be found in the provider application details.
- Complete and submit an online application. You will be required to enter information related to your business and you must provide proof you meet the qualifications.
- Submit any additional information requested by the Department of Social and Health Services or an Area Agency on Aging within 30 calendar days of the first request for information.
- Be responsive to requests from the Department of Social and Health Services or the Area Agency on Aging processing your application.

If you no longer want to become a provider, you can withdraw your application.

Can I get help completing my application?

You can get help with completing your application through our self-paced training modules available in the provider toolkit. You can also contact the WA Cares team and a provider network navigator will follow up with you to provide any help you need to complete the application.

Depending on your service type and location, you may also be able to get help from your local Area Agency on Aging.

My application was denied. What can I do now?

Depending on the denial reason, you may be able to reapply in the future.

Permanent disqualifiers will prevent you from reapplying and becoming a registered provider. These may include but are not limited to failed background checks due to barred offenses, substantiated findings and a contract terminated for cause.

Providers have the right to appeal an application denial. Appeal resources are automatically sent to each denied applicant with the notice of denial.

Providers can submit an appeal request with the Office of Administrative Hearings.

If I expand my service offerings, do I need to reapply?

To offer a new service, you must meet minimum qualification for that service. If you meet minimum qualifications, submit a new application to begin the process of adding an additional contract to your WA Cares registration.

Do I have to reapply for registration every year?

You are not required to reapply every year to remain a registered provider. You will be required to periodically update minimum qualifications that have an expiration date or that require renewal. For example, a background check, business and professional license, and insurance information require periodic updates.

If you went through the discontinuation of registration process, you will be required to reapply before you can begin providing services again.

How do I upload documents to my application?

You can attach documents directly to your provider application. If you are unable to attach documents to your application, you can contact us.

BACKGROUND CHECKS

Is there a background check?

All providers are required to complete a name and date of birth background check. However, adult family home, assisted living and nursing home providers have facilities that are separately licensed by the Department of Social and Health Services. As such, they are not obligated to complete a new background check when applying to become a provider.

Before you apply, all entity owners and contract signatories must undergo a background check through the Department of Social and Health Services. If you have had a background check completed in the past 90 days, the results can be submitted and used for your application. All other staff background checks will be the responsibility of the provider and are subject to the Washington Administrative Code and Revised Code of Washington governing the licensure or other credential required for the service type.

An agency owner and contract signatory may be asked to also complete a fingerprint background check if they haven't resided in Washington state for three consecutive years before submitting an application. You will be contacted by DSHS or an Area Agency on Aging if a fingerprint check is necessary. Providers and entity owners designated by the Health Care Authority as posing an increased financial risk of fraud, waste, or abuse to the Medicaid program will also be subject to a fingerprint check.

For more information about background checks, visit the background check central unit website.

What happens if I fail my background check?

Providers are required to meet all minimum qualifications to be registered. Those who cannot pass the background check will not become WA Cares providers.

What if my background check comes back as requiring additional review?

If your results say "review required," you have not been immediately disqualified, but additional review is required.

The WA Cares team will complete a character, competence and suitability assessment to determine your eligibility.

I already completed a background check with the Department of Social and Health Services or an Area Agency on Aging. Do I need to complete another one?

If your background check was completed within the past 90 days through the Department of Social and Health Services Background Check Central Unit, it remains valid and can be used for your current application. You must submit the confirmation number. If a review was required, we will complete that review based on the information provided in the prior background check.

If your background check was completed more than 90 days ago, a new background check must be completed.

REGISTRATION

What are the registration requirements?

To become a registered provider, you must:

- Submit an online application
- Meet minimum qualifications for your service type outlined in administrative rule and client service contracts
- Contract with either the Department of Social and Health Services or an Area Agency on Aging.

Once you have met these requirements and have a contract in place, you will be registered as a provider by the Department of Social and Health Services and you will be added to the WA Cares Provider Directory.

The Department of Social and Health Services is responsible for issuing and discontinuing all provider registrations, as necessary.

How do I get added to the WA Cares Provider Network Directory?

You will be asked in your application to provide the information you want displayed in your directory listing. Once you are registered, the information is sent to the online WA Cares Provider Network Directory.

The listing will include:

- Your name
- The service(s) you provide
- Your contact information
- Any additional languages you offer to beneficiaries who use your services

The directory, which is hosted by Community Living Connections, is the primary way beneficiaries can find providers.

How long will the registration process take?

The entire registration process could take up to 90 days to complete. The entire process includes the application, minimum qualification verification and contracting, as well as the final steps in the registration process.

Timeframes can vary based on completeness of applications, timeliness of returning required documents and volume of applications at the time of submission. Applications are reviewed in the order they are received.

Please check your email regularly to avoid delays in processing your application. You must submit any additional information requested by the Department of Social and Health Services or an Area Agency on Aging within 30 calendar days of the first request.

CONTRACTING

Do I need to be contracted to provide services?

You are required to have a WA Cares contract with the Department of Social and Health Services or an Area Agency on Aging to become registered as a WA Cares provider. This must be in place before providing paid services to beneficiaries.

If your contract is terminated or ends, your registration will end.

If I offer services in multiple counties, can I use a single contract?

Providers who offer a service statewide can have a single contract through the Department of Social and Health Services. Statewide means you serve all 39 counties in the state. If you do not serve all 39 counties, you will need to hold individual contracts with the appropriate Area Agencies on Aging.

If the Department of Social and Health Services is the designated contracting agency for the service contract you will hold, one contract is sufficient even if your service area does not cover all 39 counties.

Depending on the service and location, the Department of Social and Health Services or an Area Agency on Aging may be responsible for processing your application and contracting with you, including ongoing monitoring.

Do I need to have a WA Cares contract if I am already contracted with another Department of Social and Health Services program?

You will need separate contracts to provide a paid service for each program.

How long will my contract last?

Depending on the service type, most contracts are either two or four years. There may be circumstances where a shorter contract may be necessary.

You cannot extend a contract beyond the standard length for your service type. At the end of your contract term, you will have the option to renew it or allow it to end.

You must have a valid contract to be a registered provider. If your contract is terminated or ends, your registration will also end.

What are the monitoring requirements for my contract?

You will be monitored to ensure you continue to meet your service type's minimum qualifications, that you are meeting contractual obligations and operational standards, and following the statement of work in your contract.

How can I renew my contract?

Either the Department of Social and Health Services or an Area Agency on Aging will reach out to discuss contract renewal. If you decide to renew your contract, WA Cares will work with you on that process.

PAYMENTS AND PROVIDERONE

As a new provider, how do I enroll in ProviderOne?

If you are a medical provider, you will need to apply for a Core Provider Agreement with the Health Care Authority prior to contracting and registering as a WA Cares provider.

For nonmedical providers, once contracted and registered as a WA Cares provider, you're automatically enrolled in ProviderOne and will have access to the WA Cares menu via the ProviderOne Provider Portal.

If I am a current ProviderOne user, do I need to re-enroll or create an additional account?

You do not need to re-enroll in ProviderOne. You will have access to the WA Cares menu via the ProviderOne Provider Portal in your existing account once contracted and registered as a WA Cares provider.

Will payments to providers be processed using the ProviderOne system?

ProviderOne is the primary claims processing entity for the WA Cares Fund.

Providers with National Provider Identifiers are required to have a Core Provider Agreement with the Health Care Authority if they are going to have claims processed through the ProviderOne system.

If you don't want to hold a Core Provider Agreement with the Health Care Authority, you can have your claims processed by the contracted financial management services vendor. This option will not be available until July 1, 2026.

Do I need to have a Core Provider Agreement to contract?

Providers with National Provider Identifier requirements will need to have a Core Provider Agreement with the Health Care Authority. Providers with National Provider Identifier numbers must have executed a Core Provider Agreement with the Health Care Authority prior to contracting and registering as a WA Cares provider. National Provider Identifier providers without a Core Provider Agreement with ProviderOne are encouraged to initiate the process of establishing it early due to processing times exceeding six months.

Beginning in July 2026, medical providers that do not want to sign a Core Provider Agreement will still have the option of contracting with WA Cares, but the financial management services vendor will coordinate all the aspects of work required in ProviderOne.

Do I need to have a National Provider Identifier number?

All medical professionals and organizations intending to contract with WA Cares will need a valid National Provider Identifier number attached to their Core Provider Agreement.

How do I correct an atypical National Provider Identifier number?

Medical providers that have an atypical National Provider Identifier number should apply for a valid National Provider Identifier number through the National Plan and Provider Enumeration System. If an atypical National Provider Identifier number is attached to your current Core Provider Agreement, you will need to request an update to your ProviderOne ID to reflect the valid National Provider Identifier number. To do this, contact the Provider Enrollment team via the Health Care Authority's online contact form.

Do I need to monitor the remaining benefit amount for each beneficiary?

It is the beneficiary's responsibility to manage their benefit. You will be required to validate the beneficiary's balance in ProviderOne before creating a pre-authorization. A pre-authorization will be denied if it exceeds the beneficiary's available balance.

Where can I get help with my ProviderOne account?

To learn more about the ProviderOne system, including how to set up your account, enrollment, pre-authorizations, claims, checking a beneficiary's balance, and payments, you can refer to the training and education materials or visit the ProviderOne for WA Cares website.

For additional assistance, you may contact the Health Care Authority's Medical Assistance Customer Service Center. For the quickest resolution, complete the secure contact form. You can also call 800-562-3022 Monday through Friday from 7 a.m. to 4:30 p.m.

Where can I learn more about payments and ProviderOne?

To learn more about payments and ProviderOne you can reference the Billing Guide and ProviderOne Essentials or the self-paced training modules available in the provider toolkit. You can also visit the ProviderOne for WA Cares website.

RATES

Why did I have to provide my rates when I applied?

Your rate information is required for informational and monitoring purposes. This information will be used by the Department of Social and Health Services and the Area Agencies on Aging to gain a better understanding of providers' usual, customary and reasonable rate ranges.

Providers cannot bill WA Cares beneficiaries more than they would charge a member of the public who needed the same service under the same circumstances in the same location.

How are rates determined?

Maximum rates are established in Chapter 388-116 WAC.

WA Cares does not have case managers, so it is your responsibility to discuss your rate with the beneficiary within the established limit for each service. The beneficiary must agree to the rate before you create a pre-authorization for services, which acts as a formal agreement to the rate discussed and agreed to.

Can I request an exception to the maximum rate?

If you believe a beneficiary needs a rate that exceeds the established maximum rate for that service, you may submit a request with justification in writing to the Department of Social and Health Services. All requests will be considered by the WA Cares Team, and you will be notified of the decision. Any exception that is granted will only apply to that specific beneficiary for that specific service.

PRE-AUTHORIZATIONS

How long does my pre-authorization last?

Pre-authorizations can be created for up to three calendar months, except for:

- Care transition coordination pre-authorizations, which can be up to 60 days.
- Environmental modification pre-authorizations, which can be up to 6 months.

If a beneficiary wants to continue receiving your services beyond the pre-authorization timeframe, you will need to submit a new pre-authorization for their approval.

What happens after I create a pre-authorization?

Once you submit a pre-authorization in ProviderOne, the beneficiary needs to approve or deny the pre-authorization through their WA Cares account. Providers do not have access to this portal.

The beneficiary has 30 calendar days to approve or deny the pre-authorization, or up to midnight two days before the start date. If they don't take action in time, the pre-authorization request times out and you will be notified of a "timely denial." You will need to work with the beneficiary to determine if they are still interested in the service. If they would like to continue with services, you will need to submit a new pre-authorization. Providers may also reach out at any time to beneficiaries to inquire about the status of the pre-authorization or remind them action is needed.

Providers can only begin services after a pre-authorization is approved.

Can I cancel a pre-authorization after the beneficiary has approved it?

You may cancel a pre-authorization if no services were rendered, the pre-authorization dates are future dates and you have notified the beneficiary you are cancelling the service. After the beneficiary has been notified that you will not provide the service, contact WA Cares team to cancel the pre-authorization.

Can I discontinue services with a beneficiary?

You can decide to stop providing services to a beneficiary, or you and the beneficiary may decide together to end your service agreement. After services have started, only the beneficiary can request to modify the end date of the pre-authorization. Work with the beneficiary to agree on the new end date. They will then contact the WA Cares team to revise the end date of services.

You will have 60 days from the revised end date of the pre-authorization to claim for all services performed while the pre-authorization was active.

CLAIMS

How long do I have to submit a claim for payment?

You must submit your error-free claims within 60 calendar days from the latest end date of the pre-authorization. You can bill as frequently as you wish during the service period, and payment will be issued weekly per the existing payment schedule for ProviderOne.

Claims submitted after the 60-day deadline will be denied automatically and funds will return to the beneficiary's balance.

I was underpaid/overpaid by WA Cares. How can I get this corrected?

Contact the Medical Assistance Customer Service Center if the payment was processed through ProviderOne. If you are being paid by the contracted financial management services vendor, you should reach out to the vendor directly.

Where can I learn more about submitting and modifying claims in ProviderOne?

To learn more about submitting and modifying claims in ProviderOne, you can reference the Billing Guide and ProviderOne Essentials or the self-paced training modules available in the provider toolkit. You can also visit the ProviderOne for WA Cares website.

COORDINATION OF BENEFITS

What is coordination of benefits?

Coordination of benefits is the process the Health Care Authority uses to determine who pays for overlapping service when someone is enrolled in Medicaid and another plan that both cover the same service. By law, Medicaid is the payer of last resort. Coordination of benefits is the responsibility of the Health Care Authority.

How does coordination of benefits impact WA Cares services?

Beginning July 1, 2026, the ProviderOne system will begin to automatically apply coordination of benefits to WA Cares services. This means that if a person is eligible and enrolled in both Medicaid and WA Cares, and accessing a service available under both programs, they will need to use their WA Cares Fund balance to pay for the overlapping service until they have

exhausted their benefits or there is less than $250 remaining in their WA Cares benefits account.

Which services could be impacted by coordination of benefits?

Providers can use the service code data sheet that corresponds to their contracted service or the maximum rates workbook on the provider toolkit to view the service codes and modifiers that are used for each WA Cares service. The service code and modifier for the WA Cares service must match the service code and modifier used by the Medicaid program for coordination of benefits to apply.

Who is responsible for coordination of benefits?

The Health Care Authority is responsible for coordination of benefits to ensure no Medicaid funds are used when a Medicaid service is also available in WA Cares and the beneficiary is enrolled in both programs. Coordination of benefits may impact payment to providers. Questions regarding coordination of benefits should be referred to the Medical Assistance Customer Service Center at Health Care Authority using their online form or by phone at 800-562-3022.

Where can I learn more about coordination of benefits?

See the provider resource for coordination of benefits on our provider toolkit.