Attestation of Compliance for Eligibility to Receive Home and Community Based Services Direct Care Workforce Provider Supplemental Payment

The Mississippi Division of Medicaid (DOM) is issuing one-time Supplemental Payments to eligible 1915(c) Home and Community Based Services (HCBS) Direct Care Workforce Providers to increase access to HCBS, strengthen the HCBS workforce, and build provider capacity to meet the needs of individuals receiving HCBS in these programs. This opportunity is being offered through federal savings available under Mississippi's American Rescue Plan Act (ARPA) Section 9817 HCBS Spending Plan and authorized through a CMS approved Appendix K. The below attestation is confirmation that my agency will comply with all applicable requirements pertaining to eligibility for 1) requests for payment of these funds, and 2) the receipt of these funds as prescribed by DOM in written memos, protocols, or other communication. I further affirm that I will maintain documentation to demonstrate my agency's compliance with DOM requirements, and cooperate fully with all audits or other requests for documentation related to these payments.

Attestation:

☐ I understand that, by signing this attestation, I agree that it is my responsibility to 1) review eligibility requirements for this funding opportunity, 2) only use the funds for eligible expenditures/purposes, and 3) properly document and retain documentation showing that the funds were properly spent.

☐ I commit, as an authorized representative, that complete documentation of compliance with these requirements will be maintained, and that records will be available upon request for auditing and validation of compliance for all payments received. Failure to provide sufficient documentation to auditors will be considered non-compliance and will result in repayment of funds.

☐ I acknowledge that any ARPA Section 9817 funding accepted by my agency for which eligibility requirements are not met is subject to recoupment, and that any such funding received, or any claims or requests for such funding for which eligibility requirements are not met, is subject to potential False Claims Act violations.

☐ I commit that at least 75% of the supplemental payment received must go directly to retention/ recruitment bonuses for individuals currently or newly employed and working as direct care staff who are making under $50,000 a year. All other funds can be used to supplement expenditures directly related to business administrative costs.

☐ I understand that these funds shall not be used to pay bonuses to administrators/executive staff or owners or their relatives.

☐ I understand that these funds shall not be used to support long term wage increases.

☐ I am a part of senior leadership within the provider agency with authority to sign on behalf of the agency.

☐ I understand that funds must be fully expended by March 31, 2024.

Provider Information	
Agency Name:	**Medicaid Provider Number(s):**
Tax Identification Number:	
Address:	
Printed name of signature:	
Title:	
Date:	
Authorized signature:[1]	

[1] A scanned, imaged, electronic, photocopy or stamp of the above signature shall have the same force and effect as an originally executed signature.