Office of Developmental Programs (ODP)
Provider Attestation Form for One-Time Supplemental Payment

Instructions:
Providers will complete this attestation form to be considered to receive a one-time supplemental payment under the 1915(c) Home and Community-Based Services Waivers or Appendix K. Providers seeking a one-time supplemental payment for the period of April 1, 2021 through March 31, 2022 must submit: (1) a requested amount of supplemental payment, (2) provider details and (3) acknowledge and attestation sections.

Completed forms should be sent to Rick Smith at riesmit@pa.gov. In the subject line of your e-mail, please use "MPI xxxxxxxxx Supplemental Payment Attestation," (xxxxxxxxx is 9 digit MPI).

Once the attestation form is submitted and the amount requested is confirmed, providers will receive the funds via a Gross Adjustment at their largest billing service location. Further communication on timing of payments will follow.

For questions regarding the completion of this form, please contact Rick Smith at riesmit@pa.gov.

Requested Amount of Supplemental Payment:

- *Requested amount may not exceed* **5% of total claims** (or 2% total claims for AWC providers) paid in the Consolidated, Community Living, P/FDS, and Adult Autism Waivers for the period of **7/1/19-6/30/20** or **7/1/20-6/30/21,** whichever is greater ***and*** *for the following services*: Advanced Supported Employment; Behavioral Support; Benefits Counseling; Communication Specialist; Community Participation Support; Companion; Consultative Nutritional Services; Family/Caregiver Training and Support; Homemaker/Chore; Housing Transition and Tenancy Sustaining Services; In-Home and Community Support; Licensed and Unlicensed Life Sharing; Music, Art and Equine Assisted Therapy; Licensed and Unlicensed Residential Habilitation; Respite (Excluding Respite Camp); Shift Nursing; Small Group Employment; Supported Employment; Supported Living; Supports Broker and Supports Coordination.
  Please exclude revenue associated with cost-based and/or exceptional residential rates (if applicable) from your calculation.
- Note: When considering the amount of the supplemental payment, providers may request less than 5% of total claims (see above) if they do not anticipate having enough expense during the identified time period to use it all. AWC services rendered by a Type 54 provider should be requested under a separate attestation. If a provider renders both AWC and traditional services, two attestation forms should be submitted.

Requested Amount of Supplemental Payment:	

Provider Details:

Name of Provider:	
MPI (9 digits):	
Name of Provider's Authorized Representative:	
Title of Provider's Authorized Representative:	
Authorized Representative's Phone Number:	
Authorized Representative's Email Address:	
Signature of Provider's Authorized Representative: (electronic signature acceptable)	
Date:	
One-Time Supplemental Payment Category:	High Staff Vacancy and Turn Over Rates

Acknowledgement and Attestations:

(Please initial all statements to which you are acknowledging or attesting)

I acknowledge that any supplemental payment received by (name of provider) will be subject to recoupment if it is identified in a state or federal audit or any other authorized third-party review that (name of provider) has inappropriately billed for services or received duplicative payments for services provided or if expenses were reimbursed by duplicative funding streams.

I attest that any supplemental payment received by (name of provider) will be used to fund only recruitment, retention and COVID-19 related staffing expenses for direct support professionals or supports coordinators to include funding for hazard pay, costs of recruitment efforts, sign-on bonuses, retention bonuses, and other incentive payments). I further attest that no portion of the supplemental payment will be utilized to increase executive compensation.

I attest that for the period from December 1, 2021 through June 30, 2022, (name of provider) will not stop providing any service or close any service location without first obtaining written consent from ODP.

I attest that (name of provider) will comply with all reporting requirements concerning the use of the supplemental payment by (name of provider). I acknowledge that I understand that failure to comply with the reporting requirements may result in recoupment of funds.