

**OFFICE OF DEVELOPMENTAL PROGRAMS (ODP) COMMUNITY PARTICIPATION SUPPORTS (CPS)
PROVIDER ATTESTATION FORM**

(To be completed by eligible providers seeking to receive retainer payments under the 1915(c) Home and Community-Based Services Waivers, Appendix K)

Providers that are seeking retainer payments for the period beginning July 1, 2020 must attest to the following:

(Please initial all statements to which you are attesting.)

I attest that any retainer payments received by _____ will be subject to recoupment if inappropriate billing or duplicative payments for services occurred, or if expenses were reimbursed by duplicative funding streams, as identified in a state or federal audit or any other authorized third party review.

I attest that _____ has not and will not lay off staff, and has and will maintain staff wages at or above existing levels from the period beginning July 1, 2020 through the end of any period covered by the retainer payments.

I attest that _____ has not received funding from any other sources, including but not limited to unemployment benefits and Small Business Administration loans, that would cause current quarterly revenue to exceed revenue from the quarter 10/1/19 through 12/31/19. I further attest that any anticipated retainer payments will not cause current quarterly revenue to exceed revenue from the quarter 10/1/19 through 12/31/19.

Name of Provider

MPI (9 digits)

Name of Provider's Authorized Representative

Title of Provider's Authorized Representative

Signature of Provider's Authorized Representative

Date