BDS Attestation of Requirements & Authorization to Pay One-time for a Supplemental Recruitment, Retention, and Training Payments

Date: _____

Provider Agency Requirements

To accept a one-time NH Medicaid supplemental recruitment, retention, and training payments under this initiative, you on behalf of the Provider Agency, as the Organized Health Care Delivery System, and any of the Provider Agency's subcontractors agree to the following requirements:

1. The Provider Agency and all subcontractor(s) will make payments in accordance with:
    a. BDS 22-39 NH HCBS One-Time Supplemental Recruitment, Retention & Training Payments Service Coordinator Guidance;
    b. BDS 3785 *Attestation of Requirements & Authorization to Pay Supplemental Recruitment, Retention and Training Payments* (this form); and,
    c. Any other requirements set forth by the federal Centers for Medicare & Medicaid Services (CMS) or the Department.
2. At least 80% of the supplemental payments must be spent on recruitment, retention, and training payments to:
    a. Existing Service Coordinators;
    b. Existing Immediate Supervisors;
    c. New Service Coordinators and New Immediate Supervisors.
3. Each Provider Agency and their subcontractor(s) must adopt a brief written Supplemental recruitment, retention, and training Payments plan that outlines the rationale and amount of recruitment, retention, and training Payments and disseminate the plan to the Department. The spending plan must clearly identify how at least 80% of the funds will be used for recruitment, retention, and training for current or new case managers. This attestation and the spending plan must returned to the department before the department can release funds to the case management agency. This attestation and the spending plan must be returned to the department via: HCBSARPAPayment@dhhs.nh.gov
4. The Provider Agency and all subcontractor(s) agrees to complete BDS 3795 SC *Supplemental, Recruitment, Retention, and Training Expense Report* and provide it to the Department by 11/1/22. BDS 3795 SC must provide employee and contractor-level details on the supplemental recruitment, retention, and training payments, including records of administrative costs.
5. The Provider Agency and all subcontractor(s) understands that the expenditures it makes under this initiative are subject to audit at the Department's discretion or from CMS, and payments made contrary to guidance are subject to recoupment by the Department and other sanctions.
6. The Provider Agency and all subcontractor(s) acknowledges that it must retain, maintain, and make available to a state or federal audit authority, or any other authorized third-party reviewer upon request, copies of all documentation related to expenditures made under this initiative, including but not limited to personnel records, NH Medicaid claims data, and provider agency financial data.
7. The Provider Agency and all subcontractor(s) understands that misrepresentation or falsification of any information contained on BDS 3785 SC *Attestation of Requirements & Authorization to Pay Supplemental Recruitment, Retention and Training Payments* or BDS 3795 SC *Supplemental, Recruitment, Retention, and Training Expense Report* may be punishable by fine and/or imprisonment under state or federal law.
8. The Provider Agency and all subcontractor(s) certifies that any information provided to the Department regarding this initiative is a true, correct, and complete statement prepared from the books and records of the Provider Agency as of the date signed.
9. The individual submitting this form is authorized to make these representations on behalf of the Provider Agency.

Provider Agency Expenditure Report Requirements

By November 1, 2022, the Provider Agency must submit an expenditures report to the Department on BDS 3795 SC *Recruitment, Retention, and Training Expense Report*. BDS 3795 will be completed using the instructions tab of the workbook.

In addition to this report, the Provider Agency must provide any documentation requested by the Department or CMS as part of an audit.

Date:

Bureau of Developmental Services Area Agency Attestation
(Completed by Area Agency Representative)

Your signature below certifies that you are an authorized representative of the agency named below, and you certify that the agency used or will use 80% of the supplemental payments for the express purpose of recruitment, retention, and training of Service Coordinator staff. The state may request an audit of our records to confirm your compliance with the payment eligibility requirements as stated in this document above.

Your signature below also certifies that you have read and agree to the Provider Agency Requirements and Provider Agency Expense Report Requirements on the prior page.

Your signature below also indicates that you intend to use at least 80% of the payments for the express purpose of recruitment, retention, and training of Service Coordinator staff.

Printed Name of Individual Submitting Verification	Individual's Title	Area Agency

☐ By checking this box I certify that the funding will be used for the express purpose of recruitment, retention, and training of Service Coordinator staff and according to the requirement as stated in this document above.

Date: _____ Electronic Signature: _____

(See Next Page for Sub-Contractor Vendor Attestation)

Bureau of Developmental Services Provider/Agency Subcontractor (Vendor) Attestation
(Completed by Provider/Agency Subcontractor (Vendor) Representative)

Your signature below certifies that you are an authorized representative of the agency named below, and you certify that the agency used or will use 80% of the Supplemental recruitment, retention and training payments for the express purpose of recruitment, retention and training of Service Coordinator staff, exclusively for the purpose of increasing wages and/or benefits paid to individuals providing services directly to recipients. The state may request an audit of our records to confirm our compliance with the payment eligibility requirements as stated in this document above.

☐ Express purpose of recruitment retention and training of staff

Printed Name of Individual Submitting Verification	Individual's Title	Area Agency/Provider Agency

☐ By checking this box, I certify that the funding was used for the checked initiative(s) and according to the requirement as stated in this document above.

Date: _____ Electronic Signature: _____

Return to HCBSARPAPayment@dhhs.nh.gov

Bureau of Development Services (BDS) Authorization to Pay
(Completed by BDS Bureau Chief or Designee)

My signature below certifies that BDS' verifies the Provider/Agency Attestation.

Printed Name of BDS Staff	BDS Staff Title

☐ By checking this box, I certify I have reviewed and verified the Provider/Agency Attestation; and, authorize payment to Provider/Agency.

Date: _____ Electronic Signature: _____

Authorize Direct Payment
(Completed by BDS Business Administrator or Designee)

☐ By checking this box, I authorize payment to Provider/Agency.

Date: _____ Electronic Signature: _____