N.H. Department of Health & Human Services (DHHS)
Division of Long Term Supports & Services (DLTSS)
Bureau of Elderly & Adult Services (BEAS)

105 Pleasant St.
Concord, NH 03301

BEAS POLICY RELEASE (PR)	
PR NUMBER:	**24-08**
TO:	Director of DLTSS, Melissa Hardy; All BEAS Staff; and CFI Providers and Case Managers
FROM THE OFFICE OF:	**Bureau Chief of Elderly and Adult Services (BEAS), Wendi Aultman**
SIGNATURE:	Wendi Aultman Digitally signed by Wendi Aultman Date: 2024.07.29 16:02:16 -04'00'
SUBJECT:	Revisions and Renumbering of BEAS Forms 3780, Attestation and Payment
EFFECTIVE DATE:	**Upon Release**

SUMMARY

This Policy Release (PR) releases revisions to BEAS Form 3780, *Attestation for DSWPP* and BEAS Form 3780, *CMA Attestation to Policy.*

DESCRIPTION OF REVISIONS MADE TO FORMS

The following changes have been made to BEAS Forms:

- BEAS Form 3780, *Attestation for DSWPP:*
  - Was renumbered to BEAS Form 3782, *DSWPP Attestation and Payment Authorization*
  - Minor formatting edits
- BEAS Form 3780, *CMA Attestation to Policy:*
  - Added an 'Incidents' section for attestation under Policy and Procedures
  - Minor formatting edits

FORMS INSTRUCTIONS

Remove and Destroy	Insert/Replace
BEAS Form #3780, *Attestation for DSWPP*, BEAS GM 23-28 Rev 2023 1 double sided sheet	BEAS Form #3782, *DSWPP Attestation and Payment Authorization*, BEAS PR 24-08 Rev 07/2024 1 double sided sheet
BEAS Form #3780, *CMA Attestation to Policy*, Rev 2023 1 singled sided sheet	BEAS Form #3780, *CMA Attestation to Policy & Procedure*, BEAS PR 24-08 Rev 07/2024 1 singled sided sheet

DISPOSITION

This PR may be destroyed once the content has been noted and the posting instructions carried out.

DISTRIBUTION

This PR and new versions of BEAS Form 3780 and BEAS Form 3782 will be distributed according to the electronic distribution list for BEAS policy releases. This PR and BEAS Forms 3780 and 3782 will be available internally on the DHHS (N:) drive, in the BEAS folder for staff to access and on the DHHS website at https://www.dhhs.nh.gov/programs-services/adult-aging-care for public access.

STATE OF NEW HAMPSHIRE
DEPARTMENT OF HEALTH & HUMAN SERVICES
DIVISION OF LONG TERM SUPPORTS AND SERVICES
BUREAU OF ELDERLY & ADULT SERVICES

Direct Support Worker Payment Program (DSWPP) Attestation & Payment Authorization

Date:_____

Provider Agency Attestation and Requirements

To accept a one-time NH Medicaid DSWPP recruitment, retention and training payment under this initiative, you on behalf of the Provider Agency agree to the following requirements:

1. The Provider Agency will make payments in accordance with the requirements contained in:
    a. BEAS GM 23-28 New Hampshire Home and Community Based Services Direct Support Worker Payment Program
    b. BEAS 3782 *Direct Support Worker Payment Program (DSWPP) Recruitment, Retention, and Training Payment* (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 payments will be spent on recruitment, retention, and training payments to:
    a. Existing Direct Support Workers (DSWs), including Direct Support Professionals (DSPs);
    b. Existing Immediate Supervisors; and
    c. New DSWs and New Immediate Supervisors.
    d. The 80% of the recruitment, retention and/or training payments cannot be paid to case managers as they are not direct support.

3. The Provider Agency 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.

4. The Provider Agency understands that misrepresentation or falsification of any information contained on BEAS 3782 *Direct Support Worker Payment Program (DSWPP) Recruitment, Retention, and Training Payment* (this form) may be punishable by fine and/or imprisonment under state or federal law.

5. The Provider Agency 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.

6. The individual submitting this form is authorized to make these representations on behalf of the Provider Agency.

Bureau of Elderly and Adult Services Provider/Agency Attestation
(Completed by Provider/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 payments for the express purpose of recruitment, retention and training of direct support staff, which does not include case managers. The state may request an audit of our records to confirm our compliance with the payments eligibility requirements.

Your signature below also certifies that you have read and agree to the Provider Agency Requirements.

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 DSW staff.

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

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

Date: _____ Electronic Signature: _____

Upon Completion Return to **HCBSDSWPP@dhhs.nh.gov**

Bureau of Elderly and Adult Services (BEAS) Verification of Provider Agency Claims Submission & Authorization to Pay
(Completed by BEAS Bureau Chief or Designee)

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

Printed Name of BEAS Staff	BEAS Staff Title

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

Date: _____ Electronic Signature: _____

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

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

Date: _____ Electronic Signature: _____

STATE OF NEW HAMPSHIRE
DEPARTMENT OF HEALTH & HUMAN SERVICES
DIVISION OF LONG TERM SUPPORTS AND SERVICES
BUREAU OF ELDERLY & ADULT SERVICES

Direct Support Worker Payment Program (DSWPP) Attestation & Payment Authorization

Date:_____

Provider Agency Attestation and Requirements

To accept a one-time NH Medicaid DSWPP recruitment, retention and training payment under this initiative, you on behalf of the Provider Agency agree to the following requirements:

1. The Provider Agency will make payments in accordance with the requirements contained in:
    a. BEAS GM 23-28 New Hampshire Home and Community Based Services Direct Support Worker Payment Program
    b. BEAS 3782 *Direct Support Worker Payment Program (DSWPP) Recruitment, Retention, and Training Payment* (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 payments will be spent on recruitment, retention, and training payments to:
    a. Existing Direct Support Workers (DSWs), including Direct Support Professionals (DSPs);
    b. Existing Immediate Supervisors; and
    c. New DSWs and New Immediate Supervisors.
    d. The 80% of the recruitment, retention and/or training payments cannot be paid to case managers as they are not direct support.

3. The Provider Agency 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.

4. The Provider Agency understands that misrepresentation or falsification of any information contained on BEAS 3782 *Direct Support Worker Payment Program (DSWPP) Recruitment, Retention, and Training Payment* (this form) may be punishable by fine and/or imprisonment under state or federal law.

5. The Provider Agency 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.

6. The individual submitting this form is authorized to make these representations on behalf of the Provider Agency.

Bureau of Elderly and Adult Services Provider/Agency Attestation
(Completed by Provider/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 payments for the express purpose of recruitment, retention and training of direct support staff, which does not include case managers. The state may request an audit of our records to confirm our compliance with the payments eligibility requirements.

Your signature below also certifies that you have read and agree to the Provider Agency Requirements.

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 DSW staff.

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

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

Date: _____ Electronic Signature: _____

Upon Completion Return to **HCBSDSWPP@dhhs.nh.gov**

Bureau of Elderly and Adult Services (BEAS) Verification of Provider Agency Claims Submission & Authorization to Pay
(Completed by BEAS Bureau Chief or Designee)

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

Printed Name of BEAS Staff	BEAS Staff Title

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

Date: _____ Electronic Signature: _____

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

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

Date: _____ Electronic Signature: _____

STATE OF NEW HAMPSHIRE
DEPARTMENT OF HEALTH & HUMAN SERVICES
DIVISION OF LONG TERM SUPPORTS AND SERVICES
BUREAU OF ELDERLY & ADULT SERVICES

Case Management Agency Policy & Procedure Attestation

Purpose: The purpose of this form is to allow Case Management Agencies to attest to having provided required policies & procedures that remain unchanged since the last Case Management Agency Quality Assurance Review. This attestation cannot be used for any policy or procedure not designated as being met during the last Quality Assurance Review.

Case Management Agency Name: _____

Please initial only the required policies & procedures that:

- were designated as being met in your last Quality Assurance Review;
- remain unchanged since your last Quality Assurance Review; **and**
- have been provided to the Department within the previous five years.

You must provide copies of any required policies & procedures if:

- the policy & procedure was designated as not being met in your last Quality Assurance Review;
- the policy & procedure has been revised or updated since your last Quality Assurance Review; **or**
- it has been five or more years since the policy & procedure has been provided to the Department.

Using this attestation is voluntary and if utilized, will need to be completed annually. If you do not wish to complete this attestation, you will be required to provide copies of all policy and procedures listed below at the time of the annual Quality Assurance Review.

Policy or Procedure	Administrative Rule	Initials
Criminal Background Check for all employees	He-E 805.04(c)(1)	
BEAS State Registry Checks for each employee	He-E 805.04(c)(2)	
Mandated Reporting of Abuse, Neglect, or Exploitation	He-E 805.04(c)(4)	
Reporting of Sentinel Events	He-E 805.04(c)(5)	
Incidents	He-E 805.04(c)(5)	
Complaints	He-E 805.04(c)(5), (10)	
Supervision	He-E 805.04(c)(9)	
Orientation	He-E 805.04(c)(6)	
Participant Satisfaction	He-E 805.04(c)(11)	
Protection of Participant Records including HIPAA compliance	He-E 805.04(c)(12)	

Your signature below certifies that you are an authorized representative of the Case Management Agency named on this form. You attest that the Case Management Agency met the policy & procedure requirements in the last Quality Assurance Review, the policies & procedures initialed above have not been revised or updated since the Case Management Agency's last Quality Assurance Review, and the policies & procedures have been provided to the Department within the past five years.

Printed Name	Job Title
Signature	Date