Complete and return this form ONLY if you did not receive a pre-filled form with your payment notification letter

Office of Long-Term Living (OLTL) Provider Attestation for Strengthening the Workforce Payment

Providers that are seeking one-time supplemental payments to strengthen the workforce based on their claim and encounter payments for the period July 1, 2020 thru March 31, 2021 must attest to the following:

(Please initial all statements to which you are attesting and provide the name, title and signature of the authorized representative.)

_____I attest that any payments received by _____will be subject to recoupment 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 the supplemental payments received by _____will be used to fund the following expenses:

(*please check all items you intend to use the funding for*):

_____Sign-on Bonuses (new workers)
_____Retention Payments (existing workers)
_____Leave Benefits –health insurance premiums or other employee benefit
_____COVID-related paid time off/ offering paid sick leave
_____Incentives for vaccination along with paid time off
_____Purchase Personal Protective Equipment and Testing Supplies

_____I further attest that no portion of the supplemental payments will be utilized to increase executive compensation.

_____I attest that _____has and will comply with any and all reporting requirements as determined by the OLTL on the use of any supplemental payments. I acknowledge that failure to comply will result in recoupment of funds.

Name of Provider:	
Promise ID/Medical Assistance Provider ID number (13 digits):	
Name of Provider's Authorized Representative:	
Title of Provider's Authorized Representative:	
Signature of Provider's Authorized Representative:	
Amount of Payment: Amount calculated by OLTL	Amount calculated by OLTL