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 Adult Daily Living Providers

Providers that are seeking one-time supplemental payments to strengthen the workforce based on their claim and encounter payments for the period January 1, 2019 thru December 31, 2019 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 the 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
- _______Retrofit Adult Day Centers to protect individuals from COVID
- _______Expenses incurred to re-open adult day center after COVID closure
- _______Expenses to develop alternative models to providing adult day services

_______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