ATTESTATION AND FUNDING REQUEST FROM AR ARPA ALLOCATION FOR Exceptional Costs of Biohazardous Medical Waste, COVID-19 Testing and other Unreimbursed costs

I, (NAME AND TITLE) , on behalf of (FACILITY NAME ) , AR Medicaid ID Number: (AR MEDICAID ID NUMBER) Vendor Number: (VENDOR NUMBER) request and attest to following:

The nursing facility requests allotment of funds to address extraordinary unreimbursed costs of biohazard medical waste disposal, COVID-19 testing of staff and residents and other unreimbursed, mandatory COVID-19 costs incurred from March 3, 2021 through February 28, 2022 caused primarily by the Delta Variant per the AR ARPA Proposal approved by the Arkansas Legislative Council on August 9, 2021. The purpose of these formula-based payments is to provide one-time funds to assist skilled nursing facilities in meeting some of the continued exceptional, unreimbursed costs of biohazardous medical waste disposal, COVID-testing and other unreimbursed COVID-19 costs.

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| --- | --- |
| Range of Licensed Beds in Nursing Facility | Budget Per Facility |
| 50 to 69 | $89,187 |
| 70 to 95 | $124,545 |
| 96 to 119 | $165,809 |
| 120 to 999 | $212,951 |

The nursing facility must provide DHS with documentation of unreimbursed incurred expenses for cost items listed below from March 3, 2021 through February 28, 2022. Acceptable documentation may include, but is not limited to, any documents or files sufficient to evidence actual obligation or expense of funds. DHS may request supplemental documentation, as needed. Previously claimed expenses for biohazardous medical waste disposal and Covid testing should not be claimed again.

The facility requests the following amount of funding from the AR ARPA allocation:

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| --- | --- |
| $ \_\_\_\_\_\_\_\_\_\_\_\_ | Biohazardous Waste Disposal |
| $ \_\_\_\_\_\_\_\_\_\_\_\_ | COVID-19 Testing of Staff |
| $ \_\_\_\_\_\_\_\_\_\_\_\_ | COVID-19 Testing of Residents |
| $ \_\_\_\_\_\_\_\_\_\_\_\_ | Door Screeners for Staff and Visitors |
| $ \_\_\_\_\_\_\_\_\_\_\_\_ | Additional Laundry Costs for Residents and Staff |
| $ \_\_\_\_\_\_\_\_\_\_\_\_ | Mask Fit Testing |
| $ \_\_\_\_\_\_\_\_\_\_\_\_ | Infection Control Supplies |
| $ \_\_\_\_\_\_\_\_\_\_\_\_ | Supplies Required for Socially Distanced Dining |
| $ \_\_\_\_\_\_\_\_\_\_\_\_ | Supplies for Separate Quarantine and Isolation Units |
|  |  |
| $ \_\_\_\_\_\_\_\_\_\_\_\_ | **TOTAL ALLOCATION REQUESTED** |

The facility attests that:

1. We are a DHS licensed skilled nursing facility and certified to participate in Medicaid (or Medicaid and Medicare).
2. We will submit a Medicaid cost report for SFY 2021 and understand a Medicaid cost report for SFY 2022 is also required if any ARPA funds requested or received are attributable to SFY 2022.
3. We have served Medicaid beneficiaries in SFY 2021 and agree to continue accepting and serving Medicaid patients during the public health emergency.
4. We agree to cooperate with any state or federal audit and provide DHS with access to financial records.

**Signed and Agreed:**

|  |  |
| --- | --- |
| **Facility Name** |  |
| **Facility AR Medicaid ID Number** |  |
| **Facility Vendor Number** |  |
| **Signer’s Printed Name** |  |
| **Signer’s Title** |  |
| **Signer’s Email Address** |  |
| **Signer’s Telephone Number** |  |
| I hereby attest that all the all of the statements and facts above are true and correct to the best of my knowledge and belief; that I am an officer or agent of the facility named herein and I am authorized to submit this form on behalf of said facility; that the facility shall retain records sufficient to support any claims or statements made for no less than seven (7) years and make them available to the Arkansas Department of Human Services (DHS), federal HHS Office of the Inspector General (OIG), and any other lawful federal or state authority, upon request; that the facility shall fully cooperate with any state or federal audit concerning ARPA payments; that the funds requested herein are requested for necessary expenditures to help maintain operations during the pandemic and mitigate ongoing unreimbursed expenses for biohazardous medical waste disposal, COVID-19 testing and other unreimbursed, mandatoryCOVID-19 costs and that none of these funds are used to:   * Duplicate or supplant funding from any other federal or state program. Payments or other reimbursement for direct patient care is not included as funding from a federal or state program; or * Pay any increase in management fees to administrative personnel.   The total amount of the reimbursement may not exceed the maximum payment as set forth in this proposal, even if the particular facility incurs costs in excess of the maximum amount determined by the formula. To the extent that expenses are subsequently reimbursed under another federal or state program, funds disbursed from the state’s portion of the American Rescue Plan approved by the American Rescue Plan Act Steering Committee and authorized by the Arkansas Legislative Council will be reconciled and recovered.  **Signature** | |
| **Date** *(Cannot be later than 1/21/22)* | |