ATTESTATION AND FUNDING REQUEST FROM AR ARPA ALLOCATION FOR

Assistance with Increased Need for Staff During Pandemic

AND

Temporary Assistance with Unreimbursed Fixed Property 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 the following (please mark each program with an 🗷 if the nursing facility is requesting to participate in the ARPA Funding.):

**1. Assistance with Increased Need for Staff During Pandemic**:

* The facility requests allotment of funds to maintain staffing and operations during the pandemic and to address some of the labor-related costs of meeting CMS, CDC, and OSHA requirements caused primarily by the Delta Variant per the AR ARPA Proposal approved by the Arkansas Legislative Council on August 9, 2021.

**2. Temporary Assistance with Unreimbursed Fixed Property Costs**:

* The facility requests one-time funding equivalent to 18-months of the Medicaid rate cuts due to total occupancy under 80% and a portion of the per bed value-associated cuts caused primarily by the Delta Variant per the AR ARPA Proposal approved by the Arkansas Legislative Council on August 9, 2021.

In the event a nursing facility does not file a complete and timely Medicaid cost report(s) as required per Qualification #2, the Department may recover any or all of the American Rescue Plan Act (APRA) funds the nursing facility received and will suspend any further disbursement of ARPA funds to the facility.  Nursing facilities experiencing a change of ownership (CHOW) must, at a minimum, file a Medicaid cost report(s) for the time period for which any ARPA funds are received or expended by the facility.  For any recovery initiated from a facility that experienced a CHOW, if recovery of funds is not immediately available from the previous owner, the successor owner(s) taking operational control following a CHOW will be required to repay the ARPA funds. For homes that had a CHOW process during the period of time covered by these funds, funds are to be distributed to the operator proportional to the duration of the time period covered.

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:**

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| **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 these are necessary expenditures to address the problems and needs described in this proposal caused by the public health emergency with respect to COVID-19 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 September 30, 2021)* | |