**Arkansas Department of Human Services**

**Care Continuity Emergency Response**

**Extension Reporting Form (10/7/20)**

**Instructions**

Please complete this form then print the document and sign the attestation on the third page, scan the document as a pdf then e-mail it, along with receipts and any other supporting documentation to caresactfunding@dhs.arkansas.gov. Please note the program policies linked at <https://humanservices.arkansas.gov/resources/response-covid-19/response-covid-19-providers-1> .

**Provider Detail**

Provider Category: Choose an item.

Provider Name: Click or tap here to enter text.

Medicaid ID: Click or tap here to enter text.

Contact Name: Click or tap here to enter text.

Contact E-mail: Click or tap here to enter text.

Contact Phone No.: Click or tap here to enter text.

Address: Click or tap here to enter text.

Report Date: Click or tap to enter a date.

Expense Dates: Choose an item.

Due Dates for submission depend on the Expense Dates:

|  |  |  |
| --- | --- | --- |
| Expense Dates | Eligible Provider | Documentation Due Dates |
| March 18 – May 30, 2020 | ***Additional New Providers*** | October 30, 2020 |
| May 31 – November 15 | All Eligible Providers | November 30, 2020 |

**Reimbursement Purpose**

Eligible providers may be reimbursed for any of the following suggested purposes or may propose additional improvements, not included below, for DHS consideration and approval prior to payment:

1. [ ]  Costs associated with expanding the use of telemedicine and telehealth by shifting to or enhancing available telemedicine services through equipment, technology, and facility upgrades, e.g. training staff and purchasing tablets for staff and clients;

**Specify**: Click or tap here to enter text.

**Amount Requested:** Click or tap here to enter text.

1. [ ]  Additional workforce support or training, including training staff on delivering services via telemedicine;

**Specify**: Click or tap here to enter text.

**Amount Requested:** Click or tap here to enter text.

1. [ ]  Shifting to or enhancing available telemedicine services through equipment, technology, and facility upgrades;

**Specify**: Click or tap here to enter text.

**Amount Requested:** Click or tap here to enter text.

1. [ ]  Purchase or lease of specialized equipment;

**Specify**: Click or tap here to enter text.

**Amount Requested:** Click or tap here to enter text.

1. [ ]  Re-configuring patient intake areas or rooms to maintain social distancing and reduce the risk of COVID-19 transmission;

**Specify**: Click or tap here to enter text.

**Amount Requested:** Click or tap here to enter text.

1. [ ]  PPE and enhancing cleaning and sanitation services beyond what would be required under normal infection control policy, and in compliance with CDC recommendations;

**Specify**: Click or tap here to enter text.

**Amount Requested:** Click or tap here to enter text.

1. [ ]  Emergency operations facility improvements;

**Specify**: Click or tap here to enter text.

**Amount Requested:** Click or tap here to enter text.

1. [ ]  Changing business practices to expand services available and location of services and safe delivery of services in clinic settings; e.g. shifting hours of service availability and instituting screening;

**Specify**: Click or tap here to enter text.

**Amount Requested:** Click or tap here to enter text.

1. [ ]  Expanding use of in-home services (payment would be used to establish ability to change method of providing services, e.g. training staff. Virtual services are not included component); and

**Specify**: Click or tap here to enter text.

**Amount Requested:** Click or tap here to enter text.

1. [ ]  Maintaining operations by adding extended hours or additional days, or shifting scheduled hours to accommodate well vs. sick visits.

**Specify**: Click or tap here to enter text.

**Amount Requested:** Click or tap here to enter text.

1. [ ]  Other.

**Specify**: Click or tap here to enter text.

**Amount Requested:** Click or tap here to enter text.

**ATTESTATION**

I, [Point of Contact/Agent Name] \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, hereby attest that:

[ ]  these are necessary expenditures due to the public health emergency with respect to COVID-19 and none of these funds are used to

* duplicate or supplant funding from any other source of payment including by future rate increases or from federal funding
* offset loss of revenue
* provide “retention” or retainer payments
* pay bonuses
* pay any increase in management fees to administrative personnel

[ ]  [Provider Name] \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, shall retain records sufficient to support each and every payment claimed herein, for so long as may be deemed necessary, but in no case less than seven (7) years;

[ ]  [Provider Name] \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, shall make such records available to the Arkansas Department of Human Services and/or any other lawful authority, upon request; and

[ ]  upon penalty of perjury, all of the facts contained in the foregoing Report are true and correct to the best of my knowledge, information, and belief.

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Agent Signature

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Date

Upon completion of all sections above, please submit this report to the attention of **“CCEP**”to caresactfunding@dhs.arkansas.gov.