**Background**

The Personal Protective Equipment (PPE)/Cleaning program is a limited program funded by the CARES Act, intended to help providers with extraordinary PPE and cleaning costs as the result of the public health emergency. DHS has a total $1.2 million for this program, and payments will be made only while funds are available. Examples of acceptable expenses include costs for professional cleaning services due to COVID-19 exposures on the facility premises and costs for PPE and cleaning supplies over-and-above the costs for those items that the facility would have expended. Acceptable proof of expenses include copies of receipts and invoices marked paid.

**Instructions**

Payments will be made on a first-come basis using the timestamp of the email by which a complete form and supportive documentation is submitted to DCWP@dhs.arkansas.gov. If a form is submitted, but is incomplete and must be corrected, the timestamp DHS will use will be the timestamp of the email with the corrected form – not the initial email. DHS requires a “wet signature” on each form. That is, e-signatures and typed signatures will not be accepted.

DHS requires proof of actual expenses; not obligations to make future payments. Documentation, such as receipts or paid invoices, should show that the provider actually spent the exact dollar amount for which the provider is requesting reimbursement and should include details of the type of expense (should match description of expense in the “**Specify:**” field/s below).

You may submit questions to DCWP@dhs.arkansas.gov but those will not hold or affect a providers place in line. Questions may be directed to DCWP@dhs.arkansas.gov but posing questions neither tolls the time-period for submitting forms nor reserves a provider’s place in line for payment.

Please complete this form then print the document and sign the attestation on the final page, scan the document as a pdf then e-mail it, along with receipts and any other supporting documentation to DCWP@dhs.arkansas.gov.

Due Dates for documentation:

|  |  |
| --- | --- |
| Expense Dates | Documentation Due Dates |
| Jan 1, 2021 – March 31, 2021 | April 30, 2021 |

**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.

**Reimbursement Purpose**

Eligible providers may be reimbursed for any of the following suggested purposes:

1. [ ]  Purchase of PPE;

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

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

1. [ ]  Enhanced 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.

**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 **“PPE/Cleaning**”to DCWP@dhs.arkansas.gov.