



State of New Jersey

DEPARTMENT OF HUMAN SERVICES
DIVISION OF MENTAL HEALTH AND ADDICTION SERVICES
PO BOX 362
5 COMMERCE WAY
HAMILTON, NJ 08691

PHILIP D. MURPHY
Governor

CAROLE JOHNSON
Commissioner

SHEILA Y. OLIVER
Lt. Governor

VALERIE L. MIELKE, MSW
Assistant Commissioner

PROVIDER AGENCY ATTESTATION CORONAVIRUS RELIEF FUND (CRF) COVID –ELIGIBLE EXPENSES

I, _____, authorized representative for _____ (Provider Agency), hereby affirm and attest that effective March 9, 2020 and during the COVID-19 New Jersey State of Emergency and the Coronavirus Relief Funding (Funding) that the:

- a.) Provider Agency is duly licensed by the State of New Jersey and is an existing DMHAS contract provider as of March 9, 2020; and
- b.) Provider Agency utilized the Funding provided in the HHS Coronavirus Relief Fund (CRF) Grant No. for COVID-19 testing of staff and consumers that it serves and has maintained the appropriate documentation including all that is required in the within DMHAS Guidance Document, including but not limited to, the date of the testing, the name of the staff person, the name of the consumer, the name of the vendor providing the testing services and the invoice for the cost of the testing; and
- c.) Provider Agency utilized the Funding for Personal Protective Equipment (PPE) including face coverings, surgical masks, N95 masks, face shields, gowns, gloves and goggles, and the vendor provided the invoices; and
- d.) Provider Agency utilized the Funding for the purchase, maintenance, upgrading of technology that is HIPAA and 42 CFR Part 2 compliant, including but not limited to hardware and software that is deemed appropriate for telehealth and telecommunications under the appropriate State and federal legislation and regulations as amended during the COVID-19 state of emergency, and that the technology is utilized for the purposes of remote service delivery. Provider Agency maintained the documentation required in the within Guidance Document, including but not limited to the date of purchase of the specific technology, the vendor invoices, and the names of the staff persona and names of the consumers provided with the technology; and

- e.) Provider Agency utilized the Funding for the purchase of cell phones and appropriate cell phone plans for consumers for the purpose of delivery of services remotely meeting the specific criteria in the Guidance Document. Provider Agency is responsible for maintaining the documentation required in the within Guidance Document, including but not limited to the date of purchase, the vendor invoices and names of the consumers and staff to whom cell phones and cell phone plans were provided; and

- f.) Provider Agency utilized the Funding for Emergency Rate Payments for direct care staff providing in-person services only. The Eligible Staff for Emergency Rate Payments are: case managers, clinical staff, including nurses, physicians and therapists, residential staff, peer specialists, and other staff meeting the qualifications specified by DMHAS given prior approval by DMHAS, if appropriate under the terms of the Guidance Document. Provider Agency certifies that Emergency Rate Payments were not greater than 20% of the direct care staff regular salary and did not represent a wage enhancement, or bonus. Provider Agency certifies that Executive management of the agency were not included in the request for CRF reimbursement for Emergency Rate Payment. Documentation is maintained as required in the within Guidance Document, including but not limited to the date(s) Emergency Rate Payment was provided, the name of the staff and the timesheets of eligible staff; and

- g.) Provider Agency acknowledges and represents that it continues to bill Medicaid in accordance with federal and State Medicaid guidance and requirements and that none of the requests for Funding under this Guidance Document have been submitted for reimbursement or reimbursed by any other State, federal, or local entities such as DMHAS contract funds, federal emergency management agency (FEMA), federal communications commission (FCC), US Health and Human Services Provider Funds or the DMHAS Emergency Relief Funds (March 25, 2020 Policy through current).

I affirm and attest that the foregoing statements made by me are true. I understand that if Provider Agency fails to comply with any of the above, DMHAS reserves all rights of remedy and enforcement, including but not limited to recoupment of funds.

 Signature of Authorized Representative

Date: _____, 2020