Kentucky Department for Medicaid Services
NF $29 Add On Payment (SPA 21-0003)
Attestation Statement

Provider Name: _____

Provider Number: _____

For the provider identified above, our facility has received and will receive an add-on to our per diem rate in the amount of $29 for dates of service 1/1/2021 – 12/31/2021. This payment has been and will be made in accordance with Disaster SPA 21-0003 and 2021 House Bill 192.

By signing this form on behalf of the provider noted above, I attest that the reimbursement increase has been or will be used for personal protective equipment, COVID-19 testing, and staffing for Medicaid eligible nursing home residents in accordance with the SPA and House Bill 192. Additional documentation will be made available if requested by the Department for Medicaid Services (the Department), and I understand that a sample of claims and supporting documentation may be reviewed to evaluate compliance with the state plan and legislation sponsoring the $29 add-on.

Additionally, I am aware that it is the responsibility of the facility to consider payments received by the Department in conjunction with any other COVID relief payments and properly report the payments in accordance with any payment terms and conditions for the relief payments.

Agree to statements above by signing the form and providing contact information.

_____ _____

Signature Printed Name & Title

Date: _____

Telephone: _____

Email Address: _____

Provider Name: _____ Provider #: _____

Note: If questions regarding the form should be directed to someone other than the signor, please indicate below with contact information.

Contact Name and Title: _____

Contact Telephone: _____

Contact E-mail: _____

Please return the completed form to Myers and Stauffer LC within 30 calendar days (9/30/2021).
This form may be submitted via email to kyofc@mslc.com or via fax at 502-695-3068.