Supplemental Payment
Phase 2 Quarterly Attestation

Providers wishing to request Phase 2 Supplemental Payments, must complete the following steps:

- Submit a provider agreement opting into Phase 2 of the Supplemental Payment Program; and
- On a quarterly basis submit the following:
    - financial documentation demonstrating the cost of delivery of Medicaid services exceed the standard Montana Medicaid reimbursement (providers may use the quarterly schedule example or submit their own financial report); and
    - attestation signed by an agency's CEO or CFO (found below).

To be eligible for Phase 2 Supplemental Payments the provider agrees to:

- Sustain or increase current levels of HCBS service delivery; and
- Invest in workforce recruitment and retention.

Records and Documentation

A Provider that receives funds under this initiative should maintain documentation according to their normal records retention process.

Medicaid Provider Certification and Agreement

By signing this application and in consideration for the payment of funds based upon this application, the Medicaid Provider identified below, represents, and agrees as follows:

1. Provider certifies that Department and information included in this agreement are complete, accurate and true to the best of the Provider's knowledge. Provider agrees to the terms and conditions of this provider agreement. Provider agrees that it will make, maintain, and provide to authorize governmental entities and their agents, records, and documentation in accordance with the requirements specified in this agreement.
2. Provider understands that payment of funds based upon this request will be from federal and state funds, and that any false claims, documents, or concealment of material fact, may be prosecuted under applicable federal or state laws.

3. Provider understands that funds may be required to be repaid to the Department if the Provider fails to maintain the required records or meet the HCBS Supplemental Payment Phase 2 Requirements previously described.

Requesting Provider Identifying Information

Provider Name: _____

Provider Tax ID: _____

Signature of Program Manager: _____ Date: _____, 2022

Name of Program Manager (please print)

_____

Street address: _____City/Zip _____

Contact person: _____

Email: _____

Phone: _____

Please submit completed form to HHSHCBSSupplementalPayment@mt.gov