[Please place on company letterhead]

DSP SUPPLEMENTAL PAYMENT ATTESTATION FORM

This form is required for eligible DD Waiver providers to receive reimbursements under the DSP Supplemental Payment Program. This attestation form would also be applicable to any requirement stipulated in the Appendix K.

Provider Name: [Insert name of IDD Provider]

Provider Number: [Insert the Medicaid Provider Number]

Address: [Insert address of the Provider]

Time Period: FY 2022

By affixing my signature, the undersigned hereby attests, assures, and declares under penalty of perjury Providers compliance as a HCBS DD Waiver Provider seeking of the DSP supplemental payment program as follows:

1. The supplemental payments will be used to fund DSP bonus payment.
2. The provider understands that:
    - Direct support professional must be an employee of an HCBS DD Waiver provider who provides direct services to individuals with developmental disabilities for at least 50% of the employee's work hours.
    - Direct services for which the individual is eligible to be paid must include working with an individual providing support with self-care activities, behavior management, and community integration pursuant to an Individual Service Plan (ISP); and
    - An employee as used in this section excludes managers, administrators, and contract employees
3. Provider understands that the supplemental payment will be subject to recoupment if inappropriate use occurs (*i.e.* used outside the specified item in #1 above).

Signature: _____ Date: _____

Print Name: _____

Title of Authorized DD Waiver Provider: _____