SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
Healthy Connections MEDICAID

**Date:**

**To:** South Carolina Department of Health and Human Services
(via email: appendixk@scdhhs.gov)

| ***Provider Name** | ***Provider Medicaid ID (Six-digit legacy ID)** | **Provider NPI** |
|---|---|---|

****Required field. Note: Please submit a separate form for each Provider Medicaid ID.***

Pursuant to guidance issued by the Centers for Medicare and Medicaid Services (CMS) dated June 30, 2020 related to retainer payments made prior to and during the coronavirus disease 2019 (COVID-19) public health emergency (PHE), I attest to the following:

• Retainer payments received by the provider named above will be subject to recoupment if inappropriate billing or duplicate payments for services occurred (or in periods of disaster, duplicate uses of available funding streams), as identified in a state or federal audit or any other authorized third party review. Note that "duplicate uses of available funding streams" means using more than one funding stream for the same purpose.

• The provider named above will not lay off staff and will maintain wages at existing levels.

• The provider named above has not received funding from any other sources, including but not limited to unemployment benefits and Small Business Administration loans, that would exceed its revenue for the last full quarter prior to the PHE, 10/1/2019 – 12/31/2019.

• Retainer payments at the level provided by the state will not result in revenue to the provider named above that exceeds that of the quarter prior to the PHE.

• The provider named above acknowledges that if it had not already received revenues in excess of the pre-PHE level but receipt of the retainer payment in addition to those prior sources of funding results in exceeding the pre-PHE level, any retainer payment amounts in excess will be subject to recoupment.

• The provider named above acknowledges that all claims are billed for dates of service for the identified payment episode periods.

By signing below, I verify the provider named above agrees to and will comply with the above requirements. Attestations must be completed with all information for timely processing. Providers with multiple Medicaid IDs are required to submit an attestation for each ID.

| Printed name of Provider's Representative | Signature | Date |
|---|---|---|

Title

Please select the service(s) for which retainer payments are being requested. If the service is not listed, please refer to form 950K1.

| | | **Actual Revenue per Period (Dates of Service)** 30 calendar days | | |
|---|---|---|---|---|
| **Service (Procedure Code)** | *** Average Monthly Revenue Amount (07/2019 – 02/2020)** | **Period 1 (3/16/2020 – 4/14/2020)** | **Period 2 (4/15/2020 – 5/14/2020)** | **Period 3 (5/15/2020 – 6/13/2020)** |
| Agency Companion Services (S5135, X6986, X0274) | | | | |
| Attendant Care Services (S5125, X0241, X0247, X0243) | | | | |
| Nursing Services (S9123, S9124, T1002, T1003) | | | | |
| Personal Care Services (S5130, T1019) | | | | |
| Respite (S5150, S9125, T1005, X6985, X7028) | | | | |

* Average Monthly Revenue Amount = Total Revenue/8 months

Printed name of Provider's Representative _____ Signature _____ Date _____

Title _____