DIVISION OF HEALTH CARE FINANCING AND POLICY
Supplemental Reimbursement Unit
Application and Attestation for American Rescue Plan Home and Community Based Services
Direct Home Care Worker Supplemental Payment

Section I: Instructions

This application is for Nevada Medicaid providers who render Home and Community Based Services (HCBS) and have in-home direct care workers. Only one application will be accepted per provider. Please complete the information in the sections II and IV, sign and return by email with the required Staff Roster to AmericanRescuePlan@dhcfp.nv.gov.

Section II: Provider Information

PROVIDER NAME		DOING BUSINESS AS NAME (if applicable)	
STREET ADDRESS	CITY	STATE	ZIP
COUNTY	PROVIDER TELEPHONE NO.	PROVIDER EMAIL ADDRESS	
CONTACT NAME	CONTACT PHONE NUMBER	DESIGNATED CONTACT E-MAIL ADDRESS	

Check all applicable Home and Community Based provider types:

☐ PT 30 PSC Agency NPI	☐ PT 38 (Subspecialty 216) SLA NPI	☐ PT 83 ISO NPI
☐ PT 48 (Subspecialty 39/191/199) NPI	☐ PT 58 (Subspeciality 39/189/191/199) NPI	

A roster of current home care workers employed by you as of November 1, 2021 must be attached with this application in order to be considered a valid application. The roster shall include the following information for each eligible staff:

1. Employee Last and First Name
2. Date of Birth
3. NPI (excluding PT38)
4. Employee Start Date

Section III: Information

Under the American Rescue Plan Act (ARPA) Spending Plan, Section 9817 Nevada's the Division of Health Care Financing and Policy has the opportunity to fund a one-time $500 supplemental payment to each current, eligible HCBS in-home direct care worker providing services through a Personal Care Agency, Intermediary Service Organization or a Supportive Living Arrangement. An additional $500 bonus payment will also be distributed after six months for remaining as a Medicaid HCBS in-home direct care worker.

In order to implement the supplemental payment program, Providers in good standing with the Division of Health Care Financing and Policy (not terminated, on payment suspension, or other status that would prohibit distribution of funds through the Provider for the benefit of individual direct care workers referenced above) must apply to be eligible for the Supplemental Payment to Home Care Workers and in completing this document attest to the following:

- That they are in good standing with all state and federal requirements related to status as a Medicaid Provider,
- That they will distribute the $500 direct payment within 30 days of receipt and additionally provide proof to the Division of Health Care Financing and Policy of each $500 payment made to HCBS in-home direct care worker in their employment within 30 days of distribution to the employee.
- That they are attaching a list of the names of the employees to which the payments will be made, including the employee start date in each instance.
- That they understand that this program is for the direct benefit of in-home direct care workers and administrative costs or other purported fees of the Provider cannot be taken from the $500 direct payment (see above for provision related to any actual direct costs, such as payroll).
- That they will immediately supplement this application if the composition of the disclosed staff changes and if a distribution has been made to the Provider and payment is not made to the designated individual, that they will arrange return of allocated funds for that employee immediately.

Section IV: Attestation

I attest that I am a current Medicaid Provider in good standing with the Division of Health Care Finance and Policy under state and federal law (including but not limited to the Federal Office of Inspector General and the Centers for Medicare and Medicaid Services).

I attest that the Provider Designated in Section II will distribute the Supplemental Payment issued to the individual staff indicated as eligible as outlined in Section III within 30 days of receipt from Nevada Medicaid.

Authorized Representative Signature:	*Authorized Representative Printed Signature:*	*Date:*