ATTENDANT CARE ENHANCED PAYMENT PARTICIPATION ATTESTATION AND RELEASE OF INFORMATION FORM

Community First Health Plans, Inc. (Community First) offers all eligible, credentialed, and contracted Providers the opportunity to participate in the Community First STAR+PLUS Attendant Care Enhanced Payment (ACEP) option, which is based on funding by the Texas Legislature. To participate, Providers must allocate at least 90% of the dollars received under this option to the Community Care Attendant(s) as stipulated in the rules outlined in Title 1, Texas Administrative Code (TAC) §355.112.

_____ ("Provider") is requesting to receive reimbursement at a Participant Level of _____ and acknowledges their participation in the program will be reviewed at a minimum annually to ensure the enhanced payments received are being used for the proper purpose.

RELEASE OF INFORMATION

As part of the process for participation in the Community First ACEP option and for the purpose of verifying any information provided, I, the undersigned authorized agent of the Provider, grant Community First permission to contact any individual, institution, facility, or agency identified on, or relative to, this Attestation. Further, I hereby consent and authorize Community First to request, receive, and inspect any and all records pertinent to this consideration.

As a Community First contracted Provider or authorized agent on behalf of the Provider, I, the undersigned authorized agent, am required to supply Community First with verification of all cost reports submitted to participate in the Community First ACEP Program.

ATTESTATION

I certify that the information used in the Community First desk audit, including, but not limited, to cost reports, is complete, accurate, and current. I acknowledge that any misstatements, misrepresentations, or omissions from these reports constitute grounds for denial or summary dismissal from the Community First ACEP option and may result in recoupment of funds received. I have reviewed this information as of the most recent date listed below.

All required information must be submitted in its entirety for any review to be conducted and completed by Community First. Please return this completed form with confirmation of award level and HHSC contract number by emailing it to **networkmanagement@cfhp.com.**

Changes in award levels must be submitted with this Attestation Form and HHSC contract number. The new rate will take effect the first of the month following 30 days post submission to Community First.

Print Name: _____
TIN: _____
NPI: _____
HHSC Contract Number: _____
Date: _____
Signature: _____ *(Stamped signature is not acceptable)*