DIRECT CARE WORKER RETAINER PAYMENT ATTESTATION AND ACKNOWLEDGMENT

This Direct Care Worker Retainer Payment Attestation and Acknowledgment ("Attestation") applies to Direct Care Workers as defined in 42 C.F.R. § 441.302(k)(1)(ii) and 42 C.F.R. § 441.311(e)(1)(ii) who normally furnish habilitation and/or personal care services under an approved service plan to Medicaid beneficiaries and who are unable to furnish those services due to the impact(s) of Hurricane Helene. Eligible Direct Care Workers must complete and execute this Attestation as a condition for receipt of retainer payment, regardless of whether payment is made to the Direct Care Worker by Medicaid Direct or an NC Managed Care Prepaid Health Plan, Behavioral Health Intellectual/ Development Disabilities Tailored Plan, or Prepaid Inpatient Health Plan, as part of North Carolina Medicaid's response to Hurricane Helene. By submitting this Attestation, the undersigned Direct Care Worker hereby agrees, acknowledges, and attests that:

1. The undersigned is a Direct Care Worker who normally furnishes services to one or more Medicaid beneficiary(ies) under an active service plan and is currently unable to provide services due to direct impacts from Hurricane Helene.

2. The undersigned Direct Care Worker will report any retainer payment billed, sought or received which is the subject of this attestation in submitting any unemployment insurance claim during the period in which retainer payment is received from NC Medicaid, a NC Managed Care Prepaid Health Plan, Behavioral Health Intellectual/ Development Disabilities Tailored Plan, or Prepaid Inpatient Health Plan, as part of North Carolina Medicaid's response to Hurricane Helene.

3. If the undersigned Direct Care Worker receives a retainer payment from NC Medicaid, a NC Managed Care Prepaid Health Plan, Behavioral Health Intellectual/ Development Disabilities Tailored Plan, or Prepaid Inpatient Health Plan, that in addition to receipt of funding from other sources would cause the undersigned Direct Care Worker to exceed the undersigned Direct Care Worker's income for the last full quarter prior to the Hurricane Helene Emergency on September 25, 2024, Retainer Payment paid to the Provider subject to the Provider Attestation and Acknowledgment will be recouped.

4. The undersigned Direct Care Worker will retain the availability to assist the Medicaid beneficiary(ies) with activities of daily living and instructional activities of daily living consistent with an approved service plan when the impacts of Hurricane Helene that prevented the delivery of services to the Medicaid beneficiary have abated.

5. The undersigned Direct Care Worker will receive retainer payment not to exceed the maximum reimbursement rate or wages for hours/ units authorized during a thirty (30) day payment period under an active service plan approved prior to Hurricane Helene.

6. The undersigned Direct Care Worker will only seek, bill for, and/or receive retainer payment if the Medicaid beneficiary is unable to receive services due to impacts from Hurricane Helene, or where the Direct Care Worker is unable to furnish services due to the impacts of Hurricane Helene.

7. The undersigned Direct Care Worker will seek, bill for, and receive payment for no more than one (1) thirty-day retainer payment for each Medicaid beneficiary to whom the Direct Care Worker normally provides services consistent with an active, approved service plan and is unable to furnish those services due to impact(s) from Hurricane Helene.

8. The undersigned Direct Care Worker will notify North Carolina Medicaid and will not seek, bill, or fail to return retainer payment received due to lay-off or other employment termination by the Direct Care Worker's employer.
9. The undersigned Direct Care Worker will execute and submit this Attestation to his/her/their employer before receipt of any retainer payment made as part of NC Medicaid's response to Hurricane Helene. The undersigned Direct Care Worker will retain and furnish to the Department and/or Managed Care Plan making the retainer payment, upon its request, any other appropriate documentation to support retainer payment received.

10. Retainer Payment is subject to state and federal audit or other review by the Department and is subject to recoupment if the Direct Care Worker or his/her/their employer engages in inappropriate billing; receives duplicate payment for services, including receipt of payment for services from another available funding stream; or receives retainer payment to which the Direct Care Worker was not entitled, due to error, fraud, or change in circumstances following the receipt of retainer payment arising under this Attestation, as identified by state or federal audit or any other authorized third-party review.

11. The undersigned Direct Care Worker does not participate in any hold harmless arrangement for any health care-related tax specified under 42 C.F.R. § 433.68(f)(3) in which the State or other unit of government imposing the tax provides for any direct or indirect payment, offset, or waiver such that the provision of the payment, offset, or waiver directly or indirectly guarantees to hold the taxpayer harmless for all or any portion of the tax amount.

12. The information in this Attestation is truthful, accurate, and complete, to the best of the undersigned Direct Care Worker's knowledge.

The undersigned hereby certifies that the information contained in this Attestation is true and accurate. By signing this Attestation, the undersigned acknowledges the requirements set forth in paragraphs one (1.) through twelve (12.) of this Attestation and the resulting obligations. The undersigned further acknowledges that NC Medicaid reserves the right to request an individualized review and approve use of the funds distributed. The undersigned hereby certifies that they have the authority to submit this Attestation and, by signing below, affirms the information set forth in paragraphs one (1.) through twelve (12.) herein.

Staff Information:

Signature: _____

Name: _____

Title: _____

Date: _____

Employer Name: _____

Provider agency/EOR Information

Provider agency/EOR name:

If EOR, name of Financial Support Agency:

Individual completing this form:

Primacy email address:

Primary phone number:

Requested Date range for Retainer payment:_____(<31 consecutive days)