



## Attestation for Retainer Payments

Date: \_\_\_\_\_

To: Division of Developmental Disabilities

From: \_\_\_\_\_

Agency Name: \_\_\_\_\_

Contact Number: \_\_\_\_\_

Pursuant to CMS guidance dated June 30, 2020 related to retainer payments, I attest to the following:

- The agency acknowledges that retainer payments will be subject to recoupment if inappropriate billing or duplicate payments for services or duplicate uses of available funding streams, as identified in a state or federal audit or any other authorized third party review, occurs. Note that “duplicate uses of available funding streams” means using more than one funding stream for the same purpose.
- The agency will not lay off staff, and will maintain wages at existing levels.
- The agency has not received funding from other sources, including but not limited to unemployment benefits and Small Business Administration loans, that would exceed revenue for the last full quarter prior to the Public Health Emergency (PHE), or that the retainer payments at the level provided by the State will not result in revenue exceeding that of the quarter prior to the PHE. If receipt of retainer payments does result in revenues in excess of pre-PHE levels, the excess will be subject to recoupment.

By signing below, I verify that the agency I represent is in compliance with the above requirements.

_____	_____	_____
CEO or Designee Name	Signature	Date
_____	_____	_____
Witness Printed Name	Signature	Date