NEBRASKA

Good Life. Great Mission.

DEPT. OF HEALTH AND HUMAN SERVICES

Jim Pillen, Governor

ARPA Section 9817 Home and Community Based Services Home Health Provider Relief Payments

Submission Checklist and Acceptance Form (Enclosure C)

Submission Checklist:

- ☐ Home Health Provider Payment Data Summary File (See enclosure A, Data Layout Requirements File with layout, instructions, and example)
- ☐ Completed DHHS ACH/W9 Form (See enclosure B)
- ☐ Signed Submission Checklist and Acceptance Form (See enclosure C)

Acceptance Criteria:

- ☐ Recipient acknowledges it is their responsibility to retain detailed records documenting the use of these funds in accordance with the allowable uses of the funds (increasing staff wages, hiring and/or retention bonuses, covering increased costs for providing services associated with the COVID-19 Public Health Emergency, and investing in infrastructure needed by the provider to enhance or expand HCBS services for Medicaid beneficiaries).
- ☐ Recipient acknowledges that DHHS reserves the right to request documentation and/or reporting on the use of the funds.
- ☐ Recipient acknowledges that DHHS reserves the right to request repayment of the payment in the event that the provider fails to use the funds for the allowable uses. This includes, but is not limited to, if the funds are not spent or an audit determines that the use of the funds were documented in accordance with the acceptable uses of the funds.
- ☐ Recipient acknowledges that the receipt of the funds does not constitute a joint venture between your organization and NE DHHS; and does not constitute an assumption of liability or indemnification between NE DHHS and your organization.

_____

Name and Title of Recipient Authorized Representative

_____ _____

Signature of Recipient of Authorized Representative Date

Providers should submit their completed Provider Relief Payment requests to DHHS at DHHS.MedicaidHCBSARPA@Nebraska.gov.