



Department of Human Services
Division of Mental Health and Addiction Services

Provider Agency Attestation
Emergency Monthly Payment Under COVID-19 State of Emergency

I, _____, authorized representative for _____, hereby affirm and attest that effective March 20, 2020 and during the COVID-19 New Jersey State of Emergency funding period:

- a. Provider Agency shall make a good faith effort to provide all mental health and substance use disorder treatment services for which Provider Agency is licensed (as appropriate) and under Fiscal Year 2020 contract(s) with DMHAS; and
- b. Provider Agency shall be open for admission and provide the vital services that contribute to consumers' health and well-being that are ***reasonably feasible under current staffing conditions, consumer demand and COVID-19 State of Emergency mandates and guidance***; and
- c. Provider Agency shall make it a ***priority to triage and assess existing clients/consumers and potential clients/consumers*** for levels of risk, including but not limited to risk of hospitalization or relapse. This risk assessment shall lead to a plan for the consumer to receive vital services, including but not limited to medication management. Agency shall provide directly or arrange for vital services; and
- d. Provider Agency shall use all Monthly Payments provided by DMHAS exclusively to support its Fiscal Year 2020 contract(s) with DMHAS; and
- e. Mental Health Provider Agency shall maintain a monthly roster of clients/consumers served with Monthly Payment funding and shall make the roster available to DMHAS upon demand. Substance Use Disorder Provider Agency shall continue to enter client admissions into NJSAMS; and
- f. Provider Agency shall maintain appropriate documentation for services that are funded by the Monthly Payment and provided during the COVID-19 New Jersey State of Emergency funding period. Appropriate documentation includes, but is not limited to: name of the client/consumer; name and title of the staff person providing service; date(s) of service; time of day and length of time contact was provided; nature of the contact (face-to-face, audio only telehealth, audio with visual telehealth), name of individual(s) with whom contact was maintained on behalf of the client/consumer (if individual refuses, such refusal must be documented); and summary of the services provided; and
- g. Provider Agency shall continue to bill Medicaid in accordance with federal and State Medicaid guidance and mandates; and
- h. Provider Agency acknowledges that the following Department of Human Services contract policies (access to records and facilities, audit requirements and contract monitoring) apply to Monthly Payment funds and services supported by such funds.

Provider Agency will maintain and provide documentation necessary to determine compliance with this Attestation and its good faith efforts; and

- i. Provider Agency acknowledges that its SFY20 contract will be extended through December 31, 2020 and that all contract requirements apply to timeframes not affected by the emergency Monthly Payments. More specifically, for the months prior and subsequent to the emergency funding period (that is, prior to March 1, 2020 and subsequent to June 30, 2020), FFS billing shall be processed via NJMHAPP (for MH) and via NJDAS.net (for SUD), and all NJDHS contract rules shall apply.

I affirm and attest that the foregoing statements made by me are true. I understand that if Provider Agency fails to comply with any of the above, DMHAS reserves all rights of remedy and enforcement, including but not limited to recoupment of funds.

Dated: _____, 2020

Authorized Representative Signature