State of New Jersey
Department of Human Services
P.O. BOX 700
TRENTON, NJ 08625-0700

PHILIP D. MURPHY
Governor

SHEILA Y. OLIVER
Lt. Governor

CAROLE JOHNSON
Commissioner

PROVIDER AGENCY ATTESTATION

CORONAVIRUS RELIEF FUND (CRF) COVID–ELIGIBLE EXPENSES

I,_____, authorized representative for _____ (Provider Agency), hereby affirm and attest that effective March 9, 2020 and during the COVID-19 State of Emergency:

a) Provider Agency is duly authorized to conduct business in the State of New Jersey and is an eligible Division provider, as defined in the DHS Guidance for Coronavirus Relief Fund (Guidance Document), as of March 9, 2020; and

b) Provider Agency used the Funding for Personal Protective Equipment (PPE) including face masks, surgical masks, N95 masks or equivalent respirators, face shields, gowns, gloves, and/or goggles. In addition to this reimbursement request, Provider Agency maintains the documentation required by Guidance Document, including but not limited to the dates of purchase and the vendor invoices; and/or

c) Provider Agency used the Funding for cleaning and infection control measures, including extra materials, supplies, and/or partitions necessary to reduce the risk of COVID-19 transmission. In addition to this reimbursement request, Provider Agency maintains the documentation required by Guidance Document, including but not limited to the dates of purchase and the vendor invoices; and/or

d) Provider Agency used the Funding for the purchase, maintenance, and/or upgrade of technology that is HIPAA and 42 CFR Part 2 compliant, including but not limited to hardware and software that is deemed appropriate for remote services under the appropriate State and federal legislation and regulations as amended during the COVID-19 State of Emergency, and that the technology is used for the purposes of remote service delivery. In addition to this reimbursement request, Provider Agency maintains the documentation required by the Guidance Document, including but not limited to the dates of purchase, the vendor invoices, the names of the staff members provided with the technology (if individually assigned), and the names of the consumers provided with the remote services; and

e) Provider Agency acknowledges and represents that it continues to bill the Division or Medicaid program for services in accordance with State and federal requirements and that the items contained in this reimbursement request have not been submitted for reimbursement or reimbursed by any other State, federal, or local entity, such as other State funding sources, the Federal Emergency Management Agency (FEMA), the Federal Communications Commission (FCC), US Health and Human Services Provider Funds, or any other relief funds.

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, the Department reserves all rights of remedy and enforcement, including but not limited to recoupment of funds and offset of future payments, reimbursements and any other amounts payable to Provider Agency by the State.

_____ Date: _____, 2020

Signature of Authorized Representative