ATTENDANT CARE ENHANCED PAYMENT PARTICIPATION
ATTESTATION AND RELEASE OF INFORMATION FORM

Molina Healthcare of Texas, Inc. offers all eligible, Molina credentialed and contracted providers the opportunity to participate in the Molina STAR+PLUS Attendant Care Enhanced Payment (ACEP) Option which is based on funding by the Texas Legislature. To participate, providers must allocate at least 90% of the dollars received under this option to the Community Care Attendant(s) as
stipulated in the rules outlined in Title 1, Texas Administrative Code (TAC) 355.112.

____ ("Provider") is requesting to receive reimbursement at a Participant

Level of ______________________, and acknowledges that participation in the program will be reviewed at a minimum annually to ensure the enhanced payments received were used for the proper purpose.

RELEASE OF INFORMATION:

As part of the process for participation in the Molina ACEP option and for the purpose of verifying any information provided, I, the undersigned authorized agent of the Provider grant Molina Healthcare of Texas, Inc. or Molina Healthcare, Inc. ("Molina") permission to contact any individual, institution, facility or agency identified on, or relative to, this Attestation. Further, I hereby consent and authorize Molina to request, receive and inspect any and all records pertinent to this consideration.

As a Molina contracted Provider or authorized agent on behalf of Provider, I, the undersigned authorized agent, am required to supply Molina with verification of all cost reports submitted to participate in Molina's Attendant Care Enhanced Payment (ACE) option.

ATTESTATION:

I certify the information used in the Molina "desk audit" including but not limited to cost reports is complete, accurate, and current. I acknowledge that any misstatements, misrepresentations, or omissions from these reports constitute for denial or summary dismissal in the Molina ACE option that may result in recoupment of funds received. I have reviewed this information as of the most recent date listed below.

All required information must be submitted in its entirety in order for any review to be conducted and completed by Molina. Please return this completed form with an updated W9 in the enclosed envelope, or by emailing it to mhtxacep@molinahealthcare.com or faxing 877-900-8452.

I hereby acknowledge that action on the cost reports will be delayed until all required information is received and/or verified.

Print Name: ____

TIN: ____

NPI: ____

HHSC Contract ID: ____

Signature: ____
(Stamped signature is not acceptable)

Date: ____