**COVID-19: Adult Day Care Provider Medicaid Retainer Payment Request Form**

We recognize the financial impact that the 2019 novel coronavirus (COVID-19) is having on certain home and community-based service providers. As such, providers of stand-alone adult day care services are eligible to receive financial assistance in the form of retainer payments. To be considered for the retainer payment, adult day care providers must complete this form and submit it to the specific health plan email or fax number below. **In the subject line, please include “ADC Retainer Payment”.**

|  |  |  |
| --- | --- | --- |
| **Plan Name**  | **Email Address** | **Fax Number** |
| Aetna Better Health  | FL\_LTC\_SAT@aetna.com | 1-860-607-8854 |
| Florida Community Care | adc\_ahca\_cvresponse@fcchealthplan.com | 1-800-862-6569 |
| Humana Medical Plan | ltcnetworkrequests@humana.com | 1-727-897-5872 |
| Molina Healthcare | MFLProviderServices@MolinaHealthCare.com | 1-562-499-0719 |
| Simply Healthcare  | ltcprovrelations@amerigroup.com | 1-866-495-3017 |
| Staywell | FloridaProviderRelations@wellcare.com | 1-813-865-6764 |
| Sunshine Health | LTC\_SSHP\_member\_info\_request@centene.com | 1-855-469-3306 |
| UnitedHealthcare | fl\_ltc\_network@uhc.com | 1-844-868-1591 |

**NOTE: Adult day care providers must submit a separate form to each plan for which a retainer payment is requested.**

1. **Provider Identification**

For providers with multiple locations, a separate submission form must be submitted for each location where a retainer payment is requested.

|  |  |
| --- | --- |
| Provider Name:  |  |
| Provider ID: |  |
| Address: |  |
| Contact Name: |  |
| Telephone Number: |  |
| Email Address: |  |

1. **Reason for Retainer Payments**

Place an “X” next to the reason for the retainer payments.

|  |  |
| --- | --- |
|  | The location where services are normally rendered is closed due to the state of emergency and I am not rendering services to any LTC enrollees or I am only able to partially render services in an alternative setting (e.g., the enrollee’s home). |
|  | The provider location remains open, but I am unable to serve all enrollees due to enrollees that are quarantined, hospitalized, refusing to receive services.  |

1. **Additional COVID-19 Related Financial Assistance**

Place an “X” next to each that apply.

|  |  |
| --- | --- |
|  | I have **requested** financial assistance through federal or state COVID-19 relief programs, including but not limited to the Paycheck Protection Program, small business loan, etc. |
|  | I have **received** financial assistance through federal or state COVID-19 relief programs, including but not limited to the Paycheck Protection Program, small business loan, etc. |

1. **Attestations**

Place an “X” next to each statement. Providers must agree to each of the following in order to qualify for the retainer payment.

|  |  |
| --- | --- |
|  | I am experiencing financial hardship as a result of the COVID-19 pandemic. |
|  | I agree I will not lay off staff and will maintain staff salary, wages and benefits at existing levels. |
|  | I agree to re-hire staff who have already been laid off as a result of the COVID-19 pandemic by May 31, 2020. |
|  | In those cases where I am currently providing expanded services, I will continue providing services, per the individual plan of care. If I am unable to provide services, I will immediately notify the managed care plan so alternative services can be arranged.  |
|  | I agree that by accepting the retainer payment, I will continue providing services as outlined above, but not bill for services rendered during the month in which the retainer payment was made but continue to provide whatever services we are still able to render to enrollees.  |
|  | I am not in bankruptcy. |
|  | I have no outstanding delinquent Medicaid overpayments with the managed care plan. |
|  | I agree that funds received from Medicaid retainer payments and other funding sources related to the COVID-19 pandemic, including but not limited to the Paycheck Protection Program, shall not exceed total operating expenses for the time period for which the funds are intended. If funds exceed the total operating expenses, I will return any overpayment to the plan. |
|  | I understand that a referral may be made for investigation of potential fraud or abuse under the Medicaid program if the provider makes a false statement on this form.  |

1. **Signatures**

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| Authorizing Official Title: |  |
| Authorizing Official Name: |  |
| Authorizing Official Signature: |  |
| Date: |  |