TN Division of TennCare | LTSS

Attestation of Compliance for Eligibility to Receive Enhanced Home and Community Based Services (HCBS) Federal Medical Assistance Percentage (FMAP) Funding for Direct Support Professionals (DSPs)

Enhanced HCBS FMAP Funds are dollars being used within Tennessee's Home and Community Based Services (HCBS) Programs—CHOICES, Employment Community First CHOICES (ECF), Katie Beckett (KB), and 1915(c) Waiver Programs—to increase access to HCBS, strengthen the HCBS workforce, and build provider capacity to meet the needs of individuals receiving HCBS in these programs. The time-limited funding provided under Tennessee's American Rescue Plan Act (ARPA) Federal Medical Assistance Percentage (FMAP) Initial Spending Plan allows Direct Support Professionals (DSPs to be eligible for payments upon meeting custom/specific quality metrics related to the completion of competency-based training that are anticipated to improve the quality of service delivery and quality of life of those receiving services. The below attestation is confirmation that I will comply with all applicable requirements pertaining to eligibility for 1) the submission of claims or requests for payment of these federal funds, and 2) the receipt of these federal funds as prescribed by TennCare in written memos, protocols, or other communication. I further affirm that I will provide my agency with documentation to demonstrate my compliance with TennCare requirements and cooperate fully with all reporting and/or evaluations, audits, or other requests for documentation related to these payments.

Attestation:

☐ I attest that I am currently working as a Direct Support Professional (DSP) for a Home and Community Based Services (HCBS) provider.

☐ I commit, as a Direct Support Professional (DSP), to register for the E-Badge Academy through the TennCare provided Formstack Reporting Tool. Additionally, if my information changes (ex: employer, email address, name, etc.), I will inform TennCare by updating the "HCBS Direct Support Professional/Front Line Supervisor Information" page.

☐ I understand, as a Direct Support Professional (DSP), that incentivized bonus payments will be offered to each DSP who completes a nationally accredited core-competency-based training program and receives one or more of the three-tiered credentials through the National Association of Direct Support Professionals (NADSP) E-Badge Academy. The incentive payment to Direct Support Professionals (DSPs) will correspond to each milestone achieved. Additionally, Direct Support Professionals (DSPs) who complete the required training, achieving a DSP credential, will be compensated for training time at a set rate determined by TennCare.

☐ I understand, as a Direct Support Professional (DSP), that as a condition of receiving these quality incentive payments, I agree to provide data (ex: pre/post surveys) to help evaluate the efficacy of the approach in increasing satisfaction and quality (for the person supported as well as the workforce), and in improving workforce recruitment and retention.

☐ I acknowledge, as a Direct Support Professional (DSP), that this funding is time-limited and will not be available through ARPA funds past March 31, 2025.

☐ I understand if there are any indications that any Direct Support Professional (DSP) engaging in activities to maximize incentive payments through fraudulent means will be reported to the TennCare Office of Program Integrity, the TBI, and Tennessee Attorney General's office for an investigation related to violation of the False Claims Act.

Attestation Type	
☐ **Initial** ☐ **Annual Renewal** ***(annual renewals are due 365 days from the date on the initial attestation)***	
Direct Support Professional Information	
Name:	**Date of Birth:**
Phone Number (Primary): **Phone Number (Secondary):**	**Home Address:**
E-mail Address:	
Provider Information	
Provider Name:	**Supervisor Name:**
Supervisor's E-mail Address:	**Provider Region:**
Provider's Address:	
Printed name of signature:	
Title:	
Date:	
Authorized signature:[1]	
Previous Provider Information (if needed)	
Provider Name:	**Supervisor Name:**
Dates of Employment:	**Provider Region:**
Provider's Address:	
Were any badges obtained while employed with this provider?	
Previous Provider Information (if needed)	
Provider Name:	**Supervisor Name:**
Dates of Employment:	**Provider Region:**
Provider's Address:	
Were any badges obtained while employed with this provider?	

[1] A scanned, imaged, electronic, photocopy or stamp of the above signature shall have the same force and effect as an originally executed signature.