Attestation of Compliance with Section 6032 of the Federal Deficit Reduction Act

Provider/Entity Name:_____

SSPS Provider Number or NPI:_____

Address: _____

City, State, ZIP Code:_____

I hereby attest, under the penalty for false statement, that in my capacity as

_____,
(Position or Office held by entity's authorized representative)

I have the authority to make this attestation on behalf of the entity listed above. I have read Section 6032 of the Deficit Reduction Act of 2005 (the Act). I have examined the above-named provider/entity's policies and procedures. Based on that review, the provider/entity listed above has complied with all applicable requirements of §1902(a)(68) of the Social Security Act (42 USC 1396a(a)(68)) to educate employees and contractors concerning the:

- Federal False Claims Act established under sections 3729 through 3733 of Title 31, United States Code (31 USC §3729-3733),
- Administrative remedies for false claims and statements established under Chapter 38 of Title 31, United States Code (31 USC §3801 et seq.),
- State laws pertaining to Medicaid fraud, abuse, civil or criminal penalties for false claims and statements (RCW 74.66), and
- Whistleblower protections under such laws, with respect to the role of such laws in preventing and detecting fraud, waste and abuse in Federal health care programs.

Furthermore, the provider/entity will continue to comply with these provisions to remain eligible for payment under Washington's Home and Community Based Services program. I understand that if any statements in this declaration are false, they may be subject to prosecution under the Washington perjury law, RCW 9A.72, as well as the laws cited in this declaration.

I declare under penalty of perjury under the laws of the state of Washington that the foregoing is true and correct.

Executed on (date) _____For Federal Fiscal Year **2013**

_____
Signature of Chief Executive Officer/President/Vice President or Authorized Representative

_____
Print or Type Name and Title

_____
Signature of Corporate Secretary/Treasurer Date

_____
Print or Type Name and Title

Mail or fax the completed form to:
Department of Social and Health Services
Aging and Long-Term Support Administration
Home and Community Services Division
PO Box 45600
Olympia, WA 98504-5600
FAX: 360-438-8633