Valley Area Agency on Aging Provider Compliance Attestation Document

Valley Area Agency on Aging (VAAA) Provider Enrollment, Screening and Disclosure Requirements

Attestation

I,_____, as a legally authorized representative of (Provider Agency Name)_____, hereby certify that the following statements are true and accurate:

Please read each statement below and check each box.

☐ Will conduct monthly screenings using the Office of Inspector General's (OIG) List of Excluded Individuals/Entities (LEIE) and Michigan's OIG sanction and debarment database on all employees who will/may work with MI Choice Waiver participants through my contracted relationship with VAAA;

☐ Will notify VAAA immediately if an employee has been excluded from the above databases, and **stop all VAAA payments to the identified employee until further notice from VAAA;**

☐ Do not have a director, officer, partner, managing employee, or person with beneficial ownership of 5% or more of the equity who is currently debarred or suspended by any State or Federal agency;

☐ Do not have a contract, employee, consulting service, or any other agreement with people or entities debarred or suspended from the provision of items or services;

☐ Disclosures, if any, have been made to Valley Area Agency on Aging, MDHHS-OIG or the Centers for Medicare and Medicaid Services (CMS);

☐ I understand the above statements will be verified at VAAA's request.

_____
Provider Agency Name

_____
Signature of Provider Agency Authorized Representative

_____
Title of Provider Agency Authorized Representative

_____
Date

_____
Email address of Provider Agency Authorized Representative

_____
Phone Number of Provider Agency Authorized Representative