Rate Enhancement Affidavit

A MATERIAL OR FALSE STATEMENT OR OMISSION MADE IN CONNECTION WITH THIS AFFIDAVIT MAY SUBJECT THE PERSON AND/OR ENTITY MAKING THE FALSE STATEMENT TO ANY AND ALL CIVIL AND CRIMINAL PENALTIES AVAILABLE PURSUANT TO APPLICABLE FEDERAL AND STATE LAW.

State of Texas_____§
County of_____§

Definitions:
Participating Provider: Someone participating in rate enhancement.
Rate Enhancement: An additional amount of monies paid to provider to be passed on for compensation of direct care staff.

I,_____ **(full name printed)**, swear an oath under penalty of law that I am _____**(title)** of_____ **(company)** and that the statements submitted in this affidavit are true and correct to the best of my knowledge.

I further swear that I or my company have met the requirements set forth in 15 TAC §355.112 which states that allowable enhancement fund compensation for attendants (as defined above) was applied either as salaries and/or wages, including payroll taxes and workers' compensation, or employee benefits to direct care staff.

I agree to submit to an audit, examination and review of books, records, documents and files, in whatever form they exist, of the named company and its affiliates, inspection of its places(s) of business and equipment, and to permit interviews of principals, agents, and employees. I understand that refusal to permit such inquiries shall be grounds for whatever civil and criminal penalties are available pursuant to applicable federal and state law and/or termination of my contract with Superior HealthPlan, Inc.

Should an audit result in a finding of non-compliance with these requirements, it could result in recoupment of those enhanced payments and termination of the contract with Superior HealthPlan. It shall also be grounds for whatever civil and criminal penalties are available pursuant to federal and state law.

To prevent any delay in processing, it is very important to include the following information on the returned affidavit: Tax Identification Number (TIN), your assigned NPI number and the nine digit HHSC contract number awarded to you from the Texas Health and Human Services (not to be confused with your five-to-six digit license number).

Business Name: _____ **Business Tax ID:** _____

Program Type	HHSC Contract Number	Provider's Billing NPI or Atypical ID
PHC		
DAHS		
Assisted Living		

Please check one of the following:

☐ I contract with HHSC for Rate Enhancement and wish to participate in Superior's Rate Enhancement Program.
☐ I no longer contract with HHSC for Rate Enhancement as of _____ and wish to remain in Superior's Rate Enhancement Program.
- If selected, what is the *last rate you received during your contract with HHSC? _____
**If we are unable to verify your previous rate with HHSC, confirmation will be required before we can process your submission.*

☐ I have never contracted with HHSC, but wish to request participation with Superior HealthPlan's Rate Enhancement Program, at the level allowed by Superior HealthPlan.
☐ I wish to be removed from Superior's Rate Enhancement Program. **Please Note**: By checking this box, I understand that I will no longer receive rate enhancement payments from Superior HealthPlan as of January 1, 2021.

Affiant's Signature **Affiant's Phone Number and E-mail**

Date: _____