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| (For DHS Use Only) |

The Indirect-Care Worker Payment (ICWP) is intended for certain workers who are employed or contracted staff of Long Term Supports and Services (LTSS) providers. Eligible indirect care workers are those who do not qualify for Direct Care Worker Payments, but whose work activities involve direct in-person contact with patients/residents/clients. Administrative staff, physicians, dentists, and pharmacists are excluded. Although an LTSS provider applies for the ICWP payment on a worker’s behalf, the payment must pass-through to the worker. This pass-through requirement shall not, however, affect an LTSS provider’s duties regarding tax or other lawful withholding. For purposes of the ICWP and DCWP programs, individual workers may *not* be counted as both an indirect care worker and a direct care worker for the same LTSS provider.

**Payments will begin after Legislative approval.**

**Section 1**

1. Report Date: Choose an item.
2. Provider (Entity) Name: Click or tap here to enter text.
3. Point of Contact/Agent Name: Click or tap here to enter text.
4. Provider Type: Choose an item.

**Section 2**

1. Complete the following table.

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Indirect Care Employees working in facilities with *no* COVID-19 positive patients. | | | | | | | |
| Medicaid ID | NPI | Hourly Schedule | | Number of employees | | Employer contribution to FICA and retirement, not to exceed 10% | |
| Click or tap here to enter text. | Click or tap here to enter text. | 20-39 hours per week | | Click or tap here to enter text. | | Click or tap here to enter text. | |
| Click or tap here to enter text. | Click or tap here to enter text. | 40+ hours per week | | Click or tap here to enter text. | | Click or tap here to enter text. | |
| Click or tap here to enter text. | Click or tap here to enter text. | Regular split-shift schedule that overlaps weeks and equals or exceeds 150 hours per month, not including overtime | | Click or tap here to enter text. | | Click or tap here to enter text. | |
| Indirect Care Employees working in facilities with COVID-19 positive patients. | | | | | | | |
| Medicaid ID | NPI | Hourly Schedule | | Number of employees | | Employer contribution to FICA and retirement, not to exceed 10% | |
| Click or tap here to enter text. | Click or tap here to enter text. | 1 – 19 hours per week | | Click or tap here to enter text. | | Click or tap here to enter text. | |
| Click or tap here to enter text. | Click or tap here to enter text. | 20-39 hours per week | | Click or tap here to enter text. | | Click or tap here to enter text. | |
| Click or tap here to enter text. | Click or tap here to enter text. | 40+ hours per week | | Click or tap here to enter text. | | Click or tap here to enter text. | |
| Click or tap here to enter text. | Click or tap here to enter text. | Regular split-shift schedule that overlaps weeks and equals or exceeds 150 hours per month, not including overtime | Click or tap here to enter text. | | Click or tap here to enter text. | |
|  | | | | | | | |
| Indirect Care Contractors working in facilities with *no* COVID-19 positive patients. | | | | | | | |
| Medicaid ID | NPI | Hourly Schedule | | Number of contractors | | Employer contribution to FICA and retirement, not to exceed 10% | |
| Click or tap here to enter text. | Click or tap here to enter text. | 20-39 hours per week | | Click or tap here to enter text. | | Click or tap here to enter text. | |
| Click or tap here to enter text. | Click or tap here to enter text. | 40+ hours per week | | Click or tap here to enter text. | | Click or tap here to enter text. | |
| Click or tap here to enter text. | Click or tap here to enter text. | Regular split-shift schedule that overlaps weeks and equals or exceeds 150 hours per month, not including overtime | | Click or tap here to enter text. | | Click or tap here to enter text. | |
| Indirect Care Contractors working in facilities with COVID-19 positive patients. | | | | | | | |
| Medicaid ID | NPI | Hourly Schedule | | Number of contractors | | Employer contribution to FICA and retirement, not to exceed 10% | |
| Click or tap here to enter text. | Click or tap here to enter text. | 1 – 19 hours per week | | Click or tap here to enter text. | | Click or tap here to enter text. | |
| Click or tap here to enter text. | Click or tap here to enter text. | 20-39 hours per week | | Click or tap here to enter text. | | Click or tap here to enter text. | |
| Click or tap here to enter text. | Click or tap here to enter text. | 40+ hours per week | | Click or tap here to enter text. | | Click or tap here to enter text. | |
| Click or tap here to enter text. | Click or tap here to enter text. | Regular split-shift schedule that overlaps weeks and equals or exceeds 150 hours per month, not including overtime | Click or tap here to enter text. | | Click or tap here to enter text. | |

1. Please attach proof of your certification from the Arkansas Department of Human Services, Division of Provider Services and Quality Assurance (DPSQA). (Please only submit this proof with initial submission; not with subsequent submissions.)

**ATTESTATION**

I, [Point of Contact/Agent Name from Section 1.C.] \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, hereby attest that:

[LTSS provider Name] \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, shall not retain any portion of any payment received, other than as duly authorized and pursuant to applicable laws or judgments;

☐ [LTSS provider Name] \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, shall retain records sufficient to support each and every payment claimed herein, for so long as may be deemed necessary, but in no case less than seven (7) years;

☐ [LTSS provider Name] \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, shall make such records available to the Arkansas Department of Human Services and/or any other lawful authority, upon request; and

upon penalty of perjury, all of the facts contained in the foregoing Report are true and correct to the best of my knowledge, information, and belief.

Agent Name

Date

Upon completion of all sections above, please submit this report to the attention of **“ICWP**”to [DCWP@dhs.arkansas.gov](mailto:DCWP@dhs.arkansas.gov).