INVOICE

NORTH COUNTRY COMMUNITY MENTAL HEALTH PREMIUM PAY WAGE PASSTHROUGH PROVIDER ATTESTATION AS TO HOURS WORKED

CMHSP Provider: (Enter Name Here)

Service Site	(enter site/home name)
Person Completing Form	(enter name and title)
Completion Date: mm/dd/yy	(enter date)
Service Month	(enter month)

Please Complete Requested Data for Each Employee

Employee Name	Hours Worked per month	Premium Pay Rate $2.00	Manually Calculate Total Employee Premium Pay
SAMPLE - Sam I am	100	$2.00	$ 200.00

MANUALLY CALCULATE ALL VALUES AND INVOICE TOTAL PRIOR TO SUBMITTAL

Employee Totals		$2.00/hr	
Employer Adm/Fringe		$0.24/hr	
Total Request		$2.24/hr	

By my signature below, I attest that _____ (Provider Entity) complied with the requirements of Medicaid L- Letter 20-28, to the best of our knowledge and belief, and has or will provide the $2.00 wage increase to all eligible direct care workers. I agree to retain documentation to show how this increase was allocated for this purpose and to make those records available upon request.

For Manual Invoice Preparation, please print legibly and manually calculate all lines or column totals. Please use two pages if required.

Authorized Provider Signature and Date

Authorized CMHSP/PIHP Signature and Date