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 $2.25	Total Employee Premium Pay
SAMPLE - Sam I am	*100*	*$2.25*	*$ 225.00*
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Employee Totals	-	$2.25	$0.00
Employer Adm/Fringe		$0.27	$0.00
Total Request			**$0.00**

By my signature below, I attest that _(Provider Entity)_ complied with the requirements of Medicaid L - Letter 21-30, 20-28, L20-42, L20-67, and L21-02 to the best of our knowledge and belief, and has or will provide the $2.25 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.

Authorized Provider Signature and Date

Authorized CMHSP/PIHP Signature and Date