Attestation of Compliance with Section 6032 of the Federal Deficit Reduction Act

Provider/entity name: _____

NPI: _____ KMAP provider number: _____

Address: _____
Street City State Zip Code

I hereby attest that, as a condition for receiving payments exceeding $5 million per federal fiscal year, I have read Section 6032 of the Deficit Reduction Act of 2005 (the Act), and have examined the above-named provider / entity's policies and procedures. Furthermore, the provider / entity will continue to comply with these provisions to remain eligible for payment under the Kansas Medical Assistance Program.

Based on that review, the provider / entity is in compliance with the requirements of the Act to educate employees and contractors concerning:

- The Federal False Claims Act established under sections 3729 through 3733 of Title 31, United States Code
- Administrative remedies for false claims and statements established under Chapter 38 of Title 31, United States Code
- State laws pertaining to Medicaid fraud, abuse
- Civil or criminal penalties for false claims and statements
- Whistleblower protections under such laws, with respect to the role of such laws in preventing and detecting fraud, waste, and abuse in Federal health care programs

I declare that the provider / entity must continue to comply with these provisions to remain eligible for payment under the Kansas Medical Assistance Program. I understand that if any statements in this declaration are false, they may be subject to prosecution under the Kansas perjury law, K.S.A. 21-3805, as well as the laws cited in this declaration.

I declare under penalty of perjury under the laws of the state of Kansas that the foregoing is true and correct.

For Federal Fiscal Year (FFY): _____
(Attest for the previous FFY, for example Oct 1, 2013-Sept 30, 2014 is FFY2014 and the attestation is to be submitted Oct-Dec 2014.)

_____ _____
Signature of Chief Executive Officer/President/Vice President Date

_____
Print or type name and title

_____ _____
Signature of Corporate Secretary/Treasurer Date

_____
Print or type name and title

Fax the completed form to:
Fax: 785-296-4813
Attention: Provider State Program Manager
Kansas Department of Health and Environment / Division of Health Care Finance

Revised 4/2021