

M.T.E. and Wagner v. DSHS
PROVIDER CERTIFICATION OF WORK

I certify that I was a qualified Individual Provider of Medicaid-funded personal care services living with and providing services to a recipient of Medicaid-funded personal care services who was, at the time of service, under the age of 18 years, between July 1, 2005 and November 30, 2011 (the "Class Period).

I certify that I provided personal care services in excess of the amount authorized by DSHS during the identified months in the Class Period.

I further certify that I was not paid for the personal care services performed in excess of the amount authorized by DSHS during the identified months.

I certify that the information provided in this Claim Form is true and correct. I understand that the payment of my claim may involve federally funded Medicaid dollars.

I authorize Epiq Systems to obtain any necessary information from the Washington Department of Social and Health Services and/or the Medicaid recipient to whom I provided services who is identified on the attached claim form to confirm this certification.

Signature: _____ Date: _____

Type or Print Your Name (required): _____

Name of Person who received services (required): _____

Date of Birth of the person who received services (required): _____

You **must** include the following information with this claim form: (1) the dates when you lived with a child Medicaid recipient and provided personal care services in excess of those authorized by DSHS (month/year); (2) the address at which you lived; and (3) the child Medicaid recipient to whom you provided personal care services. Please see the enclosed "Instructions for Claim Form" material under "Documentation" for a list of the type of documents that must be submitted to establish each element.

Current Address: _____
(Street or P.O. Box)

City, State and Zip Code

Daytime/Evening
Telephone Numbers: _____ (day) _____ (eve.)

Please include your DSHS identification number: _____