

**PROVIDER ATTESTATION FOR SIGNATURE ON FILE and RDR CONTACT
NURSING FACILITY ASSESSMENT RESIDENT DAY REPORTING FORM**

Provider Name: _____

Facility ID: _____

By signature and date below, I/we certify that I/we possess all necessary powers and authority to make the representations set forth on the quarterly Resident Day Reporting Form and to execute the same on behalf of the Provider and, in so doing, to bind the Provider, including the owner(s) of the Provider and any persons who derive any rights from the Provider and its enrollment in the Medical Assistance Program. I/we further certify that the information submitted on the Resident Data Reporting Form for each Resident Day Quarter is accurate and complete as submitted. I/we understand that this information is being relied upon to make payment of Federal and State funds and that if the information is false or if there has been any material concealment of material facts: (1) I/we may be subject to those penalties pertaining to unsworn falsifications to authorities, as set forth at 18 Pa. C.S. Section 4904; (2) the Provider's participation in the Medical Assistance Program may be terminated; and (3) criminal or civil penalties may be imposed against the Provider, its owner(s), and other responsible persons.

This representation is valid until the Signature on File or RDR Contact is replaced. At that time, an updated form would need to be mailed to the address listed below.

Signature of File Date

Print Name (Signature on File) Email Address

RDR Contact Date

Print Name (RDR Contact) Email Address

If you would like to add or remove an employee from our contact list, please contact RA-NH_Assessments@pa.gov. (Note there is an underscore between the H and A.)

FOR OFFICE USE ONLY:

RECEIVED: _____ ENTERED: _____ INITIAL: _____