Payments are restricted to licensed Emergency Medical Services professionals (i.e. Emergency Medical Technicians and Paramedics) for the days they work. Payments for days on leave or working offsite are not permissible. Payments will be made to the EMS professional’s employer, who must maintain documentation to be audited. Payments cannot be used for equipment, training, environmental modifications, offsetting revenue losses, or any cost other than payment directly to EMS professionals and employer’s share of FICA and retirement benefits established as of April 5, 2020. Payments are taxable to the individual EMS professionals according to applicable laws, and the pass-through requirement for these payments shall not affect the employer’s duties regarding lawful withholding. **FICA/Retirement amounts should be calculated based solely on the worker payments being claimed; not based on any other wages.** None of the expenses to be reimbursed under this payment initiative can be reimbursed under any other federal or state program. To the extent that expenses are subsequently reimbursed under another federal or state program, funds disbursed from the Arkansas Coronavirus Relief Fund will be reconciled and recovered. When submitting, be sure to **hand-sign your report, send only one (1) report per email message, and specify only “Ambulance DCWP” in the subject line of your email.** Failure to do so could cause unnecessary delays in processing your reports.

**Section 1**

1. Report Period:

Week 1 (4/5/2020 - 4/11/2020)  Week 2 (4/12/2020 - 4/18/2020)

Week 3 (4/19/2020 - 4/25/2020)  Week 4 (4/26/2020 - 5/2/2020)

Week 5 (5/3/2020 - 5/9/2020)  Week 6 (5/10/2020 - 5/16/2020)

Week 7 (5/17/2020 - 5/23/2020)  Week 8 (5/24/2020 - 5/30/2020)

1. Ambulance Service Name: Click or tap here to enter text.
2. Point of Contact/Name of Person Completing Report: Click or tap here to enter text.
3. Medicaid ID, if applicable: Click or tap here to enter text.

**Section 2**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Number of EMS professionals who worked 20-39 hours/week | x Payment Rate | = Total Payments Claimed | + Employer contribution to FICA and established retirement plan in effect as of 4/5/2020 | = Total Amount Claimed |
| #\_\_\_\_\_\_\_\_\_\_\_ | x $125 | $\_\_\_\_\_\_\_\_\_\_\_\_ | $\_\_\_\_\_\_\_\_\_\_\_\_ | $\_\_\_\_\_\_\_\_\_\_\_\_ |
| Number of EMS professionals who worked 40+ hours/week or 150+ hours/month | x Payment Rate | = Total Payments Claimed | + Employer contribution to FICA and established retirement plan in effect as of 4/5/2020 | = Total Amount Claimed |
| #\_\_\_\_\_\_\_\_\_\_\_ | x $250 | $\_\_\_\_\_\_\_\_\_\_\_\_ | $\_\_\_\_\_\_\_\_\_\_\_\_ | $\_\_\_\_\_\_\_\_\_\_\_\_ |
| TOTALS | | Add amounts above and enter sum below | Add amounts above and enter sum below | Add amounts above and enter sum below (the sum of the amounts above should equal the sum of the amounts to the left) |
| $\_\_\_\_\_\_\_\_\_\_\_\_ | $\_\_\_\_\_\_\_\_\_\_\_\_ | $\_\_\_\_\_\_\_\_\_\_\_\_ |

**ATTESTATION**

I, [Point of Contact/Agent Name from Section 1.C.] \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, hereby attest that [Ambulance Service Name] \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_:

* Shall not use any funds received from this report to duplicate or supplant funding from any other source of payment including by future rate increases or from federal funding
* Shall not use any funds received from this report to offset loss of revenue;
* Shall not use any funds received from this report to provide “retention” or retainer payments;
* Shall not use any funds received from this report to pay bonuses;
* Shall not use any funds received from this report to pay any increase in management fees to administrative personnel;
* Has not claimed any individual worker under more than one worker-category for the week reported herein;
* Shall not retain any portion of any payment to the direct or non-direct care workers claimed above, other than as duly authorized and pursuant to applicable laws or judgments;
* Shall retain records sufficient to support each and every payment claimed herein, for so long as may be deemed necessary, but in no case less than seven (7) years;
* Shall make such records available to the Arkansas Department of Human Services and/or any other lawful authority, upon request; and
* Upon penalty of perjury, all of the facts contained in the foregoing Report are true and correct to the best of my knowledge, information, and belief.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date Agent Name

Date

Upon completion of all sections above, please submit this report to the attention of **“Ambulance DCWP**”to [DCWP@dhs.arkansas.gov](mailto:DCWP@dhs.arkansas.gov).