

Michigan Recuperative Care Provider Attestation Form
Michigan Department of Health and Human Services

Provider Information

Provider Name		Provider National Provider Identifier (NPI) Number	
Service Location Address	City	State	Zip Code

Contact Name
Office Phone Number
Office Fax Number

Recuperative care is a transitional program for eligible Medicaid beneficiaries who are experiencing homelessness and are too ill or frail to return to their living environment, but are not ill enough to continue to need hospital-level care or skilled nursing care. Recuperative care is a short-term program that allows these beneficiaries to recover post-hospitalization, receive case management services, room and board, access medical care or other Medicaid services, and supportive services.

The recuperative care provider must meet all the following to enroll, participate and bill Michigan Medicaid for recuperative care services.

I attest that our setting meets the following criteria to administer a recuperative care program in the State of Michigan.

Initials (do not use Xs or checkmarks) are required.

Our setting has the following:

- _____ Meets the National Institute for Medical Respite Care (NIMRC) standards for medical respite care programs (<https://nimrc.org/standards-for-medical-respite-programs/>).
- _____ Private or semi-private rooms for beneficiaries.
- _____ Allow 24-hour access to rooms.
- _____ Clean linens for each beneficiary upon admission.
- _____ At least three meals per day provided.
- _____ Secure place to store personal belongings.
- _____ Secure medication storage accessible by the beneficiary.
- _____ Appropriate storage for all durable medical equipment.

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- _____ On-site access to laundry and shower facilities.
- _____ 24-hour access to staff, and staff on-site that are minimally trained in first aid and basic life support on-site always.
- _____ Written policies to allow beneficiary visitors to enter the facility/room.
- _____ Written policies and procedures for life-threatening emergencies.
- _____ A facility that is compliant with local and state fire safety standards.
- _____ A facility that is compliant with federal Americans with Disabilities Act (ADA) requirements and that meets the individual beneficiary's functional needs.
- _____ I attest that we will have the appropriate providers available based on the member's plan of care (POC). These will include one or more of the following: registered nurse, licensed practical nurse, case manager, mental health counselor, social worker, or community health worker.

An administrator, manager, director, or other person authorized to sign must initial each applicable statement. Write the name and title of the person signing this attestation statement. This person must be disclosed to MDHHS on the Disclosure of Ownership and Control Interest of an Entity or in the Owners and Authorized Persons section of the Michigan Provider Screening and Enrollment application.

I attest to the accuracy of all information on this form.

Check if signing electronically:

I am signing this form electronically. My name as typed in the signature field is my legally binding signature. I understand that my electronic signature has the same legal effect and can be enforced in the same way as a handwritten signature.

Authorized Officer Name (Print or Type)	Authorized Officer Title
Authorized Officer Signature	Date

AUTHORITY: Title XIX of the Social Security Act
 COMPLETION: Is Voluntary but is required if payment from applicable program is sought.

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