ATTESTATION FORM

(Use to request Competitive Integrated Employment (CIE) Supplemental Payment)

The provider agency must retain the original signed form. Complete and submit this attestation form to DOH.DDDEmploymentServices@doh.hawaii.gov.

Participant:	**Provider Agency:**
Employer:	**Start Date:**
Position Description:	

Typical Work Schedule:

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday

I attest the following requirements have been met to receive the supplemental payment:

1) The participant has been placed in a new job (that matches their employment goals, interests, and abilities) in an integrated community setting that aligns with Medicaid HCBS Settings Rule:
   a. A location where the participant interacts with other persons who are not individuals with disabilities (co-workers, supervisors, customers, general public) to the same extent as employees who are not individuals with disabilities and who are in comparable positions.
   b. Interaction must extend beyond job coaches or others who are associated with the provision of supports.
2) The participant is not employed by a business owned by, managed by, or financially related to the provider agency.
3) No more than two supplemental payments have been received within the participant's ISP plan year.
4) The participant is earning minimum wage or higher. Participant's hourly wage is: _____.
5) The participant has maintained employment for 90 days and has worked at least one hundred (100) hours (accounting for sick and vacation time).
6) On-the-job accommodations (if needed) have been identified and implemented with the participant and employer. Describe the following:
   a. Type of accommodation(s):

   b. When and how the accommodation is applied:

7) Natural support at the worksite has been identified and developed for the participant to achieve maximum independence.
   a. Identify the position of the person providing natural support to the participant at the worksite:

   b. If the natural support is not available, how will the employer support the participant:

8) The participant has been scheduled to work a minimum of ten (10) hours per week for at least 10 weeks. (Complete table below.)

Week	Dates	Hours Worked
Week 1		
Week 2		
Week 3		
Week 4		
Week 5		
Week 6		
Week 7		
Week 8		
Week 9		
Week 10		
Week 11		
Week 12		
TOTAL		**0**

Demonstrate the 10-hours for 10 weeks requirement was met by listing only dates/hours the participant actually worked. Do not include dates for sick and/or vacation leave taken by the participant.

***NOTE:** DOH-DDD may verify a participant's employment status with their employer.

By signing, I attest I am authorized to sign on the provider agency's behalf and the information in this document is true and accurate.

Print Name of Person Completing Form

Title

Signature

Date

This form can be signed electronically ("E-sign") or printed and signed. An E-sign is accepted as an original signature.