ATTESTATION REGARDING FEDERALLY FUNDED PROGRAMS

In accordance with Paragraph 9.11 of the 24 Hour Residential Treatment Contract (CONTRACTOR'S EXCLUSION FROM PARTICIPATION IN A FEDERALLY FUNDED PROGRAM):

I, the undersigned, certify that I am not presently excluded from participation in federally funded health care programs, nor is there an investigation presently pending or recently concluded of me which is likely to result in my exclusion from any federally funded health care program, nor am I otherwise likely to be found by a federal or State agency to be ineligible to provide goods or services under a federally funded health care program.

I further certify as the official responsible for the administration of _____ (hereafter "Contractor") that none of its officers, employees, agents and/or subcontractors are not presently excluded from participation in any federally funded health care programs, nor is there an investigation presently pending or recently concluded of any such officers, employees, agents and/or subcontractors which is likely to result in an exclusion from any federally funded health care program, nor are any of its officers, employees, agents and/or subcontractors otherwise likely to be found by a federal or State agency to be ineligible to provide goods or services under a federally funded health care program.

I understand and certify that I will notify DMH within 30 calendar days, in writing of:

- Any event that would result in Contractor or any of its officers, employees, agents and/or subcontractors being excluded or suspended under federally funded health care programs, or
- Any suspension or exclusionary action taken by an agency of the federal or State government against Contractor, or one or more of its officers, employees, agents and/or subcontractors, barring it or its officers, employees, agents and/or subcontractors from providing goods or services for which federally funded healthcare program payment may be made.

Name of authorized official (Official Name)_____
Please print name

Signature of authorized official _____ Date _____