DEPARTMENT OF HUMAN SERVICES
NURSING FACILITIES
RATES AND POLICY

Supplemental Nursing Services Agency (SNSA) Attestation Form

By signing this attestation form, you confirm that you have read and agree to the requirements listed below and agree to comply on an ongoing basis as long as your organization is providing staff to nursing facilities under this COVID-related temporary waiver.

The purpose of this waiver is to increase the wages of the frontline workers as a form of hazard pay for working in a nursing facility impacted by COVID. This waiver is not intended to provide additional profits to staffing agencies. Any amounts in excess of the maximum charges that are permitted under this waiver should be paid to the applicable SNSA employee(s), in addition to their regular wages; this is referred to as the pass through requirement. Alternatively, the SNSA must provide documentation to the commissioner describing the reasons and emergency situation justifying why the pass through requirement cannot currently be met and the duration for which a waiver of this requirement is necessary. This attestation must be provided to the state before any application to waive the maximum charges will be approved.

In the box below, provide a breakdown of the charges being billed to the nursing facility and specifically how these excess charges will be passed directly on to the employee(s) working in nursing facilities with COVID-19. For *example*: Hourly rate billed to the nursing facility for an RN under this COVID-related waiver: $75.00. Standard hourly rate of pay for the SNSA RN prior to this COVID-related waiver: $48.00. Hourly rate of pay to the SNSA RN during this COVID waiver will be the total of the standard rate of $48 plus the COVID hazard pay in the amount of $17.35 for a total hourly rate of pay of $65.35. Please be explicit and list the hourly rate billed to the facility and the hourly rate paid to the temporary staff provided. If the increase in hourly rate billed and hourly rate to staff is not the same, please provide reasoning and justification for why the pass through requirement cannot be met.

Name, address and phone number of SNSA:

Name of nursing facility involved:

Signature of Authorized Representative of the SNSA

Date signed

Print Name

Title

Return this completed and signed form via email to mary.cahill@state.mn.us.