Attendant Compensation Rate Enhancement Program Request for Participation Attestation

The Attendant Compensation Rate Enhancement Program (ACEP) is a Texas Health and Human Services (HHS) program that allows additional payments for services delivered by non-medical attendants who care for Texas Medicaid recipients. Assisted Living and Residential Care, Personal Attendant Services (PAS) and Day Activity and Health Services (DAHS) providers may be eligible to receive this rate enhancement. To participate, eligible providers must allocate at least 90% of the dollars received under this option to the Community Care Attendant(s) as stipulated in the rules outlined in Title 1, Texas Administrative Code (TAC) 355.112. If previously enrolled, you must attest to your participation or verify any changes each year by completing this form.

As a contracted Provider or authorized official on behalf of Provider, I, the undersigned authorized official, am required to supply Community Health Choice with verification of all cost reports submitted to participate in the Attendant Compensation Rate Enhancement Program (ACEP). Further, I hereby authorize Community to request, receive and inspect all records pertinent to this consideration.

I wish to participate in the Attendant Compensation Rate Enhancement Program with the Community Health Choice STAR+PLUS plan. This information is required by the state. You can learn more about the state guidelines at https://pfd.hhs.texas.gov/long-term-services-supports/2025-rate-enhancement-attendant-compensation-information .

ATTESTATION:
I certify the information provided including but not limited to cost reports is complete, accurate, and current. I acknowledge that any misstatements, misrepresentations, or omissions from these reports constitute for denial or dismissal from the Attendant Care Enhancement Program that may result in recoupment of funds received. I have reviewed this information as of the most recent date listed below.

Name:____ Tax ID Number: ______________________________

Address: ____________________________________City: _________________________State: ____Zip Code_______

NPI Number: ___________________________Current Rate Enhancement Level(s): Priority_______ , Non-Priority_______

DADS Contract Number: ___________________________

Signature: _______________________________ Date: ________________________________

Print Name:______________________________ Title:________________________________

Mail To: Community Health Choice Attn: Contracting Team-ACEP
4888 Loop Central, Suite 600
Houston, TX 77081

Email: CHC.ACEP@CommunityHealthChoice.org

This year's rate enhancement will be effective September 1, 2024. After we receive your form and confirm your participation in the program, we'll update your Community Health Choice STAR+PLUS Participation Agreement with the rate enhancement. If you have any questions, please call Provider Services **at 888-760-2600.**

Thank you.