**Certification of Wage Pass-Through Form (2021)**

Nursing Facility_____ NPI_____

Name _____ Title _____

Phone_ _____ Email _____

List below the names of all Direct Care Workers, as defined above, employed as of October 1, 2021.

| Last Name | First Name | Job Title | SS# (last four digits) | Date of Hire | Hourly rate (including payroll taxes) prior to rate increase | Hourly rate (including payroll taxes) after rate increase | Monthly cost of all other benefits prior to rate increase | Monthly cost of all other benefits after rate increase |
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**Attestation**

I, _____, hereby attest that eighty percent (80%) of rate increases resulting from the application of the inflation index to a direct-care rate adjusted for resident acuity and an indirect-care rate comprised of a base per diem for all facilities received by _____[Agency]_____effective October 1 was dedicated to increased compensation for eligible direct care workers. I further attest that, to the best of my knowledge and belief, the above information is accurate and complete as of the date below. _____[Agency]_____ has maintained records to support this attestation, and hereby acknowledges that such records may be subject to inspection or audit by EOHHS.

Nursing Facility _____

Name _____ Title _____

Signature _____ Date _____