



Missouri Department of Health and Senior Services
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 RELAY MISSOURI for Hearing and Speech Impaired: 1-800-735-2466 VOICE: 1-866-735-2460



Randall W. Williams, MD, FACOG
 Director

Michael L. Parson
 Governor

HCBS ASSESSMENT ATTESTATION

Any person or corporation who obtains or attempts to obtain, or aids or abets any other person to obtain, by means of a willfully false statement or representation, or by willful concealment or failure to report any fact or event required to be reported by any law, regulation, or rule of this state or the United States, or by impersonation, collusion, or other fraudulent device, any public assistance benefits, programs, and services, shall be guilty of the crime of stealing” (205.967, RSMo).

By signing here, I attest that the information concerning my health and level of need for assistance is truthful and accurate to the best of my knowledge.

Participant Name	Participant Signature	Date
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No health care provider shall knowingly make or cause to be made a false statement or false representation of a material fact in order to receive a health care payment, including but not limited to:

- (1) Knowingly presenting to a health care payer a claim for a health care payment that falsely represents that the health care for which the health care payment is claimed was medically necessary, if in fact it was not;
- (2) Knowingly concealing the occurrence of any event affecting an initial or continued right under a medical assistance program to have a health care payment made by a health care payer for providing health care;
- (3) Knowingly concealing or failing to disclose any information with the intent to obtain a health care payment to which the health care provider or any other health care provider is not entitled, or to obtain a health care payment in an amount greater than that which the health care provider or any other health care provider is entitled;
- (4) Knowingly presenting a claim to a health care payer that falsely indicates that any particular health care was provided to a person or persons, if in fact health care of lesser value than that described in the claim was provided.” (191.905, RSMo).

By signing here, I attest that I have documented the information provided to me by the participant and collateral contacts accurately.

Assessor Name	Assessor Signature	Date
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