False Claims Act Policy Attestation:

I attest that I have read and understand the False Claims Act Policy and hereby agree to abide by the contents of said policy. I understand that as a provider of services reimbursed by Medicaid, I am required to report any identified or suspected fraud, waste, and abuse immediately to my supervisor for investigation and subsequent action as deemed appropriate by the OIG.

_____

Employee Signature

_____

Employee Name (Printed)

_____

Date