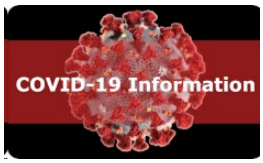
The Arc
Central Chesapeake Region



Quarantine Wage Documentation Requirement

931 Spa Road | Annapolis, MD 21401
Submit with Appendix K Timesheet or
E-time Submittal: FMSTimesheets@thearcccr.org
FMS Direct: 1.866.252.6871 | FMS Fax: 1.888.272.2236
Need help? Open a customer service ticket!

Appendix K – Quarantine Wage Documentation Requirement

To request payment for quarantine wage services, the Appendix K Timesheet or electronic time submittal *MUST* be accompanied by this form. This form provides a means for self-directed participants to provide the required supporting documentation to authorize the FMS to provide payment for quarantine wage services.

- As indicated in DDA Appendix K #7 – Increased Rate for Supporting Person with COVID-19 Virus, the DDA is implementing increased rates (150% of wage) for directly supporting participants that have a positive COVID-19 determination, and therefore are isolated, to account for the increased cost of the provision of services while maintaining participants' health and safety.
- For eligible participants, the increased rate can be requested beginning the date that the participant was determined positive and may be billed up to 21 consecutive days while the participant is in isolation.
- The Appendix K Timesheet or electronic time submittal is required to request quarantine wage payments for eligible staff based on the criteria noted in the guidance.
- Special quarantine wage service codes, as identified on the Appendix K Service Codes form, are required to be utilized on the Appendix K Timesheet or via electronic time submittal in order to appropriately request quarantine wage payments.
- Electronic and verbal signatures are permissible on all Appendix K documentation.

Employee: _____ Service Code: _____
(Last Name, First Name - person receiving increased rate)

Participant/Employer Name: _____
(Last Name, First Name - individual receiving services)

Date of Determination (Positive for COVID-19): _____
(Date begins 21-day period of eligibility for increased rate)

Source of Determination: _____
(COVID-19 test result, determination by physician, local health dept, testing site, other)

Signature: _____Date: _____
(Participant/Designated Representative/Guardian)