KDADS FMS Provider
Affirmation of DSW Funds Distribution

Kansas
Department of Aging and Disability Services

Provider Name: _____

Provider Mailing Address: _____

City, State, Zip: _____

Medicaid Billing Number: _____

Provider NPI: _____

Telephone Number: _____

Agency Contact: _____

Time Period Reported: _____

Total DSW Funds Received: _____

Total DSW Funds Disbursed: _____

Total Excess Funds Enclosed: _____

Enclosed Check No: _____

I hereby certify under penalty of perjury that, to the best of my knowledge and belief, the information above is true and accurate. I further certify that all excess funds received for the reimbursement of Direct Service Workers for the years identified were distributed to Direct Service Workers, and there were no excess funds for the periods identified above.

By: _____ Date: _____
Signature

Print Name: _____

Title: _____

Please attach additional supporting documentation.

Please forward to:
KDADS Accounting/Fiscal Services Manager
503 S. Kansas Ave
Topeka, KS 66603-3404