# INELIGIBLE PERSONS POLICY ACKNOWLEDGEMENT AND ATTESTATION

I, ________________________________________, have read and have received a copy of the
(Print Name Clearly)

**INELIGIBLE PERSONS POLICY**; understand its contents, and acknowledge my responsibility to adhere to the County and the department policies and procedures described therein. **Refusal to sign does not exempt your compliance with these regulations.**

**I attest and certify that:**

- I am not presently excluded from participation in federal and state funded health care programs.
- I am not currently, nor have I been, the subject of an investigation by any duly authorized regulatory or enforcement agency.
- I understand that I am required to report any change of eligibility status that impacts participation in state or federal healthcare programs and any notification of investigation/adverse action by any duly authorized regulatory or enforcement agency within 5 working days of notification. Failure to do so may result in withdrawal of job offer for potential candidates or disciplinary action, up to and including termination of employment, if a current employee.

________________________________________ / ________________________________________
Printed Name of Employee/Applicant Employee/Applicant Signature

________________________________________ ____________________ ______________
Job Title Date Employee ID

________________________________________ / ________________________________________
Printed Name of Supervisor Supervisor Signature

☐ Employee/Applicant refused to sign

Routing:
Original: Personnel File
Copy to: Employee
Copy to: Supervisor