NEW JERSEY HUMAN SERVICES

DMHAS
Division of Mental Health and Addiction Services

Bilingual Mental Health Clinician Stipend Program
Provider Agency Attestation

I,_____, authorized representative for _____ ("Qualifying Agency"), and in support of the application of _____ ("Applicant") for the DMHAS Bilingual Mental Health Clinician Stipend Program (Stipend Program), hereby affirm and attest:

1. Applicant provided proof from _____, an accredited undergraduate and/or graduate institution of higher education, of a terminal degree in [**Identify one of the following: psychiatry, nursing, social work, psychology, professional and/or marriage and family counseling**], a Qualifying Discipline of the Stipend Program.
2. Applicant maintains a valid N.J. license as _____ with a terminal degree conferring eligibility under N.J. State law and regulation to deliver direct services, with the requisite supervision, in _____ [**Identify one of the Qualifying Disciplines: psychiatry, nursing, social work, psychology, professional and/or marriage and family counseling**].
3. Applicant provided or displayed substantial evidence of proficiency in _____ [**Identify one or more languages, including but not limited: Arabic, Chinese (Mandarin and/or Cantonese), French, Gujarati, Haitian Creole, Hindi, Italian, Korean, Polish, Portuguese, Russian, Spanish, Tagalog, Urdu, Vietnamese, American Sign Language], a Qualifying Language of the Stipend Program**].
4. Applicant is employed by, or an independent contractor for, Qualifying Agency, a DMHAS-contracted agency that provides direct mental health or co-occurring mental health and substance use disorder treatment services in the community.
5. Applicant committed to provide mental health and/or co-occurring mental health and substance use disorder treatment services in the community, on a full-time basis (that is, a minimum of 28 hours per week), and will use Qualifying Language skills to provide direct care services at Qualifying Agency, in a DMHAS-funded program, for two (2) consecutive years, beginning the date of DMHAS Stipend Program approval or Applicant's employment/contract start date, whichever is later.
6. Qualifying Agency will remit monthly Stipend Program payments only for current, approved training, supervision and/or loan repayments, in accordance with the Stipend Program policy. Qualifying Agency will secure and maintain accurate and timely documentation of current invoices for approved expenses, and evidence of satisfaction/credit for prior Stipend Program payments.
7. Qualifying Agency will notify DMHAS in writing if at any time during Stipend Program participation the Applicant leaves its employ, or seeks to modify any aspect of Application's obligations to provide direct care services or secure licensure.
8. Qualifying Agency will notify DMHAS in writing if at any time Qualifying Agency determines Applicant violates the Stipend Program, or if Qualifying Agency becomes aware of any information that violates Stipend Program policy.
9. Qualifying Agency will refund to DMHAS any payments made to Applicant or for the benefit of Applicant if Qualifying Agency or Applicant violates the terms of, or is otherwise terminated from, the Stipend Program.

I affirm and attest that the foregoing statements made by me are true. I understand that if any of the statements made by me are false, or if Qualifying Agency fails to comply with any of the above, Qualifying Agency is subject to all DMHAS rights of remedy and enforcement, including but not limited to recoupment of funds.

_____ Date

_____ Authorized Representative