



**Commonwealth of Massachusetts**  
**Executive Office of Health and Human Services**  
MassHealth  
Casemix Unit  
100 Hancock Street, 6th Floor  
**Quincy, MA 02171**

### **Electronic Management Minutes Questionnaire (MMQ) Certification Statement**

The undersigned certifies that the statements below are applicable to each electronic submission of MMQ data and that the information contained in each submission is true, accurate, and complete. The provider understands that any falsification or concealment of a material fact may be prosecuted under federal and state laws.

The nursing facility agrees to the following.

- ◆ Follow the Instructions for Completing Initial and Semiannual Management Minutes Questionnaire (MMQs) (Appendix E in the *Nursing Facility Manual*).
- ◆ Ensure that the submitted MMQ data is completed under the direct supervision of a registered nurse who can attest to its accuracy.
- ◆ Keep any records necessary to disclose fully the extent of services the provider furnishes to members. Such records must be maintained in accordance with and for the duration specified in MassHealth's Administrative and Billing Regulations at 130 CMR 450.000.
- ◆ On request, furnish to MassHealth, the Secretary of the United States Department of Health and Human Services, or the Attorney General's Medicaid Fraud Control Unit any information maintained under the previous paragraph.
- ◆ Comply with any laws, rules, and regulations governing MassHealth.

\_\_\_\_\_  
Provider Name  
(d/b/a name)

\_\_\_\_\_  
MassHealth Provider Number (PID/SL)

\_\_\_\_\_  
Name of Administrator

\_\_\_\_\_  
Signature of Administrator

\_\_\_\_\_  
Date

\_\_\_\_\_  
E-Mail Address of MMQ Contact

This form will be placed on file and will be effective for the term of the nursing facility's contract with MassHealth.