



Retention Bonus Claim Attachment Form for Continuous Skilled Nursing

For CSN and Home Health Agency Use

The Retention Bonus Claim Attachment Form for Continuous Skilled Nursing must be completed and submitted for each agency-employed nurse who qualifies for a continuous skilled nursing (CSN) retention bonus. Information provided on this form applies only to the agency nurse and dates of service indicated on this form.

MassHealth does not reimburse for CSN retention bonuses if this form is not attached to the claim. Claims paid without this form completed in its entirety, or claims paid for a higher reimbursement amount than the form shows, will be subject to recoupment in accordance with 130 CMR 450.235: *Overpayments*.

Agency Information (must be specific to the agency nurse employer)

Agency Name: _____

Agency MassHealth Provider ID and Service Location: _____

Agency Staff Person Completing This Form: _____

Agency Nurse Information

Agency Nurse Name: _____

Agency Nurse License Number: _____

Agency Nurse Employment Start Date: _____

Qualifying Dates of Service for Retention Bonus

Year: _____

Service Quarter: ☐ April–June ☐ July–September ☐ October–December ☐ January–March

Date of Service (may include date ranges)	MassHealth Member ID	Number of CSN Hours Provided
Ex. 04-01-2023 through 04-10-2023	Ex. 0123456789	Ex. 30

Attestation

By signing below, I attest to the following under the pains and penalties of perjury:

1. The information provided on this form is accurate.
2. The full amount of the retention bonus, as specified in CSN Agency Bulletin 11 and Home Health Agency Bulletin 82, will be paid to the qualifying agency nurse.
3. The agency will only accept payment from MassHealth for the appropriate retention bonus amount, as specified in CSN Agency Bulletin 11 and Home Health Agency Bulletin 82.

Agency Nurse Supervisor Name: _____

Agency Nurse Supervisor Signature: _____ Date: _____