LOUISIANA DEPARTMENT OF HEALTH
Office for Citizens with Developmental Disabilities

# OCDD HAZARD PAY RETURN FORM

| Participant's Name: (List only 1 participant per form.) | Number of Days Previously Approved | Dates Approved | Dates Used | Names of Direct Service Workers Who Used the Days | Number of Days Being Returned |
|---|---|---|---|---|---|
| | | | | | |

**If all 40 days have been billed you complete this form. If there are days left please fill out the OCDD Request for Hazard Pay—HCBS Providers (OCDD-PF-20-019).**

I understand that only COVID-19 positive tests reported to the SCA will be considered for this hazard pay process.

I understand that the following individuals who became DSWs under the **COVID-19 exceptions** are **NOT eligible** for hazard pay:

*Legal guardians, including parents of minor children; *Household members that became DSWs under the exception process

I have verified that the DSW(s) listed above are eligible or ineligible for hazard pay based on the OCDD Hazard Pay policy/criteria and marked the appropriate box in the table above**.**

_____ _____
Provider Representative's Signature Date

_____
Provider Representative's Name and Title (Printed)

_____ _____
SCA Representative's Signature Date

_____
SCA Representative's Name and Title (Printed)

**To Be Completed By SCA Only**

| LaSRS Positive COVID-19 Test Date | # of Days Released | SC Supervisor Completing Data Entry |
|---|---|---|
| | | |

**SCA - Forward copy of completed form to Statistical Resources, Inc. (SRI) and the LGE**