Bilingual Bonus for Certified Proficient Direct Service Staff Capacity Building Project
Provider Agency Participation Attestation and Agreement

Treatment Provider Agency Name: _____

By signing below, the Treatment Provider Agency (hereafter Provider) acknowledges and agrees that the Bilingual Bonus Program for Certified Proficient Direct Service Staff Capacity Building Project is intended to strengthen the capacity to deliver language access services through qualified bilingual staff and interpretation services.

The following conditions of participation in the FY 2026–2027 for Certified Proficient Direct Service Staff Capacity Building Project are:

1. The Provider agrees to make every reasonable effort to sustain and expand language access capacity through available organizational resources, staffing, and operational practices.
2. The Provider agrees to maintain compliance with all applicable language access requirements, program guidelines, and reporting requirements.
3. The Provider agrees to make good-faith efforts to recruit, retain, and support qualified bilingual staff and/or interpreters.
4. The Provider agrees to evaluate and pursue strategies that sustain their provision of non-English language services beyond the incentive period.
5. The Provider shall participate in activities required by SAPC. These activities support program evaluation, quality improvement, and the enhancement of language access services. Such activities may include, but are not limited to, participation in meetings and trainings, as well as responding to surveys, questionnaires, and other designated feedback requests.
6. The Provider acknowledges and certifies that the invoiced amount represents the total eligible reimbursement incurred by the agency for providing additional compensation to eligible bilingual staff.
7. The Provider agrees that any service or funds not in compliance with this information notice may result in contract actions, including corrective action plans and recoupment of funds.

By signing below, I certify that I am authorized to represent the Provider and confirm understanding and agreement with the participation requirements of the FY 2026-2027 Certified Proficient Direct Service Staff Capacity Building Project.

Authorized Agency Representative (Print Name): _____

Title: _____

Signature: _____

Date: _____