LOUISIANA
Custom-Fit Opportunity

Quality Jobs Program

ACR-HEALTH CARE CERTIFICATION

CONTRACT NUMBER ____________

COMPANY'S NAME ____________ **REPORTING PERIOD** ____________
mm/dd/yy - mm/dd/yy

Check the appropriate box

☐ For fully insured companies, provide the monthly breakdown of the rates and provide documentary evidence of those rates (such as the renewal notification from the health insurance carrier)

☐ If you are a self insured company, list the actuarially determined COBRA rates or the monthly conventional equivalent rate and provide documentary evidence of those rates. Is the 2% administrative charge included in these rates? ☐ **YES** ☐ **NO**
(The COBRA rates or monthly conventional equivalent rate can be found in the COBRA renewal, a letter from the actuary, or a third-party administrator (TPA) renewal.)

* You must attach the explanation/summary of the Basic Health Benefit Plan or Health Insurance Coverage for this reporting period.

Basic Health Benefits Plan or the Health Insurance Coverage – that which is required to be offered and/or provided shall include coverage for basic hospital care, coverage for physician care, and coverage for health care which shall be the same as that provided to executive, administrative, or professional employees. Coverage must become effective no later than the first day of the month 90 days after hire date.

Provide one completed form per plan and submit in conjunction with the Annual Certification Report for the same reporting period.

Name of Basic Health Benefits Plan or the Health Insurance Coverage: ____________

Was this plan offered to all individuals employed in new direct jobs? ☐ **YES** ☐ **NO**

Does coverage become effective no later than the 1st day of the month 90 days after employee hire date? ☐ **YES** ☐ **NO**

If no, when? ____________

Was the value of the health care plan used in meeting the minimum wage requirement for either the 5% or 6% classification? ☐ **YES** ☐ **NO**

If yes, provide the total number of employees holding a new direct job during this filing period? ____________

And provide the number of employees holding a new direct job that have elected the coverage for this filing period? ____________

Monthly Premiums (Rates)	**Employee Monthly Premium**	**Employer Monthly Premium**	**Total Monthly Premium**
Employee Only			
Employee & Spouse			
Employee & Children			
Employee & Family			

For Act 387 Contracts:
$/per hour amount of the Premium Paid by the Employer for employee coverage only $ ____________

For Pre-Act 387 Contracts:
Insurance Premium Paid by Employer for Single coverage for employees earning < $50,000 annually % ____________
Insurance Premium Paid by Employer for Single coverage for employees earning ≥ $50,000 annually % ____________
Insurance Premium Paid by Employer for Family coverage % ____________

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CERTIFICATION

(Must have legal authority to sign this document)

I hereby certify that the Quality Jobs project identified in this document with the above referenced number and additional materials meet all of the requirements of R.S. 51:2451, et seq. and applicable regulations. I hereby certify that the information provided in this document and additional materials is true and correct, and I am aware that my submission of any false information or omission of any pertinent information resulting in the false representation of a material fact may subject me to civil and/or criminal penalties for filing of false public records (R.S. 14:133) and/or forfeiture of any tax credits or rebates approved under this program. I understand that application and information submitted with it shall not be returnable to the applicant.

______________________________	______________________________
Original Signature	Printed Name and Title

____

Date