Attachment B-3

NEW YORK STATE DEPARTMENT OF HEALTH
OFFICE OF HEALTH INSURANCE PROGRAMS
DIVISION OF HEALTH CARE FINANCING
BUREAU OF LONG TERM CARE REIMBURSEMENT

LONG TERM HOME HEALTH CARE PROGRAM
Annual Certification of Compliance with Home Care Worker Wage Parity

I hereby certify that all Medicaid services provided by _____ (LTHHCP Name) for the period March 1, 2012 and subsequent are in full compliance with the terms of subdivision c of section 3614 of the Public Health Law, Home Care Worker Wage Parity and any regulations promulgated pursuant to this provision of Law. I further certify that I will maintain all records necessary to verify compliance with the terms of this section (including required licensed home care service agency attestations and information) for a period of no less than ten years from the end of the applicable calendar year; and that such records will be subject to audit by the Department and/or its agents for possible retroactive recoupment of Medicaid payments for services that are determined to be in less than full compliance.

Name of LTHHCP_____

Operating Cert. No._____

Does organization currently have a collective bargaining agreement (CBA) that covers home care aides?
Please indicate Yes or No _____ If yes, attach the names of the entities the CBAs are with.

Signature _____

Name (Please Print) _____

Title (Please Print) _____

Please note that only the following individuals may sign the attestation form:

Proprietary Sponsorship – Operator/ Owner

Voluntary Sponsorship – Officer (President, Vice President Secretary or Treasurer), Chief Executive Officer, Chief Financial Officer or Chairperson of the Governing Board

Public Sponsorship – Public Official Responsible for the Operation of the Facility