

Attachment B-1

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

**MANAGED CARE ORGANIZATION
Annual Certification of Compliance with Home Care Worker
Wage Parity**

I hereby certify that all Medicaid services provided or arranged for by _____
(MCO Name) for the period March 1, 2012 and subsequent are in full compliance with the Home
Care Worker Wage Parity terms of section 3614-c of the Public Health Law 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 certified home
health agency and 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 MCO _____

National Provider Identifier _____

Does organization currently contract with providers who have a collective bargaining agreement
(CBA) that covers home care aides?

Please indicate Yes or No _____ If yes, the MCO must collect information on 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 /Chief Executive Officer

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 MCO