Attachment A-3

NEW YORK STATE DEPARTMENT OF HEALTH
OFFICE OF HEALTH INSURANCE PROGRAMS

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, 2016 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 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._____

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

Please note that the Department reserves the right to request additional information in the future to ensure compliance with terms of section 3614-c of the Public Health Law.