ATTESTATION:

I have the authority to make this attestation legally binding on _____(Name of Agency/Facility) and attest that this survey was completed using facility specific 2021 data to the best of my knowledge and ability and is true and complete. I will provide any supporting documentation requested by the NYS Department of Health, the NYS Department of Labor, the NYS Office of the Medicaid Inspector General, and/or any other enforcement, audit, or oversight agency and/or body. This document is to be submitted to ALP-Rates@health.ny.gov no later than COB October 14, 2022.

Agency/Facility Name:

Provider ID/Corp ID/Op-Cert Number:

Name of CEO or CFO (Please Print):

CEO/CFO Signature:

Date: