Census Date ______________

NEW YORK STATE - DEPARTMENT OF HEALTH
Division of Health Care Financing

MINIMUM DATA SET (MDS) CENSUS ROSTER SUBMISSION OPERATOR'S CERTIFICATION

Facility ____

Operating Certificate Number ____________________________

The following statement must be read and a certification of such be signed by the operator or administrator for the appropriate ownership category. Please enter only one signature. Care should be exercised so that the signature and title of the responsible individual appear under the correct sponsorship (ownership) category.

CERTIFICATION STATEMENT

Misrepresentation or falsification of any information contained on this form may be punishable by fine and/or imprisonment under New York State law and Federal law.

CERTIFICATION OF OPERATOR

I certify that the MDS Census Roster data transmitted under **DCN** ____________________ is correct and accurate and includes all residents in the facility as of the midnight census date of ___________________ **[date].**

I also certify that I have read the above statement and that the information furnished is true and correct to the best of my knowledge.

____________________ Proprietary: ____
Date

Signature of Operator
or Principal Partner or
Principal Officer of Corporation*

____
Title

Voluntary: ____
Signature of Administrator

____
Title

Governmental: ____
Signature of Commissioner or
Administrative Officer

____
Title

*An administrator who is not an operator is NOT acceptable

(02/2009)

Please mail completed Certification form to:

Resident Assessment Unit
Room 943
Corning Tower, Empire State Plaza
Albany, NY 12237