



# STATE OF NEW YORK DEPARTMENT OF HEALTH

Corning Tower The Governor Nelson A. Rockefeller Empire State Plaza Albany, New York 12237

Richard F. Daines, M.D.  
Commissioner

Wendy E. Saunders  
Chief of Staff

January 12, 2009

Mr. Carl Young, President  
New York Association of Homes  
and Services for the Aging  
150 State Street, Suite 301  
Albany, NY 12207

Dear Mr. Young:

**Re: New York State Health Facility Cash Receipts Assessment Program Mandatory Electronic Filing of Monthly Reports**

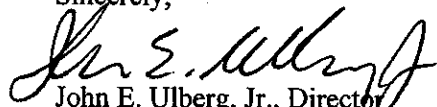
We are sending you this letter to inform you of the Department's intent to have all Residential Health Care Facilities (RHCFs) submit their Health Facility Cash Receipts Assessment reports electronically for reporting periods beginning April 1, 2009, and subsequent.

The Department is providing this advance notice to your association in order to inform your membership of the imminent electronic filing requirement. Presently, this software application is being used by 34% of all nursing homes. By having the remaining facilities report electronically, the mathematical errors that often result in unintended interest and penalty billings will be eliminated and facilities will know immediately that their reports were submitted in a timely manner.

To facilitate this process, a website is available at [www.hcrapools.org](http://www.hcrapools.org). To file electronically, RHCFs must first establish an electronic filing account with the Office of Pool Administration (OPA) and be assigned a secure User ID and password. The RHCFs cannot access the web application to electronically file and/or electronically sign the reports until they have both the User ID and Password. If RHCFs have not yet established an account by completing the enclosed Form 4412 and returning it to OPA, it is highly recommended that they establish their account well in advance of the mandatory electronic filing effective date. They do not have to wait until the effective date to begin filing electronically. It should be noted that hard copy reports will no longer be accepted for the report period beginning April 1, 2009.

If the facilities wish to learn more about electronic filing, they can call the electronic filing help desk at OPA at (315) 671-3800 or contact OPA through e-mail at [webpools@hcrapools.org](mailto:webpools@hcrapools.org). If you should have any other questions, please contact Mr. Roland Guilz at DOH at (518) 474-1673.

Sincerely,

  
John E. Ulberg, Jr., Director  
Division of Health Care Financing

Enclosure

cc: Dan Heim  
Darius Kirstein

## INSTRUCTIONS

### ELECTRONIC FILING USER ID AND PASSWORD APPLICATION

All providers licensed under Article 28 are required to pay an assessment on cash operating receipts. The monthly assessment payments are due to the Pool Administrator within 15 days following the end of each calendar month to which the assessment applies. A website has been established at [www.hcrapools.org](http://www.hcrapools.org) to facilitate this process.

While electronic filing is designed to be user friendly, a help desk has been established to aid those users requiring assistance. If you need general assistance or assistance in obtaining copies of the electronic filing screens and the electronic reporting certification forms, please contact the help desk at (315) 671-3800 or via e-mail at [webpools@hcrapools.org](mailto:webpools@hcrapools.org).

Upon receipt of this form, the Office of Pool Administration will assign a secure electronic filing user ID and password to you, which you will receive via return mail. This user ID and password will be used by you to access the web-based payment process and electronically sign the certification that accompanies the monthly report.

**New Request/Revision to Existing Account:** Check the appropriate box. An entity requesting an initial account/password should check the *New Request* box; an entity that has an existing account and is advising the Department of a change to that account should check the *Revision to Existing Account* box.

**Provider Name:** Enter name of entity that will be submitting the reports electronically.

**Federal Tax ID #:** Enter federal employer tax identification number assigned to the entity named above.

**Operating Certificate #:** Enter Operating Certificate number assigned by the Department of Health to the entity named above.

**MMIS #:** Enter the MMIS # assigned by the Office of Medicaid Management to the entity named above.

**Type of Facility:** Enter a check mark in the appropriate box, hospital or nursing home.

**Signature:** Must be signed by the Administrator or Controller or duly authorized individual of the entity named above.

**Name/Title/Phone Number (Please Print):** Enter name, title and phone number of the person signing above.

**Address/City/State/Zip Code:** Enter address of the person signing above.

**E-mail Address:** Enter e-mail address of the person signing above.

**Date:** Enter date this form is signed.

**ELECTRONIC FILING USER ID AND PASSWORD APPLICATION**

**New Request**

**Revision to Existing Account**

**Provider Name:** \_\_\_\_\_

**Federal Employer Identification # (FEIN):** \_\_\_\_\_

**Operating Certificate #:** \_\_\_\_\_

**MMIS #:** \_\_\_\_\_

**Type of Facility (check appropriate box):**

**Nursing Home**

**Hospital**

By signature below, the Chief Financial Officer or other duly authorized individual of the above named entity authorizes the Office of Pool Administration to assign a secure electronic filing user ID and password. This information will be mailed directly to the attention of the signer and must remain secured. It is the responsibility of the above named entity to ensure that this information is released only to those individuals requiring knowledge thereof.

**Signature** \_\_\_\_\_

**Name (Please Print)** \_\_\_\_\_

**Title** \_\_\_\_\_

**Phone Number** \_\_\_\_\_

**Address** \_\_\_\_\_

**City** \_\_\_\_\_ **State** \_\_\_\_\_ **Zip Code** \_\_\_\_\_

**E-mail Address** \_\_\_\_\_

**Date** \_\_\_\_\_

**Note:** All fields on this form are required to be accurately completed in order for your request to be processed.

**Please mail completed form to:**  
Mr. Jerome Alaimo, Pool Administrator  
Office of Pool Administration  
Excellus BlueCross BlueShield, Central New York Region  
PO Box 4757  
Syracuse, New York 13221-4757