ATTESTATION:

I hereby attest that this survey was completed 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 January 6, 2021.

Agency/Facility Name:

Provider ID/Corp ID/Op-Cert Number:

Name of CEO or CFO (Please Print):

CEO/CFO Signature:

Date: