**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 December 23, 2022.**

**Agency/Facility Name:**

**Provider ID/Corp ID/Op-Cert Number:**

**Name of CEO or CFO (Please Print):**

**CEO/CFO Signature:**

**Date:**