

Attachment B-2

**NEW YORK STATE DEPARTMENT OF HEALTH
OFFICE OF HEALTH INSURANCE PROGRAMS
DIVISION OF HEALTH CARE FINANCING
BUREAU OF LONG TERM CARE REIMBURSEMENT**

**CERTIFIED HOME HEALTH AGENCY
Certification of Compliance with Home Care Worker Wage Parity**

I hereby certify that all Medicaid services provided by _____
(CHHA Name) for the period March 1, 2012 and subsequent are in full compliance with the Home Care Worker Wage Parity terms of section 3614-c of the Public Health Law and any regulations promulgated pursuant to this provision of Law. I further certify that I will maintain all records necessary to verify compliance with the terms of this section (including required licensed home care service agency attestations and information) for a period of no less than ten years from the end of the applicable calendar year; and that such records will be subject to audit by the Department and/or its agents for possible retroactive recoupment of Medicaid payments for services that are determined to be in less than full compliance.

Name of CHHA _____

Operating Cert No _____

Signature _____

Does organization currently have a collective bargaining agreement (CBA) that covers home care aides?

Please indicate Yes or No _____ If yes, attach the names of the entities the CBAs are with.

Name (Please Print) _____

Title (Please Print) _____

Please note that only the following individuals may sign the attestation form:

Proprietary Sponsorship – Operator/ Owner

Voluntary Sponsorship – Officer (President, Vice President Secretary or Treasurer), Chief Executive officer, Chief Financial Officer or Chairperson

Public Sponsorship – Public Official Responsible for the Operation of the Facility