

Home Care Rate Appeal Form

NYS Department of Health – Office of Health Insurance Programs – Division of Finance and Rate Setting

In accordance with Section 505.14(h)(7)(iii)(c) of NYCRR 18, providers have **90 Days** from the date of the rate notification Dear Administrator Letter (DAL), to submit a request for a Rate Appeal and revision of the posted rates. Please e-mail the filled out and signed Form to: CHHA-rates@health.ny.gov – for Certified Home Health Agencies (CHHA), or PersonalCare-Rates@health.ny.gov – for Personal Care / Consumer Directed Personal Assistance Program Agencies.

Agency Contact Information (must be an Agency CEO or CFO):

1. Agency Name:		2. Medicaid MMIS ID #	3. Federal Tax ID:	
4a. Street Address:		4b. City:	4c. State:	4d. ZIP Code:
5a. Contact Name:	5b. Contact Title:	6. Telephone #	7. Email Address:	

Appeal Details:

Reason for Appeal In accordance with per Section 505.14(h)(7)(iii)(c) of NYCRR 18, Department will only consider the appeal requests that adhere to the below criteria:	Rate Setting Schedules (3, 4, 5 and 7) That Apply and Require Adjustments According to Section 505.14(h)(7)(iii)(c)	Documentation Required for DOH Review
Mathematical, statistical, fiscal, or clerical errors exist, including data submission errors in cost reports.		Adjusted cost report submission via the web-based Tool and required supporting documentation submitted via the SFTP site
New or unanticipated costs associated with programs or services mandated or approved by the Commissioner.		
New or unanticipated costs associated with programs or services mandated or approved by the Commissioner.		

Description of Basis for Rate Appeal and Adjustments Requested: (attach additional pages if necessary)

Supporting Documentation Included:

Agency Certifier's (CFO or CEO) Signature: _____ Date: _____

Certifier's Name and Title: _____