New York State Department of Health
Office of Health Insurance Programs
Nursing Facility Open Appeals Attestation

Facility_____
Operating Certificate Number_____
MMIS# _____

Certification Statement

Misrepresentation or falsification of any information contained on this form may be punishable by fine and/or imprisonment under New York State Law and Federal Law.

Certification of Operator

I hereby attest that the information provided on the attached Nursing Facility Open Appeals Impact Workbook was completed, to the best of my knowledge and ability, in accordance with the New York State statutes, regulations and policies that govern Medicaid reimbursement for nursing facilities. I have the authority to sign the RHCF- 2 or 4 and that I have the authority to bind the above listed facility. I understand that, if the submitted impact is approved for payment, the appeals will be considered fully resolved, subject to OMIG audit. All of the open appeals from the provided listing for this facility under all operating certificate numbers and names have been included. No appeals have been added to the workbook that do not appear on the open appeal listing provided by the Department.

I will provide any supporting documentation as requested by the Department of Health, the Office of the Medicaid Inspector General and any other audit, enforcement or oversight agency and/or body.

I understand that this attestation is in lieu of an appeal rate changes. Further, I understand that any challenge to any approved payment that coincides with the submitted Nursing Facility Open Appeals Impact Workbook, through administrative action or otherwise, will result in forfeiture of the amounts received for the attested appeals resolution.

I understand that this in no way limits the administrative appeal rights of the facility and that an administrative appeal may be pursued in accordance with applicable New York State statutes, regulations and policies, including any rights under 10 NYCRR 86-2.13 & 86-2.14.

I understand that the Department of Health's acceptance of the attached schedule, in no way precludes the Office of the Medicaid Inspector General from conducting audits and/or exercising its oversight capacity in any manner whatsoever, including, but not limited to, actions taken pursuant to 18 NYCRR Parts 517, 518 and 519.

I hereby certify that I have read the foregoing conditions and that I have the legal authority to bind the above listed facility to the terms herein.

Modifications of the terms contained herein shall render this attestation null and void.

_____
DATE

_____
SIGNATORY'S NAME (PRINTED)

_____
SIGNATURE

_____
SIGNATORY'S TITLE