ATTACHMENT #2– OPTION C

Solicitation of Interest #20836

Nurses Across New York Loan Repayment Program – Cycle 3

Nurse Applicant Employed by Certified Home Health Agency, Licensed Home Care Services Agency, or Hospice Attestation

THIS ATTESTATION ("Attestation"), is entered into and made a part of the Solicitation of Interest for the Nurses Across New York Loan Repayment Program – Cycle 3 Application dated as of _____, 20___ ("Application"), between

_____ ("Facility"), and

_____ ("Nurse").

THIS ATTESTATION is being signed under penalty of perjury and shall be subject to confirmation by the New York State Department of Health (the Department) surveillance of agency records.

NOW, THEREFORE, in consideration of the foregoing, the Facility and the Nurse agree that:

The nurse will be employed by a Certified Home Health Agency licensed by the New York State Department of Health pursuant to Public Health Law Article 36, a licensed Home Care Services Agency licensed by the New York State Department of Health pursuant to Public Health Law Article 36., or Hospice licensed by the New York State Department of Health pursuant to Public Health Law Article 40, and spending a minimum of 144 hours of service per month for 12 months of the year providing direct clinical patient care to patients belonging to a medically underserved population.

This population is defined as:

"Low-income people; racial and ethnic minorities; immigrants; women; lesbian, gay, bisexual, transgender, or other-than-cisgender people; people with disabilities; older adults; persons living with a prevalent infectious disease or condition; persons living in rural areas; people who are eligible for or receive public health benefits; people who do not have third-party health coverage or have inadequate third-party health coverage; and other people who are unable to obtain health care."

IN WITNESS WHEREOF, this Attestation has been entered into by the Nurse and on behalf of the Facility as of this ____ day of _____, 20____.

NURSE NAME: _____

Signature of Nurse: _____

FACILITY NAME: _____

Signature Of Authorized Representative: _____

Name (Print): _____

Title: _____