

Attachment A-1

**NEW YORK STATE DEPARTMENT OF HEALTH
OFFICE OF HEALTH INSURANCE PROGRAMS**

**MANAGED CARE ORGANIZATION
Annual Certification of Compliance with Home Care Worker
Wage Parity**

I hereby certify that all Medicaid services provided or arranged for by _____
(MCO Name) for the period March 1, 2020 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 certified home
health agency and 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 MCO _____

National Provider Identifier _____

Signature _____

Name (Please Print) _____

Title (Please Print) _____

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

Proprietary Sponsorship – Operator/ Owner /Chief Executive Officer

Voluntary Sponsorship – Officer (President, Vice President, Secretary or Treasurer), Chief Executive
Officer, Chief Financial Officer or Chairperson of the Governing Board

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

Please note that the Department reserves the right to request additional information in the future to
ensure compliance with terms of section 3614-c of the Public Health Law.