Attachment 3

NEW YORK STATE DEPARTMENT OF HEALTH
OFFICE OF HEALTH INSURANCE PROGRAMS

LONG TERM HOME HEALTH CARE PROGRAM
Attestation of Compliance with Fair Labor Standards Act (FLSA) Funding

I hereby certify that funding for all Medicaid home care services provided by _____ (LTHHCP Name) in accordance with the Department's April 2017 *Dear Colleague Letter on FLSA Implementation*, will be passed through to the home care worker, in its entirety. I further certify that I will maintain all records necessary to verify compliance with this directive (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.

In addition, I will provide the managed care organization, if applicable, and/or the Department (when applicable) with all information to verify my compliance with the terms of this directive (including this attestation) and that such information shall be made available to the Department upon request.

Please check the appropriate box:

- ☐ Fee-For-Service
- ☐ Managed Care

Name of LTHHCP _____

Operating Cert. No._____ Date _____

Signature _____

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 of the Governing Board

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

Please note that the Department reserves the right to request additional information in the future to ensure compliance with terms of the April 2017 *Dear Colleague Letter on FLSA Implementation*.