Application for CDPAS FLSA Pool Participation

GENERAL INSTRUCTIONS

This application form should be used by Consumer Directed Personal Assistance (CDPA) Fiscal Intermediaries (FI) seeking consideration to participate in the CDPAS Fair Labor Standards Act (FLSA) Pool Program. Participation is open to all FI's statewide.

FLSA Reference Material

The following reference materials may be of assistance when completing this application:

- US Department of Labor, Minimum Wage and Overtime Pay for Direct Care Workers: www.dol.gov/whd/homecare

Submission Requirements

Submit one copy of the application to:

BIP@health.ny.gov

Subject line: CDPAS FLSA Application

The application must contain either an electronic signature or the original signature authorizing the application by the FI's Director or other responsible signatory.

Acknowledgement/Completeness Review

The Office of Health Insurance Programs will electronically acknowledge receipt of the application. If the application is determined to be incomplete it will be returned for revision and resubmission. All applications to be considered must be fully completed and submitted by **December 19, 2014**. Applications that do not meet this criteria will not be considered for CDPAS FLSA BIP payments.

As part of the review process, applicants should be aware that additional information may be requested.

Whom to Contact for Assistance

Any questions concerning the application process should be directed to the Office of Health Insurance Programs, New York State Department of Health by e-mail at BIP@health.ny.gov

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I. IDENTIFYING DATA

Instructions

Enter the name and address of the Fiscal Intermediary.

Enter the name of the person who is assigned to provide additional information regarding the application.

The authorizing signature can only be the Director or responsible signatory for the Fiscal Intermediary.

THE INDIVIDUAL DELEGATED AUTHORITY BY THE APPLICANT TO SUBMIT THE APPLICATION MUST SIGN THIS PAGE.

Name of FI: ______________________________

Address: ______________________________
STREET

______________ ______________ ______________
CITY STATE ZIP

Telephone: ______________ FI MMIS ID: ______________

Name of Person to Contact for Additional Information: ______________________________

Address: ______________________________
STREET

______________ ______________ ______________
CITY STATE ZIP

Telephone: ______________ Fax #: ______________ E-mail: ______________

Authorizing Signature

I, the undersigned, hereby certify under penalty of perjury that I am duly authorized to subscribe and submit this application and that the information contained herein and attached hereto, is accurate, true and complete in all material aspects.

Name (print or type): ______________________________ Date: ______________

Signature: ______________________________ Title: ______________

II. PROGRAM PARTICIPATION QUALIFICATIONS

Please be advised that only FI's that have an MMIS Provider ID number assigned will qualify.

The following questions must be answered as part of the application

1. How many CDPA workers are employed through your FI? _______

2. How many of those CDPA workers worked more than 40 hours per week in any week from 4/1/14 to 6/30/14? _______

3. What is the total number of overtime hours worked by those CDPA workers from 4/1/14 to 6/30/14? _______

4. What is the weighted hourly rate paid to those CDPA workers in that quarter? _______

   Please weight based on the number of workers who work overtime. For example, you have 100 workers with overtime hours and 90 of them are in County A and 10 of them are in County B. If the rates are $11.00 in County A and $12.00 in County B, then the weighted average would be $11.10.

5. Please attach your overtime policy or a summary as applicable.