NEW YORK STATE OF OPPORTUNITY. Department of Health

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New York HCBS Assisted Living Programs Workforce Initiative Attestation

As part of New York State's American Rescue Act Home and Community Based Service Spending Plan for Home and Community-Based Services (HCBS) efforts, New York State Department of Health (Department) has chosen to invest in Assisted Living Programs (ALP) Workforce Initiative. Specifically, to strengthen, enhance, and expand workforce.

The State will distribute $40 million to eligible Assisted Living Programs through a one-time supplemental payment as described in the approved New York State American Rescue Act Home and Community Based Service Spending Plan under the Improve and Support the Assisted Living Program (ALP) Workforce initiative. The purpose of this supplemental payment is to support programs impacted by the COVID-19 pandemic. New York State will distribute these funds based on individual members served by each program through a one-time lump sum payment in late 2023 or early 2024. Of the total funds available, 90% will be distributed proportionally by members served by each facility. The remaining 10% will be distributed to facilities serving less than 30 members proportionately by members served at each facility. Funding may not be used to supplant the level of State funds expended for Home and Community-Based Services (HCBS).

Please be aware that all funding is contingent upon approval by the Centers for Medicare and Medicaid Services (CMS) of this investment. The Department remains in the process of seeking approval from CMS through a State Plan Amendment.

In the event that CMS approves this process and funding, eligible providers will be responsible for using their awards towards the Workforce Initiative. **To be eligible for these awards, providers will be responsible for submitting the attestation and spending plan by Friday February 23, 2024. The online survey must be submitted to the State before Friday March 1, 2024.** Providers that do not submit this attestation form, spending plan and survey will not be eligible for funding. Providers that are not open before October 1, 2023 will not be eligible for supplemental payments. Providers must also be open at the time which payments are distributed on or before in spring of 2024. If a site has an intent to close, the site will not be eligible. If a site closes before March of 2025, the funds will be recouped prior to closure being approved.

Providers will also be required to submit quarterly information and site surveys to the State beginning January 2024 to retain their awards and maintain eligibility for future HCBS enhanced FMAP funding opportunities. Additionally, sites that fail to expend funds, or expend funds on non-approved uses, will be ineligible for future awards and/or subject to recoupment of their award.

Section 1: Instructions

1. You must submit your responses by Friday February 23, 2024. A reminder notice will be sent to the email address on file.
2. Failure to submit the attestation by the deadline will result in exclusion from payment.
3. All providers must submit a copy of this attestation to the Department through the method set forth in Section 6 of this document and must maintain a copy of this attestation.
4. Please note that electronic signatures will be the legal equivalent of a handwritten signature. Individuals that have sufficient authority to bind the provider may sign this application. This includes, for example:
   Owner
   Chief Executive Officer
   Chief Operating Officer
   President/Officer
   Chairperson
   Chief Financial Officer
   Governing Board
5. Please make sure that all information is answered completely and matches what is on file with Medicaid and eMedNY.

Section 2: Authorized Signatory

Identify the individual who is authorized to sign this attestation. This individual must be authorized to make legal commitments on behalf of the providers.

Name:

Position:

Email Address:

Phone Number:

Section 3: Site Information

Please provide the following information:

Provider Name:

Provider ID Number(s):

Organization/Individual Email:

EIN Number(s):

State Financial System (SFS) Vendor ID:

Facility ID:

Operating Certificate:

Owner/Officer Name (see instructions, #4):

Section 4: Activities and Budget:

Please select the programs and/or strategies that your program site will develop from the list below. Additional detail on these strategies is available in the Assisted Living Programs document.

Workforce:

☐ Workforce retention strategies

☐ Development, implementation, and promotion of training programs for staff

☐ Recruit and retain a racially and ethnically diverse and culturally competent workforce

Section 5: Spending Narrative

Please describe how you plan to use your award to implement the choices you selected above and how you will assure sustainability of implementation beyond the use of these funds. You should describe your plan for each category selected above, including details such as known expenses, timeline for implementation, etc. Please remember that you must use your awards for investments at the sites and program in which you are qualified for funding. To fulfill this requirement, you must complete the **NYSDOH ALP ADHC Spending Template** and submit to the Department through the method provided as well as maintain a copy along with this attestation.

Section 6: Attestation

I am the named authorized signatory identified above, and I attest that I have read the directions and guidance pertaining to the New York HCBS eFMAP Assisted Living Programs Workforce Initiative, including the instructions for this survey, and understand the requirements for eligibility for funding under this payment program.

I have the requisite authority to complete this attestation in accordance with the directions that I have read. All information provided in response to this survey is true, accurate, and complete and that I have taken reasonable steps to verify the accuracy thereof. I understand that funds under this program are only available for categories of expenses to institute effective infection control measures and provide workforce development funds for recruitment and retention of qualified staff expressly identified and described by the Department herein and in related provider guidance and that I must use my award to develop at least one such program or strategy. I also understand that such funds may not be used to supplant any existing or planned expenses, including any portion of any settlement obligations or other liabilities owed by the provider, or any related person or entity, prior to November 1, 2023.

Further, I understand that payment under this program will be from federal and/or state public funds and that any false claims or non-approved use of such funds are strictly prohibited and **will result in becoming disqualified for any further funds under this program and may result in civil or criminal fines and/or prosecution under applicable federal and state laws.**

In addition, I understand that as a condition of receiving and retaining these funds I agree and attest that the provider shall maintain compliance with all applicable state and federal wage and labor laws, and shall not engage in any unlawful conduct with respect to the employment of its employees, including any practices that are impermissible under any federal or state law. Furthermore, I understand that no payments made under this program shall be used for any capital investment.

I agree, and it is my intent, to electronically sign this document by typing in my signature, or providing a handwritten signature below. By submitting this e-document to the New York State Department of Health in this way, I understand that my e-signing and submitting is the legal equivalent of having placed my handwritten signature and affirmation on the submitted document, and am affirming to the truth of the information contained therein.

Under penalty of perjury, I hereby certify that the information provided on this form is true and accurate.

Authorized signatory signature: