Attachment A-4

NEW YORK STATE DEPARTMENT OF HEALTH
OFFICE OF HEALTH INSURANCE PROGRAMS

LICENSED HOME CARE AGENCY
Quarterly Certification of Compliance with Home Care Worker Wage Parity

I hereby certify that services provided by my organization 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.

In addition, I will provide the CHHA/LTHHCP/MCO, on a quarterly basis, all information to verify my compliance with the terms of this section (including this certification), that I will maintain all such information for a period of no less than ten years from the end of the applicable calendar year and that such information shall be made available to the Department upon request.

Name of LHCSA _____

License No. (if applicable)_____

Signature _____

Name (Please Print) _____

Title (Please Print) _____

Please note that in accordance with Parts 86-1.2 of Title 10 of the Commissioner's Administrative Rules and Regulation, only the following individuals may sign the certification form:

Proprietary Sponsorship – Operator/ Owner

Voluntary Sponsorship – Officer (President, Vice President, Secretary or Treasurer), Chief Executive Officer, Chief Financial Officer or any Member of the Board of Directors

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 section 3614-c of the Public Health Law.