New York State Health Care and Mental Hygiene Worker Bonus (HWB)

Employee Attestation

Employer Information (to be completed by the Employer)

Employer Name: _____

Employer MMIS (or SFS) number: _____

This attestation applies to the following vesting period:

- ◯ Vesting Period 1: 10/1/21 – 3/31/22
- ◯ Vesting Period 2: 04/1/22 – 9/30/22
- ◯ Vesting Period 3: 10/1/22 – 3/31/23
- ◯ Vesting Period 4: 04/1/23 – 9/30/23
- ◯ Vesting Period 5: 10/1/23 – 3/31/24

Employee Information (to be completed by the Employee)

Employee Name: _____ (print employee name).

Federally issued Social Security number (SSN): _____

or

Individual Taxpayer Identification Number (ITIN): _____

I attest that my gross wages *during* the Vesting Period were less than or equal to $62,500.

- Including wages, salaries or fees from **ALL employers** or from contract work, not just the Employer named above or other qualified employers.
- Do **not** include any bonuses or overtime pay.

I declare, affirm and certify that:

1. the information entered as part of this form is true, accurate and complete, and
2. I understand that payment under this program will be from state and/or federal public funds and that any false information provided may violate applicable state and federal laws and regulations**.**

Employee Name Print: _____

Employee Signature: _____

Date of Signature: _____