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

Employer Attestation

I, (Insert Name) am the (Insert title Owner/Officer) of (insert Provider/Employer) (the "Employer"), and I am responsible for determining eligibility of the NYS Health Care and Mental Hygiene Worker Bonus ("HWB") for the Employer.

I attest that have read the requirements of section 367-w of the Social Services Law and all guidance, including claiming guidance, pertaining to the HWB. See specific eligibility requirements and claiming guidance available through the HWB webpage: www.nysworkerbonus.com.

I attest that the Employer is a qualifying employer eligible to claim and distribute a HWB as defined in section 367-w(2)(b) of the Social Services Law, and that I have the requisite authority to complete this application and attestation.

I acknowledge that the New York State Department of Health (DOH) requires this Attestation from a qualifying employer before distributing HWB funds.

I attest that the Employer has an **Employee** attestation signed and dated by each employee that I am claiming a bonus for in this application for this vesting period.

- The employee attestation at a minimum contains:
  - The employee name;
  - The employee's social security or taxpayer identification number;
  - The employee's attestation as to the amount of the employee's gross waged during the vesting period from ALL employers and contract work;
  - The vesting period applicable to the attestation;
  - A declaration that the employee understands that the document contents are true and accurate and that providing false information may violate State and Federal laws and regulations;
  - The employee's printed name and signature;
  - Date of employee signature.

I attest that all employee(s) identified and submitted as part of the Employer's claim for bonus payments meet the requirements and are eligible for the identified HWB vesting period, including that:

- Each identified employee received no more than $62,500 in gross wages from the Employer during the vesting period, excluding any bonuses or overtime pay.
- Total payments to date made to Employer for each identified employee for the HWB have not met or exceeded three thousand dollars ($3,000) for any identified employee.

I attest that no bonus shall be claimed or paid to an otherwise eligible employee who has been suspended or excluded under the medical assistance program during the vesting period or at the time an employer submits a claim.

I acknowledge and agree that any portion of the funds distributed to the Employer for the HWB shall be subject to recovery from the Employer in the form of an overpayment and may be subject to sanction and penalty if:

- The employee is not entitled to the bonus or is paid an amount in excess of correct bonus amount.
- The Employer claims, receives and fails to pay any part of the bonus to the designated employee within the prescribed timeframe.
- The Employer fails to claim a bonus for which an employee is eligible and has provided an employee attestation to the Employer.

I hereby agree that the Employer shall pay to such qualified employees their bonus amount within thirty-days of receipt.

I acknowledge and agree that the Employer shall not retain any portion of the bonus amount. All bonus amounts received will be paid to the eligible employee or, if necessary, returned to DOH.

In addition, I understand that as a condition of receiving and distributing these funds I agree and attest that the Employer shall maintain contemporaneous records for all claims-related information and any other data or documents used to demonstrate that an employee was eligible to receive such bonus, including but not limited to employee attestations. All records, data and other information will be made available for review upon request.

Further, I understand that payment under this program will be from federal and state public funds and that any false claims, statements or documents, or concealment of a material fact or non-approved use of such funds are strictly prohibited **and may result in administrative, civil or criminal actions, including fines and/or prosecution under applicable federal and state laws.**

I declare, affirm and certify that the information entered as part of this form is true, accurate and complete and that:

1. I am the certifying official whose name and contact information appears above;
2. I have undertaken due diligence and conducted all reasonable inquiry prior to making any of the statements in this certification and have sufficient knowledge to complete this form; and
3. I acknowledge that this certification is being made in order to comply with the requirements stated herein.

I understand that by electronically signing and submitting this attestation it is the legal equivalent of having placed my handwritten signature on the submitted attestation.

Owner/Officer's Name:

Owner/Officer's Title:

Owner/Officer's Email:

Owner/Officer's Phone number:

[Include electronic signature and date fields]