

**HEALTH FACILITY CASH RECEIPTS ASSESSMENT PROGRAM**  
**DOH-4412 INSTRUCTIONS**

Designated Providers licensed under Article 28 or 36 of the Public Health law and Personal Care Service Providers that have a current contract with a local Social Services District for the delivery of personal care services pursuant to Section 367-I of the Social Services Law are required to pay an assessment on cash operating receipts. A website has been established at [www.hcrapools.org](http://www.hcrapools.org) to facilitate this process.

While electronic filing is designed to be user friendly, a help desk has been established to aid those users requiring assistance. If you need general assistance or assistance in obtaining copies of the electronic filing screens and the electronic reporting certification forms, please contact the help desk at (315) 671-3800 or via e-mail at [webpools@hcrapools.org](mailto:webpools@hcrapools.org).

Upon receipt of this form, the Office of Pool Administration will assign a secure electronic filing user ID and password to you, which you will receive via two separate return mailings. This user ID and password will be used by you to access the web-based payment process and electronically sign the certification that accompanies the monthly report.

**New Request/Revision to Existing Account:** Check the appropriate box. An entity requesting an initial account/password should check the *New Request* box; an entity that has an existing account and is advising the Department of a change to that account should check the *Revision to Existing Account* box.

**Provider Name:** Enter the name of the entity that will be submitting the reports electronically.

**Federal Employer Identification Number:** Enter the federal employer tax identification number assigned to the entity named above.

**Operating Certificate Number:** Enter the Operating Certificate number assigned by the Department of Health to the entity named above. If your organization does not have an Operating Certificate number, enter N/A.

**MMIS Number:** Enter the MMIS number assigned by the Office of Medicaid Management to the entity named above.

**Type of Facility:** Enter a check mark in the appropriate box that identifies your facility.

**Signature:** Must be signed by the Administrator or Controller or duly authorized individual of the entity named above.

**Name/Title/Phone Number (Please Print):** Enter the name, title and phone number of the Administrator or Controller or duly authorized individual completing this form.

**Address/City/State/Zip Code:** Enter the full address of the facility.

**E-mail Address:** Enter the e-mail address of the CFO or other duly authorized individual completing this form.

**Date:** Enter the date this form is signed.

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**New Request**

**Revision to Existing Account**

**Provider Name:** \_\_\_\_\_

**Federal Employer Identification Number:** \_\_\_\_\_

**Operating Certificate Number:** \_\_\_\_\_

**MMIS Number:** \_\_\_\_\_

**Type of Facility** (check appropriate box):

- Residential Health Care Facility**
- Long Term Home Health Care Provider**
- General Hospital**

- Certified Home Health Agency**
- Personal Care Service Provider**

By signature below, the Chief Financial Officer or other duly authorized individual of the above named entity authorizes the Office of Pool Administration to assign a secure electronic filing user ID and password. This information will be mailed directly to the attention of the signer and must remain secured. It is the responsibility of the above named entity to ensure that this information is released only to those individuals requiring knowledge thereof.

**Signature:** \_\_\_\_\_

**Name (Please Print):** \_\_\_\_\_

**Title:** \_\_\_\_\_

**Phone Number:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip Code:** \_\_\_\_\_

**E-mail Address:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**Note:** All fields on this form are required to be accurately completed in order for your request to be processed. If a field does not apply, write N/A.

**Please mail completed form to:**  
Mr. Jerome Alaimo, Health Fund Administrator  
Office of Pool Administration  
Excellus BlueCross BlueShield, Central New York Region  
PO Box 4757  
Syracuse, New York 13221-4757