

**MONTHLY CASH RECEIPTS ASSESSMENT REPORT CERTIFICATION**

CONFIRMATION NUMBER: \_\_\_\_\_

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

Report for the Month and Year Ended: \_\_\_\_\_

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

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

Completed by: \_\_\_\_\_

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

Telephone Number: \_\_\_\_\_

Payment Type: \_\_\_\_\_

Provider Type: \_\_\_\_\_

Enter below the name of the person who is certifying to the accuracy and correctness of the electronic report submitted under the confirmation number entered above. Persons authorized to sign this certification would be any person who is empowered to legally bind the above named facility to such commitments.

**CERTIFICATION**

(Please Print)

I, \_\_\_\_\_ am certifying to the truth and accuracy of the specified entity's report electronically, and recognize that this action is legally binding and that this information will be stored electronically as proof of my acceptance of the terms of this agreement. I certify that the data being provided has been carefully prepared based on the books and records of the specified entity, in accordance with the instructions given for the completion and filing of this report. I further certify, that to the best of my knowledge, I believe and certify that the information presented herein is accurate and correct. I certify that I am duly authorized to submit and sign the report being filed with the New York State Department of Health on behalf of the specified entity. I acknowledge and agree that each Cash Receipts Assessment Program Monthly Report submitted electronically shall be considered the final official copy. I acknowledge that I am completing the process of submitting this report electronically. While there is no need for additional signatures on this report, I acknowledge that any payment due must be received by the Office of Pool Administration in the form of a check or an electronic funds transfer before the filing will be considered complete.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Print Name: \_\_\_\_\_ Telephone Number: \_\_\_\_\_

**MAIL THIS CERTIFICATION FORM TO:**

**Regular Mail**  
Mr. Jerome Alaimo  
Assessment Fund Administrator  
Office of Pool Administration  
PO Box 4757  
Syracuse, New York 13221-4757

**Express or Overnight Mail**  
Mr. Jerome Alaimo  
Assessment Fund Administrator  
Office of Pool Administration  
333 Butternut Drive  
Syracuse, New York 13214-1803