Adirondack Health Institute

Lead Empower Innovate

WHOEVER KNOWINGLY AND WILLFULLY MAKES OR CAUSES TO BE MADE A FALSE STATEMENT OR REPRESENTATION ON THIS STATEMENT MAY BE PROSECUTED UNDER APPLICABLE FEDERAL OR STATE LAWS. IN ADDITION, KNOWINGLY AND WILLFULLY FAILING TO FULLY AND ACCURATELY DISCLOSE INFORMATION REQUESTED MAY RESULT IN DENIAL OF A REQUEST TO PARTICIPATE OR WHERE THE ENTITY ALREADY PARTICIPATES, A TERMINATION OF ITS AGREEMENT OR CONTRACT WITH AHI/AHI PPS, AS APPROPRIATE.

My signature below attests to AHI/AHI PPS that our corporation/organization ☐ *has* ☐ *does not have* a required Compliance Training Program and ☐ *is* ☐ *is not* required to have a Compliance Training Program to meet the obligations of Medicaid care, services, or supplies. I further attest that _____% of all Board Members, Sr. Management, and any workforce members involved in delivery of Medicaid care, services, or supplies, including but not limited to governing body, workforce of all levels, contractors, consultants, volunteers, and vendors have completed all organization-wide required annual Compliance Trainings. In addition to any organizational Compliance Trainings we require, **all** Board Members, Sr. Management, and any other affected individual involved in any aspect of the delivery of DSRIP care, services, or supplies, have also completed the AHI PPS Annual Compliance Training as per the materials provided by AHI's Compliance Department.

I further attest that I have distributed the PPS Corporate Compliance Plan, Code of Conduct/Conflict of Interest, Complaint Reporting and Customer Service Request Policy, Compliance Reporting Policy, WISP, and the other policies provided to me by AHI to all of my workforce members who will be working on my DSRIP project(s) and have obtained written confirmation from each workforce member that he/she has read and understands these policies and agrees to abide by them. I understand that written confirmation of receipt of these named policies must be retained for a period of six (6) years and is subject to audit by AHI or by NYS OMIG, among other enforcement agencies. I further acknowledge that these policies are subject to amendment, and policy additions or deletions may occur at any time based on operations or legal requirements and I will be notified at that time either through Policy Tech or by the link (http://www.ahihealth.org/ahipps/ahi-pps-policies-procedures/). I have further posted, or otherwise distributed, the number for the AHI PPS Compliance Reporting Hotline in a place accessible to my workforce members working on my DSRIP project(s).

Req. DSRIP Compliance Training Module Completed (mark one):
☐ *General & DSRIP Compliance* ☐ *DSRIP Compliance only*

Dated: _____, 2018

_____, NY

_____
Signature of Individual Responsible for Compliance function

_____
Print Name

_____
Title of Individual Responsible for Compliance Officer

_____
Organization

AHI Office Use Only -- Date Received by AHI: _____ ☐ A ☐ J 2018