New York State Office of the
Medicaid Inspector General

CERTIFICATION STATEMENT FOR THE SELF-DISCLOSURE STATEMENT FORM

By signing and submitting this self-disclosure application, I (or the provider) hereby affirm that:

- I (or the provider) agree to comply with all of the requirements of the Self-Disclosure Program as set forth in 18 NYCRR SubPart 521-3.
- I (or the provider) am not currently aware of being under audit, investigation or review by OMIG, unless the overpayment and the related conduct being disclosed does not relate to OMIG's audit, investigation or review.
- I (or the provider) am disclosing an overpayment and related conduct that OMIG has not determined, calculated, researched or identified at the time of this disclosure.
- I (or the provider) am not currently aware of being a party to any criminal investigation conducted by the Deputy Attorney General for the Medicaid Fraud Control (MFCU) or any other agency of the United States Government or any political subdivision thereof.
- I (or the provider) agree to repay the overpayment in full within 15 days of being notified by OMIG of the amount due, unless requested and granted an installment payment agreement.
- I (or the provider) agree to execute and return to OMIG a Self-Disclosure and Compliance Agreement where required to do so.
- I (or the provider) acknowledge that failure to cooperate with OMIG during the Self-Disclosure process may result in penalties, fines or my participation resulting from this submission being terminated in the Self-Disclosure Program and that any amount owed shall become immediately due and payable (but not sooner than 60-days from the date I identified the overpayment), including interest thereon.

_____	_____
Signature	*Date*
_____	_____
Print Name	*Title*