New York State Office of the
Medicaid Inspector General

CERTIFICATION STATEMENT FOR THE HWB SELF-DISCLOSURE STATEMENT FORM

By signing and submitting this application I (the employer) hereby affirm that:

- I am not aware of being under audit, investigation, or review by OMIG or if I am, the overpayment and the related conduct being disclosed does not relate to OMIG's audit, investigation or review.
- I 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 agree to repay the overpayment in full within 15 days of being notified by OMIG of the amount due.
- I 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*