NEW YORK STATE | Office of the Medicaid Inspector General

HEALTHCARE WORKER BONUS SELF-DISCLOSURE STATEMENT

FORM AND INSTRUCTIONS

This form is for **employers** to report, return, and explain overpayments received from the NYS Medicaid Healthcare Worker Bonus (HWB) Payment Program (Social Services Law section 367-w) to the NYS Office of the Medicaid Inspector General's Self-Disclosure Program pursuant to Social Services Law section 363-d.

In addition to the submission of this form, Employers are required to submit a copy of the Employer Attestation originally submitted to the HWB Portal and copies of all Employee Attestations relevant to the overpayment being disclosed. Additionally, Employers are required to submit copies of the HWB employee-level remittances received detailing the overpaid HWB payment(s) being disclosed. This is required for each payment that is being disclosed as an overpayment.

Employers who have identified, claimed and paid a bonus to an employee shall not have the right to recover any inappropriately paid bonus from the employee. (See SOS section 367-w(5)(d)).

Pursuant to Social Services Law (SOS) section 363-d(7)(f)(1) you are required to pay the full amount due within 15 days of receiving OMIG's notification of the amount due, or no later than the expiration of the deadline to report, return and explain (See SOS section 363-d(6)(b)). Overpayments can be repaid in a lump sum, either by check, money order or electronic payment.

WARNING: Failure to report, return and explain an overpayment within sixty (60) days of identification may result in the imposition of monetary penalties pursuant to Social Services Law section 145-b(4)(a)(iii), and other penalties and sanctions where authorized by State or Federal law. A person who provides false material information on this form or intentionally omits material information from this form may have their participation in the Self-Disclosure Program terminated.

Each section of the Healthcare Worker Bonus (HWB) Self-Disclosure Statement must be filled out in its entirety. OMIG's Self-Disclosure Unit may contact you to obtain any additional information required to process this disclosure.

PART I: EMPLOYER INFORMATION

Employer Medicaid Enrollment Information

MMIS Number (Provider ID Number)

Click or tap here to enter text.

SFS Vendor ID Number

Click or tap here to enter text.

NPI Number

Click or tap here to enter text.

Employer Business Name

Click or tap here to enter text.

Employer Business DBA (all that apply)

Click or tap here to enter text.

Employer Physical Address (include number, street name, floor/suite number, state, city and zip code)

Click or tap here to enter text.

Employer Contact Information

NOTE: This contact will be required to respond to requests for information relevant to this submission. If there are any changes to this contact information, you are required to notify OMIG.

Contact Name

Click or tap here to enter text.

Contact Title

Click or tap here to enter text.

Correspondence Address (include number, street name, floor/suite number, city and zip code)

Click or tap here to enter text.

Email Address

Click or tap here to enter text.

Phone Number

Click or tap here to enter text.

PART II: EXPLAINING THE OVERPAYMENT

Overpayment Detail

Date the overpayment was identified

Click or tap here to enter text.

Statement Explaining the Overpayment

Describe why the HWB payment(s) needs to be returned and how the error was identified. Please include any additional information that will assist in verifying the overpayment amount.

Click or tap here to enter text.

Healthcare Worker Bonus (HWB) Self-Disclosure Overpayment Report

Complete the Healthcare Worker Bonus (HWB) Self-Disclosure Overpayment Report to disclose the employee-level details of the overpayment. To complete the form, click the link below.

Healthcare Worker Bonus (HWB) Self-Disclosure Overpayment Report

Also required to be included in your submission:

- A copy of the completed Employer Attestation form originally submitted by the employer to the HWB Portal.
- Copies of the Employee Attestations relevant to the overpayments being disclosed.
- Copies of all relevant HWB employee-level remittances received detailing the overpaid HWB payment(s) being disclosed.
- Signed and dated Certification Form

PART III: ATTESTATION AND SIGNATURE

Attestation

By signing and submitting this application and Certification Form 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.