New York State Department of Health
Certification Required under 10 NYCRR §86-2.40
Attesting that MDS Data is Complete and Accurate

The Certification is to be executed by the Facility's
  a. Operator for Proprietary Facility; or
  b. Officer of a Voluntary Facility; or
  c. Public Official Responsible for Operation of a Public Facility.

Facility Name: _____ ("Facility")
Operating Certificate Number: _____
MDS Period: _____
DCN: _____
Certifying Person's Title: _____

The undersigned attests that the minimum data set ("MDS") reported by the facility to the Centers for Medicare and Medicaid Services ("CMS") on the date referenced above is complete and accurate.

By executing this certification, the undersigned acknowledges and certifies that:
1. she/he has sufficient knowledge of the facts to be able to truthfully execute this certification;
2. all statements presented in this certification are true;
3. any misrepresentation or falsification of any information contained on this certification or in any MDS submission to the CMS, may be punishable by fine and / or imprisonment under New York State Law and Federal Law. Such violations include, but may not be limited to perjury, making a false statement to a government agency, filing a false instrument, False Claims Act violations, etc.

_____
Certifying Operator, Officer or Official's Signature

STATE OF _____
COUNTY OF _____

On this _____ day of _____, 20__, before me
Personally came _____, to me known as the
_____(title) of the Facility identified herein and
Who executed the foregoing instrument, and (s)he acknowledged
to me that (s)he executed the same.

_____
Notary Public
My Commission Expires: _____

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