

**HEALTH CARE ADJUSTMENT (HCA) VI
PROVIDER APPLICATION AND ATTESTATION**

Corp ID Number: _____ Provider: _____

We are electing not to participate in HCA VI

We are electing to participate in HCA VI. We attest to the fact that the Health Care Adjustment (HCA) VI funds will be administered by us as follows:

The first use of HCA VI funds must be to offset the employer cost of the increase to existing health care benefits that is not covered by current funding levels, inclusive of HCE III & HCA IV & V.

The Health Care Adjustment (HCA) VI funds available **after** offsetting the cost of the increase to existing health care benefits will be administered as follows (check one or more items as appropriate):

- Add new benefits/enhance existing benefits
- Reduce employee paid health premiums/deductibles/co-payments
- Reduce employee payments for non-covered/non-network health related expenses
- Establish/increase existing FSA/HRA/HSA
- Make opt-out payments to employees covered under other health insurance policies

We additionally attest that a Board Resolution indicating that the funds will be spent in accordance with the checklist above has been or will be passed no later than September 30, 2010. We further attest that the provider will maintain records, available upon audit, which will document the distribution of HCA VI funds in accordance with the above.

Authorized Official _____

Printed Name

Title _____

Date _____

Phone Number _____

**Return this Form by e-mail *no later than August 13, 2010*, to:
Rate.Setting@omr.state.ny.us**

or by United States Postal Service postmarked *no later than August 13, 2010*, to:

Ms. Carlene Coons
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