

## Career Pathways Training Program Provider Attestation Form and Instructions

Providers may qualify individual facilities as a service commitment site for the Career Pathways Training (CPT) Program either by attesting to serving a patient population that consists of at least 30% Medicaid and/or uninsured individuals or through one of New York State's approved Social Care Networks.

NOTE: Medicaid Members include individuals enrolled in NYS Medicaid's fee-for-service, managed care, or dual-eligible enrolled individuals.

### Instructions

#### 1. Complete the Attestation Form

- Fill out all required fields, including organization name, authorized representative information, and date.
- Sign and date the form. Only one signature is required, even if you are attesting to multiple service commitment sites.
- This is a fillable pdf, but you can print and complete it by hand.

#### 2. Complete the Attestation Qualification Table (if applicable; see options below\*)

- Use the appropriate table to list each site address where service commitments may be fulfilled.
- Be sure to include all requested details for each site.
- The table accompanies the attestation form and does not require additional signatures.
- This is a fillable pdf, but you can print and complete it by hand.

#### 3. Review for Accuracy

- Double-check all entries for completeness and accuracy.
- Incomplete or inaccurate forms may delay processing.

#### 4. Submit Your Forms

- Email your completed attestation form and the qualification table (if applicable) to [cptpartners@flpps.org](mailto:cptpartners@flpps.org).
- FLPPS will review your forms and submit everything to the NYS Department of Health for validation.

**\*CPT Attestation Qualification Option #1:** Please complete this table for those attesting to serving at least 30% Medicaid and/or uninsured individuals. If there are multiple sites that meet the 30% threshold, each facility should be listed separately. Additional pages may be used if necessary. These sites will be included on our job board to help CPT graduates identify potential employment locations after graduation. Submitting this table along with the attestation form allows for one signature to cover multiple service commitment sites. There is no obligation to hire graduates.

**\*CPT Attestation Qualification Option #3 & #4:** For those attesting to being a contracted not-for-profit community-based organization or provider partner of a Social Care Network, complete this table. If there are multiple sites that are conducting screening, navigation, or delivering health-related social needs services through the Social Care Network, each facility should be listed individually. Additional pages may be used if needed. Submitting this table along with the attestation form allows for one signature to represent multiple service commitment sites. There is no obligation to hire graduates.

*If you have any questions or need assistance with completing the attestation form and/or the qualification tables, please email [cptpartners@flpps.org](mailto:cptpartners@flpps.org).*

# 1115 Waiver Workforce Program Provider Attestation

Providers may qualify individual facilities as a service commitment site for the Career Pathways Training (CPT) program and Healthcare Access Loan Repayment (HEALR) program either by attesting to serving a patient population that consists of at least 30% Medicaid and/or uninsured individuals or through one of New York State's approved Social Care Networks.

**NOTE:** Medicaid Members include individuals enrolled in NYS Medicaid's fee-for-service, managed care, or dual-eligible enrolled individuals.

**Organization/Facility Name:** \_\_\_\_\_

**Health System (if applicable):** \_\_\_\_\_

**Organization/Facility Address:** \_\_\_\_\_

**Organization/Facility County:** \_\_\_\_\_

Please select **one** of the following options to indicate how your organization qualifies:

- My organization is an active Medicaid-enrolled provider with a patient population that was at least 30% Medicaid and/or uninsured members during **one** of the last three (3) years.
  - Qualifying Year (select one):  2023  2024  2025
  - # of Medicaid members: \_\_\_\_\_
  - # of uninsured individuals: \_\_\_\_\_
  - Total # of individuals served: \_\_\_\_\_

**% of Medicaid and/or uninsured individuals:** \_\_\_\_\_ %

**Medicaid Provider ID Number:** \_\_\_\_\_

- My organization is a Social Care Network lead entity
- My organization is a not-for-profit Community-Based Organization that is contracted with an SCN and is providing HRSN screening, referrals, and/or services.

**Affiliated Social Care Network(s):** \_\_\_\_\_

- My organization is a contracted not-for-profit provider partner of an SCN and is providing HRSN screening, referrals, and/or services (e.g. health or behavioral health provider).

**Affiliated Social Care Network(s):** \_\_\_\_\_

I certify that the information provided above is true and accurate to the best of my knowledge and understand that any false or misleading information may result in disqualification from the program.

**Signature of Organization Executive:** \_\_\_\_\_

**Name (print):** \_\_\_\_\_ **Title:** \_\_\_\_\_

**Date:** \_\_\_\_\_ **Phone:** \_\_\_\_\_ **Email:** \_\_\_\_\_

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Attestation Qualification Option #1**

**Organization Name:** \_\_\_\_\_

<b>Facility Name and Address</b>	<b>Facility Contact (Name, Title, email)</b>	<b>Qualifying Year</b>	<b># Medicaid Members served</b>	<b># Uninsured Individuals served</b>	<b>Total # Individuals Served</b>	<b>% Medicaid/ Uninsured</b>	<b>Medicaid ID</b>

**FLPPS WIO | Career Pathways Training Program**  
**Attestation Qualification Option #3 & #4**

**Organization Name:** \_\_\_\_\_

<b>Facility Name and Address</b>	<b>Facility Contact (Name, title, email)</b>	<b>Affiliated Social Care Network</b>	<b>HRSN (including screening and referral) Services being provided at this site (Y/N)</b>