Millennium
COLLABORATIVE CARE
Igniting Healthcare Change in WNY

# Participant Attestation Statement Instructions

Attached please find the Participant Attestation Statement for Millennium Collaborative Care Performing Provider System ("Millennium PPS") led by Erie County Medical Center Corporation ("ECMCC"). New York State requires that PPSs have signed authorizations from each organization in their network. In order to certify your participation in Millennium PPS, we are requesting that you complete and return the Participant Attestation Statement.

The Attestation must be executed by an authorized officer of Participant. By submitting an Attestation, Participant is representing that it has all requisite legal authority to bind Participant, each Affiliate, and each Participating Provider listed in Attachment A to the Attestation and participation in Millennium PPS.

## Completing the attached documents:

Please fill in required information electronically or by hand with black ink in accordance with the following instructions:

### Participant Attestation Statement:

- Prior to completion, Participant must confirm that no Affiliate* of Participant or any other Millennium PPS participant has executed an Attestation on behalf of Participant or any Affiliate or Participating Provider listed in Participant's Attestation.
- Participant must fill in: the name and title of the officer executing the Attestation; Participant's legal name, address and other contact info as indicated; Participant NPI and MMIS Numbers
- If Participant or any Affiliate is an accountable care organization (ACO), independent practice association (IPA) or other network of Participants and/or Participating Providers, Participant shall submit with its Attestation documentation evidencing authority to bind each Participating Provider, such as an addendum to its agreement with each Participating Provider acknowledging the Participating Provider's agreement to participate in Millennium PPS.
- If the Participant is attesting on behalf of any Affiliates (including subsidiary entities or entities under common control), Participant shall submit with its Attestation documentation evidencing the corporate relationship between the Participant and such Affiliates.

"Affiliate" means an entity that directly or indirectly through one or more intermediaries, controls, or is controlled by, or is under common control with, Participant. An entity "controls" any entity in which it has the power to vote, directly or indirectly, 50% or more of the voting interests in such entity, or the power to direct or cause direction of management and policies of such entity, whether through the ownership of voting shares, by contract or otherwise.

## Attachment A:

- Participant must use this spreadsheet to fill in the names and NPI/MMIS Numbers all of its Participating Providers who have agreed to participate in Millennium PPS.
- If Participant is attesting on behalf of any Affiliates, Participant must fill in the legal name of each Affiliate and the names and NPI/MMIS Numbers of all of the Affiliates' Participating Providers.
- A link to Attachment A can be found on **millenniumcc.org/resources**.

## Returning the documents:

- Please return the signed Participation Attestation Statement and completed Attachment A spreadsheet to **mobrien2@millenniumcc.org**
- Subject Line should read: "[Participant Name] Attestation Statement"
- If you prefer to send hard copies, please mail to:

  Millennium Collaborative Care
  Attn: Marlene O'Brien
  1461 Kensington Avenue
  Buffalo, NY 14215

## Questions/Comments:

If you have questions, comments, or concerns regarding the completion of the Attestation Statement, please contact Marlene O'Brien (716.898.4950, mobrien2@millenniumcc.org).

Thank you for participating in the Millennium Collaborative Care PPS.

Millennium
COLLABORATIVE CARE

# Participant Attestation Statement

The undersigned individual is an authorized signatory of _____ (the "Participant"). By executing this Participant Attestation Statement, the undersigned confirms that he or she has the requisite authority to act on behalf of the Participant and confirms that the Participant agrees to participate in the Delivery System Reform Incentive Payment Program ("DSRIP") Performing Provider System ("PPS") known as the Millennium Collaborative Care PPS ("Millennium PPS") led by Erie County Medical Center Corporation ("ECMCC"). By signing this Participant Attestation Statement, the Participant formally consents to participation in the Millennium PPS and authorizes Millennium PPS and ECMCC to list the Participant as a member of the Millennium PPS provider network.

| |
|---|
| Signature: |
| Date: |
| Signer's name: |
| Signer's title: |
| Signer's email address: |
| Signer's telephone: |
| Mailing address: |
| Participant NPI: |
| Participant MMIS: |
| Primary DSRIP contact name and title (if different from above): |
| Primary DSRIP contact email: |
| Primary DSRIP contact telephone: |

# Attachment A: Data Field Definitions

The data fields used in the Attachment A spreadsheet are described below. Download Attachment A from millenniumcc.org/resources.

| Column | Field Name | Description | Example | Type |
|---|---|---|---|---|
| A | Participant Name | Participant's legal name. | Sample Medical Associates, LLC | character |
| B | Participant NPI | If Participant has more than one NPI, please list each one on an individual line | 1234567890 | numeric - 10 digits |
| 3 | Participant MMIS | If Participant has more than one MMIS, please list each one on an individual line | 12345678 | numeric - 8 digits |
| 5 | Participant Mailing Address: Street | The Participant's mailing address - street | 1234 Healthy Way, Suite 25 | character |
| 6 | Participant Mailing Address: City | The Participant's mailing address - city | Healthytown | character |
| 7 | Participant Mailing Address: State | The Participant's mailing address - state (two letter USPS) | NY | character |
| 8 | Participant Mailing Address: Zip | The Participant's mailing address - zip code (5 digit zip code or zip+4) | 12345-6789 | character |
| 9 | Affiliate Name | Affiliate's legal name. If Affiliate does business under an assumed name, both the corporate name and assumed name should be listed. Any assumed name should be preceded with "d/b/a". | Sample Suburban Health Clinic | character |
| 10 | Affiliate NPI | If the Affiliate has more than one NPI, please list each one on an individual line | 1234567890 | numeric - 10 digits |
| 11 | Affiliate MMIS | If the Affiliate has more than one MMIS, please list each one on an individual line | 12345678 | numeric - 8 digits |
| 12 | Affiliate Practice Address: Street | The Affiliate's physical practice address - street | 5678 Patient Rd. | character |
| 13 | Affiliate Practice Address: City | The Affiliate's physical practice address - city | Welltown | character |
| 14 | Affiliate Practice Address: State | The Affiliate's physical practice address - state | NY | character |
| 15 | Affiliate Practice Address: Zip | The Affiliate's physical practice address - zip | 98765-4321 | character |
| 16 | Individual Provider Last Name | The last name of an Individual Provider who is directly employed by a Participant or Affiliate | Mary | character |
| 17 | Individual Provider First Name | The first name of an Individual Provider who is directly employed by a Participant or Affiliate | Gooddoc | character |
| 18 | Individual Provider Middle Initial | The middle initial of an Individual Provider who is directly employed by an Affiliate or Participant | J | character |
| 19 | Individual Provider Credential(s) | Any credentials listed for an Individual Provider | DO | character |
| 20 | Individual Provider NPI | The NPI number of an Individual Provider who is directly employed by an Affiliate or Participant. | 1234567890 | numeric - 10 digits |
| 21 | Individual Provider MMIS | The MMIS number of an Individual Provider who is directly employed by an Affiliate or Organization. | 12345678 | numeric - 8 digits |