

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.

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