ATTESTATION

The following attestation is being submitted consistent with the Office of Addiction Services and Supports (OASAS) letter of counsel dated March 9, 2020 allowing for delivery of telepractice services by OASAS certified providers.

General Information

Applicant's Legal Name _____

Operating Certificate Number(s) _____

PRU Number(s) _____

Originating Site Address(s) (PRU locations) _____

_____

Name of Contact Person Position/Affiliation with Applicant _____

Administrative office address (Street, City, State, Zip Code) _____

_____

Telephone Number for Contact Person _____

E-Mail Address of Contact Person _____

The undersigned is submitting this attestation to deliver telepractice services consistent with Letter of Counsel issues by OASAS on March 9, 2020. The undersigned hereby attests to the following:

- That the practitioner(s) will possess a current, valid license, permit, or limited permit to practice in NYS
- The telepractice services will be conducted via telecommunication systems employing acceptable authentication and identification procedures by both the sender and the receiver;
- Provider has a relationship with a credible technology service provider;
- Services delivered will meet federal and state confidentiality requirements including, but not limited to, 42 C.F. R. Part 2, and 45 C.F.R. Parts 160 and 164 (HIPAA Security Rules);
- The spaces occupied by the patient and the practitioner both meet minimum privacy standards consistent with patient-practitioner interaction and confidentiality at a single OASAS certified location;
- Culturally competent translation services will be provided when the patient and practitioner do not speak the same language;
- Provider has written procedures for a contingency plan in the event of a transmission failure or other technical difficulties which may render the service undeliverable;
- That claim modifiers "95" or "GT" will be used on each claim that represents a service via telehealth

Statement of Compliance and Signature I, (print or type full name and title of the applicant) _____hereby attest that the telepractice standards identified on this attestation form are true, accurate and complete to the best of my knowledge. I understand that any falsification, omission, or concealment of material fact may result in revocation of approval to provide telepractice services at the above-referenced location(s) and/or may subject me to administrative, civil, or criminal liability. I also understand that this approval is for a limited time and will expire once the New York State disaster emergency for COVID-19 ends. Any extensions or continued authority to deliver telepractice services must be approved by the OASAS prior to implementation.

Name & Relationship to applicant	Date