NEW YORK STATE DEPARTMENT OF HEALTH
Office of Managed Care
Bureau of Certification and Surveillance

REGULATORY COMPLIANCE STATEMENT

INSTRUCTIONS: To be completed as indicated and returned by the regulatory agency DIRECTLY to the NYS Department of Health, Bureau of Certification and Surveillance, Empire State Plaza, Albany, NY 12237-0062.

A. **TO BE COMPLETED BY PROPOSED HMO/PHSP:**

IDENTIFYING INFORMATION

NAME OF PROPOSED HMO/PSHP: _____

NAME OF INDIVIDUAL/ENTITY UNDER REVIEW: _____

DATES OF AFFILIATION: From: / / To: / /

HEALTH CARE OPERATION TO BE REPORTED ON	Name and Address	Type of operation

B. TO BE COMPLETED BY REGULATORY AGENCY REGARDING HEALTH CARE OPERATION:

NAME OF PERSON REPLYING (Last, First, Middle Initial)

TITLE TELEPHONE NUMBER ( )

OFFICE NAME/ADDRESS

CITY STATE ZIP CODE

During the stated period, was/is this health care operation in compliance with appropriate state regulations?

☐ YES ☐ NO If "NO", please explain:

During the stated period, to your knowledge, did/do regulators in your state have any concerns about the management or performance of this health care operation? ☐ YES ☐ NO If "YES", please explain:

During the stated period, did/do regulators in your state have any concerns about the quality of health care provided by this health care operation? ☐ YES ☐ NO If "YES", please explain:

ADDITIONAL COMMENTS CAN BE MADE ON THE BACK OF THIS FORM

Signature: _____ Date: _____

Other Comments:_____