

**Non-Profit Behavioral Health / Developmental Disability Providers
Health Information Technology Investment Program**

Attachment A-1

Pass/Fail Questionnaire and Attestation

In order to be considered for funding for this RFP, Applicants must answer yes to the following questions. Applicant must also attest to their Tier Status as defined by OMH in the table below.

Applicant Agency _____ Region (using Attachment C Map) _____ County _____

1. Is your organization a 501(c)(3) nonprofit organization registered with the IRS, the NYS Department of State, and the NYS Office of the Attorney Generals' Charities Bureau? **YES** **NO**

2. Do you provide direct services in New York State to individuals and families residing in New York State? **YES** **NO**

3. Are you registered with Grants Gateway and expect to be Prequalified at the time and date that proposals are due? **YES** **NO**

4. Are you a current Medicaid provider or will you be a NYS Medicaid provider by the end of 2016? **YES** **NO**

5. Are you currently engaged in managed care or do you have a scheduled plan to be engaged in managed care by the end of 2017? **YES** **NO**

Tier 1 (highest preference)	Tier 2	Tier 3
NYS Medicaid billing revenue of less than \$500,000	NYS Medicaid billing revenue falls between \$500,000 and \$1,000,000	NYS Medicaid billing revenue over \$1,000,000
Total revenue of less than \$1,000,000	Total revenue of less than \$1,500,000	Total revenue of \$1,500,000 or greater

Using the chart above, I certify that my agency falls under Tier # _____ because I have New York State Medicaid billing between _____ and _____ dollars and a total revenue of \$ _____.

Name: _____ **Title:** _____

Signature: _____