HOSPITAL AFFIDAVIT FOR STATEWIDE WAGE INDEX RECLASSIFICATION

State of _____

County or parish of _____

I, _____ (type or print name), being duly sworn, depose and say as follows:

(1) I certify that _____ (Provider's name and Medicare provider number) ("the hospital") agrees to be included in the statewide wage index reclassification request for the State of _____ for the federal fiscal years 2018 through 2020 (October 1, 2017 to September 30, 2020).

(2) I understand that all prospective payment system hospitals in the state must apply as a group for reclassification to a statewide wage index through a signed single application.

(3) I understand that all prospective payment system hospitals in the state must agree to the reclassification to a statewide wage index through a signed affidavit on the application.

(4) I understand that all prospective payment system hospitals in the state must agree, through an affidavit, to withdrawal of an application or to termination of an approved statewide wage index reclassification.

(5) I understand that the hospital waives its rights to any wage index classification that it would otherwise receive absent the statewide wage index classification, including a wage index that it might have received through individual geographic reclassification.

(6) I certify that I am an officer of the hospital or a corporate officer of the hospital's parent corporation with authority to sign this affidavit for the hospital's inclusion in the statewide wage index reclassification request.

Signature: _____

Title: _____

Phone number: _____

E-mail address: _____

Subscribed and sworn to before me

This _____ day of _____, 20___

_____
Notary Public

My commission expires: _____