

**ATTESTATION OF “NEW HOSPITAL” STATUS AS APPLICABLE TO THE
HOSPITAL QUALITY ASSURANCE FEE PROGRAM**

As Chief Executive Officer (CEO) or equivalent of [Entity Name, DBA Hospital Name:]_____ (Provider), I hereby represent and warrant that I am authorized to execute this Attestation on behalf of Provider.

On behalf of Provider, I hereby attest, and provide accompanying supporting documentation, that, effective [date:]_____, Provider, located at [Physical Address of Hospital], was issued a General Acute Care Hospital license pursuant to §1250(a) of the California Health and Safety Code by the California Department of Public Health, and that, effective [date:]_____, Provider received its Medi-Cal Certification through the Provider Enrollment Division of the California Department of Health Care Services (DHCS). I further attest under the penalty of perjury in accordance with the Provider Bulletin Dated May 13, 2016 that Provider meets the definition of a “new hospital” as stated in California Welfare and Institutions Code Section 14169.51, subdivision (ai), for the purposes of the Program Period of the Hospital Quality Assurance Fee (HQAF) Program, codified in Article 5.230 (commencing with Section 14169.50) of the Welfare and Institutions Code.

On behalf of Provider, I hereby acknowledge that the final determination of “new hospital” status for purposes of assessing eligibility to participate in the Program Period of the HQAF Program, must be reviewed and completed by DHCS HQAF Program Staff.

CEO Signature: _____
Name: _____
Title: _____
Name of Entity/Hospital: _____
Date: _____

- - - - - This section to be completed by DHCS staff only - - - - -

DHCS Signature: _____
Name: _____
Title: _____
Name of Entity/Hospital: _____
Acceptance Date: _____