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 Bulleting 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 complete by HQAF Program Staff.

Name:_____

Title:_____

Name of Entity/Hospital:_____

Date:_____

CEO Signature:_____

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

Name of Entity/Hospital:_____

Acceptance Date:_____

Name:_____

Title:_____

DHCS Signature:_____