MEDICARE GEOGRAPHIC CLASSIFICATION REVIEW BOARD

2004 JOINT APPLICATION FOR HOSPITAL GROUPS

FOR GEOGRAPHIC RECLASSIFICATION

EFFECTIVE FEDERAL FISCAL YEAR 2006

PLEASE READ INSTRUCTIONS BEFORE COMPLETING THIS APPLICATION

THIS APPLICATION MUST BE COMPLETED AND RECEIVED BY THE MGCRB BY **5:00 P.M. EDT, SEPTEMBER 1, 2004**. FAILURE TO COMPLY WILL RESULT IN DISMISSAL.

PRINT IN INK OR TYPE WHEN COMPLETING THIS APPLICATION

I. GROUP INFORMATION

1. NAME OF THE COUNTY IN WHICH THE HOSPITALS ARE LOCATED:

____

2. IDENTIFICATION CODE FOR THE AREA INDICATED IN NUMBER 1 (REFER TO GROUP INSTRUCTIONS):

____

3. CONTACT FOR ALL COMMUNICATIONS REGARDING THIS APPLICATION:

NAME: ____
ORGANIZATION: ____
ADDRESS: ____
____
______________________________ ZIP CODE __________ - __________
TELEPHONE NUMBER: ____

4. A. THE GROUP SHOULD PROVIDE, USING THE FOLLOWING FORMAT, A LISTING OF ALL IPPS HOSPITALS IN THE COUNTY AT **ATTACHMENT A**. COLUMNS A THROUGH C ARE SELF-EXPLANATORY. FOR COLUMN D., PROVIDE AN ASTERISK IF THE HOSPITAL IS ALSO FILING AN INDIVIDUAL APPLICATION WITH THE MGCRB. IN COLUMN E, THE GROUP MUST IDENTIFY ALL HOSPITALS WHICH ARE ALREADY RECLASSIFIED FOR THE WAGE INDEX IN FFY 2006 AS PART OF A 3-YEAR RECLASSIFICATION. COMPLETE COLUMN E BY INDICATING THE AREA IDENTIFICATION CODE TO WHICH THE HOSPITAL IS RECLASSIFIED IN FFY 2006. **NOTE:** THE BOARD WILL RULE ON A GROUP RECLASSIFICATION REQUEST BEFORE IT RULES ON A HOSPITAL'S INDIVIDUAL REQUEST. IF THE BOARD RECLASSIFIES A GROUP, IT WILL DISMISS ANY INDIVIDUAL RECLASSIFICATION APPLICATION FILED BY HOSPITALS IN THE GROUP.

COL. A HOSPITAL NAME	COL. B ADDRESS	COL. C MEDICARE PROV. NUMBER	COL. D INDIVIDUAL APPLICATION	COL. E FFY 2006 RECLASS. AREA

B. IN SUPPORT OF 4.A. IMMEDIATELY ABOVE, INCLUDE AS **ATTACHMENT B** A CURRENT LETTER FROM THE APPROPRIATE CMS REGIONAL OFFICE WHICH LISTS ALL OF THE CURRENTLY LICENSED IPPS HOSPITALS IN THE COUNTY NAMED IN I.1. ABOVE.

II. RECLASSIFICATION REQUEST

NOTE: PLEASE READ THE ACCOMPANYING HOSPITAL GROUP INSTRUCTIONS FOR THE BOARD'S TREATMENT OF URBAN AND RURAL AREAS.

5. NAME OF THE AREA (RURAL /URBAN AREA) TO WHICH THE GROUP IS REQUESTING RECLASSIFICATION (THE GROUP MAY BE RECLASSIFIED TO ONLY ONE AREA):

____

6. IDENTIFICATION CODE FOR THE AREA SHOWN IN NO.5 (REFER TO GROUP INSTRUCTIONS)

____

7. THE GROUP SHOULD CIRCLE THE RECLASSIFICATION CRITERIA UNDER WHICH IT IS APPLYING AND COMPLETE THE SECTIONS INDICATED:

A. ALL HOSPITALS IN A RURAL COUNTY SEEKING REDESIGNATION TO AN URBAN AREA (42 C.F.R. 412.232). COMPLETE SECTIONS III, IV, V, THE WAGE INDEX COMPARISON AND THE AFFIDAVIT (S).

B. ALL HOSPITALS IN AN URBAN COUNTY SEEKING REDESIGNATION TO ANOTHER URBAN AREA (42 C.F.R. 412.234). COMPLETE SECTIONS III, IV, VI, THE WAGE INDEX COMPARISON AND THE AFFIDAVIT (S).

III. GENERAL INFORMATION

8. ARE ALL IPPS HOSPITALS IN THE COUNTY LISTED IN NO. 4 MEMBERS OF THE GROUP?

YES __________ NO __________

9. HAVE THE HOSPITALS IN THE GROUP ALSO REQUESTED RECLASSIFICATION AS A PART OF A STATEWIDE WAGE INDEX APPLICATION FOR FFY 2006?

YES __________ NO __________

10. IF THE GROUP APPLYING FOR RECLASSIFICATION IS AN URBAN GROUP, HAS ANY HOSPITAL LISTED IN NO. 4 ABOVE APPLIED, OR WILL BE APPLYING, TO THE CMS REGIONAL OFFICE TO BE TREATED AS BEING IN A RURAL AREA? (42 C.F.R. 412.103, REFER TO THE INSTRUCTIONS FOR FURTHER INFORMATION)?

YES __________ NO __________

IF "YES", PROVIDE A LIST OF THE HOSPITALS AT **ATTACHMENT C.** INDICATE IN THE LIST WHETHER ANY OF THE HOSPITAL APPLICATIONS HAVE BEEN APPROVED AND PROVIDE THE DATE OF THE APPROVAL.

11. IS THE GROUP REQUESTING AN ORAL HEARING?

YES __________ NO __________

IF "YES" ATTACH RATIONALE UNDER **ATTACHMENT D**.

12. PRIOR YEAR GROUP CASE NUMBER (S):

01G____________ 04G_____________ 05G____________

IV. ADJACENCY (ALL GROUPS)

13. IS THE COUNTY IN WHICH THE HOSPITALS ARE LOCATED ADJACENT (CONTIGUOUS) TO THE AREA TO WHICH THE GROUP SEEKS REDESIGNATION?

YES ____________ NO _______________

(ATTACH MAP UNDER **ATTACHMENT E**.)

V. METROPOLITAN CHARACTER (RURAL GROUP ONLY)

14. DOES THE COUNTY IN WHICH THE HOSPITALS ARE LOCATED MEET THE STANDARDS FOR REDESIGNATION TO AN URBAN AREA AS AN "OUTLYING COUNTY"?

YES ____________ NO ______________

(ATTACH THE SUPPORTING BUREAU OF THE CENSUS DATA UNDER **ATTACHMENT F**.)

VI. CBSA CRITERIA (URBAN GROUP ONLY)

15. IS THE COUNTY IN WHICH THE HOSPITALS ARE LOCATED A PART OF THE CBSA THAT INCLUDES THE URBAN AREA TO WHICH THE GROUP SEEKS REDESIGNATION?

YES ____________ NO _______________

(ATTACH OFFICIAL BUREAU OF THE CENSUS CBSA LISTING UNDER **ATTACHMENT G**.)

WAGE CRITERIA - 85 PERCENT COMPARISON (RURAL AND URBAN GROUPS)

ATTACH THE GROUP'S AGGREGATE HOURLY WAGE COMPUTATIONS USING 3-YEAR AVERAGES OF WAGES AND HOURS FOR THE 85 PERCENT COMPARISON UNDER **ATTACHMENT H**. TAB 1 OF THE GROUP APPLICATION INSTRUCTIONS PROVIDES AN EXAMPLE OF THIS COMPARISON.

AFFIDAVIT

COUNTY OR PARISH OF____________________

STATE OF_________________________

I, ____ (TYPE OR PRINT NAME), BEING DULY SWORN, DEPOSE AND SAY AS FOLLOWS:

(1) I CERTIFY THAT I HAVE EXAMINED THE ACCOMPANYING APPLICATION FOR GEOGRAPHIC RECLASSIFICATION AND ALL OF THE SUPPORTING INFORMATION AND DATA INCLUDED IN THE SUBMITTAL BY ____ ____________________ (HOSPITAL NAME AND MEDICARE PROVIDER NUMBER) THAT IS DUE TO THE MEDICARE GEOGRAPHIC CLASSIFICATION REVIEW BOARD NO LATER THAN SEPTEMBER 1, 2004. I HEREBY DECLARE UNDER PENALTY OF PERJURY (28 U.S.C. SECTION 1746) THAT THE FOREGOING IS TRUE AND CORRECT.

(2) I UNDERSTAND THAT AN OMISSION, MISSTATEMENT, MISREPRESENTATION, OR ERROR MADE IN A HOSPITAL'S APPLICATION AND SUPPORTING INFORMATION AND DATA FOR GEOGRAPHIC RECLASSIFICATION MAY BE GROUNDS FOR DENIAL OF THE HOSPITAL'S APPLICATION.

(3) I UNDERSTAND THAT AN OMISSION, MISSTATEMENT, MISREPRESENTATION, OR ERROR MADE IN A HOSPITAL'S APPLICATION AND SUPPORTING INFORMATION AND DATA FOR GEOGRAPHIC RECLASSIFICATION MAY BE CAUSE FOR LEGAL ACTION AGAINST THE APPLICANT HOSPITAL AND ITS OFFICIALS.

(4) I CERTIFY THAT I AM AN OFFICER OF THE HOSPITAL NAMED IN (1) ABOVE OR A CORPORATE OFFICER OF THE HOSPITAL'S PARENT CORPORATION WITH AUTHORITY TO SIGN THE APPLICATION FOR GEOGRAPHIC RECLASSIFICATION ON BEHALF OF THE HOSPITAL.

SIGNATURE: ____

TITLE: ____

PHONE NUMBER: ____

SUBSCRIBED AND SWORN BEFORE ME
THIS ___________ DAY OF ______________2004
(DAY) (MONTH)

____
(SIGNATURE OF NOTARY)

NOTARY PUBLIC
MY COMMISSION EXPIRES: ___________________________