MEDICARE GEOGRAPHIC CLASSIFICATION REVIEW BOARD

2004 STATEWIDE WAGE INDEX HOSPITAL APPLICATION

FOR GEOGRAPHIC RECLASSIFICATION

EFFECTIVE FEDERAL FISCAL YEARS 2006 THROUGH 2008

PLEASE READ THE 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

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

_____

2. CONTACT PERSON OF THE STATEWIDE ENTITY FOR ALL COMMUNICATIONS REGARDING THIS APPLICATION:

NAME: _____

ORGANIZATION: _____

ADDRESS: _____

_____

_____ ZIP CODE _____ - _____

TELEPHONE NUMBER: _____

3. A. THE STATEWIDE ENTITY SHOULD PROVIDE (AT **ATTACHMENT A)**, USING THE FORMAT SHOWN BELOW, A LISTING OF ALL ACUTE CARE, INPATIENT PPS HOSPITALS IN THE STATE WHICH WILL BE OPERATING AS OF THE DEADLINE FOR SUBMITTING AN APPLICATION IN 2004 (SEPTEMBER 1, 2004). COLUMNS A THROUGH C ARE SELF-EXPLANATORY. FOR COLUMN D, PROVIDE AN ASTERISK IF THE HOSPITAL IS ALSO FILING A GROUP OR INDIVIDUAL APPLICATION WITH THE MGCRB. **NOTE:** THE BOARD WILL RULE ON A STATEWIDE WAGE INDEX REQUEST BEFORE IT RULES ON A GROUP OR INDIVIDUAL REQUEST.

COL. A HOSPITAL NAME	COL. B ADDRESS	COL. C MEDICARE PROV. NUMBER	COL. D GROUP/INDIVIDUAL APPLICATION

B. IN SUPPORT OF 3.A. IMMEDIATELY ABOVE, INCLUDE (AS **ATTACHMENT B)** A CURRENT LETTER FROM THE APPROPRIATE CMS REGIONAL OFFICE, WHICH LISTS ALL OF THE LICENSED ACUTE CARE, INPATIENT PPS HOSPITALS IN THE STATE NAMED IN 1. ABOVE THAT WILL BE IN OPERATION AS OF THE DUE DATE FOR SUBMITTING APPLICATIONS TO THE BOARD IN 2004 (SEPTEMBER 1, 2004).

4. IS THE REQUIRED AFFIDAVIT FROM EACH HOSPITAL LISTED IN **ATTACHMENT A** INCLUDED AT **ATTACHMENT C**?

YES _____ NO _____

HOSPITAL AFFIDAVIT FOR STATEWIDE WAGE INDEX RECLASSIFICATION

COUNTY OR PARISH OF _____

STATE OF _____

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

(1) I CERTIFY THAT _____ (NAME AND MEDICARE PROVIDER NUMBER OF 'THE HOSPITAL") AGREES TO BE INCLUDED IN THE STATEWIDE WAGE INDEX RECLASSIFICATION REQUEST FOR THE FEDERAL FISCAL YEARS 2006 THROUGH 2008 (OCTOBER 1, 2005 TO SEPTEMBER 30, 2008) FOR THE STATE OF _____ (STATE).

(2) 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.

(3) I UNDERSTAND THAT ALL OF THE MEDICARE ACUTE CARE, INPATIENT PROSPECTIVE PAYMENT SYSTEM HOSPITALS IN THE STATE MUST AGREE, THROUGH AN AFFIDAVIT, TO A WITHDRAWAL OF AN APPLICATION OR TO TERMINATION OF AN APPROVED STATEWIDE WAGE INDEX RECLASSIFICATION.

(4) 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: _____

SUBSCRIBED AND SWORN BEFORE ME
THIS _____ DAY OF _____ 2004
(DAY) (MONTH)

_____

(SIGNATURE OF NOTARY)

NOTARY PUBLIC
MY COMMISSION EXPIRES: _____