# 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 2019 through 2021 (October 1, 2018 to September 30, 2021).

(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: ________________________________