

**MEDICARE GEOGRAPHIC CLASSIFICATION REVIEW BOARD**

2520 Lord Baltimore Drive, Suite L, Baltimore, MD 21244-2670

**2015 STATEWIDE WAGE INDEX HOSPITAL APPLICATION  
FOR GEOGRAPHIC RECLASSIFICATION  
EFFECTIVE FEDERAL FISCAL YEARS 2017 THROUGH 2019**

---

**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, 2015.**

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: \_\_\_\_\_

\_\_\_\_\_

E-MAIL ADDRESS: \_\_\_\_\_

TELEPHONE NUMBER: \_\_\_\_\_

3. A. THE STATEWIDE ENTITY SHOULD PROVIDE (AT **ATTACHMENT A**), USING THE FORMAT SHOWN BELOW, A LISTING OF ALL ACUTE CARE, IPPS HOSPITALS IN THE STATE WHICH WILL BE OPERATING AS OF THE DEADLINE FOR SUBMITTING AN APPLICATION IN 2015 (SEPTEMBER 1, 2015). COLUMNS A THROUGH C ARE SELF-EXPLANATORY. FOR COLUMN D, PROVIDE AN ASTERISK IF THE HOSPITAL IS ALSO FILING A GROUP AND/OR INDIVIDUAL APPLICATION WITH THE MGRB. **NOTE:** THE BOARD WILL RULE ON A STATEWIDE WAGE INDEX REQUEST BEFORE IT RULES ON A GROUP OR INDIVIDUAL REQUEST.

<u>COL. A</u>	<u>COL. B</u>	<u>COL. C</u>	<u>COL. D</u>	<u>COL. E</u>
HOSPITAL <u>NAME</u>	HOSPITAL <u>ADDRESS</u>	MEDICARE PROV. <u>NUMBER</u>	GROUP/INDIVIDUAL <u>APPLICATION</u>	FFY 2017 <u>RECLASS. AREA</u>

- 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 2015 (SEPTEMBER 1, 2015).

4. IS THE ORIGINAL 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 2017 THROUGH 2019 (OCTOBER 1, 2016 TO SEPTEMBER 30, 2019) 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: \_\_\_\_\_

E-MAIL ADDRESS: \_\_\_\_\_

SUBSCRIBED AND SWORN BEFORE ME  
THIS \_\_\_\_\_ DAY OF \_\_\_\_\_ 2015  
(DAY) (MONTH)

\_\_\_\_\_  
(SIGNATURE OF NOTARY)

NOTARY PUBLIC  
MY COMMISSION EXPIRES: \_\_\_\_\_