NJ FAMILYCARE
Affordable health coverage. Quality care.

ATTESTATION

NEW JERSEY COUNTY OPTION HOSPITAL FEE PILOT PROGRAM

Hospital Name: _____

CERTIFICATION BY HOSPITAL CHIEF EXECUTIVE OFFICER OR ADMINISTRATOR

On behalf of _____ hospital ("the hospital"), I hereby certify that:

- I have examined the accompanying Data Form & Preliminary DSH Limit Calculation Form for the reporting period specified and, to the best of my knowledge and belief, the information contained in the reports is true, correct, and complete and accurately reflect the information in the hospital's Medicare cost report, the hospital's financial statements and other accounting records.
- I understand that projected payments to the hospital under the New Jersey County Option Hospital Fee Pilot Program, when combined with other Medicaid and Disproportionate Share Hospital (DSH) payments, such as Charity Care payments, may exceed the federal maximum hospital-specific disproportionate share (DSH) limit in 42 U.S.C. § 1396r-4. I acknowledge that if the hospital's projected payments exceed its Hospital Specific DSH Limit, the hospital's DSH payments may be reduced as necessary to comply with federal law. (N.J.A.C. 10:52B)
- I understand that misrepresentation or falsification of any information contained in this report may be punishable by criminal, civil and administrative action, fine and/or imprisonment under state or federal law.
- I certify that that the cost of the fee shall not be assigned to any patient, insurer, self-insured employer program, or other responsible party, nor shall the fee be listed separately on any invoice or statement sent to a patient, insurer, self-insured employer program, or other responsible party.

I am authorized to make this Certification on behalf of _____ hospital.

Signature _____

Name _____
Full Name (Printed)

Title _____ **Date** / /