STATE OF MICHIGAN

Department of Licensing and Regulatory Affairs
Bureau of Survey and Certification

Attestation Statement for Exclusion from Prospective Payment System (PPS) for Psychiatric Units

Hospital Provider #: 23-

Cost reporting year:

Legal Name:

DBA Name:

Address:

City: State: Zip:

Is the excluded PPS unit at this address? Yes: ☐ No: ☐ ***If no, provide address below***

Unit Address:

City: State: Zip:

Number of Beds:

Total Sq. Ft. of Unit:

The Beds remain separate and are not co-mingled with other hospital service beds.

Room Numbers:

Deemed Status ***(If deemed, please attach a copy of the accreditation letter/certificate)***

TJC: ☐ AOA: ☐ DNV: ☐ ACHC: ☐ CIHQ: ☐ NONE: ☐

This attestation must be signed by the Administrator/Chief Executive officer of the hospital (including hospitals with excluded units). Please read the following carefully.

Statements or Entries Generally: Whoever, in any matter within the jurisdiction of any department or agency of the United States knowingly and willfully falsifies, conceals or covers up by any trick, scheme or device a material fact, or makes any false, fictitious or fraudulent statement or representations, or makes or uses any false writing or document knowing the same to contain any false, fictitious or fraudulent statement or entry, shall be fined not more than $10,000 or imprisoned not more than five years, or both. (18 U.S.C., Sec. 1001)

Based upon my personal knowledge and belief, I attest that the responses on the attached prospective payment system (PPS) exclusion worksheet are true and correct, and that this hospital currently meets and will continue to meet the applicable requirements for exclusion from PPS for the period beginning on the date indicated above as set out in Subpart B of 42 CFR Part 412. I agree that if the (hospital or unit) fails to meet any of these requirements between the date of attestation and the first day of the hospital's fiscal year, I will notify the Regional Office (PROGRAM SPECIALIST NON LTC SURVEY AND CERT OP BRANCH/US DH&HS/CMS REG V/STE. 600/233 N. MICHIGAN AVE./CHICAGO IL 60601-5519) of the change immediately in order to permit a valid determination of distinct part status prior to the beginning of the fiscal year.

I understand that the Health Care Financing Administration (HCFA) or its representative has the right to conduct an on-site survey at any time to validate whether the statements made on the attached worksheet are true.

_____ _____ _____

Administrator/CEO Signature Title Date