

Administrative Bulletin 17-09

101 CMR 701.00: Community Hospital Reinvestment Trust Fund Payments and Funding

Effective June 2, 2017

Attachment A

The acute care hospital named below is licensed under section 51 of chapter 111 of the Massachusetts General Laws and is listed as an acute care hospital eligible to receive SFY17 Community Hospital Reinvestment Trust Fund (“Trust Fund”) payments, as detailed in Administrative Bulletin 17-09.

If the acute care hospital named below accepts SFY17 Trust Fund payments, it agrees to:

- Utilize the funding received to conduct an independent financial and operational audit to recommend steps to increase sustainability and efficiency of the acute care hospital and/or utilize any unspent funding remaining after the audit has been conducted to advance steps recommended in the audit for improving or continuing health care services that benefit the uninsured, underinsured, and MassHealth populations; and
- Ensure that no activities supported using SFY17 Trust Fund payments will be duplicative of work supported by other Infrastructure and Capacity Building grants, EHR Incentive Payment Programs, the Mass HIway Implementation Grant, the CHART Investment Program, the Targeted Cost Challenge Investment Program, Delivery System Transformation Initiative, or any other Executive Office of Health and Human Services (EOHHS) or Health Policy Commission targeted funding program; and
- Submit a final report for project(s) supported by the SFY17 Trust Fund payments using a SFY17 final report template provided by EOHHS.

If a hospital does not make timely and permissible expenditure of Trust Fund payments, whether or not the hospital has sought assistance from EOHHS, and worked in good faith to identify a permissible use of Trust Fund payments, the hospital must return the funds received to EOHHS. Hospitals that return funds by June 30, 2018 will not be penalized for doing so.

I certify under the pains and penalties of perjury that the information on this form and any attached statement that I have provided has been reviewed and signed by me, and is true, accurate, and complete, to the best of my knowledge. I also certify that I am duly authorized to act on behalf of the acute care hospital named below. I understand that I may be subject to civil penalties or criminal prosecution for any falsification, omission, or concealment of any material fact contained herein.

Signature (Signature and date stamps, or the signature of anyone other than a person legally authorized to sign on behalf of the acute care hospital, are not acceptable.):

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Printed Legal Name and Title of Signatory:

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Printed Legal Name of Acute Care Hospital Represented by Signatory:

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Date:

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If you have any questions about this attestation form, please e-mail inquiries to
Stephanie.buckler@massmail.state.ma.us.