STATE OF LOUISIANA
DEPARTMENT OF HEALTH AND HOSPITALS
BUREAU OF HEALTH SERVICES FINANCING

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CERTIFICATION

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STATE OF LOUISIANA
PARISH OF _____

State Plan Qualifying Criteria:

I hereby certify that I am the _____ [title] and an authorized agent of _____ [Governmental Facility].

I further certify that

(1) as a condition of employment the physician, physician assistant, certified registered nurse anesthetists or certified registered nurse practitioner is required to turn over his fees or his Medicaid supplemental payments to _____ [Governmental Facility]; or

(2) the physician, physician assistant, certified registered nurse anesthetists or certified registered nurse practitioner has a contract under which _____ [Governmental Facility] submits claims; or

(3) the physician, physician assistant, certified registered nurse anesthetists or certified registered nurse practitioner has a contract with _____ [Governmental Facility] which constitutes an employer/employee type relationship and the physician, physician assistant, certified registered nurse anesthetists or certified registered nurse practitioner assigns any Medicaid supplemental payments to _____ [Governmental Facility]; or

(4) the physician, physician assistant, certified registered nurse anesthetists or certified registered nurse practitioner is party to a contract with _____ [Governmental Facility] to provide services at or in affiliation with _____ [Governmental Facility];

Intergovernmental Transfer Agreement:

I hereby certify that I am the _____[title] and an authorized agent of _____[Governmental Facility] (if different than above).

I further certify that _____ [Governmental Facility] is entering into an Intergovernmental Transfer Agreement with the Louisiana Department of Health in order to fund supplemental payments for services provided by physicians,

physician assistants, certified registered nurse anesthetists and certified registered nurse practitioners pursuant to the approved state plan amendment TN #17-0011.

Indemnify

I further certify that _____ [Governmental Facility], along with _____[Governmental Facility that will complete IGT if different], will hold LDH harmless and indemnify LDH for any claims, losses, or damages arising out of payments made to _____ [Governmental Facility] or to Practitioner Group under approved state plan amendment TN #17-0011.

_____ _____

Witness

[Name]
[Title]
[Governmental Facility – Qualifying Entity]

_____ _____

Witness

[Name]
[Title]
[Governmental Facility – Completing IGT (if different than above)]

SWORN AND SUBSCRIBED BEFORE ME, the undersigned Notary Public, on this _____ day of _____, 2018, at _____, Louisiana.

_____

Notary Public

#124637