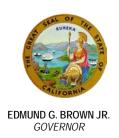


State of California—Health and Human Services Agency Department of Health Care Services



DESIGNATED PUBLIC HOSPITAL QUALITY INCENTIVE PROGRAM (QIP) PROGRAM YEAR 1 REPORT SUBMISSION CERTIFICATION FORM

I, the undersigned, certify, under penalty of perjury, the following:

- As an administrator, officer, or other individual duly authorized to sign on behalf of the QIP Entity listed below, I am authorized or designated to make this Certification, and declare that I understand that the making of false statements or the filing of a false or fraudulent claim is punishable under state and federal law;
- Any and all information reported in this QIP report and supporting documentation are, to the best of my knowledge, true, accurate and complete; and
- Any and all information reported in this QIP report and supporting documentation is based on the rules and specifications set forth in the most current PY 1 QIP Reporting Manual.

QIP Entity Official Name:		_
QIP Entity Official Title:		_
QIP Entity Official:Si	Date:ignature	
Primary Contact:	Alternate Contact:	
Phone:	Phone:	
Email:	Email:	

Email completed form to your QIP Liaison by 11:59 PM on December 15, 2018.