

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Center for Medicare, Division of Acute Care
7500 Security Boulevard
Mailstop C4-08-06
Baltimore, MD 21244-1850



**Attestation Form (FY 2024 Distribution Round):
Attestation for Use of GME Positions Distributed Under Section 126**

Hospital applicants must attest to meeting residency program requirements regarding residency rotations and the use of GME positions distributed under section 126 of the Consolidated Appropriations Act, 2021.

I hereby certify that the hospital is a Qualifying Hospital under section 126 of Division CC of the Consolidated Appropriations Act, 2021 (per section 1886(h)(9)(F)(ii) of the Social Security Act).

I hereby certify the “demonstrated likelihood” that the hospital will fill the position made available under section 126 of Division CC of the Consolidated Appropriations Act, 2021 within the first 5 training years beginning after the date the increase would be effective, as determined by the Secretary (per section 1886(h)(9)(B)(i) of the Social Security Act).

I hereby certify that if my application is for a currently accredited residency program, the number of full-time equivalent (FTE) positions requested by the hospital does not exceed the number of positions for which the program is accredited.

I hereby certify that if my hospital currently has unfilled positions in its residency program that have previously been approved by the ACGME, the number of FTE positions requested by the hospital does not exceed the number of previously approved unfilled residency positions.

I hereby certify that if my application is for a residency training program with more than one participating site, I am only requesting the FTE amount that corresponds with the training occurring at my hospital, and any FTE training occurring at nonprovider settings consistent with 42 CFR 412.105(f)(1)(ii)(E) and 413.78(g).

I hereby certify that the hospital agrees to increase the number of its residency positions by the amount the hospital’s FTE resident caps are increased under section 126 of Division CC of the Consolidated Appropriations Act, 2021, if awarded positions (per section 1886(h)(9)(C)(ii) of the Social Security Act).

I hereby certify that for the residency program for which the hospital is applying (choose one):

___ In the geographic HPSA the hospital is requesting that CMS use for prioritization of its application, at least 50 percent of the program’s training time based on resident rotation schedules (or similar documentation) occurs at training sites that treat the population of the HPSA and are physically located in the HPSA.

___ In the population HPSA the hospital is requesting that CMS use for prioritization of its application, at least 50 percent of the program’s training time based on resident rotation schedules (or similar documentation) occurs at training sites that treat the designated underserved population of the HPSA and are physically located in the HPSA.

___ In the geographic HPSA the hospital is requesting that CMS use for prioritization of its application, at least 5 percent of the program’s training time based on resident rotation schedules (or similar documentation) occurs at training sites that treat the population of the HPSA and are physically located in the HPSA, and the program’s training time at those sites plus the program’s

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training time at Indian or Tribal facilities located outside of the HPSA is at least 50 percent of the program's training time.

___ In the population HPSA the hospital is requesting that CMS use for prioritization of its application, at least 5 percent of the program's training time based on resident rotation schedules (or similar documentation) occurs at training sites that treat the designated underserved population of the HPSA and are physically located in the HPSA, and the program's training time at those sites plus the program's training time at Indian or Tribal facilities located outside of that HPSA is at least 50 percent of the program's training time.

___ None of the above apply.

I hereby certify that the hospital meets the National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (the National CLAS Standards).

I hereby certify that I understand that misrepresentation or falsification of any information contained in this application may be punishable by criminal, civil, and administrative action, fine and/or imprisonment under Federal law.

Furthermore, I understand that if services identified in this application were provided or procured through payment directly or indirectly of a kickback or where otherwise illegal, criminal, civil, and administrative action, fines and/or imprisonment may result.

I also certify that, to the best of my knowledge and belief, it is a true, correct, and complete application prepared from the books and records of the hospital in accordance with applicable instructions, except as noted.

I further certify that I am familiar with the laws and regulations regarding Medicare payment to hospitals for the training of interns and residents.

Name of Person Completing this Form

Name of Hospital

Position

Telephone Number

Name of Residency Program

Residency Program Accreditation
Number

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Signature

Date Signed *example: MM/DD/YYYY*