MONTHLY CASH RECEIPTS ASSESSMENT REPORT CERTIFICATION

PROVIDER NAME

ADDRESS

REPORT FOR THE MONTH ENDED _____ _____, _____
MONTH DAY YEAR

OPERATING
CERTIFICATE #:_____ MMIS #:_____

COMPLETED BY:_____

TITLE:_____

TELEPHONE: ( )_____

TYPE OF
PROVIDER: ☐ ARTICLE 28 GENERAL HOSPITAL
☐ ARTICLE 28 RESIDENTIAL HEALTH CARE FACILITY

CERTIFICATION

I, _____, CERTIFY THAT I AM THE CHIEF EXECUTIVE/FINANCIAL OFFICER AND/OR ADMINISTRATOR OF THIS FACILITY, AND FURTHER CERTIFY THAT THE DATA BEING PROVIDED HAS BEEN CAREFULLY PREPARED IN ACCORDANCE WITH INSTRUCTIONS CONTAINED HEREIN FROM THE BOOKS AND RECORDS WITHIN THIS FACILITY, AND TO THE BEST OF MY KNOWLEDGE, I BELIEVE THE INFORMATION PRESENTED HEREIN IS ACCURATE AND CORRECT.

_____ _____
SIGNATURE DATE