

**HOSPICE
UNIFORM ACCOUNTING REPORT (UAR)
ATTESTATION OF COMPLETENESS AND ACCURACY**

FACILITY NAME: _____

LICENSE NUMBER: **HSPC** _____ **FISCAL YEAR END DATE:** _____

UAR REPORTING PERIOD DATE RANGE > **FROM:** _____ **TO:** _____

MEDICARE COST REPORT YEAR END DATE: _____

ATTESTATION BY ADMINISTRATOR OF FACILITY OR DESIGNEE (CHECK ONE)

I attest that, to the best of my knowledge and belief, all information in this *Uniform Accounting Report* is accurate and complete.

OR

I have personal knowledge that some of the information in this *Uniform Accounting Report* is not accurate or not complete. I attest that, to the best of my knowledge and belief, all information in the report is accurate and complete, except the information identified in a document accompanying this form that:

- 1) Describes the inaccurate or incomplete information and the circumstances that make the information inaccurate or incomplete, and
- 2) States what actions the facility is taking to correct the inaccurate information or make the information complete.

Print Name

Title

**Signature (Administrator of Facility or Designee)
(REQUIRED)**

Date

SUBMIT ALL FINANCIAL REPORTING DOCUMENTS AS EMAIL ATTACHMENTS TO:
costreporting@azdhs.gov