RATES AND CHARGES
ATTESTATION OF COMPLETENESS AND ACCURACY

FACILITY NAME: _____

RATES/CHARGES EFFECTIVE: _____

(DATE)

FACILITY TYPE: **(CHECK ONE)**

☐ **Home Health Agency** **LICENSE NUMBER: HHA**_____

☐ **Outpatient Treatment Center** **LICENSE NUMBER: OTC**_____

ATTESTATION BY ADMINISTRATOR OF FACILITY OR DESIGNEE (CHECK ONE)

☐ I attest that, to the best of my knowledge and belief, all information in this *Rates and Charges Form* is accurate and complete.

OR

☐ I have personal knowledge that some of the information in this *Rates and Charges Form* 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