AGENDA ITEM or FINAL CONTRACT REVIEW SUBMITTAL FORM

AgendaTitle:
Office of Pharmacy Affairs; Hospital Certification of Ownership/Operation by a Unit of State/Local Government; Certification of Contract between Private, Non-Profit Hospital and State/Local Government to Provide Health Care Services to Low Income Individuals; Gunnison Valley Hospital

Action Requested: County Manager Signature

Parties to the Agreement: Office of Pharmacy Affairs & GVH

Term Begins: **Term Ends:** **Grant Contract #:**

Summary:
Jim Barbaut, the CFO for GVH has signed the document & is asking that Gunnison County sign as the State or Local Government Official.

Fiscal Impact:

Submitted by: Blucero **Submitter's Email Address:** blucero@gunnisoncounty.org

Finance Review: ○ Required ◉ Not Required

Comments:

Reviewed by: Discharge Date:

County Attorney Review: ◉ Required ○ Not Required

Comments:

Reviewed by: GUNCOUNTY1\atrezise Discharge Date: 6/24/2014 Certificate of Insurance Required Yes ○ No ◉

County Manager Review:

Comments:

Reviewed by: GUNCOUNTY1\mbirnie Discharge Date: 6/24/2014

◉ Consent Agenda ○ Regular Agenda ○ Worksession Time Allotted:

Agenda Date: 7/1/2014 Follow Up Agenda Date:

Revised April 2013

OFFICE OF PHARMACY AFFAIRS (OPA)
HOSPITAL CERTIFICATION OF OWNERSHIP/OPERATION
BY A UNIT OF STATE/LOCAL GOVERNMENT

In order to meet the eligibility requirement (Section 340B(a)(4)(L)(i)) of ownership/operation by a unit of state/local government this certification must be completed and signed by a representative from both parties specified below.

Gunnison Valley Hospital
Name of Hospital

711 N. Taylor Street Gunnison Colorado 81230
Street Address, City, State, Zip

I certify that the aforementioned hospital organization is owned and/or operated by a unit of the State or local government. (Please check the appropriate box below)

Owned ☐ **Operated** ☐ **Both** ☐

Signature of State or Local Government Official Date

Name of State or Local Government Official *(please print or type)*

Title and Unit of Government

Phone Number Ext. E-Mail Address

The undersigned represents and confirms that he/she is fully authorized to legally bind the covered entity and certifies that the contents of any statement made or reflected in this document are truthful and accurate. I certify that the ownership and/or operating status identified above is currently valid, and agree to inform the Office of Pharmacy Affairs of any material change as soon as reasonably possible.

James P. Barbuat 6/18/2014
Signature of Hospital Authorizing Official Date

James P. Barbuat CFO
Name & Title of Hospital Authorizing Official (e.g.: CEO, CFO, COO) ***(Please print or type)***

(970) 641-7275 jbarbuat@gvh-colorado.org
Phone Number Ext. E-Mail Address

This registration form must be completed and submitted according to the established deadlines that are published on the OPA website (www.hrsa.gov/opa).

OFFICE OF PHARMACY AFFAIRS (OPA)
CERTIFICATION OF CONTRACT BETWEEN PRIVATE, NON-PROFIT HOSPITAL AND STATE/LOCAL GOVERNMENT TO PROVIDE HEALTH CARE SERVICES TO LOW INCOME INDIVIDUALS

To demonstrate that the hospital meets the statutory definition of covered entity under section 340B(a)(4)(L)(i) as a private non-profit hospital which has a contract with a State or local government to provide health care services to low income individuals, this certification must be completed and signed by both parties.

Gunnison Valley Hospital
Name of Hospital

Gunnison, Colorado 81230
City, State, Zip

Pursuant to the requirement of Section 340B of the Public Health Service Act (42 U.S.C. 256b), I certify that a valid contract (please provide contract number or identifier if applicable #_____) is currently in place between the private, non-profit hospital named above, and the State or Local Government Entity named below, to provide health care services to low income individuals who are not entitled to benefits under Title XVIII of the Social Security Act or eligible for assistance under the State plan of Title XIX of the Social Security Act. In addition, the authorizing official certifies that when this contract is no longer valid, appropriate notice will be provided to the Office of Pharmacy Affairs. The undersigned represents and confirms that he/she is fully authorized to legally bind the covered entity and certifies that the contents of any statement made or reflected in this document are truthful and accurate.

James P. Barbuat — 6/18/2014
Signature of Hospital Authorizing Official Date

James P. Barbuat CFO
Name and Title of Authorizing Official (e.g., CEO, CFO, COO) *(please print or type)*

(970) 641-7275 — _____ — jbarbuat@gvh-colorado.org
Phone Number — Ext. — E-Mail Address

_____ — _____
Signature of State or Local Government Official — Date

_____
Name of State or Local Government Official *(please print or type)*

_____
Title and Unit of Government

_____
Address

_____ — _____ — _____
Phone Number — Ext. — E-Mail Address