

CERTIFICATION OF STATEWIDE  
MEDICAID RESIDENCY PROGRAM  
FTE RESIDENT COUNT

AGENCY FOR HEALTH CARE ADMINISTRATION  
2727 Mahan Drive  
Fort Knox, Building 3 MS #23  
Tallahassee, Florida 32308

FROM:

\_\_\_\_\_  
(NAME OF FACILITY)

\_\_\_\_\_  
(MEDICAID ID)

\_\_\_\_\_  
(STREET ADDRESS)

\_\_\_\_\_  
(CITY)

\_\_\_\_\_  
(ZIP CODE)

I HEREBY CERTIFY THAT I HAVE EXAMINED THE ACCOMPANYING STATEWIDE MEDICAID FULL TIME EQUIVALENT RESIDENT COUNT INPUT FORM AS PART OF THE STATEWIDE MEDICAID RESIDENCY PROGRAM, IN ACCORDANCE WITH AND SUBJECT TO THE PROVISIONS OF SECTION 409.909, F.S. TO THE BEST OF MY KNOWLEDGE AND BELIEF, THE INFORMATION CONTAINED IN THE REPORT SUBMITTED IS TRUE, ACCURATE, AND COMPLETE AND HAS BEEN PREPARED FROM THE FACILITY'S BOOKS AND RECORDS, EXCEPT AS NOTED:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

CHIEF EXECUTIVE OFFICER

\_\_\_\_\_  
(TYPE OR PRINT)

\_\_\_\_\_  
(SIGNATURE)

\_\_\_\_\_  
(DATE)