

**UTAH MEDICAID NURSING FACILITY**  
**State Fiscal Year 2012**  
**QUALITY IMPROVEMENT INCENTIVE (2)(viii) APPLICATION**  
**HVAC, Rule R414-504-4**

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**This form and all supporting documentation must be postmarked or faxed on or before May 31, 2012**

Facility Name: \_\_\_\_\_

Medicaid Provider I.D. \_\_\_\_\_ Administrator: \_\_\_\_\_

Please mark all that are complete:

- This facility purchased a new or enhanced its existing heating, ventilating, and air conditioning system (HVAC).
- A detailed description of the HVAC is attached.
- The HVAC was paid for by May 31, 2012.
- The HVAC was installed between July 1, 2010 and May 31, 2012.
- Proof of purchase that includes receipts and invoices, is also attached. This includes proof of payment, i.e. cancelled check(s), financial debt instrument, etc.

Qualifying facilities may receive up to \$162 per Medicaid Certified bed under this incentive (count as at 7/1/2011). This incentive is part of incentive (2). The maximum a facility may receive from all incentives in incentive (2) combined, is \$590.43 per Medicaid Certified bed (count as at 7/1/2011). Facilities will not receive more than was expended under this incentive.

Attach Spreadsheet for detail expenditures

Total Reimbursement Requested (should match spreadsheet): \$ \_\_\_\_\_

**Please ensure that all the supporting documentation is included. Failure to include all of the above detailed information will prevent the facility from qualifying.**

By submitting this application I certify that all of the above criteria have been met.

Administrator Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Note:** Division staff will not request additional information relating to this submission. Please be sure to include all necessary information in order to qualify. Fax to: 801-323-1595 <or> Mail instructions: <http://health.utah.gov/medicaid/stplan/longtermcare.htm>

**For Medicaid use only:**

Amount reimbursed

Maximum per-bed payout:

Date Paid