

# Healthy Outcomes Plan Cover Page

Proviso 33.34 A(1), C, D



Project Title

Application Date

Name of Hospital(s) [1]

Name of Hospital(s) [2]

Name of Partner(s) [1]

Name of Partner(s) [2]

I attest that, on behalf of the above named hospital(s), I am the organization representative approved to submit a Healthy Outcomes Plan (HOP) process improvement proposal. I further attest that the partner(s) signature(s) is also the approved representative for the respective organization(s) to request participation in the HOP with the above named hospital. Additionally, I attest that all partners will participate in SCDHHS HOP evaluation activities. By signing this form, the representatives certify that the information contained herein has been reviewed by all parties and all parties have had the opportunity to consult with their respective legal entity.

Hospital Representative

Date

Hospital Representative

Date

Hospital Representative

Date

*\*Additional signature lines may be added for additional community service and primary care safety net partners participating in the proposed collaboration.*