

INSTRUCTIONS FOR PHASE 2 – GENERAL DISTRIBUTION APPLICATION VIA PROVIDER RELIEF FUND APPLICATION AND ATTESTATION PORTAL

The sample application form is available at:

<https://www.hhs.gov/sites/default/files/provider-distribution-application-form.pdf>.

If you began filling out an application before August 10, 2020, the previous instructions are available at:

<https://www.hhs.gov/sites/default/files/medicaid-provider-distribution-instructions.pdf>.

Definitions

“Applicant” means an individual or entity eligible to apply.

“Included subsidiary” means an entity that (i) is a disregarded entity for federal income tax purposes and (ii) reports its revenues on the applicant’s federal income tax return’s line for “gross receipts or sales” or “program service revenue.”

“Patient care” means health care, services and supports, as provided **in a medical setting, at home, or in the community** to individuals who may currently have or be at risk for COVID-19, whereby HHS broadly views every patient as a possible case of COVID-19.

“Applicant with revenue adjustments” means an applicant that acquired or disposed of (whether by sale, termination, or otherwise) included subsidiaries such that its revenue as calculated in the table above is more than 20% larger or smaller than the adjusted revenue number as calculated using the Revenue Worksheet in Field 15.

Application Requirements

Who is eligible to apply?

To be eligible to apply, the applicant must meet all of the following requirements:

1. Either
 - a. Must have either (i) directly billed their state **Medicaid/CHIP programs or Medicaid managed care plans** for healthcare-related services during the period of January 1, 2018, to December 31, 2019, or (ii) own (on the application date) an included subsidiary that has either directly billed their state **Medicaid/CHIP programs or Medicaid managed care plans** for healthcare-related services during the period of January 1, 2018, to December 31, 2019; or
 - b. Must be a dental service provider who has either (i) directly billed health insurance companies for oral healthcare-related services, or (ii) owns (on the application date) an included subsidiary that has directly billed health insurance companies for oral healthcare-related services;
 - c. Must be a licensed dental service provider who does not accept insurance and has either (i) directly billed patients for oral healthcare-related services, or (ii) who owns (on the application date) an included subsidiary that does not accept insurance and has directly billed patients for oral healthcare-related services;
 - d. Must have billed Medicare fee-for-service during the period of January 1, 2019 and December 31, 2019; or

- e. Must be a Medicare Part A provider that experienced a change in ownership and billed Medicare fee-for-service in 2019 or 2020 that prevented the otherwise eligible provider from receiving a Phase 1 - General Distribution payment.
2. Must have either (i) filed a federal income tax return for fiscal years 2017, 2018 or 2019 or (ii) be an entity exempt from the requirement to file a federal income tax return and have no beneficial owner that is required to file a federal income tax return. (e.g. a state-owned hospital or healthcare clinic); and
3. Must have provided patient care after January 31, 2020; and
4. must not have permanently ceased providing patient care directly, or indirectly through included subsidiaries; and
5. if the applicant is an individual, have gross receipts or sales from providing patient care reported on Form 1040, Schedule C, Line 1, excluding income reported on a W-2 as a (statutory) employee.

Providers who have received a payment under Phase 1 of the General Distribution are no longer prohibited from submitting an application under Phase 2 of the General Distribution. Providers who received a previous Phase 1 – General Distribution payment are eligible to apply and, if they have not yet received a payment that is approximately 2% of annual revenue from patient care, may receive additional funds.

APPLICANTS MUST MEET ALL FIVE REQUIREMENTS IN ORDER TO SUBMIT THIS APPLICATION.

Which documentation must be uploaded to the application form?

1. The applicant's most recent federal income tax return for 2017, 2018 or 2019 or a written statement explaining why the applicant is exempt from filing a federal income tax return (e.g. a state-owned hospital or healthcare clinic).
2. If required by Field 15, the Revenue Worksheet, provided by HHS and available at: <https://hhs.gov/sites/default/files/prf-gross-revenues-worksheet.xlsx>

APPLICANTS MUST HAVE ALL REQUIRED DOCUMENTATION IN ORDER TO SUBMIT THIS APPLICATION.

When is the deadline to submit an application?

The deadline for submitting a taxpayer identification number (TIN) for validation is August 28, 2020. Applications initiated after this date will not be considered for payment.

Who should fill out the application form?

Any person authorized by the provider organization may complete this form. We recommend it be completed by an organization's corporate office, or personnel familiar with the corporate financial documents necessary to complete that application, specifically, the Chief Financial Officer or other accounting professional.

What are the terms and conditions for this distribution?

The Terms & Conditions are available at <https://www.hhs.gov/sites/default/files/terms-and-conditions-medicaid-relief-fund.pdf>.

Am I able to edit or resubmit my application?

You can only submit one application. You can edit the data on the application form, until the form is submitted. You cannot edit or resubmit the application form once it is submitted. You should not apply until you have available all of the information and documentation required by the application form.

What provider types are eligible to apply?

Providers that meet the five eligibility criteria are eligible to apply. This may include, but is not limited to, hospitals, health systems, physician practices, residential facilities, nursing service providers, Home- and Community-based Services providers, and Intermediate Care Facilities for Individuals with Intellectual Disabilities.

Application Field Instructions



Unless otherwise specified, all fields require the total number for the applicant and its included subsidiaries, if any.

Field 1

Contact Person Name

Enter the first and last name of a contact person who is authorized to submit the application and who can be contacted if HHS has additional questions or needs to follow up.

Field 2

Contact Person Title

Enter the title of the contact person listed in Field 1.

If the applicant is an individual, enter “Individual.”

Field 3

Contact Person Phone Number

Enter the phone number where the contact person listed in Field 1 can best be reached. Do not include any extensions.

Field 4

Contact Person Email

Enter the email address where the contact person listed in Field 1 can best be reached.

Field 5

Applicant Type

An Applicant Type Code is a two-character series of letters that generally summarizes an organization’s purpose. Enter the *single* code that best describes your organization from following list:

Applicant Type Code	Description
AG	Agencies (ex. foster care, developmental disabled services, etc.)
BE	Behavioral Health (Outpatient)
CA	Case Management
CL	Clinic/Center
CO	Community-based Social Support Providers
DE	Dental Services
EM	Emergency
HO	Home Health
HS	Hospital
NO	Non-emergency Medical Transport
NU	Nursing Service Providers
OB	Obstetrics/Gynecology
OP	Other Physician
PE	Pediatrics
PP	Primary Care Physician
RF	Residential Facilities
RB	Residential Facilities (Behavioral)
SA	Substance Abuse (Rehabilitation)
OT	Other

Note: Home- and Community-Based Service (HCBS) provider applicants should categorize personal care services as “Other,” code OT. Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID) applicants should categorize their services as “Residential Facilities,” code RF.

Fields 6-8 intentionally removed

Field 9

CMS Certification Number (CCN)

If applicable, enter the applicant’s CMS Certification Number (CCN). If the applicant has more than one CCN, enter only one CCN.

Field 10

Revenues

Enter the applicant’s revenue number from its most recent federal income tax return of 2017, 2018, or 2019. If the applicant for tax purposes is a:

sole proprietor or disregarded entity owned by an individual:	Enter Line 3 from IRS Form 1040, Schedule C <u>excluding</u> any income reported on W-2.
partnership:	Enter Line 1c <u>minus</u> Line 12 from IRS Form 1065.
C corporation:	Enter Line 1c <u>minus</u> Line 15 from IRS Form 1120.
S corporation:	Enter Line 1c <u>minus</u> Line 10 from IRS Form 1120-S.
tax-exempt organization:	Enter Line 9 from IRS Form 990 <u>minus</u> any joint venture income, if included in Part VIII lines 2a – 2f .
trust or estate:	Enter Line 3 from IRS Form 1040, Schedule C.
entity not required to file any of the previously mentioned IRS forms:	Enter a “net patient service revenue” number or equivalent from the applicant’s most recent audited financial statements (or management-prepared financial statements)



Applicants with revenue adjustments should enter an adjusted revenue number as calculated using the Revenues Worksheet in Field 15. The revenue amount entered in Field 10 should equal the adjusted revenue amount on line 4 of the revenue worksheet. The Revenues Worksheet in Field 15 available at: <https://hhs.gov/sites/default/files/prf-gross-revenues-worksheet.xlsx>.

Field 11

Fiscal Year of Revenues

Enter the fiscal year of the applicant's most recent federal income tax return.

Applicants that do not file a federal income tax return and have no ultimate parent entity filing a federal income tax return (e.g., state entities) should submit the fiscal year of the revenue information reported in Field 10.

Field 12

Percentage of Revenues from Patient Care

Enter the percentage of the applicant's revenues entered in Field 10 that represents amounts received for patient care rendered for the same fiscal year selected in Field 11. This percentage includes pharmacy revenue derived through the 340B program and should exclude non-patient care revenue (e.g., insurance, retail, or real estate revenues; grants; tuition).

Fields 13-14 intentionally removed

Field 15

Revenues Worksheet

Any applicant with revenue adjustments who enters an adjusted revenue number different from the applicable number shown on its most recent federal income tax return must upload the Revenue Worksheet. The worksheet is provided by HHS and is available at:

<https://hhs.gov/sites/default/files/prf-gross-revenues-worksheet.xlsx>.

“Applicant with revenue adjustments” means an applicant that acquired (whether as stock or asset purchase) or disposed of (whether by sale, termination, or otherwise) included subsidiaries such that its revenue as calculated in the table of Field 10 is more than 20% larger or smaller than the adjusted revenue number as calculated using the Revenues Worksheet in Field 15.

For dispositions, enter revenue included in the tax return uploaded in Field 16 of included subsidiaries that were disposed of. For acquisitions, enter revenue not included in the tax return uploaded in Field 16 of included subsidiaries that were acquired.

Example 1: Applicant A with its 2018 tax return covering the period of January 31 to December 31, 2018, had revenues of \$5,000,000 during that year. Applicant A acquired a provider with annual revenues of \$1,500,000 on March 20, 2019. This applicant should add the acquired provider's annual revenues of \$1,500,000 to its revenue number to arrive at the applicant's adjusted revenue number of \$6,500,000 to be entered in Field 10.

*Example 2: Applicant B with its 2018 tax return covering the period of January 31 to December 31, 2018, had revenues of \$2,000,000 during that year. Applicant A acquired a provider with annual revenues of \$1,200,000 on August 1, 2018. This applicant should add the pro-rated portion of the acquired provider's annual revenues not included in the applicant's revenue number as reported on its tax return. This pro-rated portion is calculated using the number of months during the taxable year before the acquisition, i.e. 7 (January to July, 2018). Thus, the pro-rated portion of the acquired provider's annual revenues is $7/12 * \$1,200,000 = \$700,000$. As a result, the applicant's adjusted revenues to be entered in Field 10 are \$2,700,000.*

*Example 3: Applicant B of Example 2 also sold a provider with annual revenues of \$300,000 in June 2018. Thus, the months of January through June, 2018 (6 months), are still included in Applicant B's revenues as reported on the tax return. Therefore, the applicant should subtract $6/12 * \$300,000 = \$150,000$ from the revenues number to arrive at \$2,650,000 to enter in Field 10.*

Field 16

Federal Tax Form

Upload the applicant's most recent filed federal income tax return for fiscal years 2017, 2018, or 2019.

If the applicant for tax purposes is a

sole proprietor or disregarded entity owned by an individual:	Upload IRS Form 1040 including Schedule C.
partnership:	Upload IRS Form 1065.
C corporation:	Upload IRS Form 1120.
S corporation:	Upload IRS Form 1120-S.
tax-exempt organization:	Upload IRS Form 990.
trust or estate:	Upload IRS Form 1041 including Schedule C.
entity not required to file any of the previously mentioned IRS forms:	Upload a statement explaining why the entity is not required to file a federal tax form.

Fields 17-32 intentionally removed

Field 33 To Field 36

Banking Information

Enter the applicant's banking information necessary to receive an electronic Provider Relief Fund payment.

Fields 37-48 intentionally removed