

# INSTRUCTIONS FOR THE DISTRIBUTION FOR MEDICAID, CHIP, AND DENTAL PROVIDERS VIA ENHANCED PROVIDER RELIEF FUND PAYMENT PORTAL

The application form is available at:

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

“Facility” means hospital or other inpatient facility; Ambulatory Surgical Center (ASC); Comprehensive Outpatient Rehabilitation Facility (CORF); Federally Qualified Health Center (FQHC); Rural Health Clinic (RHC); long-term care or skilled nursing facility; and hospices.

“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. Must not have received payment from the \$50 billion General Distribution; and
2. 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; or
  - 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) she owns (on the application date) an included subsidiary that does not accept insurance and has directly billed patients for oral healthcare-related services;

3. 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
4. must have provided patient care after January 31, 2020; and
5. must not have permanently ceased providing patient care directly, or indirectly through included subsidiaries; and
6. 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.

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

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**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. The applicant's Employer's Quarterly Federal Tax Return on IRS Form 941 for Q1 2020, Employer's Annual Federal Unemployment (FUTA) Tax Return on IRS Form 940, or a statement explaining why the applicant is not required to submit either form (e.g. no employees).
3. The applicant's FTE Worksheet, provided by HHS and available at: <https://hhs.gov/sites/default/files/prf-fte-worksheet.xlsx>
4. 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>

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

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**When is the deadline to submit an application?**

The deadline for submitting an application is August 3, 2020.

**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, specifically, the Chief Financial Officers 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 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.

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## Field Instructions for Medicaid, CHIP, and Dental Providers



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, PACE, 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.



If the applicant does not operate facilities as defined in Field 6, enter “0” in Fields 6, 7, and 8.

## Field 6

### Number of facilities

Enter the number of facilities that the applicant and its included subsidiaries operated on 5/31/2020.

Enter “0” if not applicable.

## Field 7

### Beds for all facilities

Enter the number of inpatient beds in facilities operated by the applicant and its included subsidiaries on 5/31/2020.

Enter “0,” if not applicable.

## Field 8

### Total number of FTE

Enter the full-time equivalent (FTE) of W-2 employees (i.e. not independent contractors) providing patient care. A 1.0 FTE works whichever number of hours the applicant considers to be the minimum for a normal workweek, which could be 37.5, 40, 50 hours, or some other standard. To compute FTE of a part-time provider, divide the total hours worked by the provider by the total number of hours that your organization considers to be a normal workweek. Providers may include staff that were furloughed as a result of the coronavirus in the counts of FTEs. Applicants should count providers and staff that were furloughed as of 5/31/2020 as 0.0 FTEs.

## 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 most recent revenue number from its federal 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 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.

## Field 13

### Lost revenues due to COVID-19

Enter the applicant’s lost revenues due to COVID-19 for March and April 2020.



If the applicant experienced a net gain in revenues due to COVID-19, enter “0” as the response.

“Lost revenues due to COVID-19” means the amount of any patient care revenue that you as a healthcare provider lost due to coronavirus, net of any increased revenues due to coronavirus (e.g. insurance-reimbursed treatment). This may include revenue losses associated with fewer outpatient visits, canceled elective procedures or services, increased bad debt, or other causes.

You may use any reasonable method of estimating the revenue during March and April 2020 compared to the same period had COVID-19 not appeared. For example, if you have a budget prepared without taking into account the impact of COVID-19, the estimated lost revenue could be the difference between your budgeted revenue and actual revenue. It would also be reasonable to compare the revenues to the same period last year.

## Field 14

### Increased Expenses due to COVID-19

Enter the applicant's increased expenses due to COVID-19 for March and April 2020.

“Increased expenses due to COVID-19” is a broad term that may cover a range of items and services, including:

- supplies used to provide healthcare services for possible or actual COVID-19 patients (e.g. PPE);
- equipment used to provide healthcare services for possible or actual COVID-19 patients;
- workforce training;
- developing and staffing emergency operation centers;
- reporting COVID-19 test results to federal, state, or local governments;
- building or construction of temporary structures to expand capacity for COVID-19 patient care or to provide healthcare services to non-COVID-19 patients in a separate area from where COVID-19 patients are being treated; and
- additional staffing costs to expand capacity or to provide more intensive medical services.

## Field 15

### Revenues Worksheet

Any applicant with revenue adjustments who enters an adjusted revenue number different from the applicable number shown on its 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 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.



If any of Fields 17 to 23 do not apply to you, enter “0.”

Patients' out-of-pocket costs are considered part of the revenue received from a payer, therefore, should be reported in the commercial payer amount or whichever category is applicable, not separated out into “other” field.



Fields 17 to 22 include revenue only from government programs, private insurance plans, or patients.

## Field 17

### Medicare Part A + B

Enter the percentage of your revenues (as submitted in Field 10) from Medicare Part A + B only for the same fiscal year selected in Field 11. Do not include Part C.

## Field 18

### Medicare Part C

Enter the percentage of your revenues (as submitted in Field 10) from Medicare Part C for the same fiscal year selected in Field 11.

## Field 19

### Medicaid / CHIP

Enter the percentage of your revenues (as submitted in Field 10) from Medicaid and / or CHIP for the same fiscal year selected in Field 11.

## **Field 20**

### **Commercial Insurer**

Enter the percentage of your revenues (as submitted in Field 10) from commercial payers for the same fiscal year selected in Field 11. Revenue from Federal Employee Health Benefit Program (FEHBP) plans should be included in the “commercial payer” category.

## **Field 21**

### **Self-Pay**

Enter the percentage of your revenues (as submitted in Field 10) from self-pay patients for the same fiscal year selected in Field 11.

## **Field 22**

### **Other Government Payer**

Enter the percentage of your revenues (as submitted in Field 10) from other government program sources for the same fiscal year selected in Field 11.

## **Field 23**

### **Other**

Enter the percentage of your revenues (as submitted in Field 10) from other sources for the same fiscal year selected in Field 11.

## **Field 24**

### **Total**

Field 24 is automatically calculated and shows the sum of Fields 17 through 23 and must equal 100%.

## **Field 25**

### **Total Amount received from Treasury SBA / PPP**

Enter the total amount received from Treasury SBA / PPP by the applicant and its included subsidiaries as of 5/31/2020. Enter “0,” if not applicable.

## **Field 26**

### **Total Amount received from FEMA**

Enter the total amount received from FEMA by the applicant and its included subsidiaries as of 5/31/2020. Enter “0,” if not applicable.

## **Field 27**

### **Primary Provider FTE**

Enter the primary provider FTE of the applicant as of 5/31/2020 as reported in the FTE Worksheet uploaded in Field 31. Include only W-2 employees (i.e. not independent contractors). The worksheet is provided by HHS and is available at:

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

If you have more than 125 primary providers, enter the actual number of FTE in Field 27, and report only 125 providers on the FTE Worksheet.



“Primary provider” includes physicians, dentists, nurse practitioners, physician assistants and midwives if these are not under a supervisory relationship with a physician. Primary Providers must be listed in the FTE Worksheet uploaded in Field 31.

A 1.0 FTE works whichever number of hours the applicant considers to be the minimum for a normal workweek, which could be 37.5, 40, 50 hours, or some other standard. To compute FTE of a part-time provider, divide the total hours worked by the provider by the total number of hours that your medical practice considers to be a normal workweek. Providers may include staff who were furloughed as a result of the coronavirus in the counts of FTEs. Applicants should count providers and staff who were furloughed as of 5/31/2020 as 0.0 FTEs.

## **Field 28**

### **Non-Primary FTE**

Enter the non-primary provider FTE as of 5/31/2020. Include only W-2 employees (i.e. not independent contractors).

“Non-primary provider” includes nurse practitioners and midwives if these are under a supervisory relationship with a physician, physician assistants, CRNAs, and all other individuals providing patient care. Providers may include staff who were furloughed as a result of the coronavirus in the counts of FTEs. Applicants should count providers and staff who were furloughed as of 5/31/2020 as 0.0 FTEs.

## **Field 29**

### **Other FTE**

Enter the Other FTE of the applicant as of 5/31/2020. Include only W-2 employees (i.e. not independent contractors).

“Other FTE” includes all employees not directly providing patient care, e.g. scheduling, billing, and accounting. Providers may include staff who were furloughed as a result of the coronavirus in the counts of FTEs. Applicants should count providers and staff who were furloughed as of 5/31/2020 as 0.0 FTEs.

## **Field 30**

### **Number of Locations**

Enter the total number of locations owned or leased by the applicant as of 5/31/2020, at which the applicant and its included subsidiaries are providing patient care.

## **Field 31**

### **FTE Worksheet**

Upload the FTE Worksheet including each primary provider, NPI, and FTE. Enter the total FTE as reported in the FTE worksheet in Field 27. Include only W-2 employees (i.e. not independent contractors). The worksheet is provided by HHS and is available at:

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

“Primary provider” includes physicians, dentists, nurse practitioners, physician assistants and midwives if these are not under a supervisory relationship with a physician.

If you have more than 125 primary providers, enter the actual number of FTE in Field 27, and report only 125 on the FTE Worksheet.

**Field 32****IRS Form 941 for Q1 2020**

Upload the applicant's most recent Employer's Quarterly Federal Tax Return on IRS Form 941 for Q1 2020.

If the applicant is not required to submit Form 941, upload the applicant's Employer's Annual Federal Unemployment (FUTA) Tax Return on IRS Form 940.

If the applicant is not required to submit either form, upload a statement explaining why the applicant is not required to submit either form (e.g. no employees).

**Field 33 To Field 36****Banking Information**

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

**Optional Fields 37 to 48**

Enter values only if instructed to do so.