This Form is Provided for Information Only **Reference ID**______________

HRSA Provider Relief Fund – Phase 4 and American Rescue Plan (ARP) Rural Distribution Revenue Application

Tax ID Number: ______________________

Name as shown on your income tax return: ______________________

Federal Tax Classification: ______________________

Business Name (if different): ______________________

Street 1: ______________________

Street 2: ______________________

City: ______________ State: __________ Zip: __________

Registration Type: ______________________

NPI: ______________________

(1) Contact Person Name: ______________________

(2) Contact Person Title: ______________________

(3) Contact Person Phone Number: ______________________

(4) Contact Person Email: ______________________

(5) Applicant/Provider Type: ______________________

Fields 6 - 8 have been intentionally removed

(9) CMS Certification Numbers (CCNs), if applicable: ______________________

REVENUES

(10) Revenues: $ ______________

(11) Fiscal Year of Revenues: ______________

(12) Revenue from Patient Care: $ ______________

(12.1) Select the Federal Tax From you will upload to support Patient Care Revenue: ______________

13. OPERATING REVENUES FROM PATIENT CARE

(13.1) 2019 Q1 (Jan 1 – Mar 31): ______________ (13.2) 2019 Q3 (July 1 – Sept 30): ______________

(13.3) 2019 Q4 (Oct 1 – Dec 31): ______________ (13.4) 2020 Q3 (July 1 – Sept 30): ______________

(13.5) 2020 Q4 (Oct 1 – Dec 31): ______________ (13.6) 2021 Q1 (Jan 1 – Mar 31): ______________

14. OPERATING EXPENSES FROM PATIENT CARE

(14.1) 2019 Q1 (Jan 1 – Mar 31): ______________

(14.2) 2019 Q3 (July 1 – Sept 30): ______________

(14.3) 2019 Q4 (Oct 1 – Dec 31): ______________

(14.4) 2020 Q3 (July 1 – Sept 30): ______________

(14.5) 2020 Q4 (Oct 1 – Dec 31): ______________

(14.6) 2021 Q1 (Jan 1 – Mar 31): ______________

SUPPORTING DOCUMENTATION: Total Annual Revenues and Annual Revenues from Patient Care

(15) *Autopopulated based on Field 12.1* ______________

(16) Upload Annual Revenues Adjustments Worksheet (if required): ______________

(17) Upload Annual Revenues from Patient Care Worksheet (if required): ______________

(18) Upload Organization Structure Documentation (if required): ______________

SUPPORTING DOCUMENTATION: Operating Revenues and Expenses from Patient Care

(19) Upload 2020 Q3 and Q4 and 2021 Q1 operating revenues and expenses from patient care documentation: ______________

(20) Upload 2019 Q1,Q3,Q4 operating revenues and expenses from patient care documentation: ______________

RURAL PROVIDERS

(21) Select "Yes" if your organization would like to be considered for an additional ARP rural payment.

Yes No

Fields 22 - 32 have been intentionally removed

BANKING INFORMATION

(33) Bank Name: ______________

(34) ABA Routing Number: ______________

(35) Account Holder Name: ______________

(36) Account Number: ______________

Terms and Conditions

If a payment is issued, all recipients must agree to its distribution's Terms and Conditions within 90 days.

By clicking 'Submit' the Recipient understands that non-compliance with any Term or Condition or any applicable statutes and regulations will result in administrative, civil, and/or criminal action being taken and certifies that, you are a bonafide legal representative of the entities represented herein and that all of the information you are submitting to a Federal Government System, under penalty and perjury of law, is true, correct, and accurate.