Reference ID _____

CARES Act Provider Relief Fund

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: _____

Group NPI (Group Only): _____

(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 Number (CCN), if applicable: _____

REVENUES

(10) Revenues: $ _____

(11) Fiscal Year of Revenues: _____

(12) Percentage of Revenue from Patient Care: _____ %

13. OPERATING REVENUES FROM PATIENT CARE

(13.1) 2020 Q1 (Jan 1 – Mar 31): _____ (13.2) 2020 Q2 (April 1 – June 30): _____

(13.3) 2019 Q1 (Jan 1 – Mar 31): _____ (13.4) 2019 Q2 (April 1 – June 30): _____

14. OPERATING EXPENSES FROM PATIENT CARE

(14.1) 2020 Q1 (Jan 1 – Mar 31): _____ (14.2) 2020 Q2 (April 1 – June 30): _____

(14.3) 2019 Q1 (Jan 1 – Mar 31): _____ (14.4) 2019 Q2 (April 1 – June 30): _____

SUPPORTING DOCUMENTS

(15) Upload Revenues Worksheet (if required): _____

(16) Upload Federal Tax Form: _____

(17) Upload supporting documents for 2019 Q1-Q2 operating revenues and expenses from patient care: _____

(18) Upload supporting documents for 2020 Q1-Q2 operating revenues and expenses from patient care: _____

Fields 19 - 32 have been intentionally removed

BANKING INFORMATION

(33) Bank Name: _____

(34) ABA Routing Number: _____

(35) Account Holder Name: _____

(36) Account Number: _____

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