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 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: _____ %

Fields 13 and 14 have been intentionally removed

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

(16) Upload Federal Tax Form: _____

Fields 17 - 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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