



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 Form 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.