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: $ __________________________

(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. 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): ______________
14. OPERATING EXPENSES FROM PATIENT CARE

(14.1) 2019 Q1 (Jan 1 – Mar 31): ____________  (14.2) 2019 Q3 (July 1 – Sept 30): ____________

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.