ATTESTATION AND FUNDING REQUEST FROM AR ARPA ALLOCATION FOR

HOSPITAL COVID SURGE STAFF FUNDING

I, \_\_\_ (CEO NAME AND TITLE)\_\_\_ , on behalf of \_\_\_(HOSPITAL NAME AND PROVIDER NUMBER)\_\_\_\_\_\_\_\_\_, attest to the following:

**Section 1. FORMULA-BASED ALLOTMENT**: The hospital requests allotment of funds to address the staffing and bed shortages and additional costs of providing COVID-19 treatment in this third wave of COVID-19 infection currently caused primarily by the Delta Variant per the AR ARPA Proposal approved by the Arkansas Legislative Council on August 9, 2021. The purpose of these formula-based payments is to assist hospitals to offset extraordinary costs related to retaining and acquiring frontline staff.

The hospital will submit the proper documentation of costs that are necessary expenditures to attain and retain frontline healthcare workers due to the public health emergency with respect to COVID-19. Acceptable documentation may include, but is not limited to, any documents or files sufficient to evidence actual obligation or expense of funds. DHS may request supplemental documentation, as needed. Examples of sufficient documentation include copies of purchase orders, contracts, receipts, payroll records, cancelled checks, and bank and credit statements.

The hospital requests the following amount of funding from the AR ARPA Formula-Based Allotment: (CHECK ONE)

[ ]  An amount equal to the full amount of my hospital’s available formula-based funding, which is:

|  |  |
| --- | --- |
|  \_\_\_\_\_\_\_\_\_\_\_\_  | Number of licensed “Medicare beds” in my facility as of March 1, 2021 |
| X $9,000.00 |  |
|  |  |
| $ \_\_\_\_\_\_\_\_\_\_\_\_  | **TOTAL FORMULA-BASED ALLOTMENT REQUEST** |

[ ]  The amount of $ AN AMOUNT LESS THAN THE TOTAL FORMULA-BASED ALLOTMENT.

**The hospital acknowledges and agrees that it cannot submit aN ARPA FORMULA COST FORM requesting funding in excess of the amount indicated in this section 1 AND THAT ALL REQUESTS MUST BE SUBMITTED BY SEPTEMBER 30, 2021.**

**Section 2. COVIDComm RECEIVING HOSPITAL ADD-ON PAYMENTS**:

The hospital requests allotment of funds to address the staffing and bed shortages and additional costs of providing COVID-19 treatment in this third wave of COVID-19 infection currently caused primarily by the Delta Variant per the AR ARPA Proposal approved by the Arkansas Legislative Council on August 9, 2021. The purpose of these formula-based payments is to assist hospitals to offset extraordinary costs related to retaining and acquiring frontline staff.

The hospital will submit the proper documentation of costs that are necessary expenditures to attain and retain frontline healthcare workers due to the public health emergency with respect to COVID-19. Acceptable documentation may include, but is not limited to, any documents or files sufficient to evidence actual obligation or expense of funds. DHS may request supplemental documentation, as needed. Examples of sufficient documentation include copies of purchase orders, contracts, receipts, payroll records, cancelled checks, and bank and credit statements.

In addition to the formula-based allotment, the hospital attests that it: (CHECK ONE)

[ ]  Used ONLY the COVIDComm system to transfer patients from my facility(ies) to other facility(ies) and therefore, is not entitled to COVIDComm Receiving Hospital Add-on Payments under the AR ARPA Proposal approved by the Arkansas Legislative Council on August 9, 2021.

[ ]  Participated as a receiving hospital of COVID-19-positive patients in the Arkansas Department of Health’s COVIDComm Transfer system as of August 20, 2021, and therefore, is entitled to COVIDComm Receiving Hospital Add-on Payments under the AR ARPA Proposal approved by the Arkansas Legislative Council on August 9, 2021.

|  |  |
| --- | --- |
|  \_\_\_\_\_\_\_\_\_\_\_\_  | Number of licensed “Medicare beds” in my facility as of March 1, 2021 |
| X $2,500.00 |  |
|  |  |
| $ \_\_\_\_\_\_\_\_\_\_\_\_  | **TOTAL COVIDComm RECEIVING HOSPITAL ADD-ON PAYMENT REQUEST** |

[ ]  Did not participate as a receiving hospital of COVID-19-positive patients in the Arkansas Department of Health’s COVIDComm Transfer system as of August 20, 2021, and therefore, is not entitled to COVIDComm Receiving Hospital Add-on Payments under the AR ARPA Proposal approved by the Arkansas Legislative Council on August 9, 2021.

**Section 3. MONOCLONAL ANITBODY (MAB) ADMINISTRATION ADD-ON PAYMENTS**:

The hospital requests allotment of funds to address the staffing and bed shortages and additional costs of providing COVID-19 treatment in this third wave of COVID-19 infection currently caused primarily by the Delta Variant per the AR ARPA Proposal approved by the Arkansas Legislative Council on August 9, 2021. The purpose of these formula-based payments is to assist hospitals to offset extraordinary costs related to retaining and acquiring frontline staff.

The hospital will submit the proper documentation of costs that are necessary expenditures to attain and retain frontline healthcare workers due to the public health emergency with respect to COVID-19. Acceptable documentation may include, but is not limited to, any documents or files sufficient to evidence actual obligation or expense of funds. DHS may request supplemental documentation, as needed. Examples of sufficient documentation include copies of purchase orders, contracts, receipts, payroll records, cancelled checks, and bank and credit statements.

In addition to the formula payment, the hospital attests that it: (CHECK ONE)

[ ]  Administered monoclonal antibodies in an outpatient setting (including emergency department) to COVID-19-positive patients as reported by hospitals through August 20, 2021, and therefore, is entitled to Monoclonal Antibody (MAB) Administration Add-on Payments under the AR ARPA Proposal approved by the Arkansas Legislative Council on August 9, 2021.

|  |  |
| --- | --- |
|  \_\_\_\_\_\_\_\_\_\_\_\_  | Number of licensed “Medicare beds” in my facility as of March 1, 2021 |
| X $1,000.00 |  |
|  |  |
| $ \_\_\_\_\_\_\_\_\_\_\_\_  | **TOTAL MAB ADMINISTRATION ADD-ON PAYMENT REQUEST** |

[ ]  Did not administer monoclonal antibodies in an outpatient setting (including emergency department) to COVID-19-positive patients as reported by hospitals through August 20, 2021, and therefore, is not entitled to Monoclonal Antibody (MAB) Administration Add-on Payments under the AR ARPA Proposal approved by the Arkansas Legislative Council on August 9, 2021.

**Section 4. FUNDING REQUIREMENTS**: The hospital further attests that:

1. We are enrolled in the Arkansas Medicaid program as of March 1, 2021, and currently accepting Medicaid beneficiaries.
2. Each critical access hospital and acute care hospital operates and staffs, according to ADH rules, an emergency department 24 hours per day, 7 days per week. Licensed distinct-part units within an acute care hospital will not be treated as separately licensed hospitals for purposes of this distribution.
3. These funds are necessary for payment of costs associated with hospital staff recruitment and retention during the COVID-19 pandemic.
4. We will maintain essential beds and appropriate levels of staffing according to Arkansas Department of Health rules.
5. We will be enrolled and maintain enrollment in both Medicare and Medicaid.
6. We will continuously operate during the declared emergency, including operating and staffing an emergency department 24 hours per day, seven days per week, if required by Arkansas Department of Health rules.
7. We have infection prevention policies and procedures in place and will report diseases, including COVID-19, as required under the Arkansas Department of Health’s rules.

**Total Funding Request:**

|  |  |
| --- | --- |
| $ \_\_\_\_\_\_\_\_\_\_\_\_  | TOTAL FORMULA-BASED ALLOTMENT REQUEST *(SECTION 1)* |
| $ \_\_\_\_\_\_\_\_\_\_\_\_  | TOTAL COVIDComm RECEIVING HOSPITAL ADD-ON PAYMENT REQUEST *(SECTION 2)* |
| $ \_\_\_\_\_\_\_\_\_\_\_\_  | TOTAL MAB ADMINISTRATION ADD-ON PAYMENT REQUEST *(SECTION 3)* |
|  |  |
| $ \_\_\_\_\_\_\_\_\_\_\_\_  | **TOTAL FUNDING REQUEST** |

**Signed and Agreed:**

|  |  |
| --- | --- |
| **Hospital Name** |  |
| **Hospital Provider Number** |  |
| **Hospital Number of licensed “Medicare beds” as of March 1, 2021** |  |
| **Printed Name of CEO** |  |
| **CEO Email Address** |  |
| **CEO Telephone Number** |  |
| I hereby attest that all the all of the statements and facts above are true and correct to the best of my knowledge and belief; that I am an officer or agent of the facility named herein and I am authorized to submit this form on behalf of said facility; that the facility shall retain records sufficient to support any claims or statements made for no less than seven (7) years and make them available to the Arkansas Department of Human Services (DHS), federal HHS Office of the Inspector General (OIG), and any other lawful federal or state authority, upon request; that the facility shall fully cooperate with any state or federal audit concerning ARPA payments; that the funds requested herein are requested for necessary expenditures to address the problems and needs described in this proposal caused by the public health emergency with respect to COVID-19 and that none of these funds are used to:* Duplicate or supplant funding from any other federal or state program. Payments or other reimbursement for direct patient care is not included as funding from a federal or state program; or
* Pay any increase in management fees to administrative personnel.

**CEO Signature** |
| **Date** *(Cannot be later than September 30, 2021)* |