2016
ELIGIBLE HOSPITAL HARDSHIP EXCEPTION APPLICATION

SECTION 1: HOSPITAL INFORMATION

Section 1.1 – Provide the following information regarding the hospital that is applying for the hardship exception for the Medicare EHR Incentive Program. All required fields are indicated with an asterisk*

Legal Hospital Name*		
National Provider Identifier (NPI) (10 digits)*	CMS Certification Number (CCN) (6 digits)*	
Hospital Address Line 1 (Street Name and Number – not a Post Office Box or Hospital Name)*		
Hospital Address Line 2 (Suite, Room, etc.)		
City/Town*	State (2 character code)*	Zip Code (5 digits)*
Email Address (This is how we will communicate with you. This field is required unless Internet access is unavailable)*		
Business Telephone Number (Include Area Code)*	Extension	

Section 1.2 – Provide the information below for the person working on behalf of the hospital applying for the hardship exception for the Medicare EHR Incentive Program. All return correspondence will be sent to the contact(s) listed in section 1.1 and 1.2. All required fields are indicated with an asterisk*

First Name*	Middle Initial	Last Name*	Suffix (i.e. Jr., Sr.)
Email Address (This is how we will communicate with you.)*			

SECTION 2: REASON FOR HARDSHIP EXCEPTION APPLICATION

Review the hardship exception reasons in Section 2. Select **ONE** reason and complete all information requested for that reason **ONLY**. All required fields are indicated with an asterisk*

REASON FOR APPLICATION	HARDSHIP EXCEPTION INFORMATION	REQUIRED SECTIONS
☐ **Infrastructure**	Eligible hospitals must demonstrate that they are in an area without sufficient internet access or face insurmountable barriers to obtaining infrastructure (e.g., lack of broadband)	Complete 1, 2.1 and 3
☐ **Unforeseen and/or Uncontrollable Circumstances**	During the past 1 or 2 fiscal years (2014 or 2015) preceding the payment adjustment year (2016), the hospital faced unforeseen and/or uncontrollable circumstances that prevented the hospital from becoming a meaningful user.	Complete 1, 2.2 and 3

☐ Section 2.1 Infrastructure

What is the size of the hospital? (Check one of the following*)

☐ Small hospital (less than 100 beds)
☐ Large hospital (more than 100 beds)
☐ Specialty hospitals/rural hospitals/community hospitals (no more than 25 beds)

Is Internet connectivity available at the hospital location by any means*?

☐ Yes
☐ No

CMS verifies Internet connectivity availability by checking the National Broadband Map database at http://www.broadbandmap.gov.

If Internet connectivity is available, what barrier is preventing the hospital from obtaining sufficient Internet connectivity? (Check each that apply to situation*)

☐ Monthly internet service fee (provide cost): [ ]

☐ Initial build out for Internet infrastructure required (provide cost): [ ]

Other Infrastructure Issue: [ ]

Items to include with the Application (*required if internet access is available)

- Infrastructure build-out cost quote from Internet Service Provider **OR**
- Proof of Other Infrastructure Issue

☐ **Section 2.3** Unforeseen and/or Uncontrollable Circumstances

Disaster

Date of Disaster (MM/DD/YYYY)*: [ ]

Indicate the county in which the hospital is located*: [ ]

Indicate the type of Disaster below*:

☐ Fire
☐ Tornado
☐ Hurricane/Tropical Storm
☐ Other (provide brief description):
☐ Disaster declared by FEMA or HHS
☐ Flood
☐ Explosion

[ ]

Hardships will be granted for natural or other disasters that destroy hospital property and prevent the demonstration of meaningful use.

Items to include with the application (*required unless declared Disaster area by FEMA or HHS)

- Proof of Disaster (examples: insurance verification, newspaper article with source, etc.)

Hospital Closure

Date of Closure (MM/DD/YYYY)*: ☐

Items to include with the application*

- Proof of closure/dissolution of Hospital*

Bankruptcy or Debt Restructuring

Date of Bankruptcy/Debt Restructuring Filing (MM/DD/YYYY)*: ☐

Is the Hospital still associated with the organization that filed for Bankruptcy/Debt Restructuring*?

☐ Yes
☐ No

Date of expected emergence from Bankruptcy/Debt Restructuring (MM/DD/YYYY)*:

☐

In order to qualify for this hardship, the date of emergence from bankruptcy or debt restructuring must be during or after the EHR reporting period.

Items to include with the application (At least one is required* and that item MUST be associated with a court system)

- Voluntary Petition - submit a signed and dated Voluntary Petition/Official Form 1 (B1) that was filed with the bankruptcy court (do not include exhibits A, B, C or D or any attached schedules).
- Involuntary Petition - submit a signed and dated Involuntary Petition/Official Form 5 (B5) that was filed with the bankruptcy court.
- In the alternative, a copy of the bankruptcy judge's order or judgment issued will be accepted. The document submitted must contain the debtor's name; the docket number and date of the court order.

EHR Certification/Vendor Issues

☐ Loss of EHR Certification
☐ Closure of EHR Vendor
☐ 2014 EHR Vendor Certification Issues and Delays, which includes:

- 2014 Product is not yet certified
- 2014 Product is certified but not yet installed
- 2014 Product is installed but not yet fully implemented

Indicate name of EHR product, version number and CEHRT number (if available) in box below.

Note: CMS EHR Certification ID is provided by the Office of the National Coordinator (ONC) via http://onc-chpl.force.com/ehrcert. If the product no longer has a Certification ID, please provide prior Certification ID.

SECTION 3: CERTIFICATION STATEMENT FOR HARDSHIP EXCEPTION APPLICATION

Section 3: Read the certification statement below and confirm the following:

GENERAL NOTICE

NOTICE: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.

SIGNATURE OF HOSPITAL REPRESENTATIVE

I certify that the foregoing information is true, accurate, and complete. I understand that the Medicare EHR Incentive Program hardship exception I requested will result in a change in the amount I will be paid from Federal Funds, and that by filling this hardship exception I am submitting a claim for Federal Funds, and the use of any false claims, statements, or documents, or the concealment of a material fact used to obtain a Medicare EHR Incentive Program hardship exception, may be prosecuted under applicable Federal or State criminal laws and may also be subject to civil penalties.

I hereby agree to keep such records as are necessary to support the application submitted for a hardship exception for the Medicare EHR Incentive Program and to furnish those records both in the application and at a future time upon request from the Department of Health and Human Services, or a contractor acting on their behalf.

No Medicare EHR Incentive Program hardship exception may be granted unless this application is completed and approved as required by existing law and regulations (42 CFR 495.102).

NOTICE: Anyone who misrepresents or falsifies essential information to receive payment from Federal funds requested by this form may upon conviction be subject to fine and imprisonment under applicable Federal laws.

ROUTINE USE(S): Information from this Medicare EHR Incentive Program hardship exception application and subsequently submitted information and documents may be given to the Internal Revenue Service, private collection agencies, and consumer reporting agencies in connection with recoupment of any overpayment made and to Congressional Offices in responses to inquiries made at the request of the person to whom a record pertains.

Appropriate disclosures may be made to other Federal, state, local and foreign government agencies, private business entities and individual providers of care, on matters relating to entitlement, fraud, program abuse, program integrity, and civil and criminal litigation relation to the operation of the Medicare EHR Incentive Program.

DISCLOSURES: This program is an incentives program. Therefore, while submission of information for this program is voluntary, failure to provide necessary information will result in delay in processing the hardship exception application or may result in a denial of a hardship exception for the Medicare EHR Incentive Program payment. Failure to furnish subsequently requested information or documents to support this attestation may result in overpayments and the issuance of an overpayment demand letter followed by recoupment procedures.

It is mandatory that you tell us if you believe you have been overpaid under the Medicare EHR Incentive Program. The Patient Protection and Affordable Care Act, Section 6402, Section 1128J, provides penalties for withholding this information.

By confirming this certification statement, I agree, and it is my intent, to sign this application and affirmation by including my name and the date below. I understand that completing the information below is the legal equivalent of having placed my handwritten signature on the submitted application and this affirmation.

☐ **Confirm***

*Date (MM/DD/YYYY): ____________

*Name of individual completing application: ____________

- This completed application and all supporting documentation must be attached to an email and sent to ehrhardship@provider-resources.com Please ensure that you have saved the application on your computer and attached it and any supporting documentation to the body of the email prior to submission.

- As a last resort, this application and all supporting documentation can be submitted via fax to **814-456-7132**