MEDICARE EHR INCENTIVE PROGRAM 2015 PAYMENT ADJUSTMENT APPLICATION for HARDSHIP EXCEPTION for CRITICAL ACCESS HOSPITALS (CAHs)

The submission deadline for a critical access hospital (CAH) is 11:59PM ET on **July 1, 2016.**

SECTION 1: APPLICANT INFORMATION

Provide the information below for the person working on behalf of the CAH to apply for the Hardship Exception. (Fields marked with * are required.) Provide required information for each in Section 4.

First Name*	Last Name*	Suffix
Company or Organization Name		
Email Address (This is how we will communicate with you.)*		
Business Telephone Number (Include Area Code)*	Extension	
Address (Street Name and Number – Not a Post Office Box)*		
City/Town*	State* (2 character code)	Zip Code (5 digits)*

SECTION 2: CIRCUMSTANCES of SIGNIFICANT HARDSHIP

Review the information below and indicate the hardship exception reason. All providers listed on this application must select the same category for consideration. Check the reason that best describes the circumstances constituting a significant hardship preventing the provider(s) from demonstrating meaningful use.

Section 2.1 – Insufficient Internet Connectivity

In order to be approved for this hardship exception, the provider(s) must attest to practicing in an area without sufficient internet access or facing insurmountable barriers to obtaining infrastructure (e.g. lack of broadband).

☐ **2.1 Insufficient Internet Connectivity**

I, _____, on behalf of the CAH(s) listed in Section 3, am requesting this Medicare EHR Incentive Program Hardship Exception and attest that the provider(s) was(were) located in an area without sufficient Internet access to comply with the meaningful use objectives requiring internet connectivity, and faced insurmountable barriers to obtaining such internet connectivity. I further attest that this insufficient internet connectivity constitutes a significant hardship in demonstrating meaningful use as defined under: 42 CFR 495.102 (d)(4)(i).

Section 2.2 Extreme and Uncontrollable Circumstances

In order to be approved for this hardship exception, the CAH(s) must attest to facing Extreme and Uncontrollable Circumstances as listed below that prevented the provider(s) from demonstrating meaningful use.

☐ **2.2.a Disaster**

I, _____, on behalf of the CAH(s) listed in Section 3, am requesting this Medicare EHR Incentive Program Hardship Exception and attest that the provider(s) faced extreme and uncontrollable circumstances in the form a natural disaster in which the EHR system was damaged or destroyed. I further attest that this extreme and uncontrollable circumstance in the form of a natural disaster constitutes a significant hardship in demonstrating meaningful use as defined under: 42 CFR 495.102 (d)(4)(iii).

☐ **2.2.b Practice or Hospital Closure**

I, _____, on behalf of the CAH(s) listed in Section 3, am requesting this Medicare EHR Incentive Program Hardship Exception and attest that the provider(s) faced extreme and uncontrollable circumstances in the form a practice or hospital closure. I further attest that this extreme and uncontrollable circumstance in the form of a closure constitutes a significant hardship in demonstrating meaningful use as defined under: 42 CFR 495.102 (d)(4)(iii).

☐ **2.2.c Severe Financial Distress (Bankruptcy or Debt Restructuring)**

I, _____, on behalf of the CAH(s) listed in Section 3, am requesting this Medicare EHR Incentive Program Hardship Exception and attest that the provider(s) faced extreme and uncontrollable circumstances in the form of severe financial distress resulting in bankruptcy or restructuring of debt. I further attest that this extreme and uncontrollable circumstance in the form of severe financial distress constitutes a significant hardship in demonstrating meaningful use as defined under: 42 CFR 495.102 (d)(4)(iii).

☐ **2.2.d EHR Certification/Vendor Issues (CEHRT Issues)**

I, _____, on behalf of the CAH(s) listed in Section 3, am requesting this Medicare EHR Incentive Program Hardship Exception and attest that the provider(s) faced extreme and uncontrollable circumstances in the form of issues with the certification of the EHR product or products such as delays or decertification, issues with the implementation of the CEHRT such as switching products, or issues related to insufficient time to make changes to the CEHRT to meet CMS regulatory requirements for reporting in 2015. I further attest that this extreme and uncontrollable circumstance in the form of EHR certification/vendor issues constitutes a significant hardship in demonstrating meaningful use as defined under: 42 CFR 495.102 (d)(4)(iii).

Section 3: Provider Identification Information (CAH)

Legal CAH Name*
National Provider Identifier (NPI) (10 digits)*
CMS Certification Number (CCN) (6 digits)*

CAH Address Line 1 (Street Name and Number – not a Post Office Box)*		
CAH Address Line 2 (Suite, Room, etc.)		
City/Town*	State* (2 character code)	Zip Code* (5 digits)

Please submit additional copies of this page as necessary if applying for multiple CAHs.
Please note: An electronic file of CCN information may alternately be submitted (xls, csv, txt).

SECTION 4: CERTIFICATION STATEMENT FOR HARDSHIP EXCEPTION APPLICATION

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 Provider REPRESENTATIVE

I certify that the information contained herein is true, accurate, and complete. I understand that the Medicare EHR Incentive Program Hardship Exception I requested may result in a change in the amount the CAH will be paid from Federal funds, and that by filling this application for a 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.

SUBMITTER WORKING ON BEHALF OF CAH: I certify that I am submitting this application for a payment adjustment on behalf of a CAH that has given me authority to act as agent. I understand that both the provider and I can be held personally responsible for all information entered.

I hereby agree to keep such records as are necessary to support the application submitted for a hardship exception of 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 application may upon conviction be subject to fine and imprisonment under applicable Federal laws.

ROUTINE USE(S): Information from this Medicare EHR Incentive Program application for hardship exception and subsequently submitted information and documents may be given to the Internal Revenue Service, private collection agencies, consumer reporting agencies in connection with recoupment of any overpayment made and to Congressional offices in response 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 in relation to the operation of the Medicare EHR Incentive Program.

DISCLOSURES: While submission of information for this program is voluntary, failure to provide necessary information for provider identification will result in delay in processing the hardship exception application or may result in a denial.

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): _____

*Type name of individual completing form: _____

- This completed application must be attached to an email and sent to ehrhardship@provider-resources.com. Please ensure that you have saved the application for your own records prior to submission.

- This application can be submitted via fax to **814-456-7132**