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| (For DHS Use Only) |

**Requesting SNF Cluster Payments from Arkansas Coronavirus Relief Fund:**

Skilled Nursing Facilities (SNFs) must use this form to request **COVID-19 Cluster Payments** from the Arkansas Coronavirus Relief Fund (“ACRF”). The ACRF is federally funded under the Coronavirus Aid, Relief, and Economic Security Act (CARES Act). These are not Medicaid or Medicare funds.

A qualified SNF may request and receive up to a maximum of $25,000 per week for necessary, unreimbursed expenses incurred due to the COVID-19 public health emergency during the period March 1, 2020 through June 30, 2020. During the week(s) claimed, the Facility must have actively served at least one positive COVID-19 patient who is also an Arkansas resident. If no facility patient was COVID-19 positive sometime during the week, the facility is ineligible for an ACRF Cluster Payment for that week. ACRF Cluster Payments are in addition to the ACRF Cost Above Cap Payments. The facility must first have necessary COVID-19 expenses to claim the maximum $150,000 ACRF Costs Above Cap Payment before receiving any ACRF Cluster Payments.

See Section 3, Terms and Conditions, for minimum qualifications and other requirements.

To request ACRF Costs Above Cap Payments, please use the separate request form provided by DHS.

**Section 1 – Information on Request and Facility**

1. Date of Request: Click or tap to enter a date.
2. Period Covered in Request (one or more weeks):

Click or tap to enter a date. – to – Click or tap to enter a date.

1. SNF Medicaid Provider Identification Number: Click or tap here to enter text.
2. Full Name of Skilled Nursing Facility: Click or tap here to enter text.
3. Facility Address: Click or tap here to enter text.
4. Full Name of Person Completing Request: Click or tap here to enter text.
5. Email Address of Person Completing Request: Click or tap here to enter text.
6. Telephone Number of Person Completing Request: Click or tap here to enter text.

**Section 2 – COVID-19 Cluster Payments**

**Requesting ACRF Cluster Payments**: A qualified skilled nursing facility may receive up to a maximum of $25,000 per week for necessary, unreimbursed expenses incurred due to the COVID-19 public health emergency during the period March 1, 2020 through June 30, 2020, provided:

* During the week, the facility actively served at least one positive COVID-19 patient who is also an Arkansas resident. If no facility patient was COVID-19 positive sometime during the week, the facility is ineligible for a ACRF Cluster Payment for that week.
* The weekly ACRF Cluster Payments are in addition to the ACRF Cost Above Cap Payments. The facility must first claim the $150,000 ACRF Costs Above Cap Payment before receiving any ACRF Cluster Payments. The ACRF Cluster Payments are only for COVID-19 expenses incurred during the March-June 2020 period that are not covered by the ACRF Costs Above Cap Payment.

**FOR WEEKS IN THE TIME PERIOD ENTERED IN SECTION 1(B):**

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| --- | --- |
| 1. Number of Weeks the Facility Qualified for ACRF Cluster Payments |  |
| 1. Maximum Amount Allowed ($25,000 x number of weeks in line A above) | **$** |
| **Total Amount Requested in this Form for These Weeks**  **(request may not exceed amount in line B above)** | **$** |

**Percentage Estimates of COVID-19 Expenses Incurred:**

Please provide percentage estimates of the types of COVID-19 incurred expenses associated with the ACRF Cluster Payments requested. These estimates will help DHS understand funding use prior to receiving the expense documentation due by August 30, 2020.

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| --- | --- |
| **Type of COVID-19 Expenses for Requested Cluster Payments** | **Estimated Percent** |
| Staffing | % |
| Environmental Modifications to Physical Structure or Systems | % |
| Additional Supplies | % |
| Additional Equipment | % |
| Specialized Equipment | % |
| Specialized Services | % |
| Staff Training | % |
| Other (please briefly describe): | % |
| Estimated percentages must equal 100% | % |

**Section 3 – Terms and Conditions**

As a condition of receipt of Cost Above Caps Payments or Cluster Payments from the Arkansas Coronavirus Relief Fund (“ACRF”), the skilled nursing facility named in Section 1 (D) on Page 1 (“Facility”) hereby acknowledges and agrees to the following Terms and Conditions. **Check each box to confirm your Facility’s understanding and acceptance of the Terms and Conditions:**

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|  | **Minimum Qualifications of Facilities Requesting Payment:**  To request ACRF Cost Above Caps Payments or ACRF Cluster Payments (“ACRF Payments”), a skilled nursing facility must, during the period March 1, 2020 through June 30, 2020, be all of the following:   1. An Arkansas licensed skilled nursing facility (SNF); 2. Not owned or operated by the State of Arkansas; 3. Enrolled in the Arkansas Medicaid program as a skilled nursing facility; and 4. Serving and accepting Arkansas Medicaid beneficiaries as patients. |
|  | **Other Sources of Payment for COVID-19 Expenses:**  ACRF Payments shall not duplicate or supplant funding the Facility receives from any other source of payment for COVID-19 expenses, including future Medicaid rate increases attributable to COVID-19 costs. To the extent that COVID-19 costs funded by ACRF Payments are subsequently reimbursed under another federal or state program, the Facility’s ACRF Payments will be reconciled and recovered. |
|  | **Lost Revenue and Certain Expenses Excluded:** The Facility shall not request or use ACRF Payments (1) to offset the loss of revenues (i.e., Medicaid, Medicare, commercial insurance, or private pay revenue) experienced during the COVID-19 public health emergency; or (2) for the following expenses: (a) supplemental wages, retention bonuses, or similar financial incentives to retain facility staff; (b) bonus payments to reward staff performance or presentism; or (c) increased management fees paid to the Facility’s parent company (or a subsidiary or related party thereof), except to pay the direct or fair market costs of nursing and other direct care services, infection control and prevention services, staff training, supplies, or equipment provided to the Facility. |
|  | **Records and Audits:** The Facility shall maintain appropriate financial records (i.e., documentation of expenses incurred, payments made to staff and vendors, and funding received from other federal or state sources for reimbursement of COVID-19 costs) sufficient to substantiate the Facility’s COVID-19 expenses claimed for ACRF Payments received. The Facility shall retain such records 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. The Facility shall fully cooperate with any state or federal audit concerning ACRF Payments. |
|  | **Deadline for Payment Requests and Expense Documentation:** By August 31, 2020: (1) all Facility requests for ACRF Payments must be submitted to DHS, and (2) the Facility shall submit receipts to substantiate the Facility’s COVID-19 expenses pertaining to the ACRF Payments received. The Facility shall return to DHS any portion of ACRF Payments received for COVID-19 expenses that are not reasonably substantiated with receipts or other documentation. |

**ATTESTATION**

I do hereby attest that all the all of the statements and facts contained in the forgoing Payment Request Form are true and correct to the best of my knowledge and belief. I further attest that I am an officer or agent of the Skilled Nursing Facility named herein and authorized to submit this Payment Request on behalf of the Facility.

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Signature of Officer or Agent Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Full Name

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Title

Upon completion, please submit this Payment Request Form to the attention of **“ACRF Cluster Payment**”at [DCWP@dhs.arkansas.gov](mailto:DCWP@dhs.arkansas.gov).