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| (For DHS Use Only) |

**Requesting Childhood Vaccination Program Payments from Arkansas Coronavirus Relief Fund:**

PCCMs must use this form to request **COVID-19 Costs Childhood Vaccination Program 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.

Qualified PCCMs may receive up to a maximum of $30.00 X the number of attribution (as of March 2020) for necessary, unreimbursed expenses incurred due to the COVID-19 public health emergency during the period March 1, 2020 through October 1, 2020. See Section 3, Terms and Conditions, for minimum qualifications and other requirements.

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

1. Date of Request: Click or tap to enter a date.
2. Period Covered in Request: Click or tap to enter a date. – to – Click or tap to enter a date.
3. PCCM Medicaid Provider Identification Number: Click or tap here to enter text.
4. Full Name of PCCM: Click or tap here to enter text.
5. Facility Address: Click or tap here to enter text.
6. Full Name of Person Completing Request: Click or tap here to enter text.
7. Email Address of Person Completing Request: Click or tap here to enter text.
8. Telephone Number of Person Completing Request: Click or tap here to enter text.
9. Total ARKids Attribution as of March 2020 Click or tap here to enter text.

**Section 2 – Childhood Vaccination Payment**

**Requesting an ACRF Childhood Vaccination Payment**: Qualified PCCMs may each receive up to a maximum of $30.00 X the number of attribution (as of March 2020) for necessary, unreimbursed expenses incurred due to the COVID-19 public health emergency during the period March 1, 2020 through October 1, 2020.

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

**Amount Requested for** **ACRF Childhood Vaccination Payment?**

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| --- |
| $ |

Maximum of $30.00 X the number of attribution (as of March 2020) for necessary incurred between March 1, 2020 through October 1, 2020.

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

For the amount requested above and the time period entered in Section 1(B), please provide percentage estimates of the general types of COVID-19 incurred expenses associated with the ACRF Childhood Vaccination Payments requested. These estimates will help DHS understand funding use prior to receiving the expense documentation due by October 15, 2020.

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| --- | --- |
| **Type of COVID-19 Expenses During Time Period**  **for the Requested PCCM Vaccination Program Payment** | **Estimated Percent** |
| Vaccine Outreach Initiatives | % |
| Immunization Delivery | % |
| Patient and Visitor Safety Procedures | % |
| Enhanced Vaccine Program Infrastructure | % |
| Electronic Heath Record System Optimization to Improve Vaccine Compliance | % |
| Mass Flu Vaccination or Parking Lot Vaccination Clinics | % |
| Estimated percentages must equal 100% | % |

**Affiliated Physicians**

Please provide the following information for all Physicians working within this PCCM:

|  |  |  |
| --- | --- | --- |
| **Physicians Name** | **Medicaid Provider ID** | **NPI number** |
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**Section 3 – Terms and Conditions**

As a condition of receipt of PCCM COVID 19 Childhood Vaccination Program Payments from the Arkansas Coronavirus Relief Fund (“ACRF”), the PCCM 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:**

|  |  |
| --- | --- |
|  | **Minimum Qualifications of Facilities Requesting Payment:**  To request PCCM Childhood Vaccination Program Payments (“ACRF Payments”), a PCCM must, during the period March 1, 2020 through October 1, 2020, be all of the following:   1. Must participate in the Vaccines for Children program; 2. Not owned or operated by the State of Arkansas; 3. Enrolled in the Arkansas Medicaid program as a PCCM; and 4. Serving and accepting Arkansas Medicaid pediatric 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 associated with provision of vaccination services, vaccination outreach, and patient and visitor safety. |
|  | **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 October 15,2020: (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 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 PCCM 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 **“PCCM Vaccination Program** at [DCWP@dhs.arkansas.gov](mailto:DCWP@dhs.arkansas.gov).