PAYMENT ADJUSTMENT YEAR 2019 MEDICARE EHR INCENTIVE PROGRAM
ELIGIBLE HOSPITAL HARDSHIP EXCEPTION APPLICATION

INSTRUCTIONS

- **The submission deadline is July 1, 2018.**

- Eligible Hospitals do **not** need to submit this application if they successfully demonstrated meaningful use in Program Year 2017, or are new and obtained a new CMS Certification Number (CCN) during 10/01/2016 through 07/01/2018, or are a Critical Access Hospital (CAH).

- To file a Hardship Exception Application, the circumstance must be beyond the Eligible Hospital's control *and* the Eligible Hospital must explicitly outline how the circumstance significantly impaired the Eligible Hospital's ability to meet meaningful use.

- If approved, this Hardship Exception is valid for the 2019 payment adjustment year only. If the Eligible Hospital needs to claim a Hardship Exception for the following payment adjustment year, a new application must be submitted.

- Determinations made by CMS or their designee regarding Hardship Exceptions are final and cannot be appealed.

- This completed application and all supporting documentation must be attached to an email and sent to ehrhardship@cms.hhs.gov.

- All Hardship Exception determinations will be returned via email from ehrhardship@cms.hhs.gov to the email address provided on the application.

- All documentation is required at the time of submission and additional documentation will not be accepted.

- If an electronic submission is not possible, please send application to the following address, CMS EHR Hardship, 7500 Security Boulevard, Mail Stop S3-02-01, Baltimore, Maryland 21244-1850

- Retain a copy if your completed hardship exception application for your records.

PAYMENT ADJUSTMENT YEAR 2019 MEDICARE EHR INCENTIVE PROGRAM
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SECTION 1: APPLICANT INFORMATION

Section 1.1 - Provide the information below for the person working on behalf of the Eligible Hospital(s) to apply for the hardship exception. (Fields marked with * are required.) Provide required information for each Eligible Hospital in Section 3.

First Name*	Last Name*	Suffix
Eligible Hospital 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)*

PAYMENT ADJUSTMENT YEAR 2019 MEDICARE EHR INCENTIVE PROGRAM
ELIGIBLE HOSPITAL HARDSHIP EXCEPTION APPLICATION

SECTION 2: CIRCUMSTANCES of SIGNIFICANT HARDSHIP

Review the information below and indicate the hardship exception reason. All Eligible Hospitals 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 Eligible Hospital(s) from demonstrating meaningful use.

Section 2.1 – Insufficient Internet Connectivity

In order to be approved for this hardship exception, the Eligible Hospital(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 Eligible Hospital(s) listed in Section 3, am requesting this Medicare EHR Incentive Program Hardship Exception and attest that the hospital(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 Eligible Hospital(s) must attest to facing Extreme and Uncontrollable Circumstances as listed below that prevented the Eligible Hospital(s) from demonstrating meaningful use.

☐ **2.2.a Disaster**

I, _____, on behalf of the Eligible Hospital(s) listed in Section 3, am requesting this Medicare EHR Incentive Program Hardship Exception and attest that the hospital(s) faced extreme and uncontrollable circumstances in the form of 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 Hospital Closure**

I, _____, on behalf of the Eligible Hospital(s) listed in Section 3, am requesting this Medicare EHR Incentive Program Hardship Exception and attest that the Eligible Hospital(s) faced extreme and uncontrollable circumstances in the form of a 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 Eligible Hospital(s) listed in Section 3, am requesting this Medicare EHR Incentive Program Hardship Exception and attest that the Eligible Hospital(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 (Certified EHR Technology (CEHRT) Issues)**

I, _____, on behalf of the Eligible Hospital(s) listed in Section 3, am requesting this Medicare EHR Incentive Program Hardship Exception and attest that the Eligible Hospital(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 2017. 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).

PAYMENT ADJUSTMENT YEAR 2019 MEDICARE EHR INCENTIVE PROGRAM
ELIGIBLE HOSPITAL HARDSHIP EXCEPTION APPLICATION

Section 3: Eligible Hospital Identification Information

Please complete this section for the Eligible Hospitals applying for a hardship exception using this form. This application is for Eligible Hospitals only. Please provide the CCN for each Eligible Hospital below. ***For additional CCNs, please submit separate applications.***

	Number of Eligible Hospitals on this application:	
	CCN (6 digits)	**Hospital Legal Name**
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PAYMENT ADJUSTMENT YEAR 2019 MEDICARE EHR INCENTIVE PROGRAM
ELIGIBLE HOSPITAL HARDSHIP EXCEPTION APPLICATION

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 HOSPITAL 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 Eligible Hospital 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 HOSPITAL(s): I certify that I am submitting this application for a payment adjustment on behalf of the hospital(s) that has (have) given me authority to act as agent. I understand that both the hospital(s) 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

PAYMENT ADJUSTMENT YEAR 2019 MEDICARE EHR INCENTIVE PROGRAM
ELIGIBLE HOSPITAL HARDSHIP EXCEPTION APPLICATION

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 hospital 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@cms.hhs.gov. Please ensure that you have saved the application for your own records prior to submission.

- If an electronic submission is not possible, please send application to the following address, CMS EHR Hardship, 7500 Security Boulevard, Mail Stop S3-02-01, Baltimore, Maryland 21244-1850