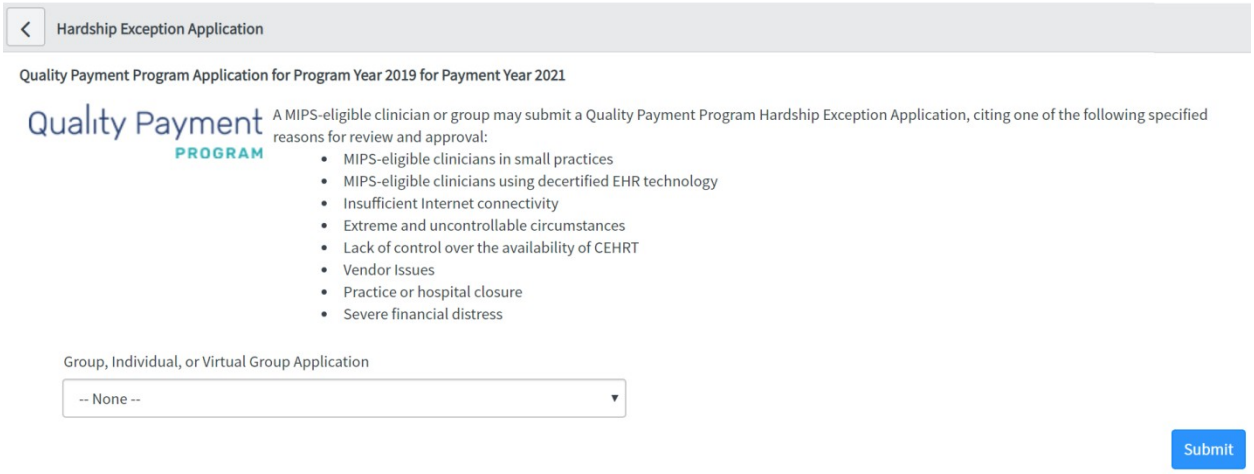
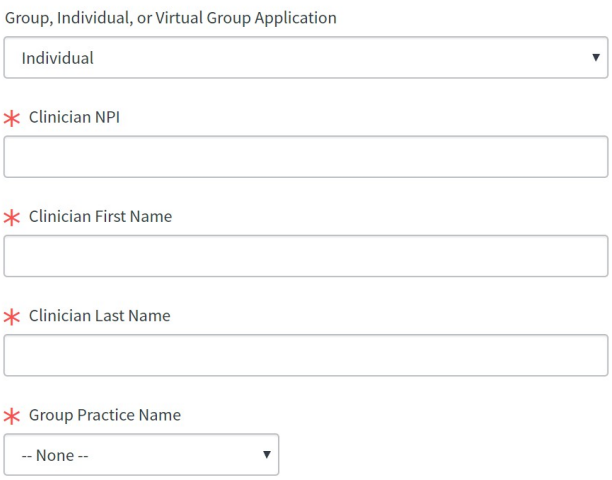
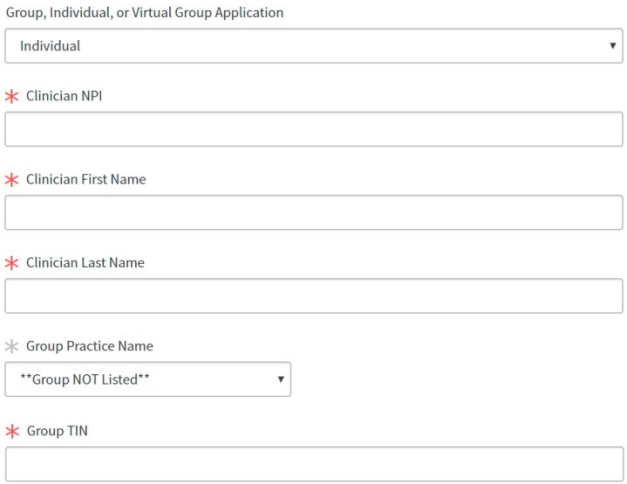
Page on form load:



Individual:



Individual- 'Group Not Listed' selected:



Group:

Group, Individual, or Virtual Group Application

Group

* Group TIN

Virtual Group:

Group, Individual, or Virtual Group Application

Virtual Group

* Virtual Group ID

Submitter/Third Party Intermediary:

Section 1: Submitter/Third Party Intermediary Information

▼ More information

Provide the information below for the person working on behalf of the clinicians.

All return correspondence will be sent to the contact listed in section 1 (Fields marked with * are required.)

* Submitter/Third Party Intermediary First Name

* Submitter/Third Party Intermediary Last Name

Company or Organization Name

* Submitter/Third Party Intermediary Email (This is how we will communicate with you.)

* Submitter/Third Party Intermediary Business Telephone Number (Include Area Code)

Extension

* Submitter/Third Party Intermediary Relationship

-- None --

* I certify that I am authorized by the clinician or group identified above to submit this application on behalf of the clinician or group

Section 2:

SECTION 2: HARDSHIP EXCEPTION CIRCUMSTANCES AND REQUEST FOR QUALITY PAYMENT PROGRAM HARDSHIP EXCEPTION

▼ More information

Review the information below and indicate the hardship exception reason which makes the promoting interoperability (PI) measures not applicable or available to your practice

Section 2.1 – Insufficient Internet Connectivity

▼ More information

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

On behalf of the clinician(s) listed in this application, I am requesting this hardship exception and attest that the clinician(s) was(were) located in an area without sufficient Internet access to comply with the promoting interoperability (PI) performance category objectives requiring internet connectivity, and faced insurmountable barriers to obtaining such internet connectivity.

2.1 Insufficient Internet Connectivity

Section 2.2 Extreme and Uncontrollable Circumstances

▼ More information

In order to be approved for hardship exception, the clinician(s) must attest to facing Extreme and Uncontrollable Circumstances as listed below that prevented the clinician(s) from meeting the requirements of the promoting interoperability (PI) performance category.
Section 2.2.a Disaster

On behalf of the clinician(s) listed in this application, I am requesting this hardship exception and attest that the clinician(s) faced extreme and uncontrollable circumstances in the form a natural disaster in which the EHR system was damaged or destroyed.

Period of time the EHR system was unavailable (MM/DD/YYYY) to (MM/DD/YYYY).

☐ 2.2.a Disaster

Start Date

End Date

2.2.b Practice or Hospital Closure

▼ More information

On behalf of the clinician(s) listed in this application, I am requesting this hardship exception and attest that the clinician(s) faced extreme and uncontrollable circumstances in the form of a practice or hospital closure.

Period of time the EHR system was unavailable (MM/DD/YYYY) to (MM/DD/YYYY)

☐ 2.2.b Practice or Hospital Closure

Start Date

End Date

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

▼ More information

On behalf of the clinician(s) listed in this application, I am requesting this hardship exception and attest that the clinician(s) faced extreme and uncontrollable circumstances in the form of severe financial distress resulting in bankruptcy or restructuring of debt.

Period of time the EHR system was unavailable (MM/DD/YYYY) to (MM/DD/YYYY)

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

Start Date

End Date

2.2.d Vendor Issues

▼ More information

On behalf of the clinician(s) listed in this application, I am requesting this hardship exception and attest that the clinician(s) faced extreme and uncontrollable circumstances in the form of vendor issues.

Period of time the EHR system was unavailable (MM/DD/YYYY) to (MM/DD/YYYY)

☐ 2.2.d Vendor Issues

Start Date

End Date

EHR Certification ID

Section 2.3 Lack of Control over the Availability of CEHRT

▼ More information

In order to be approved for this hardship application, the eligible clinician (s) must attest to a lack of control over the availability of CEHRT in 1 or more practice locations where more than 50 percent of the patient encounters occurred.

☐ Lack of Control over CEHRT Availability

Section 2.4 - EHR Decertification

▼ More information

In order to be approved for this hardship exception, the clinician(s) must attest to experiencing issues with the certification of the EHR product such as decertification.

On behalf of the clinician(s) listed in this application, I am requesting this hardship exception and attest that the clinician(s) was(were) faced with EHR decertification issues.

☐ 2.4 EHR Decertification

Start Date

If your product was decertified, you must provide the Certification number

Section 2.5 Small Practice

▼ More information

In order to be approved for this hardship exception, the clinician(s) must attest to participating in a small practice.

On behalf of the clinician(s) listed in this application, I am requesting this hardship exception and attest that the clinician(s) was(were) participating in a small practice.

☐ Small Practice

Section 3:

SECTION 3: CERTIFICATION STATEMENT FOR QPP APPLICATION

▼ GENERAL NOTICE

Failure to provide information necessary for clinician identification may result in processing delays or denial of the Quality Payment Program Hardship Exception Application.

CERTIFICATION OF CLINICIAN or CLINICIAN REPRESENTATIVE: By submitting this application, I certify that the information contained in this application is true, accurate, and complete to the best of my knowledge, information and belief. If I become aware that any information contained in this application is not true, accurate, and complete, I will inform CMS promptly. I understand that:

• Approval of this Hardship Exception Application for the Quality Payment Program may result in a change in the amount the clinician will be paid from Federal funds.
• Any person who knowingly files a claim or statement containing any false, incomplete, or misleading information, including the concealment of a material fact, may be guilty of a criminal act punishable under Federal and state law and may be subject to civil penalties.

I hereby agree to keep all records related to this Hardship Exception Application and to furnish them upon request by the Department of Health and Human Services or to a contractor acting on its behalf.

CERTIFICATION OFTHIRD PARTY INTERMEDIARY AUTHORIZED TO SUBMIT DATA ON BEHALF OF CLINICIAN(S): By submitting this application, I certify that I am submitting this Hardship Exception Application on behalf of the clinician(s) that has(have) given me authority to act as agent. I certify that the information contained herein is true, accurate, and complete to the best of my knowledge, information, and belief. If I become aware that any information contained in this application is not true, accurate, and complete, I will inform CMS promptly. I understand that any person who knowingly files a claim or statement containing any false, incomplete, or misleading information, including the concealment of a material fact, may be guilty of a criminal act punishable under Federal and state law and may be subject to civil penalties. I hereby agree to keep all records related to this Hardship Exception Application and to furnish them upon request by the Department of Health and Human Services or to a contractor acting on its behalf.

NOTICE: Under section 1128J of the Social Security Act, a person or entity must tell us if it believes it has been overpaid by Medicare, including under the Quality Payment Program. Failure to make such a disclosure may result in liability under the False Claims Act (31 U.S.C. § 3729 et seq.) and other Federal laws.

* ☐ Certify

Date

04/29/2019

* Name of individual completing form

Submit

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1314 (Expiration date: XX/XX/XXXX). The time required to complete this information collection is estimated to average 0.25 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850. ****CMS Disclosure**** Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact QPP at qpp@cms.hhs.gov.