DATA 2000 Waiver Training Payment Program
Application for Payment Instructions

Background:
Section 6083 of the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act permits payment to Federally Qualified Health Centers (FQHCs), as defined by statute under 42 U.S.C. 1395x(aa)(4), and Rural Health Clinics (RHCs), as defined by statute under 42 U.S.C. 1395x(aa)(2), for each of their employed physicians or practitioners who obtain a Drug Assistance and Treatment Act of 2000 waiver (DATA 2000 waiver) on or after January 1, 2019. Payments will be made until all funds are expended, on a first-come, first-served basis.

Uses for this form:
- Apply for a one-time payment under the DATA 2000 Waiver Training Payment Program.

Who may apply:
- Only FQHCs and RHCs may apply.
- Payments are made to FQHCs and RHCs, not individual physicians or practitioners.
- Eligible physicians and practitioners include only those who:
  1. Are a physician, physician assistant, nurse practitioner, certified nurse midwife, clinical nurse specialist, or certified registered nurse anesthetist;
  2. First obtained a DATA 2000 waiver on or after January 1, 2019;
  3. Are employed by or working under contract for the applying FQHC or RHC; and
  4. Have not already received a payment for possession of a DATA 2000 waiver under section 6083.
- FQHCs and RHCs must be registered with the System for Award Management (SAM, https://www.sam.gov/SAM/).

Instructions for completing the DATA 2000 Waiver Training Payment Program Application for Payment form:

Part A – Organization Information

Item 1. Enter the full legal name of the FQHC or RHC.

Item 2. Enter the Data Universal Number System (DUNS) number of the FQHC or RHC.

Item 3. Enter the FQHC or RHC Employer/Tax Identification Number (EIN/TIN).

Item 4. If applicable, enter the Facility CMS Certification Number (CCN). This CCN should indicate a site operated by the FQHC or RHC entered in Item 1.

Item 5. Enter the Congressional District number associated with the EIN/TIN.

Item 6. Enter the full mailing address of FQHC or RHC associated with EIN/TIN.

Item 7. Enter the full mailing address associated with the CCN, if the address is different from the EIN/TIN address provided for Item 6.

Part B – Contact Information

Item 8. Enter the prefix for the person to be contacted on matters involving this application.

Item 9. Enter the first name for the person to be contacted on matters involving this application.

Item 10. Enter the middle name for the person to be contacted on matters involving this application.

Item 11. Enter the last name for the person to be contacted on matters involving this application.

Item 12. Enter the suffix for the person to be contacted on matters involving this application.

Item 13. Enter the title for the person to be contacted on matters involving this application.

Item 14. Enter the phone number for the person to be contacted on matters involving this application.

Item 15. Enter the fax number for the person to be contacted on matters involving this application.

Item 16. Enter the email address for the person to be contacted on matters involving this application.

Part C – Physician and Practitioner Information

Item 17. Enter the prefix for the individual who has obtained the DATA 2000 waiver.

Item 18. Enter the first name for the individual who has obtained the DATA 2000 waiver.

Item 19. Enter the middle name for the individual who has obtained the DATA 2000 waiver.

Item 20. Enter the last name for the individual who has obtained the DATA 2000 waiver.

Item 21. Enter the suffix for the individual who has obtained the DATA 2000 waiver.

Item 22. Enter the individual's National Provider Identifier (NPI) number.

Item 23. Enter the individual's state medical license number.

Item 24. Enter the individual's Drug Enforcement Administration (DEA) number.

Item 25. Enter the individual's DATA 2000 waiver number.

Item 26. Check the appropriate box for this individual's physician/practitioner type.

Item 27. Enter the length of time (in hours) the practitioner attended the training to obtain the DATA 2000 waiver.

Item 28. Enter the date the individual completed the training to obtain the DATA 2000 waiver.

Item 29. Enter the date the individual obtained the DATA 2000 waiver.

Part D – Certification Statement

Item 30. Carefully read the written statement. Ensure your application comports with each requirement. Upon verification that you are compliant with the written statement, check the box and submit your application. HRSA will validate information provided prior to issuing payment.

HRSA
Health Resources & Services Administration

DATA 2000 Waiver Training Payment Program Application for Payment

Form Approved:
OMB No. 0906-XXXX
Expiration Date:
XX/XX/202X

Part A – Organization Information

1. Legal Name of Qualifying Entity (*Federally Qualified Health Center or Rural Health Clinic*)

2. DUNS Number	6. Address Associated with EIN/TIN *(Street, City, County, State, Zip/Postal Code*)
3. Employer/Tax Identification Number (*EIN/TIN*)	
4. Facility CMS Certification Number *(CCN)*	7. Address Associated with CCN *(if different from EIN/TIN) (Street, City, County, State, Zip/Postal Code)*
5. Congressional District (*location associated with EIN/TIN*)	

Part B – Contact Information

Name and contact information of person to be contacted on matters involving this application

8. Prefix	9. First Name	10. Middle Name	11. Last Name	12. Suffix

13. Title	14. Phone Number	15. Fax Number

16. Email Address

Part C – Physician and Practitioner Information

Physician or Practitioner (Click Dropdown to Add Fields for More Physicians or Practitioners)

17. Prefix	18. First Name	19. Middle Name	20. Last Name	21. Suffix

22. Practitioner's National Provider Identifier (NPI) Number	26. Practitioner Type (*Check Box*)
	☐ Physician
23. State Medical License Number	☐ Physician Assistant
	☐ Nurse Practitioner
24. Practitioner's Drug Enforcement Administration (DEA) Number	☐ Certified Nurse Midwife
	☐ Clinical Nurse Specialist
25. Practitioner's DATA 2000 Waiver Number (*If waiver number is not available, attach proof of waiver approval)*	☐ Certified Registered Nurse Anesthetist

27. Training Length	28. Training Completion Date	29. Waiver Date

Part D – Certification Statement

30. By signing this application, I certify that (1) each practitioner for which this entity is seeking payment under this application is employed by or working under contract for this facility, (2) this is the first time this entity is seeking payment on behalf of the listed practitioner(s), (3) this entity is eligible to seek payment under 42 U.S.C. 1395m(o)(3) or 42 U.S.C. 1395l(bb), (4) each practitioner is furnishing opioid use disorder treatment services, and (5) that the statements herein are true, complete, and accurate to the best of my knowledge. I am aware that any false, fictitious, or fraudulent statements or claims may subject me to criminal, civil, or administrative penalties. (U.S. Code, Title 218, Section 1001)

I agree. (*Check Box*) ☐