



Coronavirus (COVID-19) Pandemic: Medical Care Eligible for Public Assistance (Interim) (Version 2)

FEMA Policy #104-21-0004

BACKGROUND

Under the President's March 13, 2020 COVID-19 nationwide emergency declaration¹ and subsequent major disaster declarations for COVID-19, state, local, tribal, and territorial (SLTT) government entities and certain private non-profit (PNP) organizations are eligible to apply for assistance under the FEMA Public Assistance (PA) Program. This interim policy is applicable to eligible PA Applicants only and is exclusive to emergency and major disaster declarations for COVID-19. This revision supersedes the version of this policy issued on May 9, 2020.

PURPOSE

This interim policy defines the framework, policy details, and requirements for determining the eligibility of medical care work and costs under the PA Program to ensure consistent and appropriate implementation across all COVID-19 emergency and major disaster declarations. Except where specifically stated otherwise in this policy, assistance is subject to PA Program requirements as defined in Version 3.1 of the Public Assistance Program and Policy Guide (PAPPG) published on April 1, 2018.²

PRINCIPLES

- A. FEMA will provide assistance for medical care provided under COVID-19 declarations to improve the abilities of communities to effectively respond to the COVID-19 Public Health Emergency.
- B. FEMA will implement this policy and any assistance provided in a consistent manner through informed decision making and review of an Applicant's supporting documentation.

¹ www.fema.gov/news-release/2020/03/13/covid-19-emergency-declaration.

² Version 3.1 of the PAPPG is applicable to all COVID-19 declarations and is available on the FEMA website at www.fema.gov/sites/default/files/2020-03/public-assistance-program-and-policy-guide_v3.1_4-26-2018.pdf.



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C. FEMA will engage with interagency partners, including the U.S. Department of Health and Human Services' (HHS) Office of the Assistant Secretary for Preparedness and Response (ASPR), the Administration for Children and Families (ACF), the Centers for Disease Control and Prevention (CDC), the Health Resources and Services Administration (HRSA), the Centers for Medicare and Medicaid Services (CMS), and the U.S. Department of Treasury to ensure this assistance is provided in a coordinated manner without duplicating assistance.

REQUIREMENTS

A. APPLICABILITY

Outcome: To establish the parameters of this policy and ensure it is implemented in a manner consistent with program authorities and appropriate to the needs of the COVID-19 Public Health Emergency.

1. This policy applies to:
 - a. All Presidential emergency and major disaster declarations under the Robert T. Stafford Disaster Relief and Emergency Assistance Act (Stafford Act), as amended, issued for the COVID-19 Public Health Emergency and is applicable to work performed on or after January 20, 2020.
 - b. Eligible PA Applicants under the COVID-19 emergency declaration or any subsequent COVID-19 major disaster declaration, including:
 - i. SLTT government entities; and
 - ii. PNP organizations that own or operate medical facilities, as defined in Title 44 of the Code of Federal Regulations (44 C.F.R.) § 206.221(e)(5).
 - c. This policy does not apply to any other emergency or major disaster declaration.

B. GENERAL ELIGIBILITY CONSIDERATIONS FOR COVID-19 MEDICAL CARE

Outcome: To define the overarching framework for all eligible medical care work related to COVID-19 declarations.

1. All work must be required as a direct result of the COVID-19 pandemic incident in accordance with 44 C.F.R. § 206.223(a)(1).
2. Medical care and associated costs refer to assistance to support the provision of medical care, including eligible facility, equipment, supplies, staffing, and wraparound services (as defined in the **Definitions** section at the end of this document), as well as assistance for clinical care of patients not covered by another funding source as described throughout this policy.



3. Equitable Pandemic Response and Recovery

- a. As stated in [“Executive Order on Ensuring an Equitable Pandemic Response and Recovery,”](#) dated January 21, 2021, COVID-19 has a disproportionate impact on communities of color and other underserved populations, including members of the LGBTQI+ community, persons with disabilities, those with limited English proficiency, and those living at the margins of our economy.
- b. Through September 30, 2021, FEMA is funding the entire cost of the emergency protective measures made eligible by this policy.
- c. As a condition of receiving this financial assistance, Recipients and Subrecipients must focus the use of FEMA funding on the highest-risk communities and underserved populations as determined by established measures of social and economic disadvantage (e.g., the CDC Social Vulnerability Index). Recipients and Subrecipients must prioritize limited resources to ensure an equitable pandemic response. Failure to adhere to this policy could result in funding reductions and/or delays.
- d. FEMA will monitor compliance with this grant condition in concert with the obligations set forth in 44 C.F.R. part 7 and Title VI of the Civil Rights Act of 1964 that no person on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity receiving financial assistance from FEMA; and the requirement of Stafford Act Section 308 (42 U.S.C. 5151) that distribution of disaster relief be accomplished in an equitable and impartial manner, without discrimination on the grounds of race, color, religion, nationality, sex, age, disability, English proficiency, or economic status.

C. ELIGIBLE MEDICAL CARE WORK AND COSTS

Outcome: To establish parameters for eligible medical care work and costs for COVID-19 declarations.

1. Primary Medical Care Facility.

For medical care provided in a primary medical care facility (as defined in the **Definitions** section at the end of this document), work must be directly related to the treatment of COVID-19 patients. Work may include both emergency and inpatient treatment of COVID-19 patients; this includes both confirmed and suspected cases of COVID-19. Medical care related to treatment of a non-COVID-19 illness or injury in a primary medical care facility is not eligible. The following medical care activities and associated costs are eligible in primary medical care facilities.



- a. Emergency and inpatient clinical care for COVID-19 patients, including, but not limited to:
 - i. Emergency medical transport related to COVID-19;
 - ii. Triage and medically necessary tests and diagnosis related to COVID-19;
 - iii. Necessary medical treatment of COVID-19 patients; and
 - iv. Prescription costs related to COVID-19 treatment.

- b. Purchase, lease, and delivery of specialized medical equipment necessary to respond to COVID-19 (equipment purchases are subject to disposition requirements³);

- c. Purchase and delivery of Personal Protective Equipment (PPE),⁴ durable medical equipment, and consumable medical supplies necessary to respond to COVID-19 (supply purchases are subject to disposition requirements⁵);
 - i. This includes the costs of eligible SLTT government Applicants providing PPE to any public or private medical care facility that treats COVID-19 patients.

- d. Medical waste disposal related to COVID-19; and

- e. Certain labor costs associated with medical staff providing treatment to COVID-19 patients may be eligible as outlined below. Any labor costs for medical staff that are included in patient billing and/or otherwise covered by another funding source (as described in **Section D.4 Duplication of Benefits** of this policy) are not eligible for PA. Otherwise, the following labor costs may be eligible:
 - i. Overtime for budgeted medical staff providing treatment to COVID-19 patients;
 - ii. Straight time and overtime for temporary medical staff providing treatment to COVID-19 patients; and
 - iii. Straight time, overtime, and other necessary costs for contract medical staff providing treatment to COVID-19 patients. Work and associated costs must be consistent with the scope of the contract and may include costs for travel, lodging, and per diem for contract medical staff from outside the local commuting area.

- f. For primary medical care facilities, increased operating costs for administrative activities (such as medical billing) are not eligible.⁶

³ As described in Chapter 2:V.E. Disposition of Purchased Equipment and Supplies of the PAPPG (V3.1).

⁴ PPE includes items such as N95 and other filtering respirators, surgical masks, gloves, protective eyewear, face shields, and protective clothing (e.g., gowns).

⁵ As described in Chapter 2:V.E. Disposition of Purchased Equipment and Supplies of the PAPPG (V3.1).

⁶ See Chapter 2:VI.B.2. Expenses Related to Operating a Facility or Providing a Service of the PAPPG (V3.1).



2. Temporary and Expanded Medical Facilities.⁷

FEMA may approve work and costs associated with temporary medical facilities or expanded medical facilities when necessary in response to the COVID-19 Public Health Emergency. These facilities may be used to treat COVID-19 patients, non-COVID-19 patients, or both, as necessary. Medical care activities and associated costs related to treating both COVID-19 and non-COVID-19 patients in a temporary or expanded medical facility may be eligible.

- a. Costs must be reasonable and necessary based on the actual or projected need.
- b. Eligible costs for temporary and expanded medical facilities include:
 - i. All eligible items and stipulations included in **Section C.1 Primary Medical Care Facility**, but applicable to both COVID-19 and non-COVID-19 patients;
 - ii. Lease, purchase, or construction costs, as reasonable and necessary, of a temporary facility as well as reasonable alterations to a facility necessary to provide medical care services;⁸
 - iii. Mobilization and demobilization costs associated with setting up and closing the temporary or expanded medical facility;
 - iv. Operating costs including equipment, supplies, staffing, wraparound services (as defined in the **Definitions** section at the end of this document), and clinical care not covered by another funding source; ; and
 - v. Maintenance of a temporary or expanded medical facility in an operationally ready but unused status available for surge capacity for COVID-19 readiness and response when necessary to eliminate or lessen an immediate threat to public health and safety, based on public health guidance, location of areas expected to be impacted, and local/state hospital bed/ICU capacity.
- c. For contract costs related to establishing and/or operating a temporary or expanded medical facility, contracts must include a termination for convenience clause that will be implemented if the site is ultimately not needed, or the needs are less than projected, as determined by the legally responsible entity.
 - i. Ongoing and projected needs regarding continuing operations at a temporary or expanded medical facility should be based on regular assessments and the Applicant must document the review process to support its decision making.
 - ii. The assessments should include adjustments to projected needs based on guidance from public health officials, caseload trends, and/or other predictive modeling or methodologies; lead times and associated costs for

⁷ Temporary medical facilities may include Alternate Care Sites or Community Based Testing Sites if eligible work and costs related to these facilities are incurred by eligible PA Applicants.

⁸ As described in Chapter 2:VI.B.17(e) and (g) of the PAPPG (V3.1).



- scaling up or down based on projected needs; and any other supporting information.
- iii. The assessments and supporting information are necessary to determine eligibility of claimed costs and should align with PA reasonable cost guidance provided in the PAPPG⁹ and the *Public Assistance Reasonable Cost Evaluation Job Aid*.¹⁰
 - d. Costs related to expanding a primary medical care facility to effectively respond to COVID-19 must be feasible and cost effective. In most cases, permanent renovations are not eligible unless the Applicant can demonstrate that the work can be completed in time to address COVID-19 capacity needs and is the most cost-effective option. Permanent renovations and other improvements to real property with PA funds are subject to real property disposition requirements.¹¹
 - e. For temporary and expanded medical facilities, and the specific type of temporary medical facilities known as Alternate Care Sites, administrative activities and associated costs necessary for the provision of essential medical services are eligible.

3. Vaccinations

Work and associated costs to support the distribution and administration of COVID-19 vaccines may be eligible for PA. The federal government will provide the vaccine itself at no cost. There may be additional costs incurred to support the distribution and administration of the vaccine. Such costs may be eligible for PA funding when they are necessary to effectively distribute and administer COVID-19 vaccines consistent with established vaccine protocols, CDC and/or other applicable public health guidance, and PA program requirements. Eligible work and costs under PA include:

- a. Community vaccination centers.¹²
- b. PPE, other equipment, and supplies required for storing, handling, distributing/transporting, and administering COVID-19 vaccinations.
 - i. PPE includes items necessary for proper handling and administration of vaccinations as well as handling dry ice for storage and transportation needs;
 - ii. Equipment includes coolers, freezers, temperature monitoring devices, and portable vaccine storage units for transportation;
 - iii. Supplies include emergency medical supplies (for emergency medical care needs that may arise in the administration of the vaccine), sharps

⁹ As described in Chapter 2:V. Cost Eligibility of the PAPPG (V3.1).

¹⁰ The Public Assistance Reasonable Cost Evaluation Job Aid is available on the FEMA website at www.fema.gov/media-library/assets/documents/90743.

¹¹ As described in Chapter 2:V.F. Disposition of Real Property of the PAPPG (V3.1).

¹²For PA eligibility, community vaccination sites are considered temporary medical facilities consistent with Section C.2. Temporary and Expanded Medical Facilities of this policy.



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- containers (for medical waste), and supplies necessary for proper storage like dry ice; and,
- iv. Transportation support such as refrigerated trucks and transport security when reasonable and necessary.
 - c. Facility support costs, including leasing space for storage and/or administration of vaccines, utilities, maintenance, and security.
 - d. Additional staff, if necessary, including medical and support staff not paid for by another funding source and consistent with FEMA PA labor policies.¹³
 - e. Onsite infection control measures and emergency medical care for COVID-19 vaccination administration sites.
 - i. Masks/cloth facial coverings for patients;¹⁴
 - ii. Disinfection of facility and equipment in accordance with CDC guidance;¹⁵
 - iii. Temperature scanning, including purchase and distribution of handheld temperature measuring devices and associated supplies;
 - iv. Acquisition and installation of portable temporary physical barriers, such as plexiglass barriers and medical screens/dividers;
 - v. Medical waste disposal related to vaccinations; and
 - vi. Onsite emergency medical care to address adverse reactions to vaccinations or other emergency medical care needs that may arise while administering COVID-19 vaccinations.
 - f. Resources to support mobile COVID-19 vaccination in remote areas and/or transportation support for individuals with limited mobility or lack of access to transportation, when reasonable and necessary.
 - i. Equipment and supplies necessary for proper storage, handling, and transport in accordance with CDC guidance to support mobile vaccination units;
 - ii. Medical and support staff for mobile vaccination units in accordance with PA labor policies and this policy; and
 - iii. Transportation to and from vaccination sites for individuals with limited mobility. "Limited mobility" includes individuals with disabilities that require transportation assistance and individuals that are otherwise unable to get to and from vaccination sites without transportation assistance.

¹³ See Chapter 2:A. Applicant (Force Account) Labor of the PAPPG (V3.1).

¹⁴ For this policy, face masks, such as cloth face coverings, are not considered PPE. See <https://www.fda.gov/food/food-safety-during-emergencies/use-respirators-facemasks-and-cloth-face-coverings-food-and-agriculture-sector-during-coronavirus>. Note that FDA has issued an emergency use authorization (EUA) for face masks/cloth face coverings for use by members of the general public and for healthcare personnel in healthcare settings. See www.fda.gov/media/137121/download.

¹⁵ www.cdc.gov/coronavirus/2019-ncov/community/cleandisinfect/index.html.



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- g. Federally Qualified Health Centers– Vaccine-related costs incurred by a Federally Qualified Health Center (FQHC),¹⁶ Rural Health Clinics and Critical Access Hospitals that are not covered by HHS or another funding source. FQHCs fall under the authority of HHS. PA funding can be provided for eligible costs that are not covered under this authority or another source of funding.
- h. Communications to disseminate public information regarding vaccinations including translation and interpretation services as necessary.¹⁷ This may also include work and costs associated with setting up and operating a call center or website, when reasonable and necessary, for the purpose of sharing vaccination information with the public and/or to support the implementation and management of COVID-19 vaccination plans.
- i. Information Technology (IT) equipment and systems, when reasonable and necessary, for patient registration and tracking, vaccine-related inventory management, and/or analytics and reporting needs.
 - i. To the extent possible, vaccination providers should utilize existing IT systems and processes for managing the distribution and administration of COVID-19 vaccines.
 - ii. The CDC also developed the Vaccine Administration Management System (VAMS)¹⁸ for jurisdictions and healthcare providers that do not have existing IT systems for vaccination management. VAMS is an optional, web-based application that supports planning and execution for temporary, mobile, or satellite COVID-19 vaccination clinics.
 - iii. In the event existing IT systems and VAMS are both inadequate to meet the needs of vaccination providers, IT equipment and systems necessary for the distribution and administration of COVID-19 vaccines are eligible for PA.
 - iv. The systems should collect demographic data required under the Stafford Act and consistent with guidance from FEMA, and the system must be able to report data to FEMA when requested.
- j. Training and technical assistance specific to the proper storage, handling, distribution,¹⁹ and administration of COVID-19 vaccinations in accordance with CDC guidance.
- k. Vaccination administration consistent with equitable pandemic response and recovery.

¹⁶ For more information on FQHCs, visit www.hhs.gov/guidance/sites/default/files/hhs-guidance-documents/FQHC-Text-Only-Factsheet.pdf.

¹⁷ Stafford Act, Section 403(a)(3)(F) and (G); and as described at Chapter 2:VI.B. Emergency Protective Measures (Category B) at page 58 of the PAPPG (V3.1).

¹⁸ See www.cdc.gov/vaccines/covid-19/reporting/vams/index.html for more information on VAMS.

¹⁹ CDC Vaccine Storage and Handling Toolkit



- i. Recipients and Subrecipients of FEMA assistance shall collect data on race, ethnicity and disability status.²⁰ Recipients must also make best efforts to collect additional anonymized equity-focused person-level data, including information on primary language, and sexual orientation or gender identity (SO/GI). Recipients and Subrecipients must incorporate these data in their development of short-term targets for the equitable deployment of FEMA financial assistance and identify data sources, proxies, or indices, including demographic data disaggregated to reveal socioeconomic, racial, linguistic, age, gender, disability, and other indices that will enable recipients to develop short-term targets for equitable delivery of FEMA-funded assistance and to reach communities of color and other underserved populations.

- ii. Recipients and Subrecipients must submit to FEMA information documenting the following for sites selected for vaccination administration every 30 days:
 - a) For each site, provide a score on the CDC’s Social Vulnerability Index or a similar social deprivation, disadvantage, or vulnerability composite index.
 - b) A description of how the location of the site(s)—relative to other candidate locations—best advances FEMA’s focus on supporting the highest-risk communities. This justification may also include a comparison of vaccination rates for demographic groups by geographic area.
 - c) A site strategy to operationalize equitable access including, but not limited to:
 - 1) A plan for community outreach and engagement, both before and during implementation;
 - 2) A registration process that advances equity with a focus on prioritizing minoritized, marginalized, and otherwise disadvantaged groups;
 - 3) Equitable physical design of the site, including transportation and accessibility considerations; and
 - 4) A plan for ongoing evaluation and continuous improvement to ensure equitable access.

D. GENERAL ELIGIBILITY CONSIDERATIONS FOR COVID-19 COSTS

Outcome: To provide additional information about eligible costs and cost-related considerations.

- 1. **Allowability of Costs.** To be eligible, claimed costs must be allowable under 2 C.F.R.

²⁰ Consistent with the Office of Management and Budget (OMB) minimum standard collection categories as per OMB Statistical Policy Directive No. 15.
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part 200.²¹ In considering allowability, FEMA will evaluate, among other factors:

- a. Whether the cost was necessary and reasonable in order to respond to the COVID-19 pandemic. A cost is considered reasonable if, in its nature and amount, it does not exceed that which would be incurred by a prudent person under the circumstances prevailing at the time the decision was made to incur the cost.²² For COVID-19 declarations, FEMA will use Medicare rates²³ as the basis to determine reasonable costs for eligible clinical care not covered by another funding source. Both patient payments and insurance payments are considered another funding source; clinical care for which providers have received or will receive payments from patients or insurance is not eligible.
- b. Whether the cost conforms to standard PA program eligibility and other federal requirements.²⁴
- c. Whether the applicant followed its established practices and policies and procedures that apply when federal funding is not available, including standard billing and fee collection.²⁵
 - i. FEMA will not require Applicants to create a new billing process at temporary medical facilities described in C.2 and C.3.
 - ii. All work conducted and costs incurred in Primary Medical Care Facilities described in C.1 should follow the facility's standard billing practice.
 - iii. If the Primary Medical Care Facility described in C.1 did not follow its standard billing practice, the Applicant must demonstrate why following such practices would have increased an immediate threat to life and demonstrate that all costs not reimbursed by FEMA followed the same procedures.
- d. Whether the cost is documented with sufficient detail for FEMA to evaluate its compliance with federal laws, rules and other PA program requirements.²⁶

2. Cost Share for COVID-19 Declarations. PA funding authorized under COVID-19 declarations is subject to the following cost share provisions:

- a. In accordance with the February 17, 2021 memorandum from the FEMA Recovery Assistant Administrator titled "100% Federal Cost Share for COVID-19 Public Assistance Funding," FEMA will increase the federal cost share for all

²¹ 2 CFR 200.403.

²² 2 CFR 200.403(a) and 404.

²³ FEMA will use standard Medicare rates that do not include the 20 percent increase in COVID-19 Medicare DRG rates implemented by the CARES Act.

²⁴ See 2 CFR 200.403(b),(d),(e).(f) and (h) and PAPPG V3.1 (2018), and www.fema.gov/grants/procurement for additional guidance.

²⁵ 2 CFR 200.403(c).

²⁶ 2 CFR 200.302(a).



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COVID-19 declarations from 75 percent to 100 percent for eligible work performed or to be performed from January 20, 2020 through September 30, 2021.

- b. For previously awarded projects, FEMA will obligate additional funding to increase the federal funding from 75 percent to 100 percent. To minimize the administrative burden and expedite assistance, FEMA will obligate the additional 25 percent on each project via automatic amendments. Subsequently, any previously awarded donated resource project must be de-obligated. Donated resources are only eligible to offset the non-federal cost share which is no longer applicable to COVID-19 declarations.

3. Procurement Requirements for COVID-19 Declarations.²⁷

- a. States and territorial governments are required to follow their own procurement procedures as well as the federal requirements for procurement of recovered materials and inclusion of required contract provisions per 2 C.F.R. §§ 200.317, 200.322, and 200.326.²⁸
- b. Tribal governments, local governments, and PNPs must comply with the requirements of 2 C.F.R. §§ 200.318-200.326.
- c. In accordance with the March 17, 2020 memorandum from the FEMA Acting Associate Administrator for the Office of Response and Recovery, and the FEMA Assistant Administrator for the Grant Programs Directorate, for the duration of the Public Health Emergency, as determined by HHS, local governments, tribal governments, nonprofits, and other non-state entities may proceed with new and existing non-competitively procured contracts using the exigent/emergency circumstances exception in 2 C.F.R. § 200.320(c)(3). Additional resources on COVID-19 specific to grants are also available at www.fema.gov/grants under “News and Announcements” and www.fema.gov/coronavirus.
- d. SLTT governments may contract with medical providers, including private entities, to carry out any eligible activity described in **Section C. Eligible Medical Care by Facility** of this policy.
- e. Contracts must include an actionable termination for convenience clause that will be implemented if any part of the contract scope of work is ultimately not needed, or the needs are less than projected, as determined by the legally responsible entity. Ongoing and projected needs should be based on regular reviews and the

²⁷ Additional guidance regarding procurement standards is available at www.fema.gov/grants/procurement.

²⁸ For additional guidance regarding required contract clauses, see the Procurement Disaster Assistance Team’s “FEMA Contract Provisions Template” (2019 ed.) available online at www.fema.gov/media-library-data/1569959119092-92358d63e00d17639d5db4de015184c9/PDAT_ContractProvisionsTemplate_9-30-19.pdf.



Applicant must document the review process to support its decision making. All claimed contract costs must be necessary and reasonable pursuant to applicable federal regulations and federal cost principles.

4. Duplication of Benefits.

Pursuant to Section 312 of the Stafford Act, FEMA is prohibited from providing financial assistance where such assistance would duplicate funding available from another program, insurance, or any other source for the same purpose.

- a. FEMA cannot duplicate assistance provided by HHS or other federal departments and agencies. This includes, but is not limited to, funding provided by the programs listed below. FEMA is providing this list as a helpful reference, but SLTT government entities and PNPs should consult with the appropriate federal agency and the terms and conditions of each program or source of funding to determine what funding may be considered duplicative.
 - i. The Public Health Emergency Preparedness Cooperative Agreement Program;
 - ii. The Public Health Crisis Response Cooperative Agreement;
 - iii. The Epidemiology and Laboratory Capacity for Prevention and Control of Emerging Infectious Diseases;
 - iv. The Hospital Preparedness Program Cooperative Agreement;
 - v. The Regional Ebola and Other Special Pathogen Treatment Centers Cooperative Agreement;
 - vi. The National Emerging Special Pathogens Training and Education Center Cooperative Agreement;
 - vii. The Hospital Association COVID-19 Preparedness and Response Activities Cooperative Agreement;
 - viii. The Partnership for Disaster Health Response Cooperative Agreement;
 - ix. The Coronavirus Relief Fund and the Provider Relief Fund;
 - x. The COVID-19 Uninsured Program
 - xi. The Paycheck Protection Program; and
 - xii. The Immunizations and Vaccines for Children Cooperative Agreement.

- b. FEMA cannot provide PA funding for clinical care and other costs funded by another source, including private insurance, Medicare, Medicaid/CHIP, other public insurance, a pre-existing private payment agreement, or the COVID-19 Uninsured Program for uninsured patients.²⁹ The Applicant must certify that it has not received and does not anticipate receiving assistance from these sources or any other source for the same work or costs. FEMA will deobligate any PA funding that has been provided in the event that another source provides funds to the Applicant for the same clinical care or other costs.

²⁹ The COVID-19 Uninsured Program reimburses for testing and clinical care costs for the uninsured which is being provided at Medicare rates.



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- c. At no time will FEMA request or accept any Personally Identifiable Information related to the medical care of individual COVID-19 patients or for any other individual.
- d. FEMA will reconcile final funding based on any funding provided by another agency or covered by insurance or any other source for the same purpose. FEMA will coordinate with HHS to share information about funding from each agency to assist in preventing duplication of benefits.

5. Time Limitations for the Completion of Work.

- a. For all COVID-19 declarations, FEMA has extended the deadline in accordance with regulatory timeframes for emergency work at 44 C.F.R. §206.204(d) beyond six months of the date of the declaration and will notify applicants no less than 30 days prior to establishment of the deadline.

Keith Turi
Assistant Administrator, Recovery Directorate

March 15, 2021

Date



ADDITIONAL INFORMATION

REVIEW CYCLE

This interim policy will be reviewed periodically during the COVID-19 Public Health Emergency period. The Assistant Administrator for the Recovery Directorate is responsible for authorizing any changes or updates. This interim policy will sunset with the closure of the national emergency declaration for COVID-19 and any subsequent major disaster declarations for COVID-19.

AUTHORITIES and REFERENCES

Authorities

- Robert T. Stafford Disaster Relief and Emergency Assistance Act, 42 U.S.C. § 5121-5207, as amended
- Title 44 of the Code of Federal Regulations, Part 206, Subpart H
- Title 2 of the Code of Federal Regulations, Part 200

References

- Public Assistance Program and Policy Guide, Version 3.1

DEFINITIONS

To establish consistent terminology for purposes of implementing this policy, the following definitions are provided below. These definitions are specific to this policy and may differ from definitions prescribed for the same or similar terms in other policies.

1. **Medical Care:** Medical Care refers both to assistance provided to support the provision of medical care and assistance for clinical care. Examples of medical care support include eligible facility, equipment, supplies, and staffing costs.
2. **Clinical Care:** Clinical Care refers to medical treatment of individual patients including testing, diagnosis, treatment, hospitalization, prescriptions, and other costs associated with individual patient treatment typically billed to individual patients, their insurance carriers, Medicare, Medicaid, or other pre-existing payment agreements.
3. **Primary Medical Care Facility:** A primary medical care facility is the facility owned and/or operated by an eligible PA Applicant that provides medical care services. This includes any licensed hospital, outpatient facility, rehabilitation facility, or facility for long-term care.
4. **Temporary Medical Facility:** A temporary medical facility is a facility separate from the primary medical care facility that is used to provide medical care services when the primary medical care facility is overwhelmed by the declared event.



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5. **Expanded Medical Facility:** An expanded medical facility is part of the primary medical care facility and refers to an expansion of the primary medical care facility to increase its capacity when the primary medical care facility is overwhelmed by the declared event.
6. **Alternate Care Sites:** Alternate Care Site is a type of Temporary Medical Facility and broadly describes any building or structure of opportunity converted for healthcare use. It provides additional healthcare capacity and capability for an affected community separate from a traditional, established healthcare institution, though healthcare institutions may partner with eligible Applicants operating an Alternate Care Site.
7. **Community-Based Testing Sites:** Community-Based Testing Sites are strategically located sites within a community operated by a SLTT government for the purpose of providing COVID-19 testing to members of the community.
8. **Wraparound Services:** Wraparound services in the context of this policy are the same as those defined in the Alternate Care Site Toolkit. The services will differ at each temporary medical facility. Such services include, but are not limited to, the following: linen and laundry services; food preparation and delivery; biomedical waste removal, including contaminated items such as personal protective equipment; perimeter fencing; contracted security guards; professional cleaning; and other related services. The toolkit and other Alternate Care Site resources are available on the HHS website at <https://asprtracie.hhs.gov/technical-resources/111/covid-19-alternate-care-site-resources>.

MONITORING AND EVALUATION

FEMA will closely monitor the implementation of this policy through close coordination with regional and field staff, as appropriate, as well as interagency partners and SLTT stakeholders.

QUESTIONS

Applicants should direct questions to their respective FEMA regional office.



Equitable COVID-19 Response and Recovery

Recipient and Subrecipient Job Aid

A. Introduction

The Equitable COVID-19 Response and Recovery Recipient and Subrecipient Job Aid (Job Aid) provides the steps Recipients and Subrecipients must take to document that pandemic response and recovery efforts are conducted in an equitable manner to communities of color and other underserved populations, including sexual orientation and gender identity minority groups, persons with disabilities, those with limited English proficiency, and those living at the margins of our economy. The Job Aid includes specific procedures to ensure equitable medical care and vaccine administration consistent with equitable pandemic response and recovery, per FEMA Policy #104-21-0004: Coronavirus (COVID-19) Pandemic Medical Care Eligible for Public Assistance (Interim) (Version 2), hereinafter called the Medical Care Policy.¹

B. Equity Considerations for All COVID-19 Work

Recipients and Subrecipients must prioritize limited resources to ensure an equitable pandemic response.² The following items are elements Recipients and Subrecipients may consider to ensure equitable allocation of resources:

- Using the Centers for Disease Control and Prevention (CDC) Social Vulnerability Index (SVI) or similar value to determine highest-risk communities;
- Considering communities disproportionately affected by the pandemic, in terms of infection rates, hospitalization, and mortality; and
- Strengthening data collection efforts to substantiate that COVID-19 aid is reaching the highest-risk communities and underserved populations.

Recipients and Subrecipients are required to comply with applicable provisions of laws and authorities prohibiting discrimination, including but not limited to:

- Title VI of the Civil Rights Act of 1964, which prohibits discrimination based on race, color, or national origin (including limited English proficiency)
- Sections 308 and 309 of the Stafford Act, which require the impartial and equitable delivery of disasters services and activities, without discrimination on the grounds of

¹ FEMA Policy #104-21-0004: Coronavirus (COVID-19) Pandemic Medical Care Eligible for Public Assistance (Medical Care Policy) Section C.3.k., March 2021.

² Medical Care Policy Section B.3.c.



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race, color, religion, nationality, sex, age, disability, English proficiency, or economic status³

- Section 504 of the Rehabilitation Act of 1973, which prohibits discrimination based on disability
- Title IX of the Education Amendments Act of 1972, which prohibits discrimination based on sex in education programs or activities
- Age Discrimination Act of 1975, which prohibits discrimination based on age
- U.S. Department of Homeland Security regulation 6 C.F.R. Part 19, which prohibits discrimination based on religion in social service programs
- 2 C.F.R 200 - Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards, Subpart D – Post Federal Award Requirements § 200.300 Statutory and national policy requirements.

FEMA will monitor compliance for all COVID-19 Work in accordance with 44 C.F.R. Part 7. Of note, Recipients and Subrecipients must:

- Provide assurances of compliance with nondiscrimination requirements;
- Retain compliance information;
- Submit and retain complete, accurate, and timely reports; and
- Respond to requests for information⁴

C. Equitable Vaccine Administration Requirements

In addition to the requirements in Section B, FEMA will take additional steps to ensure compliance for vaccine-related work.

1. Vaccine Information Requirements

Each Recipient or Subrecipient requesting PA funding for vaccination efforts and associated activities must substantiate how equity was considered as part of its vaccine administration strategy.⁵ Upon submittal of a vaccination-related project application, the respective Recipient or Subrecipient must certify that vaccine-related efforts consider equity and advance supporting highest-risk communities.

³ Title 44 Code of Federal Regulations (C.F.R.) § 206.11 and Medical Policy Section B.3.d.

⁴ 44 C.F.R. Part 7.

⁵ Medical Care Policy Section B.3.c



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Each Recipient or Subrecipient will submit social vulnerability scores and information to substantiate an equitable vaccine administration strategy, as detailed in Section 5. The equitable vaccination information must address each of the Recipient’s or Subrecipient’s vaccine administration sites.⁶ Appendix A: Equitable Vaccine Administration Information Submission Template includes a template that may be used to submit the information (Template). One template may be submitted for all of a Recipient’s or Subrecipient’s sites, even if the Recipient or Subrecipient has or will submit multiple projects. The Template has three sections:

- Section 1: Recipient/Subrecipient Information
- Section 2: Equitable Vaccine Administration Strategy
- Section 3: Site-Specific Information

Recipients or Subrecipients may use their own template provided it includes the same level of detail and information. They should upload the information in the Applicant Profile section of FEMA’s Public Assistance (PA) Grants Portal.

Recipients and Subrecipients shall collect race, ethnicity, and disability status data, as outlined in the Medical Care Policy⁷ to determine whether target populations are being reached. These data should be collected and used to identify target populations but should **not** be submitted to FEMA. In the case of a complaint, audit or questionable compliance, FEMA may request statistical or summary information based on collected data, such as percent of each type of population. FEMA will **not** request, and Recipients and Subrecipients should not submit to FEMA, personally identifiable information⁸ to determine compliance with equitable pandemic response requirements.

2. Timeframes to Submit Information

When to submit the information to FEMA will vary based on the status of vaccination operations and FEMA funding. Recipients and Subrecipients are grouped as follows to differentiate between which deadlines apply to which Recipients and Subrecipients:

⁶ Medical Care Policy Section C.3.k.ii.

⁷ Medical Care Policy Section C.3.k.i.

⁸ Personally Identifiable Information is defined by OMB Memorandum M-07-1616 and refers to information that can be used to distinguish or trace an individual’s identity, either alone or when combined with other personal or identifying information that is linked or linkable to a specific individual.



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- Group 1: Recipients or Subrecipients that completed all their vaccination work and that:
 - a) FEMA has obligated funding, must submit the information within 30 days of the issuance of the Medical Care Policy
 - b) Have applied for, but FEMA has not yet obligated funding, must submit the information within 30 days of the vaccine-related obligation
 - c) Have not yet applied for FEMA funding, must submit the information with their initial request for FEMA vaccination funding

FEMA reviews Group 1 submissions once for completeness and compliance. As work is complete, there is no overall need from Group 1 to submit ongoing 30-day reporting. FEMA may request additional information as necessary.

- Group 2: Recipients or Subrecipients that have not yet completed all of their vaccination work and that:
 - a) FEMA has obligated funding, must submit the information within 30 days of the issuance of the Medical Care Policy
 - b) Have applied for, but FEMA has not yet obligated funding, must submit the information within 30 days of the initial vaccine-related obligation
 - c) Have not yet applied for FEMA funding, must submit the information within 30 days of the initial vaccine-related obligation

Group 2 must submit ongoing updates every 30 days until the completion of vaccination work. FEMA reviews Group 2’s submissions monthly for completeness, and quarterly for compliance.

3. Review Process

FEMA reviews submissions for completeness and compliance. Failure to comply “could result in funding reductions and/or delays”.⁹

⁹ Medical Care Policy B.3.c



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4. Identifying Target Populations

Recipients and Subrecipients shall collect race, ethnicity, and disability status data, as outlined in the Medical Care Policy.¹⁰ The collection of this information should be used to:

- Identify the highest-risk communities;
- Evaluate whether the highest-risk communities and underserved populations are being reached;
- Refine or improve the strategy, as needed; and
- Demonstrate compliance with the delivery of COVID-19 aid in an equitable manner.

5. Vaccine Administration Information

All Recipients or Subrecipients must submit the following information to FEMA to demonstrate equitable vaccine administration:¹¹

- The score on the CDC’s Social Vulnerability Index or similar social deprivation, disadvantage, or vulnerability composite index;
- A description of how the location of the site(s)—relative to other candidate locations—best advances FEMA’s focus on supporting the highest-risk communities; and
- A strategy to operationalize equitable access at each site, including but not limited to:
 - A plan for community outreach and engagement, both before and during implementation;
 - A registration process that advances equity with a focus on prioritizing minoritized, marginalized, and otherwise disadvantaged groups;
 - Equitable physical design of the site, including transportation and accessibility considerations; and
 - A plan for ongoing evaluation and continuous improvement to ensure equitable access.

Additionally, Recipients or Subrecipients in Group 2 must provide updates to this information to FEMA every 30 days.

¹⁰ Medical Care Policy Section C.3.k.i..

¹¹ Medical Care Policy Section C.3.k.ii.



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a. Social Vulnerability Scores

Recipients and Subrecipients must provide a score, such as the Centers for Disease Control and Prevention Social Vulnerability Index (CDC SVI) for each proposed site.¹² The CDC SVI specifies that “socially vulnerable populations are especially at risk during public health emergencies because of factors like socioeconomic status, household composition, minority status, or housing type and transportation.” The approach should provide specifics, as appropriate. The Recipients and Subrecipients may choose an alternate score, so long as the score follows the criteria outlined in the Medical Care Policy.

b. Outreach and Engagement

Recipients and Subrecipients must describe their approach to community outreach and engagement, both before and during implementation.¹³

The [CDC COVID-19 Vaccination Program Interim Playbook for Jurisdiction Operations](#) Section 12: COVID-19 Vaccination Program Communication¹⁴ includes a framework for developing communication objectives, targeting audiences, messaging considerations, and communication channels. In addition, the CDC has published “[COVID-19 One-Stop Shop Toolkits](#)” that can assist with communication strategies.¹⁵

Communications to disseminate public information should include translation and interpretation services as necessary¹⁶.

The following questions are elements Recipients and Subrecipients may consider when describing their approach to community outreach and engagement:

- How does the outreach and engagement strategy specifically support access to vaccinations for the highest-risk communities and underserved populations?
- What outreach and engagement strategies do you intend to utilize to reach high-risk communities and underserved populations (e.g. leverage community leaders and community-based organizations)?

¹² Medical Care Policy Section C.3.k.ii.a.

¹³ Medical Care Policy Section C.3.k.ii.c.1.

¹⁴ [CDC COVID-19 Vaccination Program Interim Playbook for Jurisdiction Operations](#) Version 2.0, Section 12, October 2020.

¹⁵ [CDC COVID-19 One-Stop Shop Toolkits](#), February 2021

¹⁶ Stafford Act, Section 403(a)(3)(F) and (G); and as described at Chapter 2:VI.B. Emergency Protective Measures (Category B) at page 58 of the PAPPG (V3.1).



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- How are you ensuring your community engagement events are accessible to individuals with disabilities, limited English proficiency, and those living at the margins of our economy?
- In what ways does the outreach and engagement strategy address vaccine confidence?

c. Registration Process

Recipients and Subrecipients must provide a registration process that advances equity with a focus on prioritizing minoritized, marginalized, and otherwise disadvantaged groups.¹⁷ The following questions are elements Recipients and Subrecipients may consider when describing their registration process:

- How does your vaccine registration process address digital disparity with online registration (e.g. internet access, computer access, etc.) or other limiting access factors to registration?
- What information or support is provided for registrants to meet their scheduled vaccine appointment (e.g. discussion of rural areas lack of access to public transportation, etc.)?
- Is your registration system advancing equity with a focus on prioritizing minoritized, marginalized, and otherwise disadvantaged groups?

d. Vaccine Site Selection

Recipients and Subrecipients must submit a description of how the location of each site - relative to other locations - best advances a focus on supporting the highest-risk communities. This may also include a comparison of vaccination rates for demographic groups by geographic area¹⁸ to identify populations likely to have access barriers in receiving a vaccine, such as:

- Socioeconomic status barriers;
- Household composition;
- Individuals with disabilities who are home based;
- Minority status and limited English proficiency; and

¹⁷ Medical Care Policy Section C.3.k.ii.c.2.

¹⁸ Medical Care Policy Section C.3.k.ii.b.



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- Housing and transportation barriers, to include crowding or group quarters, access to a vehicle, and mobile homes.

The following should also be provided for each site:

- The location (address or coordinates);
- Vaccine site type, per FEMA’s [Community Vaccination Centers Playbook](#);
- Site Status (active, planned, or closed);
- Site capacity (doses/day); and
- Actual site throughput (doses provided over the past 30 days).

e. Site Accessibility

Recipients and Subrecipients must also ensure that the vaccine site is accessible, as outlined in the FEMA Civil Rights COVID Vaccine Checklist¹⁹ and the Medical Care Policy.²⁰ Factors of accessibility design include consideration of transportation avenues to and from the site and accessibility of the physical design of the site itself. Site accessibility considerations may also include provisions made to use mobile sites or provide transportation to populations with accessibility constraints. The following questions are elements Recipients and Subrecipients may consider in describing their site accessibility approach:

- How are you ensuring access to information at the vaccine site for individuals with disabilities and/or limited English proficiency?
- What assistive technology is your site utilizing for individuals with disabilities?
- How are you ensuring that your site, or a portion thereof, is compliant with Americans with Disabilities Act²¹ accessibility requirements and for individuals requiring additional assistance (e.g. older individuals and individuals with cognitive disabilities)?
- How are you ensuring that your site is accessible by public transportation?

¹⁹ FEMA Civil Rights COVID Vaccine Checklist: “Civil Rights Considerations During COVID-19 Vaccine Distribution Efforts,” [3/21/20 \(fema.gov\)](#).

²⁰ Medical Care Policy C.3.k.ii.c.

²¹ [Americans with Disabilities Act of 1990, AS AMENDED with ADA Amendments Act of 2008.](#)



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f. Evaluation and Continuous Improvement

Recipients and Subrecipients should include a discussion of their evaluation methods and approach to continuous improvement related to equitable vaccination efforts.

The following questions are elements Recipients and Subrecipients may consider when describing their plan for evaluation and continuous improvement:

- How are you evaluating your approach to equitable vaccine administration?
- What tactical adjustments are you making based on your evaluation? Tactical adjustments may include, but are not limited to: adjusting the physical design of vaccination sites to promote accessible design, increasing transportation options to and from vaccination sites to promote equitable access, adjusting registration processes to advance equity and prioritize highest-risk and underserved communities etc.
- What is working well to promote equitable vaccine distribution?

Equitable Vaccine Administration Information Submission Template

How to Use this Template

Recipients and Subrecipients may use this template for submitting information to FEMA. To submit this information to FEMA, Recipients and Subrecipients upload this template (or their own template or report that contains the same information and level of detail) to the Applicant Profile in Grants Portal.

Group 1 Recipients or Subrecipients may use this template to provide the information one time.

Group 2 Recipients or Subrecipients may use this template to provide the information initially and every 30 days thereafter to provide any updates, improvement, or refinements to the strategy, updated status of sites, and to capture any newly established sites. If there are no changes, the information must still be provided with a statement that there are no changes since the last submittal.

Equitable Vaccine Administration Information		
Section 1: Recipient/Subrecipient Information		
Declaration #	Recipient Name Subrecipient Name	FEMA PA Code
Section 2: Equitable Vaccine Administration Strategy		
Overview of Strategy	<i>Narrative (If this is a subsequent 30-day submittal, please define any refinements/improvements derived from the ongoing evaluation)</i>	
Outreach and Engagement	<i>Narrative (If this is a subsequent 30-day submittal, please define any refinements/improvements derived from the ongoing evaluation)</i>	
Registration Process	<i>Narrative (If this is a subsequent 30-day submittal, please define any refinements/improvements derived from the ongoing evaluation)</i>	

Physical Site Design and Access	Narrative (If this is a subsequent 30-day submittal, please define any refinements/improvements derived from the ongoing evaluation)
Evaluation and Continuous Improvement Plan	Narrative (If this is a subsequent 30-day submittal, please define any changes to the plan)

Section 3: Site-Specific Information

(If this is a subsequent 30-day submittal, please define any refinements/improvements derived from the ongoing evaluation)

Associated FEMA Project #	Site	Name	Location	Status	Index Used	Vulnerability Score	Site Type	Site Capacity	Throughput	Additional site-specific details regarding: <ul style="list-style-type: none"> • Outreach and Engagement • Registration Process • Physical Site Design • Evaluation and Continuous Improvement 	Equitable Selection Considerations
<i>ID</i>	<i>ID</i>	<i>Text</i>	<i>Address GPS</i>	<input type="checkbox"/> <i>Planned</i> <input type="checkbox"/> <i>Active</i> <input type="checkbox"/> <i>Closed</i>	<i>CDC, SoVI, Other</i>	<i>Numeric Value</i>	<i>I-V</i>	<i>Doses/day projected for the next 30 days</i>	<i>Doses/day in the past 30 days</i>	<i>Narrative</i>	<i>Select all that apply:</i> <input type="checkbox"/> Community outreach and engagement was conducted for this site. <input type="checkbox"/> Site location is accessible. <input type="checkbox"/> Registration process addresses digital disparity and/or other limiting factors to registration. <input type="checkbox"/> Site collects data on demographic information as detailed in the Medical Care Policy. <input type="checkbox"/> Site location supports highest-risk communities and underserved populations. <input type="checkbox"/> Acted on results of evaluation and continuous improvement.