

## The COVID-19 PHE is Ending on [xx]

Throughout the COVID-19 public health emergency (PHE), CMS has used a combination of emergency authority waivers, regulations, enforcement discretion, and sub-regulatory guidance to ensure access to care and give health care providers the flexibilities needed to respond to COVID-19 and help keep people safer. Many of these waivers and broad flexibilities will terminate at the eventual end of the PHE, as they were intended to address the acute and extraordinary circumstances of a rapidly evolving pandemic and not replace existing requirements. To minimize any disruptions, including potential coverage losses, following the end of the PHE, HHS Secretary Becerra committed to giving states and the health care community writ large 60 days' notice before ending the PHE. He issued that notice on XXX. CMS will continue to accept waiver requests until XXX when the COVID-19 PHE officially ends.

CMS has encouraged health care providers to prepare for the end of these flexibilities as soon as possible and to begin reestablishing previous health and safety standards and billing practices. Click the button to the right to access our fact sheets that outline which blanket waivers and flexibilities will terminate at the end of the PHE, by provider type.

Fact Sheets by provider type



## CMS 1135 Waiver / Flexibility Request and Inquiry Form

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 **0938-1384 (Expires 05/31/2024)**. This is a **voluntary** information collection. The time required to complete this information collection is estimated to average **1 hour** per waiver, including the time to review the 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 Officer. 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 Adriane Saunders at [Adriane.Saunders@cms.hhs.gov](mailto:Adriane.Saunders@cms.hhs.gov).**

If you have a request or inquiry, please use this form to submit your request to CMS.

### Who are you? ?

An Organization / Provider

A Beneficiary

### What would you like to do? ?

I want to submit a waiver / flexibility request ?

I want to submit an inquiry request ?

I want to submit an inquiry request ?

Under **Section 1135 or 1812(f) of the Social Security Act**, CMS can issue several blanket waivers when there's a disaster or emergency. Blanket waivers prevent gaps in the access to care for beneficiaries affected by the emergency.

When a blanket waiver is issued, providers don't have to apply for an individual waiver. If there's no blanket waiver, providers can ask for an individual Section 1135 waiver.

## Submit a waiver / flexibility request

### 1 Select a Public Health Emergency

Select the Public Health Emergency (PHE) that applies to your waiver request

Public Health Emergency (PHE) (required) \* ?

Please select one

1135 Waiver Request when No PHE declared

### 2 Provide Your Contact Information

This will help keep you updated on your request's progress

#### Point of Contact ?

Who should CMS contact in response to this waiver request?

Email address (required) \*

Confirm email address (required) \*

First name (required) \*

Last name (required) \*

Phone number

(XXX)XXX-XXXX

#### Organization Information ?

Who is the organization making this request?

Organization name (required) \*

State/US Territory/Federal District (required) \* ?

Alaska x California x Ne

Nebraska

Nevada

New York

#### Organization Categories ?

Who is the organization making this request?

General	Emergency Provider / Supplier Types	Other
<input type="checkbox"/> Advocacy Group	<input type="checkbox"/> Medicare Advantage Plan	<input type="checkbox"/> Tribal Nation
<input type="checkbox"/> Association	<input type="checkbox"/> Part D Prescription Plan	
<input type="checkbox"/> Congressional Office	<input type="checkbox"/> State Government	
<input type="checkbox"/> Corporation	<input type="checkbox"/> State Medicaid or CHIP Agency	
<input type="checkbox"/> Department of Health and Human Services	<input type="checkbox"/> State Survey Agency	

General	Emergency Provider / Supplier Types	Other
<input type="checkbox"/> Ambulatory Surgical Center (ASC)	<input type="checkbox"/> Nursing Homes (SNF/NF)	<input type="checkbox"/> Organ Procurement Organization (OPO)
<input type="checkbox"/> Community Mental Health Center (CMHC)	<input type="checkbox"/> Outpatient Physical Therapy/Speech Therapy (OPT/ST)	
<input type="checkbox"/> Comprehensive Outpatient Rehabilitation Facility (CORF)	<input type="checkbox"/> Programs of All-Inclusive Care for Elderly (PACE)	<input type="checkbox"/> Psychiatric Residential Treatment Facility (PRTF)
<input type="checkbox"/> Critical Access Hospital (CAH)	<input type="checkbox"/> Religious Non-Medical Health Care Institution (RNCHI)	<input type="checkbox"/> Rural Health Clinic/Federally Qualified Health Center (RHC/FQHC)
<input type="checkbox"/> End Stage Renal Disease (ESRD)	<input type="checkbox"/> Hospice	<input type="checkbox"/> Transplant Center
<input type="checkbox"/> Home Health Agencies (HHA)	<input type="checkbox"/> Hospital	
<input type="checkbox"/> Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID)	<input type="checkbox"/> Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID)	

General	Emergency Provider / Supplier Types	Other
<input type="checkbox"/> Ambulance	<input type="checkbox"/> Palliative	
<input type="checkbox"/> Durable Medical Equipment (DME)	<input type="checkbox"/> Physician	
<input type="checkbox"/> Lab	<input type="checkbox"/> Other	<input type="text" value="Other Organization Category"/>

#### Organization Identification Numbers ?

What are the identification numbers for your organization?

These numbers will be different, depending on the categories you have selected for your organization including: CCN/Provider, Medicare Contract Number, or NPI.

For the categories selected above, use:

NAME-OF-IDENTIFICATION-NUMBER

Separate multiple identification numbers with a comma.

### 3 Describe your 1135 Waiver / Flexibility Request ?

Select the type of request you are making. Depending on your request type, we may ask you for additional information.

#### Request #1

Waiver Request Type (required) \* ?

#### Regulation Related to this Request ?

#### Request Description (required) \* ?

Detail a brief summary of why the waiver is needed (For example: CAH is sole community provider without reasonable transfer options at this point during the specified emergent event (e.g. flooding, tornado, fires, or flu outbreak). CAH needs a waiver to exceed its bed limit by X number of beds for Y days/weeks (be specific) and the type of relief you are seeking.

[+ Add another waiver request](#)

### 4 Submit your request

**Thank You! Your request has been successfully submitted.**

Your case number is <Case#>

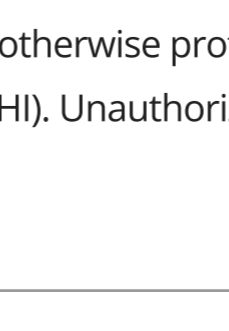
You will also receive an email confirmation summarizing your request and providing you with additional guidance.

To report technical issues please email [qnetsupport@cms.hhs.gov](mailto:qnetsupport@cms.hhs.gov) and note "1135 Waiver/Flexibility" in the subject line.

If you are requesting an 1135 waiver or making an Inquiry about a public health emergency, please submit your request at the [CMS PHE Emergency Web Portal](#). For all other questions, please contact [Emergencies@cms.hhs.gov](mailto:Emergencies@cms.hhs.gov).

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## Drop down options

PHE

1135 Waiver Request when No PHE declared

### State/US Territory/Federal District

Alabama  
Alaska  
American Samoa  
Arizona  
Arkansas  
Armed Forces America  
Armed Forces Europe  
Armed Forces Pacific  
California  
Colorado  
Connecticut  
Delaware  
Florida  
Georgia  
Guam  
Hawaii  
Idaho  
Illinois  
Indiana  
Iowa  
Kansas  
Kentucky  
Louisiana  
Maine  
Marshall Islands  
Maryland  
Massachusetts  
Michigan  
Micronesia  
Minnesota  
Mississippi  
Missouri  
Montana  
Nebraska  
Nevada  
New Hampshire  
New Jersey  
New Mexico  
New York  
North Carolina  
North Dakota  
Northern Mariana Islands  
Ohio  
Oklahoma  
Oregon  
Palau  
Pennsylvania  
Puerto Rico  
Rhode Island  
South Carolina  
South Dakota  
Tennessee  
Texas  
US Virgin Islands  
Utah  
Vermont  
Virginia  
Washington  
Washington D.C.  
West Virginia  
Wisconsin  
Wyoming

### Waiver/Flexibility Request Type

Conditions of Participation (COP)

Payment

### Help tooltips

#### Who are you?

This information helps CMS understand who you are so we can better assist you.

#### What would you like to do?

Choose the applicable option below.

#### I want to submit a waiver / flexibility request option

When there's a disaster or emergency, waivers and flexibilities help health care facilities give timely care to as many people who've been affected as possible. This means we're helping States, Federal Districts and U.S. territories to make sure people with Medicare and/or Medicaid continue to have access to care.

"Waiver" refers to a waiver or modification of a statutory requirement of the Social Security Act (Act) or its implementing regulations that may be waived or modified under the authority of § 1135 of the Act or § 1812(f). A "flexibility" is an agency policy or procedure that can be adjusted under current authority – and generally speaking, can be adjusted without reprogramming CMS's systems. CMS will implement these waivers and flexibilities as necessary and appropriate to accommodate the needs of those impacted by an emergency or disaster.

#### I want to submit an inquiry request option

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#### I want to provide a status update on my patients and/or healthcare facility residents

You may use this option to report any impact on normal operations.

#### Select a Public Health Emergency

Select the applicable Public Health Emergency from the dropdown list.

#### Provide Your Contact Information - Point of Contact

CMS uses your contact information to send responses and ask follow up questions.

#### Organization Information

An organization is an organized body of people with a particular purpose (e.g., State, Corporation, Health System, etc.). Please provide the required information for your organization.

#### Organization Information - State/US Territory/Federal District dropdown

Choose all applicable States, US Territories and/or Federal Districts where your healthcare facilities are located.

#### Provide Your Contact Information - Organization Categories

This provides CMS additional information on the type of organization requesting a waiver. Please select all applicable organizations by reviewing the data on all three tabs (At least one category must be selected).

#### Provide Your Contact Information - Organization Identification Numbers

Indicate all applicable identification numbers for the healthcare facilities/providers affiliated with your organization impacted by the PHE.

#### Describe Your 1135 Waiver / Flexibility Request

CMS uses this information to route your request to the appropriate area for faster response.

#### Describe Your 1135 Waiver / Flexibility Request - Waiver / Flexibility Request Type dropdown

Start typing key words for your request. A list of waiver option(s) that match your key word(s) will appear to choose from.

#### Describe Your 1135 Waiver / Flexibility Request - Regulation Related to this Request dropdown

Cite the regulation(s) you are requesting be waived (if applicable).



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I want to submit a waiver / flexibility request [?](#)

I want to submit an inquiry request [?](#)

## Submit an inquiry

### 1 Select a Public Health Emergency

Select the Public Health Emergency (PHE) that applies to your inquiry request

Public Health Emergency (PHE) (required) \* [?](#)

Please select one	▼
Coronavirus Disease 2019 (COVID-19)	03/13/2020 - 05/11/2023

### 2 Provide Your Contact Information

This will help keep you updated on your request's progress

#### Point of Contact [?](#)

Who should CMS contact in response to this inquiry request?

Email address (required) \*

Confirm email address (required) \*

First name (required) \*

Last name (required) \*

Zip code (required) \* [?](#)

Phone number

#### Organization Information [?](#)

Who is the organization making this request?

Organization name (required) \*

#### Organization Categories [?](#)

Who is the organization making this request?

General	Emergency Provider / Supplier Types	Other
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<input type="checkbox"/> Association	<input type="checkbox"/> Part D Prescription Plan	
<input type="checkbox"/> Congressional Office	<input type="checkbox"/> State Government	
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What are the identification numbers for your organization?

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For the categories selected above, use:

#### IDENTIFICATION NUMBER [?](#)

### 3 Inquiry

#### Request #1

Topic (required) \* [?](#)

Type (required) \* [?](#)

Click here if you do not see your type

Description (required) \* [?](#)

[+](#) Add another inquiry request

### 4 Submit your inquiry

**Thank You! Your inquiry has been successfully submitted.**

Your case number is <Case#>

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## Drop down options

### PHE

Coronavirus Disease 2019 (COVID-19)      03/13/2020 - 05/11/2023

### Topic

Medicaid / CHIP  
Medicare Advantage / Prescription Drug Plan  
Original Medicare (Part A or B)  
Qualified Health Plans

### Type

638 Tribal Clinics  
Academia  
Access to Care  
Advocate  
Ambulance  
Ambulatory Care Center  
Appeals  
Association / Society for Provider / Facility  
Attorney for Provider / Facility  
Appendix K  
Billing Agency  
Consultant for Provider / Facility  
Critical Access Hospital  
Denials  
Dialysis Facility  
Eligibility  
Employer  
End of COVID-19 PHE: 1135 Waiver Question  
Facility  
Federal / State Government Agency  
Fair Hearings  
Federally Qualified Health Center (FQHC)  
General Public  
HCBS Waivers  
Home Health  
Hospice  
Hospital  
Insurance Company  
Long Term Care Services and Supports  
Managed Care  
Medical Supplier/DME  
Nurse / Nurse Practitioner  
Nursing Home  
Payment Methodology / Rates  
Pharmacist / Pharmacy  
Physical / Occupational Therapy  
Physician  
Physician Assistant  
Provider Enrollment  
Provider - Mental Health  
Provider - Other  
Respite  
Retainer Payments  
Rural Health Clinic (RHC)  
Skilled Nursing Facility  
State Agency  
Telehealth

### What would you like to do?

Choose the applicable option below.

#### I want to submit a waiver / flexibility request option

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You may use this option to report any impact on normal operations.

#### Select a Public Health Emergency

Select the applicable Public Health Emergency from the dropdown list.

#### Provide Your Contact Information - Point of Contact

CMS uses your contact information to send responses and ask follow up questions.

#### Zip code

Please enter your 5 digit zip code.

#### Organization Information

An organization is an organized body of people with a particular purpose (e.g., State, Corporation, Health System, etc.). Please provide the required information for your organization.

#### Provide Your Contact Information - Organization Categories

This provides CMS additional information on the type of organization requesting a waiver. Please select all applicable organizations by reviewing the data on all three tabs (At least one category must be selected).

#### Provide Your Contact Information - Organization Identification Numbers

Indicate all applicable identification numbers for the healthcare facilities/providers affiliated with your organization impacted by the PHE.

### Topic

Choose from the dropdown list which category your inquiry would fall under.

### Type

Choose your inquiry type from the drop down list.