



## Provider Relief Programs Questioned Cost Attestation Form

### BACKGROUND:

This form is for providers who seek to offset Provider Relief Program (PRP) questioned costs identified in a Single Audit with other eligible COVID-19 expenditures.

### SECTION I - Instructions:

- 1. Complete Section II and III on this Attestation Form.** The reported information in this form must align with the information your organization has previously provided to the Health Resources and Services Administration (HRSA). Otherwise, HRSA may not be able to credit the appropriate organization's status.
- An **Authorized Representative** must complete Section II that follows. An Authorized Representative is an individual with legal authority to bind the organization as required for the [Provider Relief Fund \(PRF\) Acceptance of Award Terms and Conditions](#) and [American Rescue Plan \(ARP\) Rural Terms and Conditions](#).
- Submit the Attestation:** Selecting the 'Submit' button at the bottom of this form will automatically send this form directly to HRSA via a secure platform (i.e., DocuSign). Please ensure your responses are correct and complete before clicking 'Submit.'
- For questions about allowable costs,** review [45 CFR Part 75 Subpart E](#) and [HRSA's guidelines](#) on what is considered an allowable expense for PRF payments and/or ARP Rural payments.

### SECTION II - Organization Information:

Tax Identification Number (TIN): \_\_\_\_\_

Other TINs included in audit submission: \_\_\_\_\_

Organization Name as shown on the organization's income tax return: \_\_\_\_\_

Business Name, if different: \_\_\_\_\_

### Mailing Address

Street 1: \_\_\_\_\_

Street 2:

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City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

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**Authorized Representative Information**

Contact Person Name: \_\_\_\_\_

Contact Person Title: \_\_\_\_\_

Office: \_\_\_\_\_

Contact Person Phone

Number: \_\_\_\_\_

Contact Person Email: \_\_\_\_\_

**Authorized Representative Comments**

Provide any additional information or context related to the attestation if necessary:

**SECTION III – Attestation Statement:** As an Authorized Representative of the organization listed in Section II, I hereby attest that:

- I have the legal authority to act on behalf of the provider group that has received payment under the PRF and/or ARP Rural.
- I have reviewed the 45 CFR Part 75 Subpart E and [HRSA’s guidelines](#) on what is considered an allowable expense.
- The proposed PRP substitute expenditures:
  - Are considered allowable under the appropriate PRP Terms and Conditions.
  - Were incurred within the same period of availability as the original unallowed expenditures.
  - Will not be used to offset unallowable costs if expenses incurred in prior or subsequent reporting periods and/or audit reports.
  - Have not and will not be reimbursed from other sources.
- Submission of this PRP Questioned Cost Attestation Form and supporting documentation to HRSA does not guarantee an approval of, or adjustment to, the original questioned cost determination. HRSA will make this determination based off the supporting documentation provided.
- As stated in the Terms & Conditions, all information provided as part of the audit resolution or dispute resolution process, as well as all information and reports provided in the future at the request of HHS are true, accurate and complete, to the best of my knowledge. I acknowledge that any deliberate omission, misrepresentation, or falsification of any information may be punishable by criminal, civil, or administrative penalties, including but not limited to revocation of Medicare billing privileges, exclusion from federal health care programs, and/or the imposition of fines, civil damages, and/or imprisonment. Further, all recipients of PRF payments

and/or ARP Rural payments shall maintain appropriate records and cost documentation including, as applicable, documentation described in 45 CFR § 75.302 – Financial Management and 45 CFR § 75.361 through § 75.365 – Record Retention and Access, and other information required by future program instructions to substantiate that recipients used all PRP payments appropriately.

Signature

Date

**Public Burden Statement:** The purpose of this information collection is to follow 45 CFR 75 Subpart F for Provider Relief Program funding. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. The OMB Control Number for this information collection is 0906-0083 and is valid until 08/31/2024. Public reporting burden for this collection of information is estimated to average 1 hour per response, including the time for reviewing instructions, searching existing data sources, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to HRSA Reports Clearance Officer, 5600 Fishers Lane, Room 14N39, Rockville, Maryland, 20857 or [paperwork@hrsa.gov](mailto:paperwork@hrsa.gov).