Provider Relief Programs Audit Reporting Requirement Attestation Form

BACKGROUND:
This form is for providers who received the Provider Relief Programs (PRP) Reporting Requirements Attestation – Delinquent Audit Notice email.

SECTION I – Instructions:

1. **Complete all required fields 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 audit status.
2. 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, American Rescue Plan (ARP) Rural Terms and Conditions, COVID-19 Coverage Assistance Fund (CAF) Terms and Conditions, and the COVID-19 Claims Reimbursement to Health Care Providers and Facilities for Testing, Treatment, and Vaccine Administration for the Uninsured Program (UIP) Terms and Conditions.
3. **Submit the Attestation**: Clicking the 'Submit' button at the bottom of this form will send your Attestation response directly to HRSA via a secure platform (i.e., DocuSign). Please ensure your responses are correct and complete before clicking 'Submit.'

   For questions about the PRP reporting requirements, review the Post-Payment Notice of Reporting Requirements (PRF & ARP Rural), Audit Requirements, PRB Reporting and Auditing FAQ, PRF Terms and Conditions, ARP Rural Terms and Conditions, CAF Terms and Conditions, and the UIP Terms and Conditions.

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: _____

OMB Control Number: 0906-0083
Expiration Date: 08/31/2024

Business Name, if different: _____

Mailing Address

Street 1:

_____

Street 2:

_____

City: _____ State: _____ Zip: _____

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: Select only **one** option from the attestation statements listed below.

As an authorized representative of the organization listed in the subsequent section, I hereby attest that:

- I have the legal authority to act on behalf of the provider group that has received payment under the PRF, ARP-Rural, CAF, and/or UIP.

- **Under $750,000 Threshold**: This organization is not subject to the audit requirements detailed in the 45 CFR 75 Subpart F because expenditures for the organization's fiscal year did not exceed $750,000 for all federal funds received, including PRF, ARP-Rural, CAF, and/or UIP.

- **Over $750,000 Threshold, Reported**: This organization is subject to audit requirements detailed in 45 CFR 75 Subpart F and the applicable audit reports have been submitted to the Federal Audit Clearinghouse or HRSA Commercial Audit Reporting Portal, as applicable.

    - Fiscal Year Covered:
    - Select the last month of your Fiscal Year:
    - Programs Covered:

- **Over $750,000 Threshold, Not Reported**: This organization is subject to audit requirements detailed in 45 CFR 75 Subpart F and the applicable audit reports have not been submitted to the Federal Audit Clearinghouse or HRSA Commercial Audit Reporting Portal, as applicable, and are delinquent according to the reporting period associated with the receipt of funds.

    - Please estimate when you will submit your audit, Date:

- Select where you plan to submit your audit:
  - Federal Audit Clearinghouse
  - HRSA Commercial Audit Reporting Portal

- Please submit audit engagement letter to PRFaudits@hrsa.gov
  - Planned audit engagement letter submission date:

- I have reviewed the applicable Post-Payment Notice of Reporting Requirements (PRF & ARP Rural), Audit Requirements, PRB Reporting and Auditing FAQ, PRF Terms and Conditions, ARP Rural Terms and Conditions, CAF Terms and Conditions, and UIP Terms and Conditions documents in full.

I understand that submission of inaccurate information to HHS may result in legal penalties or legal action against the organization and/or the authorized representative.

As stated in the Terms & Conditions, all recipients of PRF payments, ARP Rural payments, UIP claim reimbursement payments, and/or CAF claim reimbursement 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_____