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Medicare Promoting Interoperability Program Hardship Exception Application

Eligible hospitals and Critical Access Hospitals (CAH) may submit a Medicare Promoting Interoperability (PI) Exception Application citing one of the following specified reasons for review and approval:

- Using decertified EHR technology
- Insufficient Internet Connectivity
- Extreme and Uncontrollable Circumstances

Important dates and information

If you are an eligible hospital, you must submit an application by September 02, 2025 for CMS to process your hardship exception request for the 2026 payment adjustment. The application will be available from May 1, 2025 - September 02, 2025.

If you are a CAH, you must submit an application by October 31, 2025 for CMS to process your hardship exception request the 2024 payment adjustment. The application will be available from May 1, 2025 - October 31, 2025.

For additional support or if you have any questions, please contact the CCSQ Service Center at qnetsupport@cms.hhs.gov, call 866-288-8912 or CCSQ Support Central.

* Indicates required

* Which form would you like to complete today?

Medicare PI Program Eligible Hospital Hardship

* Hospital CCN (6 Numeric digits only, example: 123456)

010001

Hospital Legal name

HOUSTON COUNTY HEALTHCARE AUTHORITY

Applicant Information

Provide the information below for the person working on behalf of the Hospital or CAH. All return correspondence will be sent to the contact listed in section **Applicant Information.**

* Submitter first name

Em

* Submitter last name

Smith

* Hospital or Organization name

Hope Hospital

* Submitter email

em@gmail.com

* Confirm submitter email

em@gmail.com

* Submitter telephone number

7035551212

Extension

XXXXXXX

* Address

123 Elm St

Suite / apartment / unit number

* City

Houston

State

Texas

* Zip Code

77001

* I certify that I am authorized by the hospital identified above to submit this application on behalf of the hospital.

Request for promoting interoperability program hardship exception

Review the information below and indicate one hardship exception reason which makes the Medicare Promoting Interoperability Program measures not applicable or available to your practice.

Note: Only one hardship exception reason can be selected at this time.

* Hardship exception reason

Insufficient Internet Connectivity

In order to be approved for this hardship exception, the Hospital or CAH must attest to practicing in an area without sufficient internet access or facing insurmountable barriers to obtaining infrastructure (e.g. lack of broadband).

On behalf of the Hospital or CAH listed in this application, I am requesting this hardship exception and attest that the Hospital or CAH was(were) located in an area without sufficient Internet access to comply with the Medicare Promoting Interoperability Program objectives requiring internet connectivity, and faced insurmountable barriers to obtaining such internet connectivity. I further attest that this insufficient internet connectivity constitutes a significant hardship in demonstrating meaningful use as defined under: 42 CFR 412.64 (d)(4)(ii)(A).

Certification statement for hardship application

NOTICE: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete, or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.

SIGNATURE OF HOSPITAL REPRESENTATIVE
I certify that the information contained herein is true, accurate, and complete. I understand that the Medicare Promoting Interoperability Program Hardship Exception I requested may result in a change in the amount the Hospital will be paid from Federal funds, and that by filling this application for a hardship exception I am submitting a claim for Federal funds, and the use of any false claims, statements, or documents, or the concealment of a material fact used to obtain a Medicare Promoting Interoperability Program Hardship Exception, may be prosecuted under applicable Federal or state criminal laws and may also be subject to civil penalties.

SUBMITTER WORKING ON BEHALF OF HOSPITAL(S): I certify that I am submitting this application for a payment adjustment on behalf of the hospital(s) that has (have) given me authority to act as agent. I understand that both the hospital(s) and I can be held personally responsible for all information entered.

I hereby agree to keep such records as are necessary to support the application submitted for a hardship exception of the Medicare Promoting Interoperability Program and to furnish those records both in the application and at a future time upon request from the Department of Health and Human Services, or a contractor acting on their behalf.

No Medicare Promoting Interoperability Program hardship exception may be granted unless this application is completed and approved as required by existing law and regulations (42 CFR §412.64(d)(4)(iii)).

NOTICE: Anyone who misrepresents or falsifies essential information to receive payment from Federal funds requested by this application may upon conviction be subject to fine and imprisonment under applicable Federal laws.

ROUTINE USE(S): Information from this Medicare Promoting Interoperability Program application for hardship exception and subsequently submitted information and documents may be given to the Internal Revenue Service, private collection agencies, consumer reporting agencies in connection with recoupment of any overpayment made and to Congressional offices in response to inquiries made at the request of the person to whom a record pertains. Appropriate disclosures may be made to other Federal, state, local and foreign government agencies, private business entities and individual providers of care, on matters relating to entitlement, fraud, Program abuse, Program integrity, and civil and criminal litigation in relation to the operation of the Medicare Promoting Interoperability Program.

DISCLOSURES: While submission of information for this hardship exception application is voluntary, failure to provide necessary information for hospital identification will result in delay in processing the hardship exception application or may result in a denial.

It is mandatory that you tell us if you believe you have been overpaid under the Medicare Promoting Interoperability Program. The Social Security Act, Section 1128J, requires the reporting and returning of overpayments.

By confirming this certification statement, I agree, and it is my intent, to sign this application and affirmation by including my name and the date below. I understand that completing the information below is the legal equivalent of having placed my handwritten signature on the submitted application and this affirmation.

* Certify statement for hardship

* Name of individual completing the form

I'm not a robot
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Privacy - Terms

Submit

Required information
Certify statement for hardship | Name of individual completing the form

A federal government website managed and paid for by the U.S. Centers for Medicare & Medicaid Services. 7500 Security Boulevard, Baltimore MD 21244

CMS.gov

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- Extreme and Uncontrollable Circumstances

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* Indicates required

* Which form would you like to complete today?

Medicare PI Program Eligible Hospital Hardship

* Hospital CCN (6 Numeric digits only, example: 123456)

010001

Hospital Legal name

HOUSTON COUNTY HEALTHCARE AUTHORITY

Applicant Information

Provide the information below for the person working on behalf of the Hospital or CAH. All return correspondence will be sent to the contact listed in section **Applicant Information.**

* Submitter first name

Em

* Submitter last name

Smith

* Hospital or Organization name

Hope Hospital

* Submitter email

em@gmail.com

* Confirm submitter email

em@gmail.com

* Submitter telephone number

7035551212

Extension

XXXXXXX

* Address

123 Elm St

Suite / apartment / unit number

* City

Houston

State

Texas

* Zip Code

77001

* I certify that I am authorized by the hospital identified above to submit this application on behalf of the hospital.

Request for promoting interoperability program hardship exception

Review the information below and indicate one hardship exception reason which makes the Medicare Promoting Interoperability Program measures not applicable or available to your practice.

Note: Only one hardship exception reason can be selected at this time.

* Hardship exception reason

Extreme and Uncontrollable Circumstances

* Extreme and Uncontrollable Circumstances

Disaster

On behalf of the Hospital or CAH listed in this application, I am requesting this hardship exception and attest that the Hospital or CAH faced Extreme and Uncontrollable Circumstances in the form of a natural disaster in which the EHR system was damaged or destroyed, or the Hospital or CAH faced Extreme and Uncontrollable Circumstances in the form of a Health Pandemic. I further attest that this Extreme and Uncontrollable Circumstance in the constitutes a significant hardship in demonstrating meaningful use as defined under: 42 CFR 412.64 (d)(4)(ii)(B).

Period of time the EHR system was unavailable (MM/DD/YYYY) to (MM/DD/YYYY).

* Start date

* End date

Certification statement for hardship application

NOTICE: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete, or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.

SIGNATURE OF HOSPITAL REPRESENTATIVE
I certify that the information contained herein is true, accurate, and complete. I understand that the Medicare Promoting Interoperability Program Hardship Exception I requested may result in a change in the amount the Hospital will be paid from Federal funds, and that by filling this application for a hardship exception I am submitting a claim for Federal funds, and the use of any false claims, statements, or documents, or the concealment of a material fact used to obtain a Medicare Promoting Interoperability Program Hardship Exception, may be prosecuted under applicable Federal or state criminal laws and may also be subject to civil penalties.

SUBMITTER WORKING ON BEHALF OF HOSPITAL(S): I certify that I am submitting this application for a payment adjustment on behalf of the hospital(s) that has (have) given me authority to act as agent. I understand that both the hospital(s) and I can be held personally responsible for all information entered.

I hereby agree to keep such records as are necessary to support the application submitted for a hardship exception of the Medicare Promoting Interoperability Program and to furnish those records both in the application and at a future time upon request from the Department of Health and Human Services, or a contractor acting on their behalf.

No Medicare Promoting Interoperability Program hardship exception may be granted unless this application is completed and approved as required by existing law and regulations (42 CFR §412.64(d)(4)(ii)).

NOTICE: Anyone who misrepresents or falsifies essential information to receive payment from Federal funds requested by this application may upon conviction be subject to fine and imprisonment under applicable Federal laws.

ROUTINE USE(S): Information from this Medicare Promoting Interoperability Program application for hardship exception and subsequently submitted information and documents may be given to the Internal Revenue Service, private collection agencies, consumer reporting agencies in connection with recoupment of any overpayment made and to Congressional offices in response to inquiries made at the request of the person to whom a record pertains. Appropriate disclosures may be made to other Federal, state, local and foreign government agencies, private business entities and individual providers of care, on matters relating to entitlement, fraud, Program abuse, Program integrity, and civil and criminal litigation in relation to the operation of the Medicare Promoting Interoperability Program.

DISCLOSURES: While submission of information for this hardship exception application is voluntary, failure to provide necessary information for hospital identification will result in delay in processing the hardship exception application or may result in a denial.

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* Name of individual completing the form

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Required information
Start date
End date

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* Indicates required

*Which form would you like to complete today?

Medicare PI Program Critical Access Hospital

*CAH CCN (6 Numeric digits only, example: 123456)

011300

CAH Legal name

WASHINGTON COUNTY HEALTHCARE AUTHORITY, INC

Applicant Information

Provide the information below for the person working on behalf of the Hospital or CAH. All return correspondence will be sent to the contact listed in section **Applicant Information.**

*Submitter first name

Em

*Submitter last name

Smith

*CAH or Organization name

Critical Care Place

*Submitter email

em@gmail.com

*Confirm submitter email

em@gmail.com

*Submitter telephone number

7035551212

Extension

XXXXXXX

*Address

123 Elm St

Suite / apartment / unit number

*City

Houston

State

Texas

*Zip Code

77001

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*Hardship exception reason

Extreme and Uncontrollable Circumstances

*Extreme and Uncontrollable Circumstances

Disaster

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Period of time the EHR system was unavailable (MM/DD/YYYY) to (MM/DD/YYYY).

*Start date

*End date

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Medicare PI Program Critical Access Hospital

* CAH CCN (6 Numeric digits only, example: 123456)

010001

CAH Legal name

HOUSTON COUNTY HEALTHCARE AUTHORITY

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Em

* Submitter last name

Smith

* CAH or Organization name

Hope Hospital

* Submitter email

em@gmail.com

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* Submitter telephone number

7035551212

Extension

XXXXXXX

* Address

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Suite / apartment / unit number

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Houston

State

Texas

* Zip Code

77001

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