PRA Disclosure Statement

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ATTENTION!

Never include protected health information (PHI) and personal identifiable information (PII) in documentation submitted to CMS for review. CMS will NOT review ECE requests containing sensitive information or any documentation that violates HIPAA laws.

Request for an Extraordinary Circumstances Extension/Exception (ECE)
Collection of Information

This document is a vital resource for your facility, providing essential information for requests regarding Extraordinary Circumstances Extension or Exception (ECE). Please complete this document and submit it to the email address for your Program Type (see Section 7), along with any supporting documentation. Requests for an ECE must be submitted within 90 days of the date that the extraordinary circumstance occurred.

1. Facility Identification	
CMS Certification Number (CCN)	**[Six-digit number]:** Click or tap here to enter text.
Facility Name (Full legal name of the facility)	**[Text field]:** Click or tap here to enter text.
Facility Address (Street, City, State, ZIP Code)	**[Text field]:** Click or tap here to enter text.
Facility Type:	Choose an item.
Program Type: [Check one or all that are applicable] ☐ Hospice - QRP	
☐ HHA - QRP	
☐ IRF - QRP	
☐ LTCH - QRP	
☐ SNF - QRP	
☐ SNF - VBP	
2. Contact Information	
CEO Name and/or any designated facility personnel	**[Text field]:** Click or tap here to enter text.

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Phone Number	**[Text field]:** Click or tap here to enter text.
Email Address	**[Text field]:** Click or tap here to enter text.

3. ECE Request Type

[Check One]:
☐ Exception ☐ Extension

4. Category

[Check one or all that are applicable]:
☐ Natural Disaster
☐ Man-made Disaster
☐ Other Circumstances

5. Type of Data Impacted

Identify which types of data are currently impacted or will be impacted by the event. Choose all that apply.

☐ Assessment-based data
☐ CDC National Healthcare Safety Network (NHSN)
☐ CAHPS Survey
☐ Data Validation Records
☐ Other
[Text field]: Click or tap here to enter text.

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6. A. Extraordinary Circumstances Issue Description

This section ensures that CMS has sufficient detail to evaluate the validity of the ECE request. Please provide the following information:

- *Description of the event (examples provided above) associated with the reason for requesting the exception and extension;*
- *A date when the provider believes that it will again be able to fully comply with the requirements for the data specified in Section 5 and a justification for the proposed date;*
- *Any other documentation supporting the rationale for seeking the exception and extension;*
- ***NOTE: CMS will be unable to review requests that fail to provide the necessary documentation nor accept any files that are larger than 20 MB (megabytes).***

[Text field]:

Click or tap here to enter text.

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6. B. SNF VBP Program: Additional Information Required

*If your request is **unrelated** to the SNF VBP Program, leave this section blank.*

Specify the type of data affected and how long it was affected:	Beginning (MM/DD/YY)	Through (MM/DD/YY)
☐ MDS assessment data ☐ Payroll data ☐ Claims data		
☐ MDS assessment data ☐ Payroll data ☐ Claims data		
☐ MDS assessment data ☐ Payroll data ☐ Claims data		

If the program for which you are seeking an exception or extension is the SNF VBP Program, please provide evidence of the impact on the care the SNF provided to its residents.

[Text field]:

Click or tap here to enter text.

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7. Acknowledgement
The acknowledgments include certifying the accuracy and completeness of the provided information, confirming efforts to comply with CMS requirements despite exceptional circumstances, understanding that CMS will review the request but approval is not guaranteed, acknowledging reporting obligations if the request is denied, authorizing a designated contact person to manage related matters, providing a signature along with the representative's title and signing date, and recognizing CMS's right to audit and deny requests if inaccuracies are found.
Digital or Physical Signature **or the Name of the authorized representative:** [Text field]: Click or tap here to enter text.
Title or position: [Text field]: Click or tap here to enter text.
Date of signing: [Date]: Click or tap to enter a date.

Please return this form and send it, along with any supporting attachments, to

Program	**Email address**
HH QRP	HHAPUReconsiderations@cms.hhs.gov
Hospice QRP	HospiceQRPReconsiderations@cms.hhs.gov
IRF QRP	IRFQRPReconsiderations@cms.hhs.gov
LTCH QRP	LTCHQRPReconsiderations@cms.hhs.gov
SNF QRP	SNFQRPReconsiderations@cms.hhs.gov
SNF VBP Program	SNFVBPquestions@cms.hhs.gov

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CMS Next Steps
• Upon receiving an Exceptional Circumstances Extension (ECE) request, the Centers for Medicare & Medicaid Services (CMS) will follow a structured process that includes acknowledging receipt by email, conducting a preliminary review by assigning a dedicated reviewer, and performing a detailed evaluation to validate the resolution efforts, including cross-checking previous submissions.
• CMS will make a definitive decision (approval, denial, or partial approval) and communicate the decision effectively in writing back to the facility or provider.
• CMS will document and maintain records, execute post-decision actions, and implement audit and monitoring procedures.