IDAHO DEPARTMENT OF HEALTH & WELFARE

COVID-19 Hospital Support Grant Application- Round 2 Funding (start date 10/4/21)

Dev. 9/23/21

Eligibility

To be eligible for this grant opportunity, you must:

- Be a public or private hospital operating in Idaho
- Agree to the statements contained in this agreement; understanding that all information disclosed by the Provider/Payee is subject to verification. Any deliberate omission, misrepresentation, or falsification of any information contained in this application or contained in any communication supplying information to the Department of Health and Welfare may be punished by law including, but not limited to, recoupment of payments made.
- Previously received COVID-19 Hospital Support Funding (Round 1)

In signing this form and returning it to the Idaho Department of Health and Welfare, you agree to the above eligibility requirements.

Email completed application to: HospitalCOVIDSupport@dhw.idaho.gov

This grant opportunity is funded by:

- The American Rescue Plan Act of 2021 - Coronavirus State and Local Fiscal Recovery Fund (SLFRF) awarded to the state of Idaho in May 2021.
- CFDA #21.027

If additional funding sources become available, this agreement will be amended.

Please complete the following fields:

Line	Description	Data Entry Fields
A. General Information		
1	Hospital Name	
2	Business/Payee Name (if different)	
3	Payee (required) Tax ID Number	
4	Payee NPI Number	
5	Medicaid Provider ID Number (if no NPI exists, use this line to enter atypical ID for claims)	
6	DUNS Number	
7a	Street Address (Street or Post Office Box)	
7b	City	
7c	State	
7d	Zip	
8a	Contact Person Name	
8b	Phone Number	
8c	Email Address (this is critical for communication)	

Please complete the following fields:

Line	Description	Please respond Yes or No
B. Attestation and Perjury Statements		
9	I certify to the best of my knowledge and belief that the Payee does not owe the State of Idaho any back taxes.	
10	I certify to the best of my knowledge and belief that the Payee is not and does not presently employ person(s) debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from receiving funding by a government entity (federal, state, or local).	
C. Expressed Understanding of Use and Documentation of Grant Funds		
11	I understand that the purpose of this grant is to support the following strategies and agree to utilize funds only for their intended purpose: 1. Increase and/or retain staffing capacity impacted by COVID-19 2. Increase physical space for COVID-19 mitigation efforts	
12	I understand funds are awarded upon receipt of this signed document and the amount awarded is $1,000 per licensed bed in my facility.	
13	The number of licensed beds in my facility is:	Number of beds =
14	I understand these funds can be used for expenses incurred between 3/3/2021 and 12/31/2024.	
15	I understand that theses funds are subject to the requirements of the Department of the Treasury, 31 CFR 35 - CSLFRF and the 2 CFR 200 and use of the funds must align with Section E-Cost Principles.	
16	I understand grant funds cannot be used for research and development, permanent construction, purchase of promotional items, personal use items, conferences or meetings not associated with vaccine distribution, entertainment costs, lobbying activities, purchase of vehicles, purchase of incentive items, and meals or refreshments.	
17	I attest that the information in this application is true, correct, and complete, and that all costs reported are directly related to coronavirus impacts. I agree that the State of Idaho may audit the Provider's/ Payee's records related to this application, and all information requested by the Department will be provided in the event that the State of Idaho determines that such an audit is necessary. If the Payee becomes aware that any information in this application is not true, correct, or complete, it agrees to notify the Department immediately.	

Line	Description	Please respond Yes or No
C. Expressed Understanding of Use and Documentation of Grant Funds		
18	I further acknowledge that the Payee is responsible to repay any amounts paid through the American Recovery Act of 2021 that, upon audit or review, the Department determines were not properly documented, claimed, or requested by the Payee. I also agree that applying for reimbursement is not a guarantee of payment, and any distribution of funds is subject to review and recoupment if actual amounts distributed to the Payee are less than identified as payable in their records.	
19	I further certify that the information provided in this attestation and the information provided in all supporting documents and forms is true and accurate in all material respects. By my signature below, I declare, under penalty of perjury, that I have the legal authority to make such attestation and hereby bind all entities and individuals that comprise the Payee.	
20	I understand that as a recipient of these federal funds I may be required to report information under the following: • Federal Awardee Performance and Integrity Information System (FAPIIS) Disclosure Federal • Federal Funding Accountability and Transparency Act (FFATA)	
21	I understand that upon completion of this grant program, I will be required to provide a report to the Department of Health and Welfare that describes how these funds were used and financial documentation as verification. The report template will be provided by the Department of Health and Welfare.	

D. Signature: By typing my name below, I certify that the information above is true and correct.

Line	Description	Data Entry Fields
22a	Printed Name	
22b	Position	
22c	Authorized Representative (Yes/No)	
22d	Electronic Signature	
22e	Date	