Senate Bill 809 / Rider 143 Report (Updated)

November 9, 2021, Update:

In order to fulfill legislative requirements, the survey was updated on November 8, 2021. Providers who submitted this survey on or before November 8, 2021, must complete this survey again in order to complete new questions in "**Section 2 - Relief Funding Information**." All submissions received without these questions answered are now considered incomplete.

HHSC is granting a "grace period" to allow providers time to come into compliance if they fail to meet any deadlines between October 1, 2021, and November 30, 2021. While the deadlines to report will not change, HHSC will not take any of the actions listed above against a provider as long as the provider submits all the required reports due between October 1, 2021, and November 30, 2021. The grace period ends December 1, 2021.

Background

On March 13, 2020, President Donald Trump issued Proclamation 9994 declaring a national emergency due to the Novel Coronavirus Disease (COVID-19) outbreak. Governor Greg Abbott also declared a state of disaster in all Texas counties due to COVID-19 outbreak.

The 87th Texas Legislature directed the Texas Health and Human Services Commission (HHSC) to collect information from Health Care Institutions (as defined in Senate Bill 809, 87th Legislature) regarding COVID-19-related Federal Funds. HHSC must report this information to the Governor, Legislative Budget Board, and any appropriate standing committee in the Legislature in writing on a quarterly basis. The Legislature's directive to HHSC is in Senate Bill 809 (87th Legislature, Regular Session) and the General Appropriations Act (Senate Bill 1, 87th Legislature, Article II (Health and Human Services Commission) Rider 143).

Instructions

Please complete a report for **each type of health care institution (provider)** for the period January 31, 2020 - August 31, 2021. For example, if there is an assisted living facility and a hospital under the same identification number, the provider must complete a separate report for the assisted living facility and the hospital. Allocate any shared funds or costs between the providers.

The report is comprised of the following sections: (1) Provider Information; (2) Relief Funding Information; and (3) Legal Certification. Please answer all the questions. Based on the provider type, there may be additional questions. Please enter all dollar amounts rounded to the nearest $1,000.

HHSC is reviewing the required Federal reports on COVID-19 funding and spending, and will eliminate any portion of this report that duplicates Federal reporting requirements if that data becomes available.

If you have question(s) about the content of the report or need technical assistance please email the HHSC Provider Finance Department at HHSC_PFD_Survey@hhs.texas.gov (mailto:HHSC_PFD_Survey@hhs.texas.gov) with "COVID-19 Federal Funds Report" in the subject line. Please visit the HHSC Provider Finance Department Communications web page at https://pfd.hhs.texas.gov/provider-finance-communications (https://pfd.hhs.texas.gov/provider-finance-communications) for more information about the report.

* Required

Section 1 - Provider Information

If there is more than one provider type under the same NPI, a separate report must be completed for each provider type.

If the provider types listed below do not apply to the provider, a report is not required to be completed.

1. **Is the provider a "Health Care Institution" per the meaning assigned by Section 74.001, Civil Practice and Remedies Code?** *

    - Ambulatory Surgical Center
    - Assisted Living Facility licensed under Chapter 247, Health and Safety Code
    - Emergency Medical Services provider
    - Health Services District created under Chapter 287, Health and Safety Code
    - Home and Community Support Services Agency
    - Hospice
    - Hospital
    - Hospital system
    - Intermediate Care Facility for Individuals with an Intellectual Disability or Related Conditions (ICF/IID)
    - Community Living Assistance and Support Services (CLASS) Direct Service Agency (DSA) or Case Management Agency (CMA)
    - Deaf-Blind with Multiple Disabilities (DBMD)
    - Home and Community-Based Services/Texas Home Living (HCS/TxHmL)
    - Nursing Facility
    - End-Stage Renal Disease Facility licensed under Section 251.011, Health and Safety Code

    ◯ Yes

    ◯ No *(Not required to complete this report)*

2. **Provider Name** *

3. **Doing Business As (DBA)**

If applicable

4. **Provider Address** *

5. **Provider City** *

6. **Provider State (two-letter abbreviation)** *

Ex. TX

7. **Provider Zip Code** *

The value must be a number

8. **Primary Contact First and Last Name (must be an employee of the provider)** *

9. **Primary Contact Job Title** *

10. **Primary Contact Email Address** *

11. **Primary Contract Phone Number (do not include dashes or special characters)** *

Example - 1234567890

The value must be a number

12. **Secondary Contact First and Last Name (must be an employee of the provider)** *

13. **Secondary Contact Job Title** *

14. **Secondary Contact Email Address** *

15. **Secondary Contract Phone Number (do not include dashes or special characters)** *

Example - 1234567890

The value must be a number

16. **Tax Identification Number (TIN)** *

9 Digits Exactly

17. **National Provider Identifier (NPI)** *

10 Digits Exactly

18. **Texas Provider Identifier (TPI)**

9 Digits Exactly

19. **HHSC Facility ID (if applicable)**

Either 4 or 6 digits

20. **HHSC License Number (if applicable)**

21. **HHSC Contract Number (if applicable)**

9 digits

22. **HHSC Component Code (if applicable)**

Either 3 or 4 digits

23. **Did the provider have a change of ownership (CHOW)?** *

- ◯ Yes
- ◯ No

24. **What was the date of the change of ownership (CHOW)?** *

MM/DD/YYYY

Section 2 - Relief Funding Information

25. **Please provide dollar amounts for federal COVID-19 relief funding (or goods or services received instead of funding) for the period of January 31, 2020 – August 31, 2021** *

- Please round to the nearest $1,000.
- If the provider did not receive funding from a listed source, please enter 0.
- **Do not** report federal money:
  - Received as a loan during the coronavirus disease public health emergency from the United States Small Business Administration (SBA) as part of a paycheck protection program; or
  - Returned or repaid to the federal government.

The value must be a number

26. **What type of "Health care institution" is the provider?** *

- ◯ Ambulatory Surgical Center
- ◯ Assisted Living Facility licensed under Chapter 247, Health and Safety Code
- ◯ Emergency Medical Services Provider
- ◯ Health Services District created under Chapter 287, Health and Safety Code
- ◯ Home and Community Support Services Agency
- ◯ Hospice
- ◯ Hospital
- ◯ Hospital System
- ◯ Intermediate Care Facility for Individuals with an Intellectual Disability or Related Conditions (ICF/IID)
- ◯ Community Living Assistance and Support Services (CLASS) Direct Service Agency (DSA) or Case Management Agency (CMA)
- ◯ Deaf-Blind with Multiple Disabilities (DBMD)
- ◯ Home and Community-Based Services / Texas Home Living (HCS/TxHmL)
- ◯ Nursing Facility
- ◯ End-Stage Renal Disease Facility licensed under Section 251.011, Health and Safety Code

27. **What was the cost to the provider to implement the requirements for the rate increases for COVID-19?** *

The value must be a number

28. **Please provide the dollar amount of federal COVID-19 relief funding (or goods or services received instead of funding) that is forgiven through the Paycheck Protection Program (PPP) administered by the United States Small Business Administration (US SBA). Please round to the nearest $1,000.** *

The value must be a number

29. **Please provide the dollar amount of COVID-19 Federal funds spent on staffing costs.** *

Please round to the nearest $1,000

The value must be a number

30. **Please provide any additional dollar amount spent on staffing costs due to COVID-19 that was NOT reimbursed from Federal funds.** *

Please round to the nearest $1,000

The value must be a number

31. **Please provide the dollar amount of COVID-19 Federal funds spent on telemedicine equipment.** *

Please round to the nearest $1,000

The value must be a number

32. **Please provide any additional dollar amount spent on telemedicine equipment due to COVID-19 that was NOT reimbursed from Federal funds.** *

Please round to the nearest $1,000

The value must be a number

33. **Please provide the dollar amount of COVID-19 Federal funds spent on personal protective equipment (PPE).** *

Please round to the nearest $1,000

The value must be a number

34. **Please provide any additional dollar amount spent on personal protective equipment (PPE) due to COVID-19 that was NOT reimbursed from Federal funds.** *

Please round to the nearest $1,000

The value must be a number

35. **Please provide the dollar amount of COVID-19 Federal funds spent on rent & utilities.** *

Please round to the nearest $1,000

The value must be a number

36. **Please provide any additional dollar amount spent on rent & utilities due to COVID-19 that was NOT reimbursed from Federal funds.** *

Please round to the nearest $1,000

The value must be a number

37. **Please provide the dollar amount of COVID-19 Federal funds spent on dietary supplies.** *

Please round to the nearest $1,000

The value must be a number

38. **Please provide any additional dollar amount spent on dietary supplies due to COVID-19 that was NOT reimbursed from Federal funds.** *

Please round to the nearest $1,000

The value must be a number

39. **Please provide the dollar amount of COVID-19 Federal funds spent on other costs.** *

Please round to the nearest $1,000

The value must be a number

40. **Please provide descriptions of the COVID-19 Federal funds spent on other costs.** *

41. **Please provide any additional dollar amount spent on other costs due to COVID-19 that was NOT reimbursed from Federal funds.** *

Please round to the nearest $1,000

The value must be a number

42. **Please provide descriptions of the additional dollar amount spent on other costs due to COVID-19 that was NOT reimbursed from Federal funds.** *

Section 3 - Legal Certification

43. **First and last name of person completing the report.** *

44. **Email address of person completing the report.** *

45. **CERTIFICATION must be completed by an individual legally responsible for the conduct of the facility or legally authorized to bind the facility, such as the sole proprietor, a partner, a corporate officer, an association officer, a governmental official, a limited liability company member, a person authorized by the interested party on file at the time of the request, or a legal representative for the interested party. Misrepresentation or falsification of any information contained in this report may be punishable by fine and/or imprisonment.** *

- ◯ Certify Report