



Wisconsin CARES Act Provider Payment Program – Documento de Ayuda

Crear y Entregar una Solicitud

(última revisión: 9/1/20)

Este documento de ayuda es continuamente actualizado y será puesto al día según sea necesario. Consulte la página [CARES Act Provider Payment Program](#) para obtener la versión más reciente.

Este documento se refiere a “Fase 1” y “Fase 2”. Son las mismas como “ronda 1” y “ronda 2” que se describieron en otra parte.

Audiencia

Proveedores

Propósito

Este documento describirá cómo crear y entregar una solicitud para Wisconsin CARES Act Provider Payment Program (Programa de Pago del Proveedor del Acta de CARES). Usted tendrá la opción de copiar su solicitud de Fase 1, si es aplicable y de proveer información puesta al día, o empezar una solicitud nueva de Fase 2.

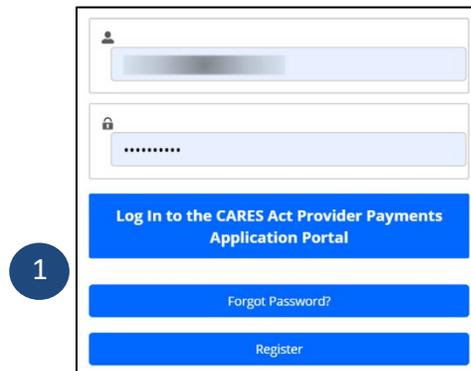
Las instrucciones empiezan en la página 2.

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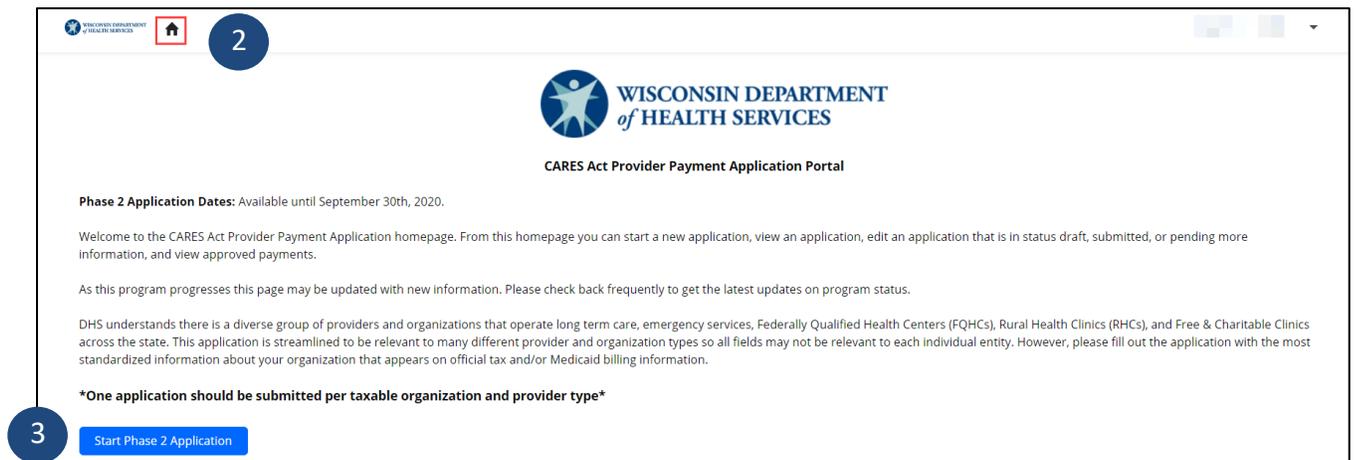
Instrucciones:

Cómo acceder la solicitud

1. Entre en su cuenta. Nota: Por favor refiérase al Documento de Ayuda –**Cómo Crear una Cuenta** para las instrucciones sobre cómo crear una cuenta nueva y el Documento de Ayuda – **Cómo Entrar en el CARES Act Provider Payment Application Portal** para entrar si usted ya tiene una cuenta. El browser requerido es Google Chrome™. Microsoft® Edge, Mozilla® Firefox®, y Apple® Safari® los cuales todos están compatibles.

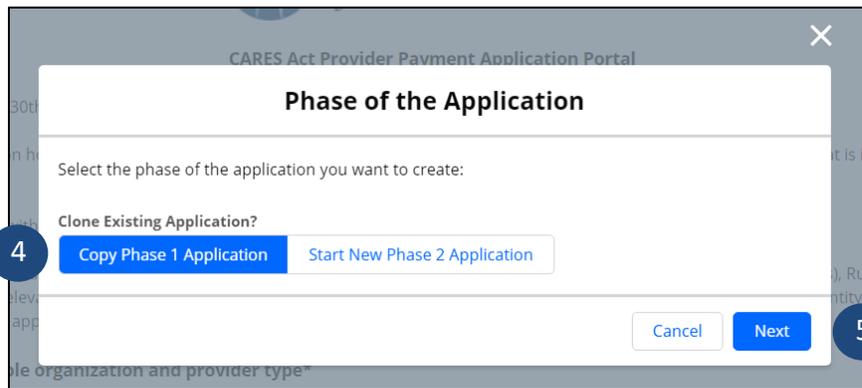


2. Vaya a la página inicio de cuenta haciendo clic en el botón del hogar (🏠) arriba en la esquina izquierda.
3. Haga clic en el botón **Submit New Application** (Entregar una solicitud nueva).

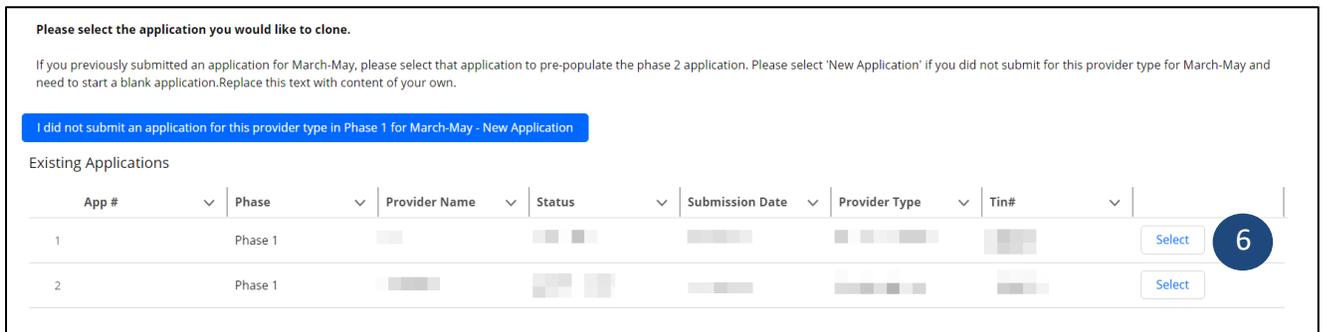


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4. Aparecerá una ventana. Usted tendrá la opción de copiar su Solicitud de Fase 1, si entregó una en junio, o de empezar una Solicitud de Fase 2 nueva. Si ésta es la primera vez que usted entrega un CARES Act Provider Payment Application, sólo podrá escoger **Start New Phase 2 Application** (Empezar nueva solicitud de Fase 2). De otra manera, escoja **Copy Phase 1 Application** (Copiar solicitud de Fase 1). Nota: Si no entregó una solicitud de fase 1 y ha creado una cuenta nueva, solamente verá el botón de Start New Phase 2 Application.
5. Haga clic en el botón **Next** (Siguiendo) para continuar.



6. Si está empezando una solicitud de fase 2 nueva, continúe en el Paso 7. De otra manera, estará copiando y agregando su solicitud de Fase 1. Haga clic en la solicitud existente que le gustaría copiar para agregar sus pérdidas/gastos para los meses de junio a agosto 2020 haciendo clic en el botón **Select** (Selección) a lado de la solicitud. Nota: Si escogió **Copy Phase 1 Application**, ciertos campos a través de la solicitud estarán pre-populados con base a la información provista en la solicitud de Fase 1.



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7. En la primera pestaña de la solicitud, revise las instrucciones. Haga clic en el botón **Next** (Siguiente) para continuar.



CARES Act Provider Payment Application - Phase 2

Cancel

IntroductionCompany InfoRevenue/Expense DetailsFile UploadReview & Submit

Introduction

Before you start this application, please read the following:

- This application asks multiple details of your organization and also your organization's 2019 Tax Return, IRS Form W-9, and IRS Quarter 1 2020 and IRS Quarter 2 2020 IRS Form 941, as applicable. You can 'Save & Exit' the application if you need to gather more information after starting.
- This application will ask about details of losses and expenses directly related to the COVID-19 pandemic from March 1 - August 31, 2020. The application also asks if your organization or its subsidiaries have received any other payments or funding to offset COVID-19 losses. All information should be specific to your organization's operations in Wisconsin. If your organization is part of a multi-state corporation you will be required to provide support for the Wisconsin operations.
- For each Tax Identification Number or Tax Return, providers can submit only 1 application (1 application for March-August if no March-May application was submitted, or 1 application for June-August if a previous application for March-May was submitted) per provider type (Assisted Living, Clinics, Emergency Medical Services, Home and Community Based Services, and Nursing Homes). If your organization has multiple locations of the same provider type that file under the same Tax Return, then only 1 application should be submitted for the organization and all subsidiaries of that provider type. If your organization has multiple Tax Identification Numbers or Tax Returns, you can submit multiple applications, 1 for each Tax Identification Number operating as each provider type. If your organization is reported for the purposes of tax filings under a parent or umbrella organization, corporation or partnership you will be required to upload additional information to explain the tax IDs and relationships to the applicant as well as calculations for the Wisconsin operations reported in the application.
- The information you report should be specific to the provider type you are submitting the application for. For example, an organization that operates both an assisted living facility and a nursing home under the same Tax Identification Number should submit two applications. One application should report only the losses, expenses, funding received, beds, and payroll specific to the organization's assisted living operations. The organization should submit a separate application for the organization's nursing home operations. If your organization is reported for the purposes of tax filings under a parent or umbrella organization, corporation or partnership you will be required to upload additional information with the calculations for the Wisconsin operations reported in the application.
- New applications can be submitted until September 30th, 2020. Please make sure all applications are properly submitted by this date. Any in-progress applications after this date will not be accepted.
- You will receive an email notification if your application is approved. Applications may take up to 2 weeks to be approved.

7
Next

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Información de la Compañía

En esta pestaña de la solicitud, escriba la información de su compañía, exactamente como está escrita en sus impuestos. Los campos con un asterisco rojo [*] son requeridos. Nota: Ponga el cursor sobre el **i** para una guía adicional al campo. Si copió su solicitud de Fase 1, cierta información en esta pestaña estará llena de datos. Sin embargo, usted puede poner al día los campos si es necesario.

1. Escriba el **First Name** (Nombre) y **Last Name** (Apellido) del Punto de Contacto principal que puede ser contactado con respecto a la solicitud. **Phone Number** (Número de teléfono) debe escribirse en este formato XXX-XXX-XXXX y la dirección de **email** en el formato de name@domain.com. También escriba su **Role in Organization** (Rol en la Organización).

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Please enter information exactly as it is entered on your taxes. This will ensure your application is processed quickly.

1 Point of Contact Information

Please enter the information for the person that will be point of contact for this application. This person will receive email updates when the application is processed.

*First Name

*Last Name

*Phone Number

*Email

Role in Organization **i**

2. Usando el menú desplegable, seleccione el **Provider Type** (Tipo de proveedor) de su organización. Ponga el cursor sobre **i** for para una guía adicional sobre los diferentes tipos de proveedores. Nota: los hogares familiares para adultos de 1-2 camas deben seleccionar Assisted Living como su **Provider Type**. *Aparecerán campos adicionales dependiendo del tipo de proveedor seleccionado.*
3. Escriba el **Organization name** (Nombre de la organización). Este es el nombre de la instalación/entidad para la cual está solicitando fondos. Asegúrese de escribir esto exactamente como aparece en los documentos de los impuestos.
4. Escriba el **Tax Identification Number (TIN)** (Número de identificación impuestos) sin los guiones. Nota: este campo tiene un límite de 10 caracteres. Los solicitantes podrían escribir ya sea su Número de Identificación de Empleador Federal (FEIN) o número de Seguro Social (SSN) según corresponda.

Details about your organization

Please provide the following details about your organization as they would appear for your Medicaid billing or tax documentation. Please provide information specific to your organization's operations in Wisconsin for number of beds, services provided, gross monthly payroll, and number of individuals served. If your organization has multiple provider types under the same TIN, please submit one application for each provider type.

Phase 2 Update: 1-2 Bed Adult Family Homes have been moved from the Home and Community Based Services provider type to Assisted Living provider type. Please select Assisted Living if you are completing an application for a 1-2 Bed Adult Family Home. Providers completing an application for multiple Assisted Living facilities should report the total number of beds for all of their Assisted Living Facilities. Please Review the Service Definition Document to confirm the services provided by your organization for HCBS.

2 *Provider Type **i**

3 *Organization name **i**

4 *Tax Identification Number (TIN) **i**

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5. Usando el menú desplegable, seleccione si sus documentos empatan el Tipo de Proveedor, TIN, y la dirección. Si escoge **No**, un campo aparecerá a continuación. Use el campo para dar una explicación sobre por qué la información provista y los documentos no empatan.
6. Si su organización está exenta de reportar ingresos de servicio en su declaración anual (tales como algunas facilidades de vivienda ocupadas por el dueño), marque la caja.
7. Si su Declaración de Impuestos o Información anual es declarada bajo un TIN diferente, marque la caja.
8. Usando el menú desplegable, indique si tiene empleados pagados reportados al IRS en el Formulario 941 ó 944. Si escoge **Sí**, aparecerán campos adicionales relacionados con Gross Monthly Payroll (Nómina mensual bruta). En esos campos, escriba el Gross Monthly Payroll de su organización para las operaciones de Wisconsin para cada mes de enero a agosto 2020 bajo el ID de Impuestos y tipo de proveedor por el cual está entregando esta solicitud. Los propietarios únicos deben dar su ingreso neto para los meses especificados.
9. Usando el menú desplegable, indique si está reportando como una management company (compañía de administración). Si escoge (**Sí**), un campo adicional aparecerá pidiéndole que escriba Subsidiary Businesses Name, Address & TIN. Por favor escribe todas las sucursales de esa compañía de administración.

The screenshot shows a portion of a web form with five numbered callouts (5-9) pointing to specific fields:

- 5** points to a dropdown menu with the label: "Does the inputted Provider Name, TIN, and Address match the documentation to be uploaded (W-9, 941, etc...)?".
- 6** points to a checkbox with the label: "Check this box if you are exempt from reporting service revenue in your annual tax return".
- 7** points to a checkbox with the label: "Check this box if your entity annual Tax or Information Return is filed under a different TIN".
- 8** points to a dropdown menu with the label: "Do you have paid employees reported to IRS on Form 941 or 944?".
- 9** points to a dropdown menu with the label: "Is this a management company?". Below this dropdown is a text input field with the label: "Subsidiary Businesses Name, Address & TIN".

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10. Si están disponibles, complete los campos adicionales: **Medicare Number** (Número de Medicare), **STAR Supplier ID** (Identificación de Proveedor STAR), **National Provider Identifier (NPI)** (Identificador Nacional de Proveedor), **Medicaid ID** (Identificación de Medicaid), y **Counties of Operation** (Condados de operación). Nota: Se requiere DQA State License Number para los tipos de proveedores – Assisted Living Facilities y Nursing Homes. No tienen licencia de DQA los hogares de familia de adultos de 1-2 camas y no se les requiere que entreguen un DQA State License Number.

A screenshot of a web form with a blue circle containing the number '10' on the left. The form contains the following fields:

- Medicare Number: A text input field with a placeholder '#####'.
- STAR Supplier Id: A text input field with a placeholder '#####' and an information icon.
- National Provider Identifier(NPI): A text input field with a placeholder '#####'.
- Medicaid ID: A text input field with a placeholder '#####'.
- Counties Of Operation: A section with an information icon, containing two columns: 'Available' and 'Chosen'. The 'Available' column is a list box with the following items: Adams, Ashland, Barron, and Bayfield. The 'Chosen' column is an empty text box.

11. Si escogió como el tipo de proveedor a **Home and Community Based Service Providers** O **Assisted Living Facilities**, campos adicionales aparecerán en la solicitud. Escriba el **Number of Individuals Served** (Número de personas servidas) por su organización cada mes de enero a agosto 2020 en el campo provisto. Continúe en el paso 13.

A screenshot of a web form with a blue circle containing the number '11' on the left. The form contains the following fields:

- Provider Type: A dropdown menu with 'Home and Community Based Service Providers' selected, highlighted by a red box.
- Organization name: A text input field with a blurred placeholder.
- Tax Identification Number (TIN): A text input field with a blurred placeholder.
- Does the inputted Provider Name, TIN, and Address match the documentation to be uploaded (W-9, 941, etc...?): A dropdown menu with a blurred placeholder.
- Check this box if you are exempt from reporting service revenue in your annual tax return: An unchecked checkbox.
- Check this box if your entity annual Tax or Information Return is filed under a different TIN: An unchecked checkbox.
- Do you have paid employees reported to IRS on Form 941 or 944?: A dropdown menu with a blurred placeholder.
- Is this a management company?: A dropdown menu with a blurred placeholder.
- Number of Individuals Served in January: A text input field.
- Number of Individuals Served in February: A text input field.
- Number of Individuals Served in March: A text input field.
- Number of Individuals Served in April: A text input field.
- Number of Individuals Served in May: A text input field.
- Number of Individuals Served in June: A text input field.
- Number of Individuals Served in July: A text input field.
- Number of Individuals Served in August: A text input field.

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12. Si escogió **Nursing Homes** como el tipo de proveedor, campos adicionales aparecerán en la solicitud. Escriba el **Number of Patient Days** (Número de días pacientes) cada mes de enero a agosto 2019 y de enero a agosto 2020. Continúe en el paso 13. .

* Provider Type ⓘ
Nursing Homes

* Organization name ⓘ
Example or

* Tax Identification Number (TIN) ⓘ
123454545

* Does the inputted Provider Name, TIN, and Address match the documentation to be uploaded (W-9, 941, etc...)?
Yes

Check this box if you are exempt from reporting service revenue in your annual tax return

Check this box if your entity annual Tax or Information Return is filed under a different TIN ⓘ

* Do you have paid employees reported to IRS on Form 941 or 944? ⓘ
No

Is this a management company?
No

* Number of Patient Days in January 2020 ⓘ

* Number of Patient Days in February 2020 ⓘ

* Number of Patient Days in March 2020 ⓘ

* Number of Patient Days in April 2020 ⓘ

* Number of Patient Days in May 2020 ⓘ

* Number of Patient Days in June 2020 ⓘ

* Number of Patient Days in July 2020 ⓘ

* Number of Patient Days in August 2020 ⓘ

13. Indique si está entregando esta solicitud en nombre de un proveedor que pertenece o es operado por una entidad de Condado, Ciudad Villa o Pueblo de Wisconsin u otra entidad de un gobierno local público autorizado bajo la Ley de Wisconsin. Esto incluye proveedores que pertenecen a múltiples entidades del gobierno local.

Please indicate if you are submitting this application on behalf of a provider that is owned or operated by a Wisconsin County, City, Village, or Town, or other public local government entity authorized under Wisconsin law. This includes providers that are jointly owned by multiple local government entities.

* Is this a local government entity? ⓘ
--None--

14. Baje y complete la **Physical Address** (Dirección física) y **Mailing Address** (Dirección de correo).
15. Haga clic en **Next** (Siguiete). *Nota: Cualquier error en esta página prevendrá que usted pueda continuar con esta solicitud.*

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Physical Address

* Physical Address Line 1

Physical Address Line 2

* Physical City

* Physical State

* Physical Zip

Mailing Address

Please use the address provided to ForwardHealth as the Checks Address. Use of a different address may result in delays processing any potential Direct Care Provider Payments your Organization would be eligible to receive.

* Mailing Address Line 1

Mailing Address Line 2

* Mailing City

* Mailing State

* Mailing Zip

Save & Exit Back **Next**

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16. Haga clic en **plus sign** (signo afirmativo) para usar la dirección física validada o déjela sin marcar para usar la dirección física que usted escribió.
17. Haga clic en **plus sign** (signo afirmativo) para usar la dirección de correo validada o déjela sin marcar para usar la dirección de correo que usted escribió.
18. Haga clic en **Next** (Siguiete).

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16 Click the plus sign below to use the validated physical address our system found. Leave unchecked to use the physical address you entered.

+

Validated Address:

Address Entered:

17 Click the plus sign below to use the mailing physical address our system found. Leave unchecked to use the mailing address you entered.

+

Validated Address:

Address Entered:

Save & Exit Back **Next**

18

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Detalles de Ingresos /Gastos

En esta pestaña de la solicitud, escribirá los ingresos perdidos y gastos de su organización relacionados con COVID-19. Nota: si copió su Solicitud de Fase 1, cualquier gasto/pérdida que reportó previamente será pre-populada, y no podrá de escribir gastos/pérdidas adicionales de marzo-mayo

1. Escriba el ingreso bruto de Wisconsin de su organización para el año 2019 para el tipo de proveedor identificado en esta solicitud, tal como aparece en sus documentos de impuestos.

2. Si su organización ha recibido cualquier otro pago de CARES Act Provider Relief Fund Payments, escoja Sí. Si no es así, escoja No y siga en el paso 6.
3. Si escoge Sí, haga clic en el botón **Add** (Agregar) para agregar información sobre los fondos que usted recibió.

4. Aparecerá una pantalla. Complete todos los campos relacionados con los otros fondos recibidos. Nota: Si usted entregó una solicitud de la Fase 1, no podrá agregar fondos recibidos durante la Fase 1.
5. Haga clic en el botón Save (Guardar). Nota: Puede agregar múltiples otros fondos haciendo clic en Add (Agregar) después de guardar cada entrada de gastos

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6. Si desea editar entradas de fondos, haga clic en para una entrada. Elija **Edit** (Editar). Para borrar las entradas de fondo, escoja Delete (Borrar) del menú despegable.

7. Si su organización **no** tiene **sucursales** del mismo tipo de proveedor, escoja No y continúe en el paso 10. Si su organización tiene sucursales, escoja Sí. Aparecerá una pregunta adicional. .
8. Si su sucursal del mismo tipo de proveedor no ha sido aprobada o recibido CARES Act Provider Relief Fund Payment adicional, escoja No. Continúe en el paso 10. De otra manera, escoja Sí. Se le indicará que agregue Subsidiary Other Funds (Fondos de otras sucursales). .
9. Haga clic en el botón **Add** (Agregar) para agregar fondos que han sido aprobados o recibidos para sus sucursales.

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10. Complete la información relacionada con los fondos adicionales. Haga clic en **Save** (Guardar). Nota: Puede agregar varios 'New Other Funds' (Otros fondos nuevos) haciendo clic en **Add** (Agregar) después de guardar cada entrada de gasto.

The screenshot shows a form titled "New Other Funds" with the following fields: "Date Received" (dropdown), "Subsidiary TIN" (text), "Subsidiary Name" (text), "Subsidiary Payment/Loan Type" (dropdown), "Subsidiary Payment/Loan Name" (text), "Subsidiary Payment/Loan Amount" (text), "Phase" (dropdown, currently set to "Phase 2"), and "Application" (text with a clear button). At the bottom are "Cancel" and "Save" buttons. A blue circle with the number "10" is on the left, with a bracket pointing to the form fields. Another blue circle with "10" is on the right, pointing to the "Save" button.

11. Para las siguientes preguntas, escriba solo los gastos/pérdidas para los meses de enero a agosto de 2020. Sin embargo, se le pedirá que escriba por separado su marzo - mayo de 2020 y junio - agosto de 2020 gastos/pérdidas seleccionando las fechas apropiadas.
12. Si su organización no sufrió una pérdida en ingresos durante los meses marzo a mayo 2020 y junio a agosto 2020 debido a COVID-19, continúe en el paso 15.
13. Haga clic en el botón **Add** (Agregar) para escribir **lost revenue** (pérdida de ingresos). Nota: Siga las instrucciones en la solicitud para calcular la pérdida de ingresos de su organización.

Please enter the amount of lost revenue for your organization and provider type directly related to lower Wisconsin service needs associated with the COVID-19 pandemic from March 1, 2020 to August 31, 2020.

Only enter lost revenue that is directly related to business within Wisconsin due to COVID 19. Organizations should calculate lost revenue by taking their total revenue for March, April, May, June, July, and Aug of 2019 and subtracting their total revenue for March, April, May, June, July, and Aug of 2020. For example, if your organization received a total of \$150,000 in revenue for March, April, May, June, July, and Aug of 2019 but only received \$110,000 in revenue for those same six months in 2020, you would enter \$40,000.

Organizations submitting an application for nursing homes will have their lost revenue calculated by taking the difference in patient days from March through August of 2020 and March through August of 2019 and multiplying difference by their average all payor per diem rate for their facilities' 2019 fiscal year.

 Lost Revenue

13

Add

14. Escriba la pérdida de ingresos (Cantidad) de marzo - mayo 2020 y de junio – agosto 2020 escogiendo la Fecha apropiada y escribiendo la cantidad.
15. Haga clic en el botón **Save** (Guardar).

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The screenshot shows a 'New Expense' form. Callout 14 points to the 'Date' dropdown menu which is currently set to '--None--'. Callout 15 points to the 'Save' button at the bottom right of the form. Other fields include 'Amount', 'Phase' (set to 'Phase 2'), and 'Application'.

16. Si su organización no tuvo ningún gasto de equipo asociado con COVID-19 durante los meses de marzo-mayo 2020 y de junio a agosto 2020, continúe en el paso 19.
17. Escriba cualquier **Equipment expenses** (Gastos de equipo) asociado con COVID-19 durante los meses de marzo-mayo 2020 y de junio – agosto 2020 haciendo clic en **Add** (Agregar). Nota: Puede agregar múltiples entradas de gastos haciendo clic en **Add** (Agregar) después de guardar cada entrada de gasto.

Please enter the type and amount of expenses for your organization and provider type related to additional staffing necessary for Wisconsin service provision during the COVID-19 pandemic March 1, 2020 to Aug 31, 2020.

Expenses related to the purchase equipment and supplies may include PPE, disinfectants, other equipment or supplies, technology, or facility modifications for service provision during the COVID-19 pandemic.

Equipment Expenses (0) 17 [Add](#)

18. Aparecerá una ventana. Complete todos los campos y haga clic en **Save** (Guardar).

The screenshot shows the 'New Expense' form with callout 18 pointing to the 'Date', 'Amount', and 'Equipment/Staffing Types' fields. The 'Date' dropdown is set to '--None--'. The 'Amount' field has a small information icon. The 'Equipment/Staffing Types' dropdown is also set to '--None--'. Below it is a text area labeled 'If other, please describe'. The 'Phase' dropdown is set to 'Phase 2' and the 'Application' dropdown is also set to '--None--'. The 'Save' button is highlighted with callout 18.

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19. Si su organización no tuvo gastos de personal asociado con COVID-19 durante los meses de marzo-mayo 2020 y de junio-agosto 2020, continúe en el paso 22.
20. Escriba cualquier **Staffing expenses** (Gastos de personal) adicionales asociados con COVID-19 durante los meses de marzo-mayo 2020 y junio-agosto 2020 haciendo clic en **Add** (Agregar). Nota: Puede escribir múltiples entradas de gasto de personal haciendo clic en **Add** (Agregar) después de guardar cada entrada de gasto.

Please enter the type and amount of expenses for your organization and provider type related to additional staffing necessary for Wisconsin service provision during the COVID-19 pandemic March 1, 2020 to Aug 31, 2020.

Expenses related to additional staffing costs may include hazard pay, retainer payments to staff, overtime payments, sick leave, or other additional staffing costs necessary for service provision during the COVID-19 pandemic.

 Staffing Expenses (0) 20

21. Aparecerá una ventana. Complete todos los campos y haga clic en **Save** (Guardar).

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New Expense

* Date
--None--

* Amount

* Equipment/Staffing Types
--None--

If other, please describe

Phase
Phase 2

Application

21

22. Si su organización no tuvo gastos de “telehealth” asociados con COVID-19 durante los meses de marzo-mayo 2020 y junio-agosto 2020, continúe en el paso 25.
23. Escriba cualquier **Telehealth expenses** (Gastos de Telehealth) asociados con COVID-19 durante los meses de marzo-mayo 2020 y junio-agosto 2020 haciendo clic en **Add** (Agregar). Nota: Puede escribir múltiples entradas de gasto de telehealth haciendo clic en Add (Agregar) después de guardar cada entrada de gasto.

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Please enter the amount of expenses related to telehealth software that was purchased and necessary for Wisconsin service provision during the COVID-19 pandemic from March 1, 2020 to Aug 31, 2020.

Telehealth expenses include video conferencing or communication software used to aid with virtual communication with patients.

📺 Telehealth Expenses (0) 23

24. Aparecerá una ventana. Complete todos los campos y haga clic en **Save** (Guardar).

New Expense

* Telehealth Expenses Amount

Please describe purchase

Phase
Phase 2

Application

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25. Haga clic en el botón **Next** (Siguiente) al final de la esquina derecha de la página para continuar con la sección siguiente.

Please enter the amount of expenses related to telehealth software that was purchased and necessary for Wisconsin service provision during the COVID-19 pandemic from March 1, 2020 to Aug 31, 2020.

Telehealth expenses include video conferencing or communication software used to aid with virtual communication with patients.

📺 Telehealth Expenses (1)

EXPENSE NAME	Phase	Date	Telehealth Expenses Amo...	Please describe what was ...

⚠️ Please ensure you have entered all of your Wisconsin COVID-19 expenses and lost revenue. You are not eligible for funding if you do not have any relevant COVID-19 Wisconsin expenses or lost revenue.

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Carga del Archivo

En esta pestaña de la solicitud, usted cargará una copia de los documentos que se le requieren. Refiérase al texto de la solicitud para identificar el documento respectivo que se le requiere que entregue basándose en el tipo y la situación de su proveedor.

1. Haga clic en el botón **Upload Files** (Cargar archivos) para cargar una copia de los documentos requeridos.

Applications without the required forms uploaded may be denied. Once an application is denied a future application with the same tax ID and provider type will also be denied.

- **Mandatory for ALL applications:** Upload your current IRS W-9 form. If you do not have a W9 please complete one using this link and upload it <https://www.irs.gov/pub/irs-pdf/fw9.pdf>
- **Mandatory for ALL applications:** Download the DOA-6460 Form and complete the form. Please upload the completed form with your other documentation as part of your application. [Download Here](#)
- **Mandatory for most applications:** Upload your final 2019 Federal Tax Form 1040, 1065 or 1120 based on your required IRS filing. Non-profit entities would upload the final 2019 federal form 990. If you are unable to provide a final 2019 federal tax return, or IRS form 990 for a non-profit entity, a final 2019 Profit and Loss statement documenting revenue and expenses AND the 2018 filed federal tax return must be uploaded. Any change to the final 2019 profit and loss statement resulting from an independent CPA firm audit after application submission should be submitted to the DHSDMSDCPP@dhs.wisconsin.gov mailbox. The only entities that do not need to upload a 2019 tax form are entities (such as owner occupied Assisted Living Facilities) that are not required to report the revenue related to their entity, or entities that are newly owned in 2020. These entities should upload a document explaining their situation. Applications that receive funding may be subject to audit.
- **Mandatory if you have employees:** Upload your Quarter 1 2020 IRS Form 941.
- **Mandatory if your application TIN and tax return, 941, and W9 TINs are not the same:** Upload a document with a listing of name, legal relationship/structure, role, and TIN for each TIN and a 2019 P&L statement for the application service type.

Upload file File Name File Size

1 Or drop files

You must upload the appropriate documentation for your organization to be eligible for CARES Act Provider Payments. To ensure that all needed documents have been uploaded, check each type of document uploaded.

IRS Form W-9

* DOA 6460

* **Please select the appropriate tax checkboxes based on the status of your 2019 tax return (or 990 for a non-profit)**

Option 1: Final 2019 tax return (or 990 for a non-profit)

Option 2: If the final 2019 tax return (or 990) is not available you may upload both documents:

Final 2019 tax year profit and loss statement

Final 2018 tax return or 990

Q1 2020 IRS Form 941

Q2 2020 IRS Form 941

Other

4

5

2. Una ventana mostrará el estatus de su carga.
3. Cuando los archivos están cargados, según lo indica la marca de chequeo verde, haga clic en el botón **Done** (Terminado).

2 Upload Files

PDF 28 KB

1 of 1 file uploaded **3**

File Name File Size

Help Document: Create and Submit an Application

4. Escoja los archivos que va a cargar marcando la casilla de verificación. Nota: Se requiere que todas las solicitudes entreguen una copia del formulario IRS W-9 actual y del formulario DOA-6460
5. Haga clic en el botón **Next** (Siguiendo) en la esquina derecha abajo.

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Revisar & Entregar

1. En la página final Submission (Sumisión), revise el texto y su solicitud. Puede revisar la información haciendo clic en el botón **Back** (Atrás).
2. Complete todos los campos. Nota: La persona que completa la confirmación y atestación de la firma electrónica debe ser autorizada de hacerlo en nombre de su organización. En la mayoría de los casos éste debe ser un oficial de la organización.
3. Haga clic en el botón **Submit** (Entregar).

CARES Act Provider Payment Application - Phase 2

Phase 1 Application number -, Organization Name -

Cancel

Review & Submit

Signing the Application

Before you submit this application for direct care providers, please check the following:

- Check that all information is entered correctly.
- Check that any required files are uploaded. Failure to upload required documents may result in a denied application. Funds issued for applications identified with missing required documents may be subject to recovery.

Electronic Signature Acknowledgement

I hereby attest that I have been authorized to complete this attestation and survey on behalf of my organization.

I attest that the costs and lost revenue my organization is reporting on this application are limited to my organization's operations in Wisconsin and that they are attributable to the COVID-19 pandemic or the associated impacts. I further certify that these costs or losses have not been reimbursed by another outside source, other than the funds and loans I've listed in this application.

I further attest that I have uploaded the required files and understand that failure to do so may result in recovery of any funds received.

I further attest that my organization has documentation and will maintain documentation for the information reported on this application and will provide this documentation if requested. In addition, I understand that by accepting this funding, I attest that my organization will participate in and provide any documentation needed in any review of funding received or use of funding, including but not limited to formal audits or informational survey. I also attest that failure to provide any of the requested documentation or to comply with any aspects of the review process might result in recoupment of the CARES Act funding my organization received.

I further attest that, as required by Wis. Stat. § 16.765, my organization will not discriminate against any employee or applicant for employment because of age, race, religion, color, handicap, sex, physical condition, developmental disability as defined in s. 51.01 (5), Wis. Stats., sexual orientation as defined in s. 111.32 (13m), Wis. Stats., or national origin, and will take affirmative action to ensure equal employment opportunities. My organization posts (or will post) in conspicuous places, available for employees and applicants for employment, notices setting forth the provisions of the State of Wisconsin's nondiscrimination law.

Pursuant to 2019 Wisconsin Executive Order 1, I further attest that my organization will hire only on the basis of merit and will not (and did not) discriminate against any persons performing any work for which reimbursement is sought on account of their military or veteran status, gender identity or expression, marital or familial status, genetic information or political affiliation.

By checking this box and typing my name below, I am electronically signing my application. I understand that an electronic signature has the same legal effect and can be enforced in the same way as a written signature.

*First Name M.I. *Last Name

*Title *Address

2 1 3

Save & Exit Back Submit

Help Document: Create and Submit an Application

4. Después de una entrega exitosa, usted verá la página siguiente.

