

**Patients That Received Health Resources and Services Administration (HRSA)
Administered COVID-19 Uninsured Program Payments Attestation**

On behalf of, [insert provider name/#] _____ for the fiscal year ended _____, I [insert your name and your title] attest that we have excluded all patient encounters from our charity care and bad debt listings for uninsured patients that received HRSA administered COVID-19 Uninsured Program payments, as authorized by the Coronavirus Aid, Relief, and Economic Security (CARES) Act (Pub. L. 116-136).

Furthermore, I understand that under the terms and conditions of the HRSA-administered COVID-19 Uninsured Program, these payments are considered payment in full for such care or treatment and should not be claimed as uncompensated care on W/S S-10 of the Medicare Cost Report.

Signature

Date