## APPLICATION FOR REQUEST FOR RELIEF FROM THE COVID-19 EMERGENCY HEALTHCARE SYSTEM RELIEF FUND IN ACCORDANCE WITH EMERGENCY ORDER #9 PURSUANT TO EXECUTIVE ORDER 2020-04

PLEASE COMPLETE THIS APPLICATION IN ITS ENTIRETY.

**Missing or incomplete information will only result in processing delays**.

**Submit completed requests to:** [healthcarerelieffund@dhhs.nh.gov](mailto:healthcarerelieffund@dhhs.nh.gov) along with any supporting documentation you wish to be considered in making your request for relief.

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| --- | --- |
| **Date of Application:** |  |

|  |  |
| --- | --- |
| **Applicant is:**  **(please check one)** | Hospital |
| Other: Please specify |

|  |  |  |  |
| --- | --- | --- | --- |
| **Organization’s Name:** | | | |
| **Organization’s Physical Address:** | Address: | | |
| City | State | Zip |
| **Organization’s Mailing Address:** | Address: | | |
| City | State | Zip |
| **Contact Person’s Name:** |  | | |
| **Contact Person’s Telephone:** | Business | Cell | |
| **Contact Person’s**  **Email:** |  | | |

|  |  |
| --- | --- |
| **Amount of Funds Requested:** |  |
| **Describe how the funds will be used:** |  |
| **Explain why the funds are necessary for the maintenance of an essential component of the State’s healthcare system during the COVID-19 state of emergency:** |  |
| **Explain what will happen if your request is denied:** |  |

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| **Applicant’s Certification:** |
| I do hereby certify that all information provided in or attached to this application is complete, accurate, and up-to-date as of the date specified below. I further certify that there are no willful misrepresentations of the answers to questions herein, and that I have made no omissions with respect to any of my answers to the questions presented. I understand that it is my responsibility to immediately notify the department in regard to any changes, corrections, or updates to the information provides, using the email address: [healthcarerelieffund@dhhs.nh.gov](mailto:healthcarerelieffund@dhhs.nh.gov). I also understand that this application is being submitted to determine eligibility for relief from the COVID-19 Emergency Healthcare System Relief Fund in accordance with Emergency Order #9 pursuant to Executive Order 2020-04. I also understand that any decision on this application is subject to approval by the Governor’s Office and no funds will be disbursed without his prior written approval.  Dated:  Applicant Signature      Print Name |

**DO NOT WRITE BELOW THIS LINE – FOR OFFICE USE ONLY**

Date Application Received: Date Application Reviewed:

Date Application Approved:

Commissioner/Designee Application Approved by:

Name/Title

Finance/Designee Application Approved by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name/Title