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https://www.maine.gov/decd/economic-recovery-grants

Maine Health Care Financial Relief Grant: Application

General Instructions

The Grant Application must be completed and submitted by 11:59 PM EST on December 10, 2020.
You must complete each step before proceeding to the next step of the application and must complete the application in its entirety before submitting. You may review and/or change the information you previously entered by clicking on the step name or using the "Previous" button. You will also have the opportunity to review a summary of all the information you entered before submitting your Grant Application. Note: The form will not save previously entered information if you close the window prior to submission. To submit, click the "Submit" button in the "Signature" step. If you close the Grant Application before submitting it, you will need to start over. After submitting, you will receive a confirmation email with a copy of the submitted application excluding all sensitive Personally Identifiable Information (PII). All sensitive information, including Personally Identifiable Information (PII), is encrypted at-rest and in-transit throughout the process. Information collected by this system will not be shared or used for any other purposes besides grant selection and distribution except as may be required by Maine's Freedom of Access Act, 1 M.R.S Section 401 et seq. It is likely that some of the information provided will be accessible under Maine's Freedom of Access Act (1 M.R.S. Section 401 et seq.); however, proprietary information, tax or financial information, and PII will not be disclosed.
Further instructions will be provided for each step. If you have any questions that are not addressed in instructions or the Maine Economic Recovery Grant Program Frequently Asked Questions (https://www.maine.gov/decd/economic-recovery-grants/faq), please call 1-800-872-3838 and press 3 or email BizAwards.DECD@maine.gov.
For Maine State Tax questions, please contact the Maine Revenue Service Taxpayer Contact Center via phone at 1-207-624-9784 or email at taxpayerassist@maine.gov.
Additional assistance may be provided by reaching out to your local economic development or non-profit support organization.
Please note: You should submit the Grant Application as early as possible before the deadline. **The application deadline is 11:59 PM EST on December 10, 2020**.

Eligibility Criteria:

The Maine Health Care Financial Relief Grant Program is intended to assist in covering losses incurred as a direct result of the COVID-19 pandemic and related public health response. Providers will be liable for any misuse of funds. The grants are taxable income and subject to audit.

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- Suggested provider expenses may include but are not limited to:
  - Payroll costs and expenses;
  - Rent or mortgage payments for provider facilities (unless otherwise waived by lessor/lender);
  - Utilities payments;
  - Purchase of personal protective equipment required by the provider;
  - Provider related equipment;
  - Investments that will support your organization's long-term sustainment;
  - Expenses incurred to replenish inventory or other necessary re-opening expenses; and
  - Necessary operating expenses.
- Examples of unallowable expenses include (list is not all-inclusive):
  - Depreciation expense
  - Entertainment
  - Lobbying
  - Goods and Services for Personal Use
  - Fines, Penalties, Damages and other Settlements
- Funds must be spent on operations that are strictly within Maine.
- This grant is considered reportable income; therefore, funding received from this grant must be included with reportable income at tax time. For applicable providers, a Form 1099 will accompany any awarded grant monies.

To qualify for a Maine Health Care Financial Relief Grant your business/organization must:

1. Demonstrate a need for financial relief based on lost revenues or expenses incurred since March 1, 2020 due to COVID-19 impacts or related public health response;
2. Demonstrate an expected 20% loss in revenue minus expenses for 2020;
3. Be a health care provider which has accepted Medicaid members in 2020, including:
   a. Hospitals and nursing facilities of any size which were not previously eligible under the Economic Recovery Grant Program

   b. Congregate Care Facilities and Home and Community Based Waiver Providers, of Behavioral Health and Intellectual/Developmental Disabilities Services, Group Practices, and other Medicaid Providers with more than 250 employees which were not previously eligible under the Economic Recovery Grant Program
4. Have significant operations in Maine (provider headquartered in Maine or have a minimum of 50% of employees and contract employees based in Maine);
5. Be current and in good standing with all Maine State payroll taxes, sales taxes, provider taxes, and state income taxes (as applicable) through September 30, 2020;
6. Have a Date of Incorporation or Purchase before August 1, 2019;
7. Be in good standing with the Maine Department of Labor;
8. Be in good standing with the Maine Department of Health and Human Services;
9. Not be in bankruptcy;
10. Not have permanently ceased all operations;
11. Be in consistent compliance and not be under any current or past enforcement action with COVID-19 Prevention Requirements; and
12. For health care providers other than hospitals and nursing facilities, employ a combined total of more than 250 employees and contract employees throughout 2020.
    a. For the purposes of this calculation, count 1 employee or contract employee if they are employed, on average, at least 30 hours of service per week or 130 hours of service per month. Count 0.5 for each part-time employee who is employed, on average, less than this.
13. If eligible for and/or awarded funds as part of Phase 1 or 2 of the Maine Economic Recovery Grant Program, your provider is ineligible for this Phase.

For non-profit organizations: Only organizations that file Form 990 or Form 990-EZ are eligible to apply.

A group of affiliated entities must only submit one grant application. Please coordinate with other affiliated entities prior to submitting an application.

For purposes of the Maine Health Care Financial Relief Grant Program, your provider is considered affiliated with any other provider that:

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1. Has the same Federal Taxpayer Identification Number (including Social Security Number)
2. Has the same corporate parent or grandparent
3. Is majority owned (more than 50%) by the same owner or group of owners

Note: If submitting an application for affiliated entities with the same corporate parent or grandparent, or same majority ownership, but different TINs, please report the TIN for each affiliate in the "Affiliated Providers" section.

What you will need to complete this application:

You will need the following information about your provider (and all affiliated providers) before you begin your Maine Health Care Financial Relief Grant application:

1. Federal Taxpayer Identification Number (TIN)
    - Federal Employer Identification Number or Social Security Number
    - If submitting an application for affiliated entities with different TINs, you will need to report the TIN for each affiliate
2. National Provider Identifier(s)
3. Type of business/organization (non-profit or for-profit)
4. Data Universal Number System (DUNS) number. To set-up or verify a DUNS number, visit https://www.grants.gov/applicants/organization-registration/step-1-obtain-duns-number.html.
    - **Note:** A DUNS number is required to receive grant funds and is part of the application.
5. Principal office address
6. "Doing business as" (DBA) name
7. Applicant address and other contact information
8. For businesses: Ownership percentage of each individual owner with greater than 25% equity
9. For sole proprietors: Total amount of unemployment compensation benefits received March 1, 2020 – September 30, 2020
10. Documentation of any other monies awarded through federal grants or loans by the CARES Act
11. 2017, 2018, and 2019 revenue, expenses, and depreciation (as applicable)
12. 2020 anticipated revenue and expenses excluding depreciation, taking into account the impact of the COVID-19 pandemic on revenue and expenses
13. An estimate and justification of how much of your 2020 losses are a direct result of the pandemic and a disruption to operations.

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14. A prepared, electronic W-9 in the event your provider is selected for a grant (https://www.irs.gov/pub/irs-pdf/fw9.pdf)

Applicant Contact Information

Note: The Applicant is the person completing this grant application.

First Name
(Required)
Last Name
(Required)
Contact Title

Contact Phone
(Required)
Phone Extension

Email Address
(Required)

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Provider Information:

Provide the following provider information:

Did your provider receive any funding from the Federal CARES Act or other Federal COVID-19 relief?

- Yes or No (Required)

(If 'Yes')
Provide the amounts of all Federal COVID-19 related grants and/or loans received by your provider through September 30, 2020.
Please Note: If your provider is affiliated with one or more other providers, provide the combined amounts received, or projected to be received, by the entire group of affiliated providers.

Round to whole dollars

Total Paycheck Protection Program (PPP) loan amount received
(Required)
Economic Injury Disaster Loan (EIDL) and/or EIDL Advance amount
(Required)

For sole proprietors: Total amount of unemployment compensation benefits received March 1, 2020 – September 30, 2020
(Required for Sole proprietors)

Total of any other grants and/or loans received by your business/organization related to COVID-19
Please Note: DO NOT INCLUDE unemployment compensation benefits in the total amount of other grants and/or loans.
(Required amount)

(If entered an amount other than 0 above)
For the total amount of other grants and/or loans above, provide the name and amount of each other grant and/or loan received:
(Required)

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Enter the amount of any grants or forgiven loans (or expected to be forgiven) that have not yet been expended or not accounted for in your revenue and expense lines from January to September 2020.
(Required)

For example: Your provider received $50,000 of PPP Loan, $10,000 of EIDL Advance, $40,000 of EIDL Loan, and $10,000 of a separate non-forgivable loan. In this scenario you would only consider the PPP Funds if they are expected to be forgiven, and the EIDL Advance and the other two loan amounts are not forgivable and should be excluded. Of the total $50,000 PPP loan you would provide the sum of the total unspent loan amount and spent loan amount as of September 30, 2020 ONLY if the following is true:

- **The amount spent or expected to be spent will be forgiven or is expected to be forgiven.**
- **You have not already included the spent amounts in net income/loss through September 30, 2020, and instead they were recorded as liabilities on your balance sheet as of September 30, 2020.**

Did your provider or an affiliated providers apply for a Maine Economic Recovery Grant during Phase 1 or Phase 2?

- Yes or No (Required)

How is your provider structured?

- Sole Proprietorship
- Partnership
- LLC (Limited Liability Company): Single-Member
- LLC: C Corporation
- LLC: S Corporation
- LLC: Partnership
- C Corp
- S Corp
- B Corp
- Non-profit

Name of Provider:
(Required)
DBA Name
(Required)

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Provider Office Address (Include County)
(Required)

Is the provider operating under a Federal Employer Identification Number or a Social Security Number?
(Required) (drop down menu)

- Federal Employer Identification Number or Social Security Number

Enter the Federal Employer Identification Number or Social Security Number
(Required)
Confirm the Federal Employer Identification Number or Social Security Number
(Required)
Enter the National Provider Identifier
(Required – Please enter all NPIs for the provider and all affiliated providers, separating multiple NPIs by commas)
DUNS Number (Allow up to two days to receive a DUNS number. Visit https://www.grants.gov/applicants/organization-registration/step-1-obtain-duns-number.html to register.)
(Required)

Provider Type Information

In what industry is your provider?
Drop Down

- ❑ Health Care and Social Assistance
- ❑ Other

(If 'Other", please list)

Please describe provider activities that generate revenue (product or service provided by provider): (100 Words)

Select your business/organization type from the following list of North American Industry Classification System (NAICS) Code Categories.
Required (searchable code bar by keyword would optimize this response, website https://www.naics.com/search/)

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Affiliated Providers

Is your provider affiliated with one or more other provider?

For purposes of the Maine Health Care Financial Relief Grant, your provider is considered affiliated with any other provider that:

1. Has the same Federal Taxpayer Identification Number (including Social Security Number)
2. Has the same corporate parent or grandparent
3. Is majority owned (more than 50%) by the same owner or group of owners

Note: If submitting an application for affiliated entities with the same corporate parent or grandparent, or same majority ownership, but different TINs, please report the TIN for each affiliate in the section below.

A GROUP OF AFFILIATED ENTITIES MUST ONLY SUBMIT ONE GRANT APPLICATION. PLEASE COORDINATE WITH OTHER AFFILIATED ENTITIES PRIOR TO SUBMITTING AN APPLICATION. FOR NON-PROFIT ORGANIZATIONS, ONLY THE ORGANIZATION THAT FILES FORM 990 OR FORM 990-EZ SHOULD SUBMIT A GRANT APPLICATION.

Is your provider considered "affiliated" as defined by the above criteria?
Yes or No

(If 'Yes' to affiliated)
Principal Office Address
(Required) (Include County)

Please list all other affiliated providers and addresses along with the Federal Taxpayer Identification Numbers (TINs)
(Required business/organization names, addresses, and all TINs associated with affiliates)

(If 'No' to affiliated, or after completion of the affiliated section)

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Individual Owner(s) (This question is not required for Non-Profit organizations)

Provide the following information for all individual owners with an ownership stake greater than 25%.

Please Note:

- If your provider is affiliated with one or more providers, the ownership percentage of each individual owner must be her/his ownership percentages of the entire group of affiliated providers.
- You must enter at least one owner.

First Name
(Required)
Middle Initial

Last Name
(Required)

Ownership Percentage
(Required)

Owner's Address
(Required)

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Financial Impact of COVID-19 Pandemic:

Please note for the following section:

1. Provide your provider's 2017, 2018, and 2019 actual revenue, expenses, and depreciation as reported on the Federal income tax lines shown below.
2. Estimate your provider's 2020 revenue and expenses excluding depreciation, taking into account the impact of COVID-19 on both revenue and expenses. DO NOT USE pre-COVID-19 projections.
3. If your provider is affiliated with one or more other providers, provide the combined revenue, expenses, and depreciation of the entire group of affiliated providers.
4. If your provider's actual 2020 revenue less expenses is more than your estimate, your grant amount, if any, may be subject to recoupment in part or in full.

Round to whole dollars

2017 Gross Receipts/Revenue
2018 Gross Receipts/Revenue
2019 Gross Receipts/Revenue

- C Corporations: Line 11 on Form 1120
- S Corporations: Line 6 on Form 1120-S
- Partnerships: Line 8 on Form 1065
- Sole Proprietorships: Line 7 on Form 1040 Schedule C or Line 9 on Form 1040 Schedule F
- Non-Profits: Line 12 on Form 990 or Line 9 on Form 990EZ
- Required (Leave blank if business/organization was not required to file for the 2017, 2018, and/or 2019 Tax Year)

2017 Expenses
2018 Expenses
2019 Expenses

- C Corporations: Line 27 on Form 1120
- S Corporations: Line 20 on Form 1120-S
- Partnerships: Line 21 on Form 1065

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- Sole Proprietorships: Line 28 on Form 1040 Schedule C or Line 33 on Form 1040 Schedule F
- Non-Profits: Form 990 Line 18, Form 990EZ Line 17

- **2017 Depreciation**
- **2018 Depreciation**
- **2019 Depreciation**

  - C Corporations: Line 20 on Form 1120
  - S Corporations: Line 14 on Form 1120-S
  - Partnerships: Line 16c on Form 1065
  - Sole Proprietorships: Line 13 on Form 1040 Schedule C or Line 14 on Form 1040 Schedule F
  - Non-Profits: Form 990 Line 22 (Part IX), Form 990EZ Line 16 (Schedule O)

2020 Gross Receipts/Revenue: Report your total gross receipts/revenue from similar sources from January 1, 2020 – September 30, 2020.

*** Your 2020 receipts/revenue should be calculated in a similar fashion to your previous years to ensure consistency. Please review FAQs for more guidance**

2020 Expenses: Report your total expenses from similar sources from January 1, 2020 – September 30, 2020.
Note: Exclude depreciation in your forecasted 2020 expenses.

Provide a description connecting your anticipated 2020 loss of income to the COVID-19 pandemic or related public health response. How is COVID-19 reducing your average income revenue less expenses? (200 word limit)
(Required)

Regarding the loss your provider has experienced in 2020, estimate the percent that is a direct result of COVID-19 or the related public health response:
(If all of your loss is a result of COVID-19 or the public health response, this would be 100%)
(Required)

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Maine Revenue Services Taxpayer Information

To assist the Department of Economic and Community Development (DECD) in evaluating your eligibility for the Maine Health Care Financial Relief Grant Program, this section authorizes Maine Revenue Services (MRS) to verify certain confidential tax information and to disclose the status of your Maine tax and filing obligations to DECD.

For Maine State Tax questions please contact the Maine Revenue Service Taxpayer Contact Center via email at taxpayerassist@maine.gov or via phone at 1-207-624-9784.

Note: Any question not answered completely and correctly will delay the review process.

Do you have any State of Maine tax liability that is presently due or owing?

- Yes or No
    - If 'Yes', please explain (limit 200 words)

During the past 7 years, were you required to file any State of Maine tax return(s) other than income tax?

- Yes or No
    - If 'Yes', please list:
        - Tax Type:_____ Account No.:_____ (ability to include numerous Tax Type and corresponding Account Number)

Have you filed State of Maine income tax returns, and returns for each of the tax types listed above, for each of the past 7 years?

- Yes or No
    - If 'No', please list the tax type, year(s), and explain why the return(s) was not filed (for example because you were not in business, or because you lived outside of Maine and were not required to file):

Tax Type:_____Year(s)_____Reason for Not Filing:_____ (ability to fill our tax type, year(s), and reason for not filing, several times)

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Provider Qualification Questions

Please answer the following statements about your provider.

My provider is current and in good standing with all Maine State payroll taxes, sales taxes, provider taxes, and state income taxes (as applicable) through September 30, 2020.

- Yes or No

My provider is in good standing with the Maine Department of Labor. (Required)

- Yes or No

My provider is in bankruptcy. 'YES' means the provider **is** in bankruptcy.

- Yes or No

My provider has permanently ceased all operations. 'YES' means the provider has closed, with no intent to reopen.

- Yes or No

My provider has a minimum of 50% of employees and contract employees based in Maine. (Required)

- Yes or No

My provider's primary location/corporate headquarters is in Maine. (Required)

- Yes or No

My provider has been in consistent compliance with COVID-19 Prevention Requirements. (Required)

- Yes or No

My provider is under or has been under enforcement action with COVID-19 Prevention Requirements.
'YES' means the provider has been or is under enforcement action due to non-compliance. (Required)

- Yes or No
    - (If YES) Provide brief justification (200 word limit)

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Additional Provider Questions:

How many full time equivalent (FTE) employees does your provider have? (Required)

- Count 1 FTE for each full-time employee (employed on average at least 30 hours of service per week, or 130 hours of service per month)
- Count 0.5 for each part-time employee (employed an average of less than 30 hours of service per week or less than 130 hours of service per month)
- Only count yourself as a FTE if you treat yourself as a W-2 employee of the company
- Include 1099 contract employees in this calculation
- (SUBMIT NUMBER)

Is your provider led by a majority of black, indigenous, immigrant or other people of color?

- Yes or No (Required)

Does your provider primarily serve Black, Indigenous, People of Color (BIPOC) communities?

- Yes or No (Required)

Does your provider primarily serve underrepresented or impoverished communities?

- Yes or No (Required)
- If yes, describe the community that makes up the majority of your client base (200 words)

Are you, your chief executive officer (executive director/president/proprietor), or equivalent able to certify that the provider will make its best-effort not to furlough or lay off any individuals from the time of application through the end of the COVID-19 outbreak period?

- Yes or No or N/A

Are you, your chief executive officer (executive director/president/proprietor), or equivalent able to certify that the provider has a material financial need that cannot be overcome without the use of emergency relief funds at this time (e.g., does not have significant cash reserves that can support your operations during this period of economic disruption)?

- Yes or No

When was your provider incorporated/registered (how old is your provider)? (Note: if you purchased your provider, use the date of purchase)

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- (Month, Year) (Required)

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Maine Health Care Financial Relief Grant Program Agreement and Certification

Certification:

I (applicant) hereby certify that;

- ❑ To the best of my knowledge and belief, all information contained in this application is true and correct and current as of the date signed below;
- ❑ I will comply with all applicable State and federal laws and regulations;
- ❑ I acknowledge that I am applying for and may receive Maine Health Care Financial Relief Grant Program funds and that I have not benefited from other federal, state or local funds that would fully cover the losses I have experienced due to the COVID-19 pandemic without the assistance I am applying for, and that the State of Maine, and the Federal Government are hereby authorized to verify the information contained herein.
- ❑ I understand that my taxpayer information is confidential under 36 M.R.S. § 191. By signing this form, I authorize Maine Revenue Services (MRS) to verify any confidential information for DECD, relating to tax years 2017, 2018, 2019, and 2020, that is necessary to evaluate my eligibility for the Maine Health Care Financial Relief Grant Program and to disclose the status of my Maine tax and filing obligations to DECD as my duly authorized representative, pursuant to 36 M.R.S. §§ 191(2)(A) or (DD)(8).
- ❑ I understand that, regarding my Maine tax and filing obligations, the disclosure will be limited to whether any Maine tax liability is presently due or owing and whether it appears, based on my responses in this authorization and a limited review of my confidential information, that I have filed all required Maine tax returns during the past 7 years.
- ❑ There are no actions, suits or proceedings pending or, to the knowledge of the applicant, threatened against or affecting the applicant and/or provider at law or in equity before any court or administrative officer or agency which might result in any material adverse change in the business or financial condition of the applicant.
- ❑ I understand that some of the information provided will be accessible and subject to disclosure under Maine's Freedom of Access Act (1 M.R.S. Section 401 et seq.).

Agreement to Electronic Signature:

By submitting this Application and checking the box for acceptance, I understand, agree and accept use of its electronic signature as binding and final.

Authority to Sign:

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I understand, agree and accept that by submitting this application, it is certifying that the person named in the signature block has authority to bind the business/organization entity and that the State is entitled to rely on this certification as actual and apparent evidence of authority to bind the business/organization entity.

Authorized Signor (Required)

Authorized Signor
(Required)
Authorized Signor: Title
(Required)
Email Address
(Required)
Confirm Email
(Required)
Date
(Required)

Please upload a copy of a completed W-9 in the event your provider is selected for a grant.