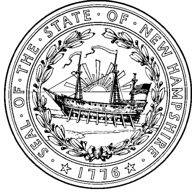

STATE OF NEW HAMPSHIRE

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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 along with any supporting documentation you wish to be considered in making your request for relief. At a minimum, relevant financial data should be included.

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 and Timing of Need:	
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:	
Is a grant or a loan being requested? If a grant is requested, explain why a grant is necessary:	

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. 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