HCBS Supplemental Payment Project – Phase 2 Quarterly Schedule

Organization Name:	**EXAMPLE**
Organization Tax ID:	
Contact Name:	
Contact Phone Number:	
Contact Email Address:	

(X) the applicable time period	**Phase/Period**	**Services Delivered Date Span**	**Services Billed By**	**Percentage Payment**
	Phase 2, Period 1	01/01/2022-3/31/2022	04/30/2022	Up to 12%
	Phase 2, Period 2	04/01/2022-9/30/2022	10/31/2022	Up to 8%
	Phase 2, Period 3	10/01/2022-03/31/2023	04/30/2023	Up to 4%

1. Costs of delivering Medicaid services exceed standard Medicaid Payments

Medicaid Revenue for eligible services:	

Enter Medicaid Revenue for ARPA Eligible HCBS Services for applicable quarter

Costs related to the provision of eligible services:	
Salaries:	
Benefits:	
Rent/Depreciation:	
Travel:	
IT:	
Overhead/Indirect:	
Other (Please specify below):	

Enter costs to administer services for applicable quarter

Costs exceeding Medicaid Revenue (calculated):	

Calculated: Revenue minus Costs

Maximum Payment Amount for Period:	

Calculated: Revenue for applicable period x payment percentage from table above.