# HCBS Supplemental Payment Project – Phase 2 Quarterly Schedule

| | |
|---|---|
| Organization Name: | |
| 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 | Attestation/Quarterly Schedule Submitted By | Percentage Payment |
|---|---|---|---|---|---|
| | Phase 2, Period 1 | 01/01/2022-3/31/2022 | 04/30/2022 | 5/16/2022 | Up to 12% |
| | Phase 2, Period 2, Quarter 1 | 04/01/2022-6/30/2022 | 07/31/2022 | 08/15/2022 | Up to 8% |
| | Phase 2, Period 2, Quarter 2 | 07/01/2022-09/30/2022 | 10/31/2022 | 11/15/2022 | Up to 8% |
| | Phase 2, Period 3, Quarter 1 | 10/01/2022-12/31/2022 | 01/31/2023 | 02/15/2023 | Up to 4% |
| | Phase 2, Period 3, Quarter 2 | 01/01/2023-03/31/2023 | 04/30/2023 | 05/15/2023 | 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.*

**Please submit completed form to HHSHCBSSupplementalPayment@mt.gov**