FORM FOR REQUESTING DISTRIBUTION OF FUNDS TO EMPLOYER FOR COVID-19 TESTING AND FOR MONTHLY REPORTING

Employer Name	Employer FEIN		
Employer Street Address	City	State	Zip Code
Total Number of Employees	Number of Unvaccinated Employees		

FUNDING REQUEST FOR DISTRIBUTION OF FUNDS TO AN EMPLOYER TO COVER COST OF EMPLOYEE COVID-19 TESTING

Number of Antigen Detection Tests Requested	Number of Molecular Diagnostic Tests Requested	Number of Proof of Immunity Tests Requested
Testing Schedule for Antigen Detection Tests	Testing Schedule for Molecular Diagnostic Tests	Testing Schedule for Proof of Immunity Tests
Anticipated Cost of Each Antigen Detection Test	Anticipated Cost of Each Molecular Diagnostic Test	Anticipated Cost of Each Proof of Immunity Test
United States Food and Drug Administration (FDA) Emergency Use Authorization Number for Antigen Detection Test	FDA Emergency Use Authorization Number for Molecular Diagnostic Test	FDA Emergency Use Authorization Number for Proof of Immunity Test
Name of the Manufacturer of Antigen Detection Test	Name of Manufacturer of Molecular Diagnostic Test	Name of Manufacturer of Proof of Immunity Test
Amount of Funding Requested for Antigen Detection Tests	Amount of Funding Requested for Molecular Diagnostic Tests	Amount of Funding Requested for Proof of Immunity Tests
MONTHLY DISBURSEMENT REPORT	**REPORT PERIOD From:** (MM/DD/YYYY)	**REPORT PERIOD To:** (MM/DD/YYYY)
Amount of Funding Received for Antigen Detection Tests	Amount of Funding Received for Molecular Diagnostic Tests	Amount of Funding Received for Proof of Immunity Tests
Date Funding for Antigen Detection Tests Was Received	Date Funding for Molecular Diagnostic Tests Was Received	Date Funding for Proof of Immunity Tests Was Received
Amount of Funding Disbursed for Antigen Detection Tests During Current Reporting Period	Amount of Funding Disbursed for Molecular Diagnostic Tests During Current Reporting Period	Amount of Funding Disbursed for Proof of Immunity Tests During Current Reporting Period
Amount of Funding for Antigen Detection Tests Not Disbursed to Employees	Amount of Funding for Molecular Diagnostic Tests Not Disbursed to Employees	Amount of Funding for Proof of Immunity Tests Not Disbursed to Employees

Important – Read Before Signing

By signing this form, you certify under penalty of perjury, based on information and belief formed after reasonable inquiry, the statements and information contained in this form and the attached documents are true, accurate, and complete.

Employer Signature	Employer Printed Name	Title	Date

For Request for Funding: In addition to providing the properly completed form(s), an employer **must** provide a proposed testing roster on the form(s) provided by the Department for that purpose.

For Monthly Reporting: In addition to providing the properly completed form(s), an employer **must** provide the original, or a digitally scanned copy, of invoices, receipts, or other documents evidencing that each test was conducted, name of each employee tested, the cost of COVID-19 testing, the name of the manufacturer of each COVID-19 test, the United States Food and Drug Administration (FDA) emergency use authorization number for each test, and a paycheck stub for the most recent pay period for each employee tested with all documents submitted in in legible format. An employer **must** provide on a monthly basis an updated proposed testing roster, a completed testing roster, and an employee separation roster to the Department of Finance and Administration. FDA emergency use authorization number information for COVID-19 tests can be found at: https://www.fda.gov/medical-devices/coronavirus-disease-2019-covid-19-emergency-use-authorizations-medical-devices/in-vitro-diagnostics-euas

Mail the completed form(s) and all documents to: Department of Finance and Administration, Office of Accounting, P.O. Box 3278, Little Rock, AR 72203-3278
Failure to furnish a properly completed form or the required documentation will delay your request for testing or claim for reimbursement.

Please see the instructions for completing the form on the next page.

IMPORTANT
PLEASE READ

EMPLOYERS THAT SEEK TO RECEIVE SFRF FUNDS

IMPORTANT: Prior to receiving State Fiscal Recovery Funds, an employer must execute the Arkansas Department of Finance and Administration COVID-19 Testing Program Subrecipient Agreement and agree to abide by its terms and conditions.

INSTRUCTIONS FOR COMPLETING THIS FORM:

1. **Employer name** – provide the complete legal name of the employer.
2. **Employer FEIN** – provide the employer's Federal Employer Identification Number.
3. **Employer Street Address** – provide the physical street address of the employer.
4. **City** – provide the city in which the employer is located.
5. **State** – provide the state in which the employer is located.
6. **Zip Code** – provide the employer's zip code.
7. **Total Number of Employees** – provide the total number of the employer's employees.
8. **Number of Unvaccinated Employees** – provide the number of the employer's employees who are not vaccinated against COVID-19.

INSTRUCTIONS FOR COMPLETING FUNDING REQUEST SECTION:

9. **Number of Antigen Detection Tests Requested** – provide the number of antigen detection tests that the employer proposes to be conducted.
10. **Number of Molecular Diagnostic Tests Requested** – provide the number of molecular diagnostic tests that the employer proposes to be conducted.
11. **Number of Proof of Immunity Tests Requested** – provide the number of proof of immunity tests that the employer proposes to be conducted.
12. **Testing Schedule for Antigen Detection Tests** – provide whether the testing schedule for antigen detection tests will be weekly, monthly, or if upon a set number of days, provide the number of days between each test.
13. **Testing Schedule for Molecular Diagnostic Tests** – provide whether the testing schedule for molecular diagnostic tests will be weekly, monthly, or if upon a set number of days, provide the number of days between each test.
14. **Testing Schedule for Proof of Immunity Tests** – provide whether the testing schedule for proof of immunity tests will be weekly, monthly, or if upon a set number of days, provide the number of days between each test.
15. **Anticipated Cost of Each Antigen Detection Test** – provide the anticipated cost of each antigen detection test.
16. **Anticipated Cost of Each Molecular Diagnostic Test** – provide the anticipated cost of each molecular diagnostic test.
17. **Anticipated Cost of Each Proof of Immunity Test** – provide the anticipated cost of each proof of immunity test.
18. **US FDA Emergency Use Authorization ("EUA") Number for Antigen Detection Test** – provide the FDA EUA for the antigen detection test that the employer proposes to use for COVID-19 testing.
19. **US FDA EUA Number for Molecular Diagnostic Test** – provide the FDA EUA for the molecular diagnostic test that the employer proposes to use for COVID-19 testing.
20. **US FDA EUA Number for Proof of Immunity Test** – provide the FDA EUA for the proof of immunity test that the employer proposes to use for COVID-19 testing.
21. **Amount of Funding Requested for Antigen Detection Tests** – provide the total dollar amount of funding requested for antigen detection tests.
22. **Amount of Funding Requested for Molecular Diagnostic Tests** – provide the total dollar amount of funding requested for molecular diagnostic tests.
23. **Amount of Funding Requested for Proof of Immunity Tests** – provide the total dollar amount of funding requested for proof of immunity tests.

INSTRUCTIONS FOR COMPLETING MONTHLY DISBURSEMENT REPORT SECTION:

24. **Report Period From** – provide the report period From date in MM/DD/YYYY format.
25. **Report Period To** – provide the report period To date in MM/DD/YYYY format.
26. **Amount of Funding Received for Antigen Detection Tests** – provide the total dollar amount of funding received for antigen detection tests.
27. **Amount of Funding Received for Molecular Diagnostic Tests** – provide the total dollar amount of funding received for molecular diagnostic tests.
28. **Amount of Funding Received for Proof of Immunity Tests** – provide the total dollar amount of funding received for proof of immunity tests.
29. **Date Funding for Antigen Detection Tests Was Received** – provide the date that the employer received funding for antigen detection tests.
30. **Date Funding for Molecular Diagnostic Tests Was Received** – provide the date that the employer received funding for molecular diagnostic tests.
31. **Date Funding for Proof of Immunity Tests Was Received** – provide the date that the employer received funding for proof of immunity tests.
32. **Amount of Funds Disbursed for Antigen Detection Tests During Current Reporting Period** – provide the total dollar amount of funds disbursed for antigen detection tests during the current reporting period.
33. **Amount of Funds Disbursed for Molecular Diagnostic Tests During Current Reporting Period** – provide the total dollar amount of funds disbursed for molecular diagnostic tests during the current reporting period.
34. **Amount of Funds Disbursed for Proof of Immunity Tests During Current Reporting Period** – provide the total dollar amount of funds disbursed for proof of immunity tests during the current reporting period.
35. **Amount of Funding for Antigen Detection Tests Not Disbursed to Employees** – provide the total dollar amount of funding previously received for antigen detection tests that has not been disbursed to employees.
36. **Amount of Funding for Molecular Detection Tests Not Disbursed to Employees** – provide the total dollar amount of funding previously received for molecular detection tests that has not been disbursed to employees.
37. **Amount of Funding for Proof of Immunity Tests Not Disbursed to Employees** – provide the total dollar amount of funding previously received for proof of immunity tests that has not been disbursed to employees.