

CORONAVIRUS RELIEF FUND
DEADLINE EXTENSION CERTIFICATION

I, _____, am the authorized representative of _____, and I certify that:

1. I received an allocation of funds from the **Delaware Department of Health and Social Services' Health Care Provider Relief Fund** from the Coronavirus Relief Fund as created in the CARES Act on behalf of _____.
2. I understand that the **Delaware Department of Health and Social Services Health Care Relief Fund** rely on this certification as a material representation for extending the deadline for previously approved expenditures to _____.
3. _____'s uses of the funds provided will be used only to cover those costs that were previously approved by the **Delaware Department of Health and Social Services** as outlined in the grant recipient's Award Letter and were incurred during the period that begins on March 1, 2020 and ends on December 31, 2021.
4. I understand that my organization may reallocate funds from one item or service that was approved by DHSS in my initial application to another item or service that was approved by DHSS in my initial application, but I may not spend funds on unapproved items or services.
5. I hereby certify that _____ has reviewed all available guidance memoranda issued by the State of Delaware Department of Justice as well as from the federal Department of the Treasury.
6. I understand that despite the extension of the deadline to December 31, 2021, funds may not be spent on goods or services that were not previously approved by the Health Care Relief Fund.
7. I understand that all previous requirements for the acceptance of a grant from the Health Care Relief Fund remain in effect.
8. Please check one of the boxes below:
 - My organization received an award in Round 1 (2020) of the Delaware Health Care Relief Fund.
 - My organization received an award in Round 2 (2021) of the Delaware Health Care Relief Fund.
 - My organization received an award in both Round 1 and Round 2 of the Delaware Health Care Relief Fund.

I certify that I have read the above certification and am authorized by _____ to execute.

By: _____

Signature: _____

Title: _____

Date: _____

Address: _____

Delaware Business License # **OR** Employer Identification Number (EIN) for 501(c)(3) designation: _____

Completed certification forms are to be scanned and emailed to DHSS_CaresAct@delaware.gov.