



**2016 PRACTICE SITE SUMMARY**  
 Ohio Dental Hygienist Loan Repayment Program  
 Ohio Dentist Loan Repayment Program  
 Ohio Physician Loan Repayment Program  
 State Loan Repayment Program

**Directions:** Complete one Practice Site Summary form for each site where the applicant practices or will practice. This page **cannot** be completed by the applicant unless he or she is the owner of the practice.

**I. Employer and Practice Site Information**

Employer Name \_\_\_\_\_

Employer Address \_\_\_\_\_ City, Zip+4 \_\_\_\_\_

Practice Site Name \_\_\_\_\_

Practice Site Address \_\_\_\_\_ City, Zip+4 \_\_\_\_\_

**II. Applicant (Clinician) Information**

Applicant's Name \_\_\_\_\_ Number of hours per week clinician practices at this practice site location? \_\_\_\_\_

Current Employment Contract (Start Date) \_\_\_\_\_ to \_\_\_\_\_ (End Date) \_\_\_\_\_ Hours per Week \_\_\_\_\_

Number of hours per week clinician spends on each of the following job duties at this practice site per week:

	<u>Patient Care</u>	<u>Teaching</u>	<u>Administration</u>	<u>Other</u>
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**III. Practice Site Profile**

A. Does this practice participate in the Ohio Medicaid program?	Yes	No	Medicaid #
B. Does this practice accept new Medicaid-eligible patients?	Yes	No	
C. Does this practice accept assignment for Medicare?	Yes	No	Medicare ID#
D. Does this practice see all patients regardless of their ability to pay?	Yes	No	
E. Does this practice utilize a sliding fee scale (SFS) for uninsured patients whose incomes are at or below 200% of the Federal Poverty Guidelines?	Yes*	No	*If yes, include a copy of SFS with the application
F. Is this practice not-for-profit?	Yes	No	
G. What percentage of patients served by the practice are of racial and ethnic minorities?		%	

H. Provide the practice site's payer mix data for the most recent 12-month period. Provide actual numbers for unduplicated patients.  
 Reporting Period: \_\_\_\_\_ to \_\_\_\_\_

Payer	Number of Unduplicated Patients	Percentage of Total Patients
Medicaid		
Medicare		
Sliding Fee Scale		
Full Fee Self-pay		
No Charge/No Payment by Client		
Private Insurance		
Other (explain)		
<b>TOTALS</b>		

I. Is this practice a Patient-Centered Medical Home? Yes\* No  
*\*If yes, through which of the following?* AACHC JC PCMH NCQA URAC

**IV. Practice Site Contact Person and Certification**

Site contact person if applicant is awarded loan repayment:

Contact Person's Name Contact Person's Position  
 Contact Person's E-Mail Address Contact Person's Phone

I certify that the information provided above is correct and can be verified with billing records.

Printed Name of Person Completing Survey Title Date

\_\_\_\_\_  
 Signature of Person Completing Survey E-Mail Address Phone