# Practice Site Summary

Directions: Complete one Practice Site Summary page 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.

1. Clinician (applicant) Name: _____ Current Employment Contract

   Practice Sponsoring Organization Name: _____ Start Date: _____ End Date: _____

   Sponsoring Organization Address: _____

   Sponsoring Organization Phone: _____ Sponsoring Organization Fax: _____

2. Practice Site Phone: _____ Practice Site Fax: _____

3. Provide the hours per week the clinician will provide patient care, precept students, perform administrative tasks, etc. at each practice. List the primary practice location first:

| Practice Site Name / Address, City, Zip+4, County | Hours / Week Pt. Care | Teach | Admin | Other |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |

4. Does this practice participate in the Ohio Medicaid program? ☐ No ☐ Yes Medicaid # _____
5. Does this practice accept new Medicaid patients? ☐ No ☐ Yes
6. Does this practice accept assignment for Medicare? ☐ No ☐ Yes Medicare ID # _____
7. Does this practice see all patients regardless of their ability to pay? ☐ No ☐ Yes
8. Does the practice use a sliding fee scale (SFS) for patients with incomes at or below 200% of the Federal Poverty Guidelines? ☐ No ☐ Yes ↓ If yes, include a copy with the application
9. What percent of the patients are racial and ethnic minorities? ____%
10. Is this practice not-for-profit? ☐ No ☐ Yes
11. Provide the practice site payer mix data for 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) | | |
| TOTALS | 0 | 0.00 |

12. Is this practice a Patient-Centered Medical Home? ☐ No ☐ Yes → If yes, through which of the following? ☐ URAC ☐ NCQA ☐ AAAHC ☐ JC PCMH
13. Site Contact Person if applicant is awarded loan repayment:

    Name of Contact: _____ Phone: _____ Email: _____

## Certification:

☐ I certify that the information provided above is correct to the best of my knowledge, and can be verified with billing records.

| Printed Name of Person Completing Survey | Title | Date |
|---|---|---|
| Signature of Person Completing Survey | Email | Phone |