BUREAU OF CLINICIAN RECRUITMENT AND SERVICE

NATIONAL HEALTH SERVICE CORPS

UNIFORM DATA SYSTEM
REPORTING INSTRUCTIONS

CALENDAR YEAR 2007

PUBLIC BURDEN STATEMENT

PREFACE

This is the Uniform Data System (UDS) Reporting Instructions for NHSC sites which do not receive grant support from the Health Resources and Services Administration, Bureau of Primary Health Care (HRSA/BPHC). Entities receiving grants from HRSA/BPHC file a different version of the UDS report for which there are separate reporting instructions.

If you have questions about the UDS, please contact the help line at either, 1-888-459-1080 or udshelp@nhscdata.net. Frequently asked NHSC UDS questions and answers will be posted on the NHSC web site at http://nhsc.bhpr.hrsa.gov/resources/uds/ . Other material will be posted on the web site including a copy of this manual, copies of the tables, a summary of the changes made to the NHSC UDS each year, the user survey form, the aggregate data for each reporting year and a brief slide show providing an update of the changes made, an overview of the reporting requirements, and a list of scheduled UDS training events. The latest version of the Microsoft Access reporting software developed for the NHSC UDS will be mailed near the end of the reporting year. If not received by mid January, copies may be requested by contacting the help line.

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OMB No. 0915-0232 Expiration: 10/31/2008

INTRODUCTION

The National Health Service Corps (NHSC) is committed to improving the health of the nation's underserved by uniting communities in need with the healthcare professions and by supporting communities' efforts to build better systems of care. The NHSC is administered by the Bureau of Health Professions within the Health Resources and Services Administration (HRSA). The NHSC Uniform Data System (UDS) is an annual calendar year report prepared by all sites with NHSC obligated clinicians which do not receive grant support from the any of the federal HRSA programs identified in Sections 330 (e),(g), (h), and (i) of the Public Health Service Act. These include: the Community Health Center Program, the Migrant Health Center Program, the Health Care for the Homeless Program, and the Public Housing Primary Care Program. Sites with NHSC obligated clinicians which receive grants from these programs file the Bureau of Primary Health Care UDS report.

Approximately half of NHSC scholarship and loan repayment clinicians serve in sites which do not receive grant support from the HRSA programs shown above. The NHSC UDS was designed specifically for these sites. Data reported in other places such as the site application, the health professional shortage area (HPSA) designation request, the provider application, or other sources are not duplicated in the NHSC UDS.

The NHSC UDS is a valuable information management system, which gives the program a good understanding of the services, users, staffing, production, finances, and managed care enrollment at the sites receiving NHSC support. This information will enable the HRSA to respond more fully to questions about the NHSC program and the populations served.

The NHSC has offered training each year since the UDS began in 1998 to explain how to complete the UDS. On-site and web based training is offered again this year, please check the NHSC web site or call 1-888-459-1080 if you are interested in participating. A brief slide show presentation which reviews the tables and the changes for this year is also available on the software installation CD and on the NHSC web site. See http://nhsc.bhpr.hrsa.gov/resources/uds/ .

There are no significant changes for the CY 2007 reporting year.

The sections of the manual which follow give general instructions and detailed instructions for each table.

GENERAL INSTRUCTIONS

This section provides instructions applicable to all tables in the NHSC UDS. Instructions for each table are presented together with the table in subsequent sections of these reporting instructions.

REPORTING PERIOD

The reporting period is the calendar year. All activity for the full calendar year is to be reported even if the first NHSC assignment starts or last assignment ends during the calendar year. In those cases where the site begins or terminates operations during the year, only part year data will be reported, but the reporting period is still the full calendar year. The calendar year reported is specified in the header and is the same for each table.

SCOPE OF ACTIVITY REPORTED

The UDS report is site specific. Clinicians fulfilling National Health Service Corps obligations are assigned to a specific site or in rare cases more than one site. The scope of activity to be reported in the UDS includes all activity at the site to which the NHSC clinician is assigned.

Activity at other sites owned or operated by the sponsoring organization is to be excluded.

All related activity of all providers at the site is to be reported, including activity of all NHSC and non-NHSC providers at the site.

Related activity includes all primary care services and related supplemental services which support the primary health care activity. These services are an integral part of the primary care delivery system, under general direction and control of the sponsoring organization, and provided by the site's providers to the sponsoring organization's patients at the approved site location or by the site's providers to the sponsoring organization's patients at approved off-site locations such as the patient's home, nursing home, emergency room or hospital.

Sites may elect to include or exclude all or some portion of referred care services paid by the sponsoring organization which are rendered to the site's patients at off-site locations. This election may be based upon the ability or ease of reporting this information on a site specific basis. The same scope of off-site referred care should be used to complete the encounter, user, charge, and cost tables.

Institutional or large provider organizations may opt to limit the scope of reportable activity to the smallest set of common primary care services that can readily be reported at the site.

WHO SUBMITS REPORTS

The UDS reports for NHSC sites are to be filed by those parties which enter into an agreement with Secretary of the Department of Health and Human Services for a NHSC provider placement and which are not currently receiving HRSA/BPHC grant support for the site where the NHSC placement is made. This may be the sponsoring organization which signs the Private Practice Assignment (PPA) agreement, the obligated clinician who signs the Private Practice Option (PPO) agreement or the sponsoring organization which signs the memorandum of agreement (MOA) for a federally employed clinician.

All sites with a NHSC obligated clinician in place at any point between April 1st and September 30th of the calendar year are to file a report. ***Those sites whose first NHSC clinician assignment begins after September 30th or whose last NHSC clinician assignment ends before April 1st are not required to file for that calendar year.***

All sites meeting the criteria above are to file a complete UDS report except for Federal Bureau of Prison (BOP), nonfederal prison, Indian Health Service (IHS), Section 638, and Immigration and Naturalization Service (INS) sites which are only to file the cover sheet, and tables 1, 2A, 2B, and 3.

Only one report per site is to be filed in those cases where more than one NHSC clinician is working at the same site for the same organization.

A single sponsoring organization is to file separate reports for each site with NHSC clinicians.

If an individual NHSC clinician is assigned to more than one site, a separate UDS report is to be filed by the sponsoring organization for each site.

Those entities which receive HRSA/BPHC grant support for the site where the NHSC assignment is made are to file the standard HRSA/BPHC UDS report.

TABLE HEADER INFORMATION

The following information is reported in the header on all UDS Tables:

Date of Submission: the date the initial or revised report is submitted.

Initial Submission or Revision: an initial report is the first report for the reporting period. Revisions are subsequent, corrected submissions.

Reporting Period: The reporting period is the calendar year. All activity for the full calendar year is to be reported even if the first NHSC assignment starts or last assignment ends during the calendar year. Not all sites whose first assignment starts or last assignment ends during the year are required to file. See the discussion in this section defining which sites are to submit reports. In those cases where the site begins or terminates operations during the year, only part year data will be reported, but the reporting period is still the full calendar year. The calendar year reported is specified in the header and is the same for each table.

UDS Number: the number assigned to the site by the NHSC. The UDS numbers are site specific and are permanently assigned at the time an NHSC vacancy is approved. A list of UDS numbers is included in the UDS training notebooks. If you do not have the number, it may be obtained by contacting UDS help line at either, 1-888-459-1080 or udshelp@nhscdata.net.

REPORT DUE DATE

Reports are typically due on February 15th or approximately 45 days following the close of the reporting year; however, this year reports are due on March 14th.

ELECTRONIC PREPARATION AND SUBMISSION

Sites are strongly encouraged to prepare and submit the UDS report using the NHSC Microsoft Access software product introduced in CY 1999 and revised each year. The software is designed to ease the reporting burden, help ensure reports are completed correctly, allow sites to file electronically, and make data management more efficient. A toll free number, 1-888-459-1080, is available for software support. The minimum computer system requirements are a CD drive, Windows 2000 and approximately 100 MB of free disk space. The Microsoft Access software is not required. The product includes a routine which will compile and summarize sample user data and automatically produce a report summarizing the site's data. The software and be distributed to all sites near the end of the calendar year.

NUMBER OF COPIES TO SUBMIT

Sites filing electronically file once and sites filing manually submit one copy of the UDS report.

WHERE TO SUBMIT REPORTS

Sites filing electronically follow the instructions included in the software. Sites filing manually send one copy to the NHSC UDS Data Center at the address shown below.

NHSC UDS Data Center
P.O. Box 666
Concord, NH 03302-0666

SUBMITTING REVISED REPORTS

Each site will be assigned a UDS editor. After the due date, revised reports should only be submitted as instructed by the site's editor. Sites filing electronically can only do so once for each site unless given an unlock code by an editor. Prior to the due date, sites may inquire about filing revised reports by contacting UDS help line at either, 1-888-459-1080 or udshelp@nhscdata.net.

REPORT DOCUMENTATION AND RETENTION

Copies of the original and revised submissions, related source documents, and supporting worksheets which substantiate the UDS data reported to the source data are to be kept on file and available for review for a minimum of three years from the submission date.

DEFINITION OF ENCOUNTERS

An encounter is a face-to-face contact between a user and a provider who exercises independent judgment in the provision of services to the individual and where the services rendered are recorded in the patient's record.

A listing of health personnel is presented in Appendix A which identifies those who are considered providers and able to generate encounters and those who are considered nonproviders and not able to generate encounters for UDS reporting purposes.

The criteria used to define reportable encounters for the UDS resemble criteria often used by payers to define a billable patient visit.

The criteria for encounters are as follows:

1. To meet the encounter criterion for independent judgment, the provider must be acting independently and not assisting another provider. For example, a nurse assisting a physician during a physical examination by taking vital signs, taking a history, or drawing a blood sample ***is not*** credited with a separate encounter. A nurse using standing orders or protocols, who sees a patient to monitor physiological signs, etc., without the patient also seeing the physician during the same visit, ***is*** credited with a medical encounter.

   Encounters also include provider contacts with patients who are in a hospital, nursing home, or other inpatient facility. A provider may not generate more than one inpatient encounter per patient per day.

2. Services such as drawing blood, collecting urine specimens, performing laboratory tests, taking x-rays, immunizations, filling or dispensing prescriptions do not constitute encounters. However, these procedures may be accompanied by services performed by medical, dental, or other health providers that do constitute encounters.

3. The patient record does not have to be a full and complete health record in order to meet the encounter criteria if a patient receives only minimal services and is not likely to return to the site. For example, if an individual receives services on an emergency basis and these services are documented, the encounter criteria are met even though a complete health record is not created. Provision of HIV counseling and testing meets these encounter criteria if documented. The same is true for services, such as employment physicals, sports physicals, etc., which are rendered to persons who do not regularly use the practice site. ***However, the services rendered must be documented. Mass screenings at health fairs do not result in encounters in part because they are not fully documented.***

4. A patient may have more than one encounter at the site per day. The number of encounters per site per day is limited as follows:

   - One medical encounter (physician, nurse practitioner, physicians assistant, certified nurse midwife, or nurse);
   - One dental encounter (dentist or hygienist); and
   - One encounter for each other type of health provider (family planning or HIV counselor, nutritionist, psychologist, podiatrist, speech therapist, etc.)

   The limitation of one encounter per provider per site per day allows for another encounter at an approved off-site location such as the hospital.

5. A provider may be credited with no more than one encounter with a given patient during that patient's visit to the site in a single day, regardless of the type or number of services provided. For example, a physician providing health education services during a physical exam is credited with a medical encounter only. If a student provider sees patients in conjunction with a nonstudent provider, only one encounter, credited to the nonstudent

provider, is counted.

6. A reportable encounter by the NHSC and other staff providers may only take place at the NHSC approved site or at any other NHSC approved off-site location such as the patient's home, the hospital, an extended care facility, or the emergency room. ***Encounters by staff providers at other sites of the sponsoring organization, at another provider's office, or any location not approved for the NHSC provider to practice, are not to be reported.***

   Encounters supplied by paid nonstaff contractors or referral providers for services rendered to the site's patients at off-site locations, many of which may not be approved for the NHSC clinician to practice, such as the referral provider's office, may either be wholly or partly included or excluded. The same scope of activity chosen to report off-site paid referral provider encounters is also to be applied to the user, charge, and cost tables.

7. When a provider renders services to several patients simultaneously, the provider can be credited with an encounter for each person if the provision of services is noted in ***each*** person's health record. Examples of "group encounters" include: family therapy or counseling sessions and group mental health counseling during which several people receive services and the services are noted in each person's health record. Group medical visits are not reported as encounters. Health education classes such as smoking cessation classes are not credited as encounters.

8. The encounter criteria are ***not*** met in the following circumstances:

   - When a provider participates in a community meeting or group session that is ***not*** designed to provide health services. Examples of such activities include information sessions for prospective users, health presentations to community groups (high school classes, PTA, etc.), and information presentations about available health services at the practice site;

   - When the only health service provided is part of a large-scale effort, such as a mass immunization program, screening program, or community-wide service program such as a health fair;

   - When a provider is primarily conducting outreach or group education sessions, not providing direct services;

   - When the only services provided are lab tests, x-rays, immunizations, TB tests, and prescription refills; and

   - When the provider and patient are not physically present together as in a phone or telemedicine consultation.

Definitions of encounters for different provider types follow:

Physician Encounter: an encounter between a physician and a patient during which medical services are provided for the prevention, diagnosis, treatment, and rehabilitation of illness or injury.

Nurse Practitioner/Physicians Assistant Encounter: an encounter between a nurse practitioner

or physician assistant and a patient during which medical services are provided and where the practitioner acts independently.

Certified Nurse Midwife Encounter: an encounter between a certified nurse midwife and a patient during which medical services are provided and where the practitioner acts independently.

Nurse Encounter (Medical): an encounter between an R.N., L.V.N. or L.P.N., and a patient in which the nurse acts as an independent provider of medical services and exercises independent judgment. The service may be provided under standing orders of a physician, under specific instructions from a previous visit, or under the general supervision of a physician, nurse practitioner, or physician's assistant who has no direct contact with the patient during the visit. Services provided by Medical Assistants are not reportable encounters.

Dentist Encounter: an encounter between a dentist and a patient during which dental services are provided for the purpose of prevention, assessment, or treatment of a dental problem, including restoration.

Dental Hygienist: an encounter between a dental hygienist and a patient during which dental services are provided and where the hygienist provides the service independently, not jointly with a dentist. Only one encounter is generated when the patient sees both the hygienist and the dentist in one day.

Mental Health Encounter: an encounter between a mental health provider and a patient during which mental health services are provided.

Substance Abuse Encounter: an encounter between a substance abuse provider (e.g., rehabilitation therapist, psychologist, social worker, counselor, etc.) and a patient during which alcohol or drug abuse services (i.e., assessment and diagnosis, treatment, aftercare) are provided.

Other Professional Encounters: encounters between an other professional provider (e.g. podiatrist, physical therapist, optometrist, audiologist, etc.) and a patient during which other professional services are provided.

Other Service Encounter: encounters between other service personnel (e.g. case managers and education specialists) and patients are ***not*** reported in the NHSC UDS.

DEFINITION OF A PROVIDER

A provider is a clinician who assumes primary responsibility for assessing the patient and documenting services in the patient's record. Providers include only individuals who exercise independent judgment as to the services rendered to the patient during an encounter. The provider who exercises independent judgment is credited with the encounter, even when two or more providers are present and participate. See Appendix A for a listing of personnel which identifies those who are considered providers and who can generate encounters for UDS reporting purposes.

Ancillary services personnel including laboratory, x-ray, and pharmacy staff are defined as nonproviders and do not generate encounters. Also, other service personnel including case managers and education specialists are defined as nonproviders and do not generate encounters.

Contract and paid referred care providers who serve the site's patients at approved on or off-site locations who document their services in the site's records are considered providers and may generate encounters for UDS reporting purposes.

DEFINITION OF A USER

Users are individuals with one or more encounters, as defined above, during the calendar year. ***An individual can be counted only once in each of the following user service categories each calendar year.***

Medical User: an individual who has one or more medical encounters during the reporting period.

Prenatal User: an individual who has one or more prenatal medical encounters during the reporting period.

Dental User: an individual who has one or more dental encounters during the reporting period.

Mental Health & Substance Abuse User: an individual who has one or more mental health or substance abuse encounters during the reporting period.

Other Professional Service User: an individual who has one or more encounters with an other professional service provider. See Appendix A for a list of other professional service providers.

Total Users: unduplicated number of individuals who have one or more encounters during the reporting period.

The exhibit which follows illustrates that each calendar year an individual may only be counted as a user once within each service category and once in the count of total users regardless of the number of encounters the individual has in the reporting period.

Exhibit 1
Patient X Encounters for the Calendar Year

Encounter Date	Service Category						
		Medical		Dental	Mental Health/ Substance Abuse	Other Professional	Total
	Prenatal	Other	Total				
Jan 15		1	1				1
Mar 10					1		1
Jun 12						1	1
Aug 01						1	1
Sep 21				1			1
Oct 03				1			1
Nov 30		1	1				1
Dec 18	1		1			1	2
Total Encounters	1	2	3	2	1	3	9
Service Users	1	NR	1	1	1	1	
Total Users							1

Note: NR means “other medical service” users are not reported in the NHSC UDS

As shown, patient X had a total of nine visits during the year, was a user of each type of service, and is counted once in the site’s total user count for the year. The table also illustrates that prenatal encounters are a subset or type of medical encounter. Please note that prenatal users and total medical users are reported but “other medical service” users are not reported in the NHSC UDS.

Total users and prenatal users are reported on Table 2. Users by service category are reported on Table 3.

It should be noted that Table 2 asks for an ***actual count of the site’s total unduplicated users and prenatal users*** in the reporting period. An actual count of total users for each of the four major service categories shown above and reported on Table 3 is preferred but may be estimated based upon a sample of patient records. One method for estimating users by service class is to divide actual encounters for that service class by the encounters per user for that service class determined from a random sample of patient records. See the illustration which follows.

Estimating Medical Users

Total medical visits for the calendar year (actual)	4,400
Medical patient records in the sample (user records)	200
Medical visits in the sample	800
Visits per patient per year in the sample (800/200)	4.0
Estimated Medical Users: Total medical visits / Visits per patient per year (4,400/4.0)	1,100

Estimates of users in the other service classes may be done in the same way as illustrated above. This requires that there be an actual count of encounters in those service classes.

Other methods for estimating users by service class are acceptable. Inquire with the help line or the assigned UDS editor.

All other user information requested in Table 2 may be estimated based upon a sample of patient records. The minimum sample size is 200 records. The NHSC software includes a routine, which will compile and summarize sample user data collected from patient records.

INSTRUCTIONS FOR COMPLETING
NHSC SITE PROFILE
COVER SHEET

The cover sheet identifies the practice site name and address, the sponsor name and address, the site contacts, and the site type.

(Lines 1 through 7) Practice Site Name and Address: name of the approved practice site, address, and ***9-digit zip code.*** The US Postal Service web site has a zip+4 look up directory. See http://www.framed.usps.com/ncsc/lookups/lookup_zip+4.html

(Lines 8 through 13) Sponsoring Agency Name and Address: name, address, and 9-digit zip code of the organization which signed the Private Practice Assignment (PPA) or Memorandum of Agreement (MOA) or the organization where the obligated clinician who signed the Private Practice Option (PPO) agreement works.

(Line 14 and 15) CEO/Executive Director and Phone: name, business phone, and phone extension of the CEO, Executive Director, or Project Director of the sponsoring organization.

(Line 16) Clinical Director: name of the Clinical Director of the sponsoring organization.

(Line 17) Governing Board Chair: if there is a governing board, the name of the Chairman of the sponsoring organization's governing board. If there is no board record N/A.

(Line 18) UDS Report Preparer/Site Contact: name of the staff person with primary responsibility for preparing the UDS report. Do not include contractors.

(Line 19, 20 and 21) UDS Report Preparer/Site Contact Phone, Fax and E-mail Numbers: business phone, and fax numbers, including area code and phone extension, plus the e-mail address for the UDS preparer/site contact identified on line 18.

(Line 22 and 23) Reimbursement Status: check yes or no if the site is or is not a certified rural health clinic or a federally qualified health center look-alike. A site can not be both. Count the reimbursement status as of the end of the calendar year.

(Line 24) Location Code: the code noted on the bottom of the cover sheet which best describes the approved site location. The codes are not intended to identify the specific services offered at the site.

(Line 25) Sponsor Code: the code noted on the bottom of the cover sheet which best describes the sponsoring organization. If appropriate, use the same code for location and sponsor.

Some examples are shown below.

- A solo private practice should be coded
  location: (2. Private practice) and sponsor: (2. Private practice).

A remote site operated by a group practice should be coded
location: (2. Private practice) and sponsor: (2. Private practice).

A community-based primary care site run by a nonprofit board of directors should be coded
location: (1. Community clinic) and sponsor: (1. Community clinic).

A freestanding community based primary care site operated by the health department should be coded
location: (1. Community clinic) and sponsor: (4. Health department).

A primary care site located in a substance abuse clinic should be coded
location: (6. Substance abuse treatment center) and sponsor: (6. Substance abuse treatment center).

A freestanding community based primary care site operated by a hospital should be coded
location: (1. Community clinic) and sponsor: (3. Hospital based clinic/hospital sponsor).

A primary care clinic located within the hospital should be coded
location: (3. Hospital based clinic/hospital sponsor) and sponsor: (3. Hospital based clinic/hospital sponsor).

A primary care unit within a university hospital based outpatient facility should be coded
location: (3. Hospital based clinic/hospital sponsor) and sponsor: (7. University).

A program targeting the homeless located in a Mental health clinic/department operated by a local mental health department should be coded
location: (5. Mental health clinic/department) and sponsor: (5 . Mental health clinic/department).

A mobile clinic serving the migrant farm worker population operated by the local health department should be coded
location: (20. Mobile clinic) and sponsor: (4. Health department).

A school clinic run by a nonprofit community based clinic organization should be coded
location: (18. School clinic) and sponsor: (1. Community clinic).

A freestanding primary care clinic operated by a university medical center should be coded
location: (1. Community clinic) and sponsor: (7. University).

A primary care unit located in and sponsored by the health department should be coded
location: (4. Health Department) and sponsor: (4. Health Department).

UDS Number: _____ OMB No. 0915-0232 Expiration Date: 10/31/2008

For Period: January 1, 2007 to December 31, 2007 Date Submitted:

COVER SHEET
NHSC SITE PROFILE

Site Profile Data	NHSC Site	
	(a)	
Practice Site Name and Address		
1.) Site Name		
2.) Street Address		
3.) Other Address/P.O. Box		
4.) City		
5.) County		
6.) State		
7.) Zip Code (Nine digits)		
Sponsoring Agency Name and Address		
8.) Sponsor Name		
9.) Street Address		
10.) Other Address/P.O. Box		
11.) City		
12.) State		
13.) Zip Code		
Contacts		
14.) CEO/Executive Director		
15.) CEO/Executive Director Phone		Extension:
16.) Clinical Director		
17.) Governing Board Chair		
18.) UDS Report Preparer/Site Contact		
19.) Preparer/Site Contact Phone		Extension:
20.) Preparer/Site Contact Fax		
21.) Preparer/Site Contact E-mail		
Site Reimbursement Status (Check Yes or No)		
22.) Certified Rural Health Clinic (P.L. 95-210)	Yes ☐	No ☐
23.) Federally Qualified Health Center Look-Alike	Yes ☐	No ☐
Site Description (Use Codes Listed Below to Complete Lines 24 & 25)		
24.) Location Code		
25.) Sponsor Code		

Site Description Codes

1. Community Clinic
2. Private Practice
3. Hospital Based Clinic/Hospital Sponsor
4. Health Department
5. Mental Health Clinic/ Department
6. Substance Abuse Treatment Center
7. University
8. Federal Prison
9. INS Facility
10. Non-Federal Prison
11. Indian Health Service
12. Section 638 Tribal Contract
13. Section 638 Tribal Compact
14. Community Social Service Center
15. HIV/AIDS Treatment Center
16. Public Housing Clinic
17. Migrant Camp or Worksite
18. School Clinic
19. Homeless Shelter
20. Mobile Clinic
21. Other-Identify

Note: Select the location code which best describes the site location and the sponsor code which best describes the organization sponsoring the site. If appropriate, use the same code for location and sponsoring organization.

INSTRUCTIONS FOR TABLE 1:
SERVICES OFFERED AND DELIVERY METHOD

This table identifies those types of services provided directly by the site ***at any point during the calendar year*** (column a), by paid referrals (column b), by unpaid referrals (column c) or by some combination of these arrangements. If none of these arrangements are in place as defined below, the service is not provided (column d).

Report the same scope of service activity as is to be reported for all other encounter, user, charge, and cost tables. Individual sites will rarely provide or refer for all of the services listed in this table. The inclusion of services on this list is not meant to imply that these services should be offered.

Delivery Method: Mark each cell that applies for each type of service with a check (T) or (X). Up to three cells per service line may be checked if applicable.

(Column a) Provided by NHSC Site: includes services rendered by all paid and volunteer providers and others such as out stationed eligibility workers who render services at the site or to the site's patients at approved off-site locations such as the patient's home, the hospital, or the nursing home.

(Column b) By Referral - Site Pays: a formal arrangement with a referral provider for services to the site's patients under which the site pays the referral provider or bills reimbursement sources for the service or both. These services are generally provided off-site. This type of arrangement is not often present in NHSC sites operating without grant support. Sites may elect to include or exclude all or some portion of the encounter, user, charge, and cost of purchased off-site referred care based upon the ability or ease of reporting this information on a site-specific basis. Regardless of the election made, record those referral services paid by the site on this table.

(Column c) By Referral - No Payment: a formal arrangement with a referral provider for services to the site's patients where the site ***does not*** pay the referral provider or bill reimbursement sources for the service. A formal referral arrangement means either a written agreement or the expectation that documentation from the referral provider will be returned for the patient record.

(Column d) Not Provided: the absence of any of the service arrangements defined above. Services are considered not provided if the only arrangement is an informal referral where there is no written agreement with the referral provider or where there is no ability to document the service in the patient record.

(Lines 1 through 53) Service Type: these are types of services which may be provided by sites. Service definitions appear below.

(Line 1) General Primary Medical Care: primary medical care services other than those identified below.

(Line 2) Diagnostic Laboratory (technical component): technical component of laboratory procedures. Does not include physician analysis or interpretation of procedure results. This service refers exclusively to medical care services not dental care services.

(Line 3) Diagnostic X-ray Procedures (technical component): technical component of diagnostic x-ray procedures. Does not include physician analysis or interpretation of procedure results. Refers exclusively to medical care services not dental care services.

(Line 4) Diagnostic Tests/Screening (professional component): professional services for the analysis and interpretation of results from diagnostic tests and screening. Refers exclusively to medical care services not dental care services. Virtually all medical clinicians have this capability.

(Line 5) Emergency Medical Services: provision of emergency services on a regular basis to meet life threatening and other health conditions needing immediate attention.

(Line 6) Urgent Medical Care: provision of medical care of an urgent or immediate nature on a regular basis.

(Line 7) 24-Hour Coverage: patient access to the site's or shared call clinicians on a 24-hour basis.

(Line 8) Family Planning Services (Contraceptive Management): contraception, birth control and infertility treatment. Includes medical provider counseling and education. Report under other services when provided by other service providers.

(Line 9) HIV Testing: testing for HIV: includes medical provider counseling and education. Report under other services when provided by other service providers.

(Line 10) Immunizations: provision of preventive vaccines such as diphtheria, tetanus, pertussis, polio virus, measles, mumps, rubella, influenza b, hepatitis b, and influenza virus.

(Line 11) Following hospitalized patients: contacts with the site's patients during hospitalizations.

(Line 12) Gynecological Care: gynecological services provided by a nurse, nurse practitioner, nurse midwife or physician, including annual pelvic exams and pap smears, follow-up of abnormal findings, and diagnosis and treatment of sexually transmitted diseases. This does not include family planning services as defined for line 8.

(Lines 13 through 19) Obstetrical Care: services related to pregnancy, delivery and postpartum care including: prenatal care, antepartum fetal assessment, ultrasound, genetic counseling and testing, amniocentesis, labor and delivery professional care and postpartum care.

(Line 20) Directly Observed TB Therapy: delivery of therapeutic TB medication under direct observation by site staff.

(Line 21) Other specialty care: medical services provided by medical professionals trained in any of the following specialty areas: allergy, dermatology, gastroenterology, general surgery, neurology, optometry, ophthalmology, otolaryngology, pediatric specialties, therapeutic radiology, psychiatry, and anesthesiology.

(Line 22) Dental Care - Preventive: services of a dentist or hygienist including cleaning, prophylaxis, sealants, and fluoride treatments.

(Line 23) Dental Care - Restorative: dentist services including fillings, crowns, extractions, dentures and similar treatment.

(Line 24) Dental Care - Emergency: dental services of an urgent or immediate nature provided on a regular basis.

(Line 25) Mental Health Treatment/Counseling: mental health therapy, counseling, or other treatment provided by a mental health professional.

(Line 26) Developmental Screening: development screening provided by a mental health professional.

(Line 27) 24-hour Crisis Intervention/Counseling: crisis counseling with access 24 hours per day to a mental health professional.

(Line 28) Other Mental Health Services: other treatment provided by a mental health professional.

(Line 30) Substance Abuse Services: includes treatment for abuse of alcohol or other drugs. Counseling and other medical or psycho social treatment services provided to individuals with substance abuse problems. May include screening and diagnosis, detoxification, individual and group counseling, self-help support groups, alcohol and drug education, rehabilitation, remedial education, vocational training services, and aftercare.

(Line 31) Hearing Screening: diagnostic services to identify potential hearing problems.

(Line 32) Nutrition Services Other than WIC: advice and consultation appropriate to individual health needs.

(Line 33) Occupational or Vocational Therapy: therapy designed to improve or maintain an individual's employment or career skills.

(Line 34) Physical Therapy: assistance designed to improve or maintain an individual's physical capabilities.

(Line 35) Pharmacy: dispensing of prescription drugs and other pharmaceutical products. Pharmacy services are considered provided even in those situations where the only drugs offered are samples dispensed by the clinician if the following criteria are met: the inventory is predefined, controlled, and stocked; and drugs are dispensed to all patients or made available on a limited basis under a written policy.

(Line 36) Vision Screening: diagnostic services to identify potential vision problems.

(Line 37) WIC Services: nutrition and health counseling services provided through the Special Supplemental Food Program for Women, Infants and Children

(Line 38) Case management: coordination of patients' primary care and related health and social service needs. Key activities include: 1) assessment of the client's needs and personal support systems; 2) development of a comprehensive, individualized service plan; 3) coordination and monitoring of services required to implement the plan; and 4) periodic re-evaluation and adaptation of the plan as necessary. Includes risk assessment, eligibility assistance, coordination and referral, follow-up, tracking, and documentation.

(Line 39) Child Care: assistance in caring for young children accompanying the patient during medical and other health care visits.

(Line 40) Discharge Planning: case management services related to an individual's discharge from the hospital.

(Line 41) Eligibility Assistance: help to get access to health, social service and other assistance programs, including Medicaid, WIC, SSI, Food stamps, pharmacy assistance and similar programs. May be provided by out-stationed eligibility workers.

(Line 42) Employment/Educational Counseling: counseling services to assist individuals define career, employment, and educational interests and opportunities.

(Line 43) Environmental Health Risk Reduction: the detection and alleviation of unhealthy conditions associated with water, sewage, solid waste, rodents, parasites, field sanitation, housing, lead paint, pesticides, and other environmental factors related to public health.

(Line 44) Food Bank/Delivered Meals: provision of actual food or meals. Does not include financial assistance for food or meals.

(Line 45) Health Education: personal assistance provided to promote knowledge regarding health and healthy behaviors, including knowledge concerning sexually transmitted diseases, family planning, prevention of fetal alcohol syndrome, smoking cessation, reduction in misuse of alcohol and drugs, improvement in physical fitness, control of stress, nutrition, and others. Included are services provided to the client's family and/or friends by non-licensed mental health staff which may include psycho social, care giver support, bereavement counseling, drop-in counseling, and other support groups activities.

(Line 46) Housing Assistance: assistance in locating and obtaining suitable temporary or permanent shelter. May include locating costs, moving costs, and rent subsidies.

(Line 47) Interpretation/Translation Services: services to assist individuals with language or communication barriers to receive and understand needed services.

(Line 48) Nursing Home and Assisted-Living Placement: assistance in locating and obtaining nursing home and assisted-living placements.

(Line 49) Outreach: case finding, education or other services to identify potential clients and facilitate access or make client referrals to available services.

(Line 50) Transportation: transportation provided for the site’s patients.

(Line 51) Home Visiting: health and other enabling services delivered to patients in the home.

(Line 52) Parenting Education: services to teach individuals child rearing and related skills.

(Line 53) Other (Specify): other services not identified above.

UDS Number: _____
For Period: January 1, 2007 to December 31, 2007

OMB No. 0915-0232 Expiration Date: 10/31/2008
Date Submitted: _____

TABLE 1
SERVICES OFFERED AND DELIVERY METHOD

Service Type (See Instructions for Definition)	Delivery Method			
	Provided by Site	By Referral Site Pays	By Referral No Pymt	Not Provided
	(a)	*(b)*	*(c)*	*(d)*
Medical Care Services				
1.) General Primary Medical Care *(other than below)*				
2.) Diagnostic Laboratory *(technical component)*				
3.) Diagnostic X-Ray Procedures *(technical component)*				
4.) Diagnostic Tests/Screenings *(professional component)*				
5.) Emergency Medical Services				
6.) Urgent Medical Care				
7.) 24 Hour Coverage				
8.) Family Planning				
9.) HIV Testing				
10.) Immunizations				
11.) Following Hospitalized Patients				
Obstetrical and Gynecological Care				
12.) Gynecological Care				
13.) Prenatal Care				
14.) Antepartum Fetal Assessment				
15.) Ultrasound				
16.) Genetic Counseling and Testing				
17.) Amniocentesis				
18.) Labor and Delivery Professional Care				
19.) Postpartum Care				
Specialty Medical Care				
20.) Directly Observed TB Therapy				
21.) Other Specialty Care				
Dental Care Services				
22.) Dental Care - Preventive				
23.) Dental Care - Restorative				
24.) Dental Care – Emergency				
Mental Health/Substance Abuse Services				
25.) Mental Health Treatment/Counseling				

Service Type (See Instructions for Definition)	Delivery Method			
	Provided by Site	By Referral Site Pays	By Referral No Pymt	Not Provided
	(a)	*(b)*	*(c)*	*(d)*
26.) Developmental Screening				
27.) 24-hour Crisis Intervention/Counseling				
28.) Other Mental Health Services				
29.) Substance Abuse Treatment/Counseling				
30.) Other Substance Abuse Services				
Other Professional Services				
31.) Hearing Screening				
32.) Nutrition Services other than WIC				
33.) Occupational or Vocational Therapy				
34.) Physical Therapy				
35.) Pharmacy				
36.) Vision Screening				
37.) WIC Services				
Other Services				
38.) Case Management				
39.) Child Care *(during visit to Site)*				
40.) Discharge Planning				
41.) Eligibility Assistance				
42.) Employment/Education Counseling				
43.) Environmental Hlth Risk Redctn *(via detectn/allevtn)*				
44.) Food Bank/ Delivered Meals				
45.) Health Education				
46.) Housing Assistance				
47.) Interpretation/Translation Services				
48.) Nursing Home & Assisted Living Placement				
49.) Outreach				
50.) Transportation				
51.) Home Visiting				
52.) Parenting Education				
53.) Other (Specify:)				

INSTRUCTIONS FOR TABLE 2

Table 2 has four parts A through D. Users are all individuals receiving at least one face-to-face encounter within the reporting period. Users and encounters are defined in the General Instructions section beginning on page eight.

The total number of users and the total prenatal users are to be based upon actual data. The total users reported on parts A, B, C, and D should be equal. The user distributions called for in parts A through D may be actual or estimated. Estimates are to be based upon a sample of patient records. The minimum sample size is 200 records of randomly selected users. Samples may be drawn from patient records. The UDS software includes a routine which will compile and summarize sampled user data. Mark the boxes in the header of each table to indicate whether the distribution is based upon actual or estimated data. "Estimated from Sample" is automatically recorded in the header when the UDS software routine is used.

The user software routine is the easiest way to get table 2 data that is not collected by an automated patient accounting system. For additional advice about using the software routine to compile and summarize data, please call the toll free support line at, 888-459-1080 or send an e-mail to udshelp@nhscdata.net.

Federal Bureau of Prison, nonfederal prison, Indian Health Service (IHS), Section 638, and Immigration and Naturalization Service (INS) sites are only to complete parts 2A and 2B of table 2.

TABLE 2 PART A:
USERS BY AGE AND GENDER AND PRENATAL USERS BY AGE

The number of users by age and gender may be actual or estimated. Estimates are to be based upon a sample of patient records. The minimum sample size is 200 records of randomly selected users. Samples may be drawn from patient records. Total users and total prenatal users are to be based upon actual data.

(Column a and b) Male and Female Users: report the number of male and female users by age. Use the individual's age on June 30th of the reporting period to identify the user's age.

(Column c) Prenatal Users: complete only if site provides or assumes primary responsibility for a patient's prenatal care services. Report total prenatal care users in the year by age group.

TABLE 2 PART B:
USERS BY RACE, ETHNICITY, AND LANGUAGE

The number of users by race, ethnicity, and the number of users requiring interpretation services may be actual or estimated. Race and ethnicity classifications are to be determined by the user records. Report the number of users where the race or ethnicity is unreported or where the patient refuses to report as "Unreported/Refused to Report" on line 8. Unreported/ Refused to Report is to be used to report missing data from actual or sampled records. It is not to be used to report that the data is not collected. Estimates are to be based upon a sample. The minimum sample size is 200 records of randomly selected users. Samples may be drawn from patient records.

(Column a) Users by Race (Lines 1 through 5, 7 and 8): report the number of users in each race category on lines 1 through 5. Report users selecting more than one race on line 7. Do not report Hispanic or Latino users as a race category in Column (a) on line 7. Report the number of users where the race is unknown as "Unreported/Refused to Report" on line 8. Unreported/Refused to Report is to be used to report missing data from actual or sampled records. It is not to be used to report that the data is not collected. The total users on line 9 column (a) equal total users on line 9 column (b).

(Column b) Users by Ethnicity (Lines 6 through 8): report the number of users in each ethnic category on lines 6 and 7. Report "Hispanic or Latino" users on line 6 and all others as "Not Hispanic or Latino" on line 7. Report the number of users where the ethnicity is unknown as "Unreported/Refused to Report" on line 8. Unreported/ Refused to Report is to be used to report missing data from actual or sampled records or surveys. It is not to be used to report that the data is not collected. If data is not collected, it is to be estimated from a sample. The total users on line 9 column (b) equals total users on line 9 column (a).

(Line 10) Users Needing Interpretation Services: the number of total users who would be better served in a language other than English. This is an estimate of all users needing interpretation services. Include in the estimate those users who needed but did not get interpretation services and those who needed and received interpretation services from a bilingual provider, other staff, their own interpreter, or another source. In a predominately Spanish speaking community and clinic, report the number of users who would require interpretation services if served in English. Include deaf patients as well as non-English speaking users. The definition is meant to be inclusive rather than exclusive.

TABLE 2 PART C:
USERS BY INCOME LEVELS

The number of users by income level may be actual or estimated. Estimates are to be based upon a sample. The minimum sample size is 200 records of randomly selected users. Samples may be drawn from patient records. The total number of users is to be based upon actual data.

(Lines 1 through 5) Percent of Poverty Level: report the numbers of users within the income

ranges identified. Income ranges are expressed as a proportion of the federal poverty guidelines. The federal poverty guidelines are updated annually in February or March and are published in the Federal Register. Copies are available from the NHSC web site at http://nhsc.bhpr.hrsa.gov/resources/uds/. Copies are also available by searching the Federal Register online under "notices" for the "Annual Update of the HHS Poverty Guidelines" at http://www.gpoaccess.gov/fr/index.html. NHSC sites are expected to make services available through the use of a sliding fee discount schedule or other documented means of eliminating financial barriers for those at or below 200 percent of the federal poverty income guideline. The data reported here should be based upon the numbers of users making use of the discount policy, the most current patient income information available, and the current federal poverty guideline. Report the number of users where the actual or sampled income data is unknown as "Unreported/Refused to report" on line 4. "Unreported/ Refused to report" is to be used to report missing data from actual or sampled records. It is not to be used to report that the data is not collected.

TABLE 2 PART D:
USERS BY PRIMARY INSURANCE TYPE

The number of users by primary insurance type may be actual or estimated. Estimates are to be based upon a sample. The minimum sample size is 200 records of randomly selected users. Samples may be drawn from patient records. The total number of users is to be based upon actual data.

A user may have coverage under more than one insurance plan, different coverage for different services and this coverage may change over the course of a year. When medical services are provided, report the user's ***primary health insurance covering primary medical care,*** if any, ***as of the last visit during the reporting period.*** If medical services are not provided, report the user's primary insurance, if any, for the services offered. Report the user's primary health insurance even though it may not have covered the services rendered during the user's last visit.

Primary insurance is defined as the insurance plan or program that the site would ***bill first*** for services rendered. For example:

Report Medicare as the primary insurance if a user has both Medicare and Medicaid because Medicare is billed before Medicaid.

Report the employer plan as the primary insurance if a user has both an employer plan and Medicare because the employer plan is billed first.

(Line 1) Medicare: users whose primary insurance is a plan for Medicare beneficiaries including Federally Qualified Health Center, Rural Health Clinic, managed care, and other reimbursement arrangements administered by Medicare or by a fiscal intermediary.

(Line 2) Medicaid: users whose primary insurance is a plan for Medicaid beneficiaries including Federally Qualified Health Center, Rural Health Clinic, managed care, EPSDT, State Child Health Insurance program (SCHIP) and other reimbursement arrangements administered either directly by the state agency or by a fiscal intermediary.

(Line 3) Other Public Insurance: users whose primary insurance is provided by federal, state, or local governments that is not reported elsewhere such as, state indigent care programs, city welfare, and similar government plans. A State Children's Health Insurance Program operated independently from the Medicaid program is an example of other public insurance. Users with health benefit plans offered to government employees, retirees and dependants such as TRICARE, the federal employees health benefit program, state employee health insurance benefit programs, teacher health insurance and similar plans are to be classified as private insurance users. Private insurance is earned and other public insurance is unearned. ***Users with no insurance but who have public categorical or other grant funds applied to their accounts for services received are to be classified as self-pay.*** The National Breast and Cervical Cancer Early Detection Program is an example of a categorical grant program which is not insurance.

(Line 4) Private Insurance: users whose primary insurance is a private insurance plan, managed care plan, or a contractual arrangement. This includes plans such as Blue Cross and Blue Shield, commercial insurance, managed care plans, self-insured employer plans, group contracts with unions and employers, and service contracts with employers and others. As noted above, users with health benefit plans offered to government employees, retirees and dependants such as TRICARE, the federal employees health benefit program, state employee health insurance benefit programs, teacher health insurance and similar plans are to be classified as private insurance users.

(Line 5) Self-Pay (no insurance): users without any health insurance. As noted above, users with no insurance but who have categorical or other grant funds applied to their accounts for services received are to be classified as self-pay.

TABLE 2- PART A
USERS BY AGE AND GENDER
AND PRENATAL USERS BY AGE

Enter an "A" (Actual) or an "E" (Estimated) in the boxes for the columns

Cols (a) & (b), Lines 1-11: ☐ *Col (c), Lines 3-8:* ☐

Age Groups	Male Users	Female Users	Prenatal Users
	(a)	*(b)*	*(c)*
1.) Under age 1			
2.) Ages 1-4			
3.) Ages 5-12			
4.) Ages 13-14			
5.) Ages 15-19			
6.) Ages 20-24			
7.) Ages 25-44			
8.) Ages 45-64			
9.) Ages 65-74			
10.) Ages 75-84			
11.) Ages 85 and over			
12.) Total Users			

TABLE 2- PART B
USERS BY RACE/ETHNICITY/LANGUAGE

Enter an "A" (Actual) or an "E" (Estimated) in the boxes for the columns

Col (b), Lines 6-8: ☐ *Col (a), Lines 1-5 + 7-8:* ☐

Users by Ethnicity		Users By Ethnicity
		(b)
Lines 1-5: Not used		
6.) Hispanic or Latino		
7.) Non-Hispanic		
8.) Unreported/Refused to report		
9.) Total Users		

Users by Race	Users By Race
	(a)
1.) Asian	
2.) American Indian or Alaska Native	
3.) Black or African American	
4.) Native Hawaiian or Other Pacific Islander	
5.) White	
6.) Line not used	
7.) More than one race	
8.) Unreported/refused to report	
9.) Total Users	

10.) Users needing interpretation Services (This line is a subset of total users)	

TABLE 2- PART C
USERS BY INCOME LEVEL
Enter an "A" (Actual) or an "E" (Estimated) in the box below
Col (a), Lines1-3: ☐
(Not Completed by Prison, IHS, Section 638 or INS sites)

Percent of Poverty Level	Number of Users
	(a)
1.) 100% and below	
2.) 101- 200%	
3.) Above 200%	
4.) Unreported/Refused to report	
5.) Total Users	

TABLE 2- PART D
USERS BY PRIMARY INSURANCE TYPE
Enter an "A" (Actual) or an "E" (Estimated) in the box below
Col (a), Lines1-5: ☐
(Not Completed by Prison, IHS, Section 638 or INS sites)

Primary Insurance	Number of Users
	(a)
1.) Medicare	
2.) Medicaid	
3.) Other Public Insurance (*specify:*)	
4.) Private Insurance	
5.) Self-Pay (No Insurance)	
6.) Total Users	

Note: Total users in Tables 2A Cols (a) + (b), 2B Col (a), 2B col (b), 2C, and 2D are equal and are to be based on actual data. User distributions may be estimated. Use sample size of 200 records or more.

INSTRUCTIONS FOR TABLE 3:
STAFFING AND UTILIZATION

This table profiles the personnel, encounters, and users by function. See Appendix A for a listing of personnel included in each major service category. The number of staff are reported in full time equivalents (FTEs). Encounters and users are defined in the General Instructions section beginning on page five. Encounters and users are reported in four major service classes including medical, dental, mental health & substance abuse, and other professional & other services. Encounters are separately reported for staff and nonstaff providers as defined below.

Staff: salaried full-time or part-time employees of the sponsoring organization who work on behalf of the site and nonsalaried individuals paid by the sponsoring organization who work ***for the sponsor on a regular schedule that is controlled by the sponsor*** under any of the following compensation arrangements: contract, National Health Service Corps assignment, retainer, capitation, block time, fee-for-service, and ***donated time.*** Provider staff work at the NHSC approved site or at approved off-site locations. Support staff may work for the site at other locations. Regularly scheduled means a preassigned number of work hours devoted to the site's activities.

Nonstaff: individuals paid by the sponsoring organization who work ***independently under their own control on their own schedule*** providing or supporting primary care and related supplemental services to the site's patients under one of the following compensation arrangements: fee-for-service, capitation, retainer, and ***donated time*** which the sponsoring organization would otherwise have to pay for the services. The FTE value of the time worked by nonstaff providers and other personnel is not reported but the encounters are recorded in column (d).

Full time equivalents (FTEs) are reported for staff and are not reported for nonstaff individuals.

Some examples of staff and nonstaff personnel are noted below.

- NHSC providers are considered staff.

- Providers working onsite under contract on a scheduled basis are considered staff.

  Referral providers who are paid by the site or sponsoring organization are considered nonstaff when working independently at unapproved off-site locations such as the referral provider's office

  Central office administrative personnel working directly for the site are considered site staff who's FTEs are counted. The FTEs of central office ***personnel who indirectly support the site are not counted.***

  Contracted support staff working under a contract which replaces personnel the site would otherwise have hired, who work directly for the site, who may work either on or off-site, and ***who work for the site on a regularly scheduled basis*** are consider "staff" whose time or FTE value is to be reported. This might include personnel employed by a practice management company, a management services organization, billing service company, or similar contractor. If individuals under these arrangements work on an irregular, unscheduled or indirect basis, they are considered nonstaff and their FTEs are not counted.

Professionals working for the site under legal, audit, actuarial, management consulting, and similar contracts for services provided on a one-time, sporadic, or unscheduled basis are considered nonstaff.

Consulting pathologists, radiologists, and other consulting providers who provide services on an unscheduled or sporadic basis are considered nonstaff.

(Column a) FTEs: Full Time Equivalents (FTEs) for ***all staff.*** Full time equivalents are computed on an individual basis by dividing the total number of hours in the reporting period for which a person was compensated by the total number of hours in the year considered by the site to be full-time. The total number of hours for which an individual was compensated includes the number of hours a person was present for work and paid for their time, as well as paid leave time including vacation, sick leave, continuing education trips, etc. An annual hours pay base of 2,080 (40 hours/week x 52 weeks/year) is typical but the base may vary by organization and by class of employee. Employees who work less than the annual hour's base are normally considered part time. An individual staff member is not to be reported as more than 1.00 full time equivalents regardless of any overtime hours worked or compensation paid. Round FTEs to the second decimal place.

Salaried provider staff FTEs are to be calculated based upon the ***number of paid hours,*** not the number of scheduled hours. A provider who schedules 32 hours per week to see patients but who is paid for a 40 hour week is considered full time or 1.00 FTE.

Contract provider and support staff FTEs are to be calculated by dividing the hours the staff work by the hours a full time employee of that type would be expected to work. The time worked in the numerator is to be taken from contracts, invoices, schedules or similar sources. The denominator or base of hours considered full-time for these arrangements should not include leave time unless leave is directly charged or the time salaried clinician's of that type are ordinarily not scheduled to see patients. For example, if full time salaried providers are expected to schedule 32 hours of patient care per week, a contract provider who was paid for 16 hours of scheduled patient care per week would be considered half time or 0.50 FTE. The annual scheduled hour's base considered full-time for contract providers is likely to vary by clinical specialty.

Time for personnel performing more than one function should be allocated as appropriate among the major personnel service categories. For example, the time of a physician who is also a medical director should be allocated between medical care services and administration. Time for nurses who also provide case management services should be allocated between medical care and case management.

The FTEs of central office staff in a multi-site sponsoring organization who provide direct support to the NHSC site are to be counted. The FTEs of central office personnel who indirectly support the site are not counted.

(Column b) Users: the unduplicated number of users seen during the reporting period within each of four major personnel service categories: medical care services; dental services; and mental health and substance abuse services; and other professional services. Users are defined in the General Instructions section of this manual. An actual count is of users by service type is preferred but may be estimated based upon a sample of records. One method for estimating users by service class is to divide actual encounters for that service class by the encounters per user for that service class determined from a random sample of patient records. See the illustration in the General Instructions section on page 11.

(Column c) Staff Encounters: encounters generated by "staff" providers whose time is reported in column (a). Encounters are defined in the General Instructions section of this manual on page five.

(Column d) Nonstaff Encounters: encounters generated by "nonstaff" or referred care providers who work independently on their own schedule at the approved site or an off-site location. ***The service must be documented in the patient's record to be a reportable encounter.***

As noted in the General Instructions section beginning on page two, sites may elect to include or exclude all or some portion of paid referred care services rendered to the site's patients at off-site locations. This election may be based upon the ability or ease of reporting this information on a site specific basis. The same scope of off-site referred care should be used to complete the encounter, user, charge, and cost tables.

Personnel by Major Service Category: staff are classified into four service categories. The categories are: medical care services; dental services; mental health and substance abuse services; other professional and other services; and administration and facility. See Appendix A for a listing of personnel included in each major service category.

(Lines 1 through 7) Physicians: (M.D. or D.O.): separate FTE and encounter totals for family practitioners, general practitioners, internists, obstetrician/gynecologists, pediatricians, psychiatrists, and all other specialists. Use board certification to classify physicians by specialty. Classify physicians with more than one board certification in the specialty representing the service the physician provides most or allocate based upon time spent.

(Line 8) Total Physicians: FTE and encounter totals for medical services, lines 1 through 7.

(Line 9) Nurse Practitioners/Physician Assistants: FTE and encounter totals for physician assistant and nurse practitioner staff performing medical services. Nurse practitioners include psychiatric nurse practitioners.

(Line 10) Certified Nurse Midwives: FTE and encounter totals for nurse midwives performing medical services

(Line 11) Nurses: FTE and encounter totals for nurses that are involved in provision of medical services, including registered nurses, licensed practical nurses, home health and visiting nurses, clinical nurse specialists, and public health nurses. If an individual's time is divided between medical and nonmedical services, allocate the FTEs to reflect this division of time. For example, nurses who provide case management or education/counseling services in addition to medical care should be allocated between medical services and other services.

Given the unusual and important role of Alaska Community Health Aides, they are reported on line 11 rather than on a nonprovider line so that their encounters and users are recognized.

(Line 12) Other Medical Support Personnel: FTE totals for medical assistants, nurses aides, and all other personnel providing services together with or in direct support of services provided by a physician, nurse practitioner, physician assistant, certified nurse midwife, or nurse. ***FTEs for registration, reception, appointments, transcription, patient records, and other support personnel are not reported here but are reported on line 32 as Patient Service Support Personnel.***

(Line 13) Total Medical Services: FTE, encounter, and user totals for medical services, lines 1 through 12.

(Line 14) Laboratory Services Personnel: FTE totals for pathologists, medical technologists, laboratory technicians and assistants, phlebotomists. This ***refers exclusively to medical personnel not dental personnel.*** Dental personnel performing laboratory services are reported on lines 18-20. Lab encounters are not reported.

(Line 15) X-ray Personnel: FTE totals for radiologists, X-ray technologists, X-ray technicians and ultrasound technicians. ***Only report medical personnel not dental personnel.*** Dental personnel performing x-ray services are reported on lines 18-20. X-ray encounters are not reported.

(Line 16) Pharmacy Personnel: FTE total for pharmacists and pharmacist assistants. Pharmacy encounters are not reported.

(Line 17) Total Ancillary Services: FTE totals for ancillary services, lines 14 through 16.

(Line 18) Dentists: FTE and encounter totals for general practitioners and specialists including oral surgeons, periodontists, and pedodontists.

(Line 19) Dental Hygienists: FTE and encounter totals for dental hygienists.

(Line 20) Dental Assistants, Aides & Technicians: FTE totals for other dental personnel including dental assistants, aides, and technicians.

(Line 21) Total Dental Services: FTE, encounter, and user totals for dental services, lines 18 through 20.

(Line 22) Mental Health and Substance Abuse Specialists: FTE and encounter totals for individuals providing counseling or treatment services related to mental health or substance abuse including clinical psychologists, clinical social workers, psychiatric social workers, psychiatric nurses, mental health nurses, and family therapists. ***Report psychiatrists on line 6 under physicians and psychiatric nurse practitioners on line 9 under nurse practitioners, not in this category.***

(Line 23) Mental Health and Substance Abuse Support Personnel: FTE totals for assistants, aides, and all other personnel providing services in conjunction with or in direct support of services provided by mental health and substance abuse specialists.

(Line 24) Total Mental Health and Substance Abuse Services: FTE, encounter, and user totals for mental health and substance abuse services, lines 22 and 23.

(Line 25) Other Professionals: FTE and encounter totals for other staff professionals providing health services, including occupational therapists, physical therapists, podiatrists, optometrists and chiropractors.

(Line 26) Case Managers and Education Specialists: FTE totals for case managers and education specialists. Case manager and education specialist encounters are not reported.

Case managers include nurses, social workers and other professional staff providing services to aid patients in the management of their health and social needs. Services include need assessments, maintenance of referral, tracking and follow-up systems and eligibility assistance when provided by staff performing broader case management functions.

Education specialists include health educators, family planning counselors, HIV counselors, HIV specialists and others who provide information about health conditions and guidance about appropriate use of health services that are not otherwise classified under outreach.

(Line 27) Outreach Workers, Transportation Staff, and Other: FTE total for individuals conducting outreach or case finding, drivers and other transportation staff, child care workers, eligibility assistance workers, housing assistance workers, interpreter, translators, and others. Outreach worker, transportation and other service encounters are not reported.

(Line 28) Other Professional and Other Service Support Personnel: FTE totals for assistants, aides, and all other personnel providing services in conjunction with or in direct support of services provided by other professional and other service providers.

(Line 29) Total Other Professional and Other Services: FTE totals for other professional and other services, lines 25 through 28. The encounter total for other professional services is reported on line 25 and line 29. The user total for other professional service encounters is reported only on line 29. Case manager, education specialist, outreach worker, transportation, and other service encounters and users are not reported.

(Line 30) Administration Staff: FTE total for administrative personnel, including the executive director, medical director, physicians or nurses with administrative responsibilities, secretaries, finance, billing, information service, communications, marketing, planning, program development, and other support staff.

(Line 31) Facility Staff: FTE total for staff with facility support and maintenance responsibilities, including custodians, housekeepers, groundskeepers, security, and other maintenance staff.

(Line 32) Patient Services Support Staff: FTE total for registration, reception, appointments, transcription, patient records, and other support personnel who provide centralized or indirect support to patient service activities.

(Line 33) Total Administration and Facility: FTE total for administration, facility, and patient service support personnel, lines 30 through 32.

(Line 34) Total: FTE and encounter grand totals. The total of unduplicated users is reported on Table 2.

TABLE 3
STAFFING AND UTILIZATION

Personnel by Major Service Categories	F.T.E.'s	Users	Staff Encounter	Nonstaff Encounter
	(a)	*(b)*	*(c)*	*(d)*
Medical Services				
1.) Family Practitioners				
2.) General Practitioners				
3.) Internists				
4.) Obstetrician/Gynecologists				
5.) Pediatricians				
6.) Psychiatrists				
7.) Other Physician Specialists				
8.) Total Physicians *(Lines 1 Thru 7)*				
9.) Nurse Practitioners/Physician Assistants				
10.) Certified Nurse Midwives				
11.) Nurses				
12.) Other Medical Support Personnel				
13.) Total Medical Services *(Lines 8 thru 12, except Col. b)*				
Ancillary Services				
14.) Laboratory Services Personnel				
15.) X-Ray Services Personnel				
16.) Pharmacy Personnel				
17.) Total Ancillary Services *(Lines 14 thru 16)*				
Dental Services				
18.) Dentists				
19.) Dental Hygienists				
20.) Dental Assistants, Aides, Technicians, and Support				
21.) Total Dental Services *(Lines 18 thru 20, except Col. b)*				
Mental Health & Substance Abuse Services				
22.) Mental Health & Substance Abuse Specialists				
23.) Mental Health & Substance Abuse Support Personnel				
24.) Total MH & SA Services *(Lines 22 and 23, except Col. b)*				
Other Professional and Other Services				
25.) Other Professionals (PT, OT, Podiatrists, Nutritionists & Other)				
26.) Case Managers and Education Specialists				
27.) Outreach Workers, Transportation Staff, & Other Service				
28.) Other Professional and Other Service Support Personnel				
29.) Total Other Professional and Other Services *(Lines 25 thru 28)*				
Administration and Facility				
30.) Administration Personnel				
31.) Facility Personnel				
32.) Patient Services Support Personnel (Patient Records, etc.)				
33.) Total Administration & Facility *(Lines 30 thru 32)*				
34.) *Total* *(Lines 13, 17, 21, 24, 29, & 33)*				

INSTRUCTIONS FOR TABLE 4:
PATIENT SERVICE CHARGES, COLLECTIONS AND SELF-PAY ADJUSTMENTS

This table shows the patient service charges, receipts, and sliding fee discounts by payment source for all related activity of all providers at the site to which the NHSC provider is assigned. See the General Instructions for a definition of the scope of activity to be reported. Report in whole dollars.

Charges and collections are to be reported in ***five pay classes:*** Medicare, Medicaid, other public, private insurance, and self-pay. Charges and receipts are to be identified with the payer which is the responsible party. For instance, Medicare receipts are attributable to Medicare even though the receipts were made by an intermediary such as Blue Shield. Similarly, charges and receipts for which a Medicare beneficiary is personally responsible such as deductibles and copayments are self-pay rather than Medicare charges and receipts.

Charges and receipts are further classified as either fee-for-service or capitated amounts. ***Fee-for-service*** means any payment arrangement other than a managed care capitation plan such as a Resource Based Relative Value System (RBRVS) fee schedule, a prospective pricing system, a fixed fee schedule, a contract rate, a cost related rate, a fee-for-service managed care plan, and similar arrangements. ***Capitated*** means those managed care plans under which the site receives a fixed payment per enrollee in exchange for an obligation to provide or arrange a defined set of covered services for a specified period of time to an enrolled individual; where the enrollee is assigned a primary care provider at the site as their principal care giver; and where the primary care provider has responsibility for authorizing any covered referred care services for the enrollee, where the patient is locked-in to the arrangement for some period and where the site assumes some measure of financial risk. Under these arrangements payment is generally made in advance on a monthly basis and the site may be fully or partially at risk to provide covered primary care, referred care, and inpatient services to enrollees with the capitation paid.

The charges and collections from managed care plans that are ***part capitation and part fee-for-service*** are classified as either fee-for-service or capitated on the appropriate payer lines.

(Column a) Full Charges: the gross charges as established by the site for the services rendered during the reporting period. Charges are reported at their full value for all services prior to any adjustments. Fee-for-service charges are uniformly reported at the full charge rate from the site's fee schedule. Site's with capitation contracts or who are reimbursed on a cost based flat fee, such as a Rural Health Clinic rate or Federally Qualified Health Center rate are to report the normal full charge from the site's fee schedule rather than the negotiated visit, capitation, or contract rate.

Charges are to reflect the amount for which the payer is responsible. ***Deductibles, copayments, and uncovered services for which the patient is personally responsible should be reclassified and reported as self-pay.*** Similarly, any charges not payable by a third party payer that are due from the patient or another third party should be deducted from the payer's charges and added to the account of the secondary payer. The reclassification of charges to secondary and subsequent payers may be estimated based upon a sample.

Sites may elect to include or exclude all or some portion of paid referred care services rendered to the site's patients at off-site locations. This election may be based upon the ability or ease of reporting this information on a site specific basis. The same scope of off-site referred care should be used to complete the encounter, user, charge, and cost tables.

(Column b) Amount Collected: the actual cash received during the period for services rendered, regardless of the date of service. This includes Rural Health Clinic and Federally Qualified Health Center settlement receipts, case management fee receipts, incentive receipts from managed care plans, and other similar receipts.

Amounts collected are the amounts collected from the payer. If there is more than one payer involved in a given encounter, the charges due from the primary payer and the amount collected from the primary payer are reported on the primary payer line. The charges due from the secondary payer are reported on the secondary payer line along with any amounts collected from the secondary payer. The reclassification of charges and collections to secondary and subsequent payers may be estimated based upon a sample of accounts.

(Column c) Adjustments: the difference between the full charges and the amount actually received or expected. The only adjustments to be reported here are self-pay adjustments.

(Line 1) Medicare (Title XVIII) Fee-for-Service: charges and receipts related to services provided to Medicare beneficiaries payable by fee-for-service insurance plans operated under Title 18 of the Social Security Act including Federally Qualified Health Center, Rural Health Clinic, or any other reimbursement arrangement excluding capitated managed care administered by Medicare or its fiscal intermediaries.

(Line 2) Medicare (Title XVII) Capitated: charges and receipts related to services provided to Medicare beneficiaries payable by capitated managed care plans operated under Title 18 of the Social Security Act. This includes supplemental or incentive receipts by the plan such as hospital or referred care pool distributions, withhold receipts, and similar amounts.

(Line 3) Total Medicare: The sum of lines 1 and 2.

(Line 4) Medicaid (Title XIX) Fee-for-Service: charges and receipts related to services provided to Medicaid beneficiaries and payable by fee-for-service insurance plans operated under Title 19 of the Social Security Act, including Federally Qualified Health Center, Rural Health Clinic, case management, fee-for-service managed care, EPSDT, State Child Health Insurance Program (SCHIP) and any other reimbursement arrangement, excluding capitated managed care, administered either directly by the state agency or by its fiscal intermediaries.

(Line 5) Medicaid (Title XIX) Capitated: charges and receipts related to services provided to Medicaid beneficiaries payable by capitated managed care plans operated under Title 19 of the Social Security Act. This includes supplemental or incentive receipts by the plan or state such as FQHC wrap-around receipts, incentive distributions, withhold receipts, and similar amounts.

(Line 6) Total Medicaid: The sum of lines 4 and 5.

(Line 7) Other Public Fee-for-Service: charges and receipts related to services provided to users and payable by fee-for-service insurance plans operated by federal, state, or local governments that are not reported elsewhere such as separately administered State Child Health Insurance Programs (SCHIP), state or county indigent care programs, city welfare, and similar plans. This may also include that portion of charges and receipts from public categorical service grants which are directly applied to a self-pay or insured patient's account. The National Breast and Cervical Cancer Early Detection Program is one example of a public categorical service grant program whose charges and receipts are classifiable as other public.

(Line 8) Other Public Capitated: charges and receipts related to services provided to users and are payable by capitated managed care plans operated by federal, state, or local governments that are not reported elsewhere such as separately administered State Child Health Insurance Programs (SCHIP), state or county indigent care programs, city welfare, and similar plans.

(Line 9) Total Other Public: The sum of lines 7 and 8.

(Line 10) Private Insurance Fee-for-Service: charges and receipts related to services provided to users and payable by fee-for-service insurance plans other than those reported above such as a private insurance plan, managed care plan, or a contractual arrangement. This includes plans such as Blue Cross and Blue Shield, commercial insurance, managed care plans, self-insured employer plans, group contracts with unions and employers, and service contracts with employers, schools, health departments, and others. Health benefit plans offered to government employees, retirees and dependants such as TRICARE, the federal employees health benefit program, state employee health insurance benefit programs, teacher health insurance and similar plans are to be classified as private insurance.

(Line 11) Private Insurance Capitated: charges and receipts related to services provided to users and payable by capitated managed care plans other than those reported above such as commercial, union, employer, and other managed care plans.

(Line 12) Total Private Insurance: The sum of lines 10 and 11.

(Line 13) Self-Pay: charges and receipts related to services provided to patients without any principal health insurance or to patients with insurance but only that portion for which the patient is personally liable such as deductible, copayments, and uncovered charges. Charges not paid by a third party payer and due from the patient should be deducted from the full charges of the third party payer and added to the full charges for the self-pay patients.

(Line 14) Total: the sum of lines 3, 6, 9, 12, and 13.

(Line 15) Self-Pay Sliding Fee Adjustments: the value of charge discounts granted to patients prior to service and based upon financial hardship. It does not include professional courtesy, staff, service incentive, or similar discounts. Also, it does not include bad debt adjustments related to patients who were initially charged full fee but unable to pay because of financial hardship or other reasons. If a hardship fund is used to pay for the referred lab, x-ray, pharmacy or other care for sliding fee patients, report the charge value of those services in column (a) and an off setting sliding fee adjustment in column (c). Sliding fee discounts reflect the site's compliance with its assurance to the NHSC that there are no financial barriers to care for those at or below 200 percent of the current federal poverty income guideline.

(Line 16) Other Self-Pay Adjustments: the value of all self-pay adjustments other than sliding fee adjustments. This includes bad debt and charity care adjustments taken or granted to self-pay patients who were initially charged a full, discounted, or partial fee but who subsequently were either unwilling or unable to pay the amounts charged. It does not include bad debt related to other pay sources which may be caused by a failure to file timely claims, payer bankruptcy or similar reasons.

(Line 17) Total Self-Pay Adjustments: the sum of lines 15 and 16.

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TABLE 4
PATIENT SERVICE CHARGES, COLLECTIONS, AND SELF-PAY ADJUSTMENTS

(Not to be completed by Prison, IHS, Section 638 or INS sites)

Payment Source	Full Charges	Amount Collected
	(a)	*(b)*
Medicare		
1.) Medicare Fee-for-Service		
2.) Medicare Capitated		
3.) Total Medicare *(Lines 1 and 2)*		
Medicaid		
4.) Medicaid Fee-for-Service		
5.) Medicaid Capitated		
6.) Total Medicaid *(Lines 4 and 5)*		
Other Public Payers		
7.) Other Public Fee-for-Service		
8.) Other Public Capitated		
9.) Total Other Public *(Lines 7 and 8)*		
Private Insurance		
10.) Private Insurance Fee-for-Service		
11.) Private Insurance Capitated		
12.) Total Private Insurance *(Lines 10 and 11)*		
Self-Pay		
13.) Self-Pay		
14.) Total *(Lines 3, 6, 9, 12, and 13)*		

Self-Pay Adjustment Type	Adjustments
	(c)
15.) Self-Pay Sliding Fee Adjustments	
16.) Other Self-Pay Adjustments (Self-Pay Bad Debt and Charity Care)	
17.) Total Self-Pay Adjustments *(Lines 15 and 16)*	

INSTRUCTIONS FOR TABLE 5:
INCOME AND EXPENSES

This table is to include the income and expense of all related activity of all providers at the site to which the NHSC provider is assigned. See the general instructions for a definition of the scope of activity to be reported. Include all direct income and expense attributable to the site. Report in whole dollars, no cents.

(Line 14) Accounting Method: Reporting income and expenses on an accrual basis is preferred. Check the box on line 14 at the bottom of the table to specify the method used.

(a) ***Cash:*** Income is recognized when cash is received and expenses are recorded when cash is disbursed.

(b) ***Accrual:*** Income is recognized in the period it is earned and expenses are recorded in the period they are incurred.

(c) ***Modified Accrual:*** Some combination of cash and accrual reporting such as when income is recognized when earned and expenses are recorded when paid.

(Line 1) Federal Income: income directly attributable to the site from federal sources where the ***sponsor is the grantee*** such as Title III of Ryan White Care Act. Federal programs funds received by sites from states or other private nonprofit entities are reported as State, Local, or Other income on line 3. Sites receiving federal grants from HRSA/BPHC programs are to file the standard UDS report.

(Line 2) Patient Service Revenue: income directly earned by the site in exchange for and based upon units of service rendered to patients. It may include fees-for-service, copayments, premiums, fixed payment rates, capitations, service contracts, and other forms of payment. Sources may include patients, Medicare, Medicaid, other public insurance, and other third parties.

Sites reporting on a cash basis report all cash receipts from patient services on line 2. This will equal the amount collected reported on Table 4 column (b) line 14. Sites reporting on an accrual basis report net revenue which is gross charges minus contractual allowances, adjustments, and bad debt. This is normally less than the gross charges reported on Table 4 column (a) line 14.

(Line 3) State, Local, and Other Income: all income directly attributable to the site that is not federal and is not classifiable as patient service revenue. Include direct income and exclude indirect income from the parent or sponsoring organization. This does not include NHSC loan repayment proceeds. This may include grants, donations, and the ***value of donated goods and services.*** Use generally accepted accounting principles when recognizing the value of donated goods and services. Recognize the value of donated goods and services the organization would otherwise be required to buy. Use conservative valuation methods. Do not impute additional value to goods or services for which some payment is made. ***Offset the recognition of any donated goods or service income with an equal amount donated goods or service expense on the appropriate expense line.***

(Line 4) Total Income: sum of lines 1 through 3.

(Line 5) Provider Compensation and Fringe: compensation and fringe earned by staff providers for their services during the reporting period. Staff providers include all proprietor, partner, shareholder, employed or contract physicians, NHSC providers, nurse practitioners, physician assistants, certified nurse midwives, licensed nurses, dentists, dental hygienists, mental health specialists, substance abuse specialists, and other professional staff. ***The providers whose compensation is reported here should correspond to the provider FTEs reported on Table 3.*** This includes gross salaries and wages, including annual and sick leave, holiday pay, overtime, bonuses, incentive payments, stipends, honoraria, partner/shareholder distributions, profit distributions, contributions to a 401(k) or similar plan, and the cost of fringe benefits.

Fringe benefits include the employer's share of life, health, disability, and other insurance, social security (FICA), FUTA, state unemployment compensation, workers compensation, employer retirement plan contributions, and deferred compensation paid or expensed during the period.

Fringe benefits do not include clinical liability insurance, membership dues, subscriptions, continuing education expense, relocation expense, travel, automobile, entertainment and other similar costs. Fringe benefits do not include NHSC loan repayment proceeds.

Do not include provider administrators or that share of provider salary and fringe spent as a site administrator such as medical director. Report these amounts as nonprovider salaries and fringe on line 6.

Payments to nonstaff providers such as consulting pathologists, consulting radiologists, other provider consultants and payments to referred care providers are reported as other clinical expenses on line 10.

(Line 6) Nonprovider Salaries and Fringe: gross salaries and wages and the cost of fringe benefits, as defined for line 5 above, earned by all nonproviders. Nonproviders include all employed staff not reported on line 5. This includes all other medical support, pharmacy personnel, laboratory services personnel, x-ray personnel, dental assistants, dental aides, mental health and substance abuse support staff, case managers, and education specialists, outreach workers, transportation staff, other service staff, administrative staff, patient service support staff, and facility staff. ***The nonproviders whose compensation and fringe is reported here should correspond to the nonprovider FTEs reported on Table 3.***

Payments to nonproviders or support staff under contract with the site such as independent contractors, management service organizations, practice management companies, billing services and similar arrangements are reported on line 11, administration, facility, and other expenses.

(Line 7) Clinical Supplies: medical, dental, lab, x-ray, mental health, substance abuse, other professional, pharmacy, and other service supplies. Exclude office, administration, and facility supplies.

(Line 8) Clinical Equipment: depreciation, leases, and rent of medical, dental, lab, x-ray, mental

health, substance abuse, other professional, pharmacy, and other service equipment. Report expenses for office equipment and furniture on line 11.

(Line 9) Clinical Liability Insurance: clinical liability or malpractice insurance premiums. Include an allocable share of clinical liability insurance attributable to the site when paid centrally by the sponsor.

(Line 10) Other Clinical Expenses: such as payments to nonstaff medical, dental, mental health and other professional providers; purchased pharmacy, lab, and x-ray services; payments for referred specialty, hospital, and other care under prepaid plans, including any expense recognized for "incurred but not reported" (IBNR) claims; and other clinical expenses such as membership dues, subscriptions, continuing education expense, provider relocation expense, clinical travel, and provider automobile expense; provider recruitment and other similar clinical expenses not reported elsewhere. Report bad debt expense as a deduction from patient service revenue.

As noted in the General Instructions section, sites may elect to include or exclude all or some portion of paid referred care services rendered to the site's patients at off-site locations. This election may be based upon the ability to report or the ease of reporting this information. The same scope of off-site referred care should be used to complete the encounter, user, charge, and cost tables.

(Line 11) Administration, Facility, and Other Expenses: administrative, marketing, telephone, communications, management information, service bureau, interest, general management expenses, and all expenses related to the use and maintenance of the facility including depreciation, rent, housekeeping, maintenance, security, and utilities. Includes purchased legal, accounting, management, and support services. Expenses exclude personal income taxes for self employed sole proprietors. Report bad debt as a deduction from patient service revenue on line 2 rather than as an expense on line 11.

(Line 12) Total Expenses: the sum of lines 1 through 11.

(Line 13) Surplus or (Deficit): line 4 minus line 12. The surplus or (deficit) is the amount after any distributions to owners which are reported on line 5.

(Line 14) Accounting Method: check the method used. See the top of this section for an explanation of the accounting methods.

TABLE 5
INCOME AND EXPENSES

(Not to be completed by Prison, IHS, Section 638 or INS sites)

Account Class	Total
Income	
1.) Federal Income	
2.) Patient Service Revenue	
3.) State, Local, and Other Income	
4.) Total Income *(Lines 1 thru 3)*	
Expense	
5.) Provider Compensation and Fringe	
6.) Nonprovider Salaries and Fringe	
7.) Clinical Supplies	
8.) Clinical Equipment	
9.) Professional Liability Insurance (Malpractice)	
10.) Other Clinical Expenses	
11.) Administration, Facility and Other Expenses	
12.) Total Expense *(Lines 5 thru 11)*	
13.) Surplus or (Deficit) *(Line 4 minus 12)*	
Accounting Method (Check the box below that describes the method used)	
14.) ☐ *Cash (a)* ☐ *Accrual (b)* ☐ *Modified Accrual (c)*	

INSTRUCTIONS FOR TABLE 6:
MANAGED CARE ENROLLMENT

This table shows the ***end of period*** enrollment in prepaid and fee-for-service managed care plans.

Managed care plans are those insurance plans with the following characteristics: the site has an obligation to provide or arrange a defined set of services for a specified period of time to an enrolled individual; where the enrollee chooses or is assigned a primary care provider at the site as their principal care giver; and where the primary care provider has responsibility for authorizing any covered referred care services for the enrollee, where the patient is locked-in to the arrangement for some period and where the site assumes some measure of financial risk. Sites may be paid by the managed care entity with a prepaid capitation or on a fee-for-service basis or by some combination of these methods.

It does not include individuals who are enrolled in managed care plans, assigned to a primary care case manager provider at another location and are referred to the site for care. It does not include members of Preferred Provider Organizations (PPOs) where the patient is free to go to other sites or providers within a network without authorization from a case manager. It does include individuals enrolled at the site in managed care plans that cover only medical services, only dental services, only mental health services or some combination of health services.

A managed care enrollee is different from a user. A user is a patient with one or more reportable encounters during the year. Managed care enrollees who do not use services during the year will not be reported as a user. Typically some portion of the enrolled population does not use services during the year. Even if all the patients in a payer class were enrolled in managed care, it would be unlikely that the number of enrollees reported on table 6 would equal the users for that payer class reported on table 2D.

(Line 1) Enrollees in Capitated Plans: the number of enrollees assigned to providers at the site as of December 31 or the end of the NHSC reporting period in managed care plans under which the site receives a fixed payment per enrollee in exchange for an obligation to provide or arrange a defined set of covered services for a specified period of time. Under these arrangements payment is generally made in advance on a monthly basis and the site assumes some financial risk. The site may be fully or partially at risk to provide covered primary care, referred care, and inpatient services to enrollees with the capitation paid.

Report members of managed care plans which reimburse ***in part on a capitated basis and in part on a fee-for-service basis*** exclusively as enrollees in Capitated plans on line *1.* ***Do not report these individuals a second time*** as enrollees in fee-for-service plans on line 2.

(Line 2) Enrollees in Fee-for-Service Managed Care Plans: the number of enrollees assigned to providers at the site as of December 31 in managed care plans under which the site receives fee-for-service payments in exchange for providing covered services to enrollees. Under these arrangements the site is not receiving advance payments in exchange for future service obligations and is not at risk. Often some portion of the fee is withheld and returned based on performance. Providers may also receive case management fees or a fixed amount per enrollee per month for managing their care. These case management plans are classified as fee-for-service managed care.

(Line 3) Total Managed Care Enrollees: the sum of lines 1 and 2.

(Column a) Medicaid: enrollees in managed care plans operated under Title 19 of the Social Security Act including plans administered directly by the state agency, a fiscal intermediary, an HMO, or other contractor.

(Column b) Medicare: enrollees in managed care plans operated under Title 18 of the Social Security Act including plans administered by Medicare, a fiscal intermediary, an HMO, or other contractor.

(Column c) Other Public: enrollees in managed care plans operated by federal, state, or local governments that are not reported elsewhere such as separately administered State Child Health Insurance Programs (SCHIP), state, county, or city indigent care programs, and similar plans.

(Column d) Private: enrollees in managed care plans operated by private entities such as insurance companies, Blue Cross, Blue Shield, employer plans, union plans, and others.

(Column e) Total: the total of columns (a) through (d).

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TABLE 6
MANAGED CARE ENROLLMENT
AS OF THE END OF THE REPORTING PERIOD

(Not to be completed by Prison, IHS, Section 638 or INS sites)

Enrollee Type	Payment Source				Total
	Medicaid	Medicare	Other Public	Private	
	(a)	*(b)*	*(c)*	*(d)*	*(e)*
1.) Enrollees in Capitated Plans					
2.) Enrollees in Fee-for-Service Plans					
3.) Total Managed Care Enrollees					

APPENDIX A
LISTING OF PERSONNEL BY TABLE 3 LINE NUMBER AND SERVICE CATEGORY WITH PROVIDER AND NONPROVIDER DESIGNATIONS

LINE	PERSONNEL BY MAJOR SERVICE CATEGORY	PROVIDER	NONPROVIDER
	MEDICAL SERVICES		
1	Family Practitioner	X	
2	General Practitioner	X	
3	Internist	X	
4	Obstetrician/Gynecologist	X	
5	Pediatrician	X	
6	Psychiatrist	X	
7	Other Specialist Physician	X	
7	Allergist	X	
7	Cardiologist	X	
7	Dermatologist	X	
7	Orthopedist	X	
7	Surgeon	X	
7	Urologist	X	
7	Ophthalmologist	X	
7	Other specialist and subspecialist	X	
9	Nurse Practitioner/Physician Assistant	X	
9	Psychiatric Nurse Practitioner	X	
10	Certified Nurse Midwife	X	
11	Nurses	X	
11	Clinical Nurse Specialist	X	
11	Public Health Nurse	X	
11	Home Health Nurse	X	
11	Visiting Nurse	X	
11	Registered Nurse	X	
11	Licensed Practical Nurse	X	
11	Alaska Community Health Aide	X	

LINE	PERSONNEL BY MAJOR SERVICE CATEGORY	PROVIDER	NONPROVIDER
12	Other Medical Support Personnel		X
12	Nurse Aide/Assistant (Certified and Uncertified)		X
12	Clinic Aide (Certified and Uncertified)		X
12	Medical Technologist (Certified and Uncertified)		X
12	Medical Assistant (Certified and Uncertified)		X
	ANCILLARY SERVICES		
14	Laboratory Services Personnel		X
14	Pathologist		X
14	Medical Technologist		X
14	Laboratory Technician		X
14	Laboratory Assistant		X
14	Phlebotomist		X
15	X-ray Personnel		X
15	Radiologist		X
15	X-ray Technologist		X
15	X-ray Technician		X
15	Ultrasound Technician		X
16	Pharmacy Personnel		X
16	Pharmacist		X
16	Pharmacy Technician or Assistant		X
	DENTAL SERVICES STAFF		
18	Dentist	X	
18	General Practitioner	X	
18	Oral Surgeon	X	
18	Periodontist	X	
18	Pedodontist	X	
19	Dental Hygienist	X	
20	Dental Assistant		X
20	Dental Technician		X
20	Dental Aide		X

LINE	PERSONNEL BY MAJOR SERVICE CATEGORY	PROVIDER	NONPROVIDER
	MENTAL HEALTH AND SUBSTANCE ABUSE STAFF		
22	Mental Health and Substance Abuse Specialists	X	
22	Psychologist	X	
22	Social Worker - Clinical or Psychiatric	X	
22	Nurse - Psychiatric or Mental Health	X	
22	Alcohol and Drug Abuse Counselor	X	
22	Nurse Counselor	X	
22	Family Therapist	X	
23	Aide or Assistant		X
	OTHER PROFESSIONAL STAFF		
25	Other Professional Personnel	X	
25	Audiologist	X	
25	Occupational Therapist	X	
25	Optometrist	X	
25	Podiatrist	X	
25	Chiropractor	X	
25	Physical Therapist	X	
25	Respiratory Therapist	X	
25	Speech Pathologist	X	
25	Nutritionists/Dietitian	X	
	OTHER SERVICE STAFF		
26	Case Manager		X
26	Social Worker		X
26	Public Health Nurse		X
26	Home Health Nurse		X
26	Visiting Nurse		X
26	Registered Nurse		X
26	Licensed Practical Nurse		X

LINE	PERSONNEL BY MAJOR SERVICE CATEGORY	PROVIDER	NONPROVIDER
26	Education Specialist		X
26	Family Planning		X
26	Health Educator		X
26	Social Worker		X
26	Public Health Nurse		X
26	Home Health Nurse		X
26	Visiting Nurse		X
26	Registered Nurse		X
26	Licensed Practical Nurse		X
26	HIV Counselor or Specialist		X
27	Outreach Worker		X
27	Patient Transportation Worker		X
27	Patient Transportation Coordinator		X
27	Driver		X
27	Child Care Worker		X
27	Eligibility Assistance Worker		X
27	Interpreter/Translator		X
28	Aide or Assistant		X
ADMINISTRATION AND FACILITY STAFF			
30	Administration Staff		X
30	Executive Director		X
30	Administrator		X
30	Finance Director		X
30	Accountant		X
30	Bookkeeper		X
30	Secretary		X
30	Director of Planning and Evaluation		X
30	Clerk Typist		X
30	Billing Clerk		X

LINE	PERSONNEL BY MAJOR SERVICE CATEGORY	PROVIDER	NONPROVIDER
30	Cashier		X
30	Director of Information Services		X
30	Data Processing Operator		X
30	Personnel Director		X
30	Director of Marketing		X
30	Marketing Representative		X
30	Enrollment/Service Representative		X
31	Facility Staff		X
31	Janitor/Custodian		X
31	Security Guard		X
31	Groundskeeper		X
31	Equipment Maintenance Personnel		X
31	Housekeeper		X
32	Patient Services Support Staff		X
32	Registration Clerk		X
32	Receptionist		X
32	Unit Clerk		X
32	Unit Secretary		X
32	Appointment Clerk		X
32	Patient Records Supervisor		X
32	Patient Records Technician		X
32	Patient Records Clerk		X
32	Patient Records Transcriptionist		X

Note:

- All line numbers refer to Table 3 and only providers generate reportable encounters.