

**INSTRUCTIONS FOR COMPLETING REQUEST TO ESTABLISH ELIGIBILITY TO PARTICIPATE IN THE
HEALTH INSURANCE FOR THE AGED AND DISABLED PROGRAM
TO PROVIDE RURAL HEALTH CLINIC SERVICES**

The filing of this request for eligibility will initiate the process of obtaining a decision as to whether the conditions for certification are met.

Please do not delay returning the form. Assistance in filling out the form is available from the State agency.

GENERAL INSTRUCTIONS

Please answer all questions as of the current date.

Return the form to the State agency in the envelope provided; retain a copy for your files. If a return envelope is not provided, the name and address of the State agency may be obtained from the nearest Social Security Administration district office.

Detailed Instructions for Specific Questions

These instructions are designed to clarify certain questions on the form. Instructions are listed in question order for easy reference. No instructions have been given for questions considered self-explanatory.

The Following to be Completed by the Applicant

Question I — Identifying Information

Insert the full name under which the clinic operates. A rural health clinic site is the location at which health services are furnished. If a central organization operates more than one clinic site, a separate Request to Establish Eligibility Application for each rural health clinic site must be submitted. In these instances, the location of the health clinic site, rather than the central organization, will determine eligibility to participate and the applicant site must be situated in a rural area which is designated as either an area with a shortage of personal health services or as a health manpower shortage area because of its shortage of primary medical care manpower. If the name of the rural health clinic site does not identify the owner(s), the name and address of the owner(s) is to be inserted in the space provided, otherwise, that space is to be left blank.

Question II — Medical Direction

Insert the name and address of the physician(s) responsible for providing medical direction for the health clinic site.

Question III — Clinic Personnel

(A), (B), and (C) – Personnel are to be described in terms of full-time equivalents. To arrive at full-time equivalents, add the total number of hours worked by personnel in each category in the week ending prior to the week of filing the request and divide by the number of hours in the standard work week (as determined by clinic policies). If the result is not a whole number, express it as a quarter fraction only (e.g., .00, .25, .50, or .75).

Exclude all trainees and volunteers.

A nurse practitioner and/or physician assistant in addition to the physician, is required for clinic eligibility and must be shown in B and/or C respectively.

(D) – Where other types of personnel are utilized (e.g., technicians, aides, etc.), the discipline, by name, is to be indicated in addition to the full-time equivalents.

Under (A), (B) and (C), include in the count only those defined as follows:

Physician — A doctor of medicine or osteopathy legally authorized to practice medicine and surgery by the State in which such function or action is performed. (A physician listed in II. above, should be included in this category for purposes of determining full-time equivalents.)

Nurse Practitioner — A registered professional nurse who is currently licensed to practice in the State, who meets the State's requirements governing the qualifications of nurse practitioners and who meets one of the following conditions:

1. Is currently certified as a primary care Nurse Practitioner by the American Nurses Association or by the National Board of Pediatric Nurse Practitioners and Associates; or
2. Has satisfactorily completed a formal one academic year educational program that:
 - (i) prepares registered nurses to perform an expanded role in the delivery of primary care;
 - (ii) includes at least four months (in the aggregate) of classroom instruction and a component of supervised clinic practice; and
 - (iii) awards a degree, diploma, or certificate to persons who successfully complete the program; or

3. Has successfully completed a formal educational program for preparing registered nurses to perform an expanded role in the delivery of primary care that does not meet the requirements of paragraph (2) of this section, and has been performing an expanded role in the delivery of primary care for a total of 12 months during the 18-month period immediately preceding the effective date of this subpart.

Physician Assistant — A person who meets the applicable State requirements governing the qualifications for assistants to primary care physicians and who meets at least one of the following conditions:

1. Is currently certified by the National Commission on Certification of Physician Assistants to assist primary care physicians: or
2. Has satisfactorily completed a program for preparing physician's assistants that:
 - (i) was at least one academic year in length;
 - (ii) consisted of supervised clinical practice and at least four months (in the aggregate) of classroom instruction directed toward preparing students to deliver health care; and
 - (iii) was accredited by the American Medical Association's Committee on Allied Health Education and Accreditation; or
3. Has satisfactorily completed a formal educational program for preparing physician assistants that does not meet the requirements of paragraph (2) of this section and has been assisting primary care physicians for a total of 12 months during the 18-month period immediately preceding the effective date of this subpart.

Question IV – Type of Control

Identify the rural health clinic in terms of its control by checking the appropriate part of A, B, C or D. Nonprofit status is based on Internal Revenue Service tax exemption interpretation; i.e., section 501 of the Internal Revenue Code of 1954.

The following, where applicable, is to be completed in addition to the above. Those rural health clinic sites which are associated with any existing Medicare provider; i.e., both are licensed as a single health entity; the rural health clinic site and the provider are subject to the bylaws and operating decisions of the same governing body; and the medical personnel of the rural health clinic site are considered by the governing body to be subject to the rules of the provider's medical staff, are to indicate this alliance by showing the Medicare provider number of the facility in the appropriate space.

State Agency Responsibility

The State agency, when reviewing IV. Type of Control, should refer to 2208 of the State Operations Manual.

A function of the resurvey process is to obtain updated statistical information on organizations providing rural health clinic services. At the time of resurvey, the surveyor will bring this form with him and request that a representative of the organization complete, sign, and date it and return it to him at the completion of the onsite visit. The surveyor will review the form for completeness and accuracy and place his initials after the signature of the organization's representative. On all resurveys insert the clinic's assigned six-digit provider number. Do not complete the categories identified as State/County or State Region at anytime; the regional office will complete these items.

REQUEST TO ESTABLISH ELIGIBILITY TO PARTICIPATE IN THE HEALTH INSURANCE FOR THE AGED AND DISABLED PROGRAM TO PROVIDE RURAL HEALTH CLINIC SERVICES

Each rural health clinic site providing rural health clinic services and desiring to establish eligibility in the health insurance program should complete this form and return it to the State agency that is handling the certification process. If a return envelope is not provided, the name and address of the State agency may be obtained from the nearest Social Security Administration district office.

PROVIDER NO.	(RH1)
STATE/COUNTY (RH2)	(RH2)
STATE REGION (RH3)	(RH3)

I. IDENTIFYING INFORMATION (TO BE COMPLETED FOR EACH CLINIC SITE)	NAME OF CLINIC		STREET ADDRESS	
	CITY, COUNTY AND STATE	ZIP CODE	TELEPHONE NO. (Including Area Code)	

NAME AND ADDRESS OF CLINIC OWNER(S)	(RH5)
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II. MEDICAL DIRECTION	
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III. CLINIC PERSONNEL (FULL TIME EQUIVALENTS)	(A) PHYSICIAN (RH6)	(B) NURSE PRACTITIONER (RH7)	(C) PHYSICIAN ASSISTANT (RH8)	(D) OTHER (RH9)
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IV. TYPE OF CONTROL (check one)	A. INDIVIDUAL		B. CORPORATION	C. PARTNERSHIP	D. GOVERNMENT		
	1. PROFIT	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	STATE 3. <input type="checkbox"/>	LOCAL 4. <input type="checkbox"/>	FEDERAL 5. <input type="checkbox"/>
	2. NON-PROFIT	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
(RH10)	If the rural health clinic site is part of an existing Medicare provider, indicate the provider number _____						(RH11)

V. FEDERAL SUPPORT	Is this clinic site receiving support from a Federal Program to provide health services in a medically underserved area or in an area with a shortage of primary care health manpower? <input type="checkbox"/> YES <input type="checkbox"/> NO (RH12)
	TITLE OF FEDERAL PROGRAM: _____ (RH13)
	Is this clinic participating in the Physician Extender Experiment Program (Section 222)? <input type="checkbox"/> YES <input type="checkbox"/> NO (RH14)

I certify that this application is true, correct, and complete. I agree, if approval is granted, that all services rendered by the clinic shall be in conformity with Federal, State, and local laws. I further understand that a violation of such laws will constitute grounds for withdrawal of approval under the regulations. This information will not be released to any persons or organizations outside the official administrative channels unless the undersigned individual specifically requests in writing that such disclosures be made. (Privacy Act of 1974 Public Law 93-579.)

SIGNATURE OF AUTHORIZED OFFICIAL	TITLE	DATE
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