**DEPARTMENT OF HEALTH AND HUMAN SERVICES**
**Health Resources and Services Administration**

**CHECKLIST FOR TERMINATING A SITE (CHKLST004)**

**Grantee Name:**
**Grantee Number:**
**CIS Tracking Number:**

## Questions for Deletion of Service Site

| **Site Name** | Site has not been selected. | **Site Address** | |
|---|---|---|---|

***1.** Describe the reason for the deletion of the service site and how it will impact your health center and the patients you serve. Include the number of patients that will be affected by the deletion of the service site. *(Provide a summary of one page or less.)*

(Maximum 3,000 Characters)
Maximum paragraph(s) allowed approximately: 3 (3000 character(s) remaining)

***2.** Was the service site to be deleted added through the below?

- ○ a change in scope within the last 36 months or;
- ○ a funded application within the last 36 months or;
- ○ other

***2a.** When do you plan to delete the site?

Date of deleting site (mm/dd/yyyy):

***3. Provide information regarding the impact of the deletion of the service site.**

**3a.** For each of the nearest locations where patients can receive services following the deletion of the site, provide the following information: name, address, distance in miles and travel time from site being deleted.

(Maximum 3,000 Characters)
Maximum paragraph(s) allowed approximately: 3 (3000 character(s) remaining)

**3b.** Average travel time for patients to service location(s)

Currently: hrs mins (Format: 99)

Following Deletion: hrs mins (Format: 99)

**3c.** Average miles traveled by patients to service location(s)

Currently: miles (Format: 9 or 9.99)

Following Deletion: miles (Format: 9 or 9.99)

**3d.** Will transportation services be available?

Yes No

**3e.** Describe how the health center will address any barriers to care that the deletion of the service site may present. *(Please provide a summary of one page or less.)*

(Maximum 3,000 Characters)

Maximum paragraph(s) allowed approximately: 3 (3000 character(s) remaining)