DEPARTMENT OF HEALTH AND HUMAN SERVICES
Health Resources and Services Administration

CHECKLIST FOR DELETING A SERVICE (CHKLST002)

Grantee Name:
Grantee Number:

CIS Tracking Number:

Questions for Deletion of Service(s)

In this CIS request, you have marked the following services for deletion:

Service has not been selected.

***1.** Describe the reason for the deletion of the service 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. *(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 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 will you stop providing the service?

Date of stopping service (mm/dd/yyyy):

***3. Provide the name, city, state, and zip code of the nearest location(s) where patients can receive this service following the deletion of the service from your scope of project.**

3a. Name and Address of nearest services

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

3b. Average travel time for patients to service location

Currently: [ ] hrs [ ] mins (Format: 99)

Following Deletion: [ ] hrs [ ] mins (Format: 99)

3c. Average miles traveled by patients to service location

Currently: [ ] miles (Format: 9 or 9.99)

Following Deletion: [ ] miles (Format: 9 or 9.99)