OMB No.: 0915-0285. Expiration Date: 08/31/2010

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| **DEPARTMENT OF HEALTH AND HUMAN SERVICES Health Resources and Services Administration FORM 3 - INCOME ANALYSIS FORM****YEAR 1  YEAR 2 (Existing Grantees only) ** | **FOR HRSA USE ONLY** |
| Grantee Name |  |
| Grant Number |  | Application Tracking Number |  |
| **PART 1: NON FEDERAL SHARE, PROGRAM INCOME**  |
| **Payor Category** | **Number OfVisits** | **Average Charge Per Visit** | **GrossCharges(a \* b)=(c)** | **Average Adjustment Per Visit**  | **Net Charges(Amount Billed)[c-(a\*d)]**  | **Collection Rate (%)**  | **Projected Income(e \* f)**  | **Actual Accrued Income Past 12 Months** |
| (a) | (b) | (c) | (d) | (e) | (f) | (g) | (h) |
| **PROJECTED FEE FOR SERVICE INCOME** |
| 1a. Medicaid: Medical |  |  |  |  |  |  |  |  |
| 1b. Medicaid: EPSDT (if different from medical rate) |  |  |  |  |  |  |  |  |
| 1c. Medicaid: Dental |  |  |  |  |  |  |  |  |
| 1d. Medicaid: BH/SA |  |  |  |  |  |  |  |  |
| 1e. Medicaid: other fee for Service |  |  |  |  |  |  |  |  |
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| **1.** |  **Subtotal: Medicaid** |

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| 2a. Medicare: all inclusive FQHC rate |  |  |  |  |  |  |  |  |
| 2b. Medicare: other Fee for Service |  |  |  |  |  |  |  |  |
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| **2.** | **Subtotal: Medicare** |

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| 3a. Private Insurance (Medical) |  |  |  |  |  |  |  |  |
| 3b. Private Insurance (Dental) |  |  |  |  |  |  |  |  |
| 3c. Private Insurance (BH/SA) |  |  |  |  |  |  |  |  |
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| **3.** |  **Subtotal: Private** |

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| 4a. Self-Pay: 100% charge, no discount (Medical) |  |  |  |  |  |  |  |  |
| 4b. Self-Pay: 0% - 99% of charge, Sliding discounts including full discount (Medical) |  |  |  |  |  |  |  |  |
| 4c. Self-Pay: 100% charge, no discount (Dental) |  |  |  |  |  |  |  |  |
| 4d. Self-Pay: 0% - 99% of charge, Sliding discounts including full discount (Dental) |  |  |  |  |  |  |  |  |
| 4e. Self-Pay: 100% charge, no discount (BH/SA) |  |  |  |  |  |  |  |  |
| 4f. Self-Pay: 0% - 99% of charge, sliding discount including full discount, (BH/SA) |  |  |  |  |  |  |  |  |
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| **4.** | **Subtotal: Self Pay** |

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| **5.** | **Subtotal: Other Public** |

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| **6.** | **TOTAL FEE FOR SERVICE** |

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| **PROJECTED CAPITATED MANAGED CARE INCOME** |
| **TYPE OF PAYOR** | **Number of Member Months (a)** | **Rate Per Member Month (b)** | **Risk Pool Adjustment (c)** | **FQHC and Other Adjustments (d)** | **Projected Gross Income (e)** |
| 7a. Medicaid: |  |  |  |  |  |
| 7b. Medicare  |  |  |  |  |  |
| 7c. Commercial |  |  |  |  |  |
| 7d. Other Public |  |  |  |  |  |
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| **7.** | **TOTAL CAPITATED MANAGED CARE** |

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| **8.** | **Managed Care Charges** |

 | **(a) Visits** | **(b) Average Charge Per Visit** | **(c) Total Charges**  |
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| **TOTAL PROGRAM INCOME [line 6, column g + line 7, column e] Matches line7 "Program Income" of SF 424A** |  |  |
| **PART 2: NON-FEDERAL SHARE, OTHER INCOME**  |
|  | **Total Other Income by Source** |
| 9. Applicant |  |
| 10. State Funds |  |
| 11. Local Funds |  |
| Other Support |  |
| 12a. Other Federal Grants |  |
| 12b. Contributions and Fundraising |  |
| 12c. Foundation Grants |  |
| 12d. Other\_\_\_\_\_\_\_\_\_\_\_(please list) |  |
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| **12.** | **Subtotal Other Support** |

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| **13.** | **TOTAL OTHER INCOME** |

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| **TOTAL NON-FEDERAL SHARE[line6, row (g) + line 7, row (e) + line 13] Matches line 5, column f, "Non Federal" Totals of SF 424A** |  |
| **Comments/Explanatory Notes for Income Analysis Form (if applicable):**  |