National Health Service Corps

Site Survey Manual

Calendar Year 2010

NATIONAL HEALTH SERVICE CORPS

SITE SURVEY MANUAL

For use to submit Calendar Year 2010 NHSC Site Survey Data

U.S. Department of Health and Human Services
Health Resources and Services Administration
BUREAU OF CLINICIAN RECRUITMENT AND SERVICE
5600 FISHERS LANE, Room 8-05, ROCKVILLE, MARYLAND 20857

OMB Number: 0915-0232 **Expiration Date: 12/31/2011**

PUBLIC BURDEN STATEMENT

PREFACE

This is the Site Survey also referred to as 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 the UDS report for which there are separate reporting instructions.

If you have questions about the Site Survey, please contact the help line at either, 1-888-459-1080 or udshelp@nhscdata.net. Frequently asked NHSC Site Survey questions and answers will be posted on the NHSC web site at http://nhsc.hrsa.gov/communities/report.htm . Other material will be posted on the web site including a copy of this manual, copies of the tables, the user survey form, the aggregate data for each reporting, and an overview of the reporting requirements. The link for the NHSC Site Survey will be emailed to the site administrator or site point-of-contact October 3rd. If not received by mid October, please contact the help line.

TABLE OF CONTENTS

INTRODUCTION.....1

GENERAL INSTRUCTIONS.....2

INSTRUCTIONS AND COVER SHEET:
- NHSC Site Survey.....10

INSTRUCTIONS AND TABLE 1:
- Services Offered and Delivery Method.....12

INSTRUCTIONS AND TABLE 2:
- Part A: Patients by Age and Gender.....18
- Part B: Patients by Race, Ethnicity and Language.....18
- Part C: Patients by Income.....19
- Part D: Patients by Payment Source.....20

INSTRUCTIONS AND TABLE 3:
- Staffing and Utilization.....24

INSTRUCTIONS AND TABLE 4:
- Charges, Collections, and Self-Pay Adjustments.....29

INSTRUCTIONS AND TABLE 5:
- Income and Expenses.....33

APPENDIX A: Personnel Listing by Service Category.....37

OMB No: 0915-0232
Exp: 12/31/2011

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 Clinician Recruitment and Service within the Health Resources and Services Administration (HRSA). The NHSC Site Survey 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 (BPHC) 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 Site Survey 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 Site Survey.

The NHSC Site Survey is a valuable information management system, which gives the program a good understanding of the services, patients, 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.

There are no significant changes for the CY 2010 reporting year, only technical edits were made to provide clarity.

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 Site Survey. 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 from January to December. 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 Site Survey is site specific. Clinicians fulfilling National Health Service Corps obligations are assigned to a specific site or in some cases more than one site. The scope of activity to be reported in the Site Survey 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 visit, patient, 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 Site Surveys 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.

All sites with a NHSC obligated clinician in place at any point between January 1st and December 31st of the calendar year are to file a report.

All sites meeting the criteria above are to file a complete Site Survey 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 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.

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 Site Survey Tables:

Date of Submission: the date the report is submitted.

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.

REPORT DUE DATE

Reports are due on December 19, 2011.

ELECTRONIC PREPARATION AND SUBMISSION

Sites are to prepare and submit the Site Survey using the survey link emailed to the site administrator. The survey tool 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, and an email address udshelp@nhscdata.net are available for technical support.

NUMBER OF COPIES TO SUBMIT

Sites should submit one copy of the Site Survey.

DEFINITIONS OF VISITS, PROVIDERS, PATIENTS AND FTES

This section provides definitions which are critical for consistent reporting of Site Survey data across sites.

VISITS

A visit is a documented face-to-face contact between a patient and a provider who exercises independent professional judgment in the provision of services to the patient. To be included as a visit, services rendered must be documented 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 visits and those who are considered nonproviders and not able to generate visits for Site Survey reporting purposes.

The criteria used to define reportable visits for the Site Survey resemble criteria often used by payers to define a billable patient visit.

The criteria for visits are as follows:

1. To meet the visit criterion for "independent professional judgment," the provider must be acting independently when serving the patient 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 visit. 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 visit. Independent judgment implies the use of the professional skills associated with the profession of the individual being credited with the visit and unique to that provider or other similarly or more intensively trained providers. Eligible visits usually involve one of the "Evaluation and Management" billing codes (99281-85, 99291-95) or one of the health maintenance codes (99381-87, 99391-97).

   Visits 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 visit 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 visits. However, these procedures may be accompanied by services performed by medical, dental, or other health providers that do constitute visits.

3. The patient record does not have to be a full and complete health record in order to meet the visit 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 visit criteria are met even though a complete health record is not created. Provision of HIV counseling and testing meets these visit 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 visits in part because they are not fully documented.***

4. A patient may have more than one visit at the site per day. The number of visits per site per day is limited as follows:
    - One medical visit (physician, nurse practitioner, physician assistant, certified nurse midwife, or nurse):
    - One dental visit (dentist or hygienist); and
    - One visit for each type of health provider (family planning or HIV counselor, nutritionist, psychologist, podiatrist, speech therapist, etc.)

5. A provider may be credited with no more than one visit 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 visit only. If a student provider sees patients in conjunction with a non-student provider, only one visit, credited to the non-student provider is counted.

6. A reportable visit 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. Visits ***by staff providers at another provider's office, or any location not approved for the NHSC provider to practice, are not to be reported.***

   Visits 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 visits is also to be applied to the patient, charge, and cost tables.

7. When a provider renders services to several patients simultaneously, the provider can be credited with a visit for each person if the provision of services is noted in ***each*** person's health record. Examples of "group visits" 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 visits. Health education classes such as smoking cessation classes are not credited as visits.

8. The visit 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 patients, 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 visits for different provider types follow:

Physician Visit: a visit 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 Visit: a visit between a nurse practitioner and a patient during which medical services are provided and where the practitioner acts independently.

Physician Assistant Visit: a visit between a physician assistant and a patient during which medical services are provided and where the practitioner acts independently.

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

Nurse Visit (Medical): a visit 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 visits.

Dentist Visit: a visit 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: a visit 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 visit is generated when the patient sees both the hygienist and the dentist in one day.

Mental Health Visit: a visit between a mental health provider and a patient during which mental health services are provided. (Note: The term "behavioral health" is synonymous with prevention and treatment of mental health and substance abuse disorders. All behavioral health visits, providers, and costs must be parsed out into mental health or substance abuse.)

Behavioral Health Visit: a visit between a behavioral health 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. (Note: The term "behavioral health" is synonymous with prevention and treatment of mental health and substance abuse disorders. All behavioral health visits, providers, and costs must be parsed out into mental health or substance abuse.)

Other Professional Visits: visits between a professional provider not listed above (e.g. podiatrist, physical therapist, optometrist, audiologist, etc.) and a patient during which other professional services are provided.

Other Service Visit: visits between other service personnel (e.g. case managers and education specialists) and patients are ***not*** reported in the NHSC Site Survey.

DEFINITION OF A PROVIDER

A provider is an individual 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 a visit. The provider who exercises independent judgment is credited with the visit, even when two or more providers are present and participate. See Appendix A for a listing of personnel whom identifies those who are considered providers and who can generate visits for Site Survey reporting purposes.

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

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 visits for Site Survey reporting purposes.

DEFINITION OF A PATIENT

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

Medical Patient: an individual who has one or more medical visits during the reporting period.

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

Dental Patient: an individual who has one or more dental visits during the reporting period.

Mental Health & Behavioral Health Patient: an individual who has one or more mental health or behavioral health visits during the reporting period.

Other Professional Service Patient: an individual who has one or more visits with any other professional service provider not specified above. See Appendix A for a list of other professional service providers.

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

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

Exhibit 1
Patient X Visits for the Calendar Year

VISIT DATE	SERVICE						
	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 Visits	1	2	3	2	1	3	9
Service Patients	1	NR*	1	1	1	1	
Total Patients							1

***Note:** NR means "other medical service" patients are not reported in the NHSC Site Survey.*

As shown, patient X had a total of nine visits during the year, was a patient of each type of service, and is counted once in the site's total patient count for the year. The table also illustrates that prenatal visits are a subset or type of medical visit. Please note that prenatal patients and total medical patients are reported but "other medical service" patients are not reported in the NHSC Site Survey.

Total patients and prenatal patients are reported on Table 2. Patients 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 patients and prenatal patients*** in the reporting period. An actual count of total patients 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 patients by service class is to divide actual visits for that service class by the visits per patient for that service class determined from a random sample of patient

records. See the illustration which follows.

Estimating Medical Patients

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

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

All other patient information requested in Table 2 may be estimated based upon a sample of patient records. The minimum sample size is 200 records.

INSTRUCTIONS FOR COMPLETING
NHSC SITE SURVEY
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 https://tools.usps.com/go/ZipLookupAction!input.action?mode=0&refresh=true

(Lines 8 through 13) Site Administrator 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) Site Survey Preparer: name of the staff person with primary responsibility for preparing the Site Survey report. Do not include contractors.

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

(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.

OMB No: 0915-0232
Exp: 12/31/2011

For Period: January 1, 2010 to December 31, 2010 Date Submitted: _____

COVER SHEET
NHSC SITE SURVEY

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)		
Site Administrator Name and Address		
8.) 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.) Site Survey Preparer		
19.) Site Survey Preparer Phone		Extension:
20.) Site Survey Preparer Fax		
21.) Site Survey Preparer E-mail		
Site Type Description (Use Codes Listed Below to Complete Line 24)		
24.) Location Code		

Site Type Description Codes

1. FQHC Look-Alike
2. Rural Health Clinic (RHC)
3. Community Mental Health Facility
4. State or Federal Correctional Facility
5. Private Practice (Solo/Group)
6. Community Outpatient Facility
7. Free Clinic
8. Indian Health Service, Tribal Clinic, or Urban Indian Health Clinic (ITU)
9. State and County Health Departments of Health Clinic
10. Immigration and Customs Enforcement (ICE) Health Service Corps
11. Hospital Affiliated Primary Care Outpatient Clinic
12. School-based Health Program
13. Mobile Unit
14. Critical Access Hospital

Note: Select the location code which best describes the site location.

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 visit, patient, 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. Sites may elect to include or exclude all or some portion of the visit, patient, 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.

MEDICAL CARE SERVICES (Lines 1 – 11)

- ***General Primary Medical Care:*** primary medical care services other than those identified below.
- ***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.

- ***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.

- ***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.

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

- ***Urgent Medical Care:*** provision of medical care of an urgent or immediate nature on a regular basis.

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

- ***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.

- ***HIV Testing:*** includes medical provider counseling and education. Report under other services when provided by other service providers.

- ***Immunizations:*** provision of preventive vaccines such as diphtheria, tetanus, pertussis, polio virus, measles, mumps, rubella, influenza b, hepatitis b, and influenza virus.

- ***Following hospitalized patients:*** contacts with the site's patients during hospitalizations.

OBSTETRICAL AND GYNECOLOGICAL CARE (Lines 12 – 19)

- ***Gynecological Care:*** gynecological services provided by a nurse, nurse practitioner, physician assistant, 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.

- ***(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.

SPECIALTY CARE (Lines 20 – 21)

- ***Directly Observed TB Therapy:*** delivery of therapeutic TB medication under direct observation by site staff.

- ***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.

DENTAL CARE SERVICES (Lines 22 – 24)

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

- ***Dental Care - Restorative:*** dentist services including fillings, crowns, extractions, dentures and similar treatment.***Dental Care - Emergency:*** dental services of an urgent or immediate nature provided on a regular basis.

MENTAL HEALTH/BEHAVIORAL HEALTH SERVICES (Lines 25 – 30)

- ***Mental Health Treatment/Counseling:*** mental health therapy, counseling, or other treatment provided by a mental health professional.

- ***Developmental Screening:*** development screening provided by a mental health professional.

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

- ***Other Mental Health Services:*** other treatment provided by a mental health professional.

- ***Behavioral Health 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.

OTHER PROFESSIONAL SERVICES (Lines 31 – 37)

- ***Hearing Screening:*** diagnostic services to identify potential hearing problems.

- ***Nutrition Services Other than WIC:*** advice and consultation appropriate to individual health needs.

- ***Occupational or Vocational Therapy:*** therapy designed to improve or maintain an individual's employment or career skills.

- ***Physical Therapy:*** assistance designed to improve or maintain an individual's physical capabilities.

- ***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.

- ***Vision Screening:*** diagnostic services to identify potential vision problems.

- ***WIC Services:*** nutrition and health counseling services provided through the Special Supplemental Food Program for Women, Infants and Children

OTHER SERVICES (Lines 38 – 53)

- ***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.

- ***Child Care:*** assistance in caring for young children accompanying the patient during medical and other health care visits

- ***Discharge Planning:*** case management services related to an individual's discharge from the hospital.

- ***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.

- ***Employment/Educational Counseling:*** counseling services to assist individuals define career, employment, and educational interests and opportunities.

- ***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.

- ***Food Bank/Delivered Meals:*** provision of actual food or meals. Does not include financial assistance for food or meals.

- ***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.

- ***Housing Assistance:*** assistance in locating and obtaining suitable temporary or permanent shelter. May include locating costs, moving costs, and rent subsidies.

- ***Interpretation/Translation Services:*** services to assist individuals with language or communication barriers to receive and understand needed services.

- ***Nursing Home and Assisted-Living Placement:*** assistance in locating a n d obtaining nursing home and assisted-living placements.

- ***Outreach:*** case finding, education or other services to identify potential clients and facilitate

access or make client referrals to available services.

- ***Transportation:*** transportation provided for the site's patients.
- ***Home Visiting:*** health and other enabling services delivered to patients in the home.
- ***Parenting Education:*** services to teach individuals child rearing and related skills.
- ***Other (Specify):*** other services not identified above.

OMB No: 0915-0232
Exp: 12/31/2011

For Period: January 1, 2010 to December 31, 2010

TABLE 1

SERVICES OFFERED AND DELIVERY METHOD

Date Submitted: _____

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/Behavioral Health Services				
25.) Mental Health Treatment/Counseling				

INSTRUCTIONS FOR TABLE 2

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

The total number of patients and the total prenatal patients are to be based upon actual data. The total patients reported on parts A, B, C, and D should be equal. The patient 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 patients. Samples may be drawn from patient records.

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:
PATIENTS BY AGE AND GENDER AND PRENATAL PATIENTS BY AGE

The number of patients 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 patients. Samples may be drawn from patient records. Total patients and total prenatal patients are to be based upon actual data.

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

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

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

The number of patients by race, ethnicity, and the number of patients requiring interpretation services may be actual or estimated. Race and ethnicity classifications are to be determined by the patient records. Report the number of patients 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 patients. Samples may be drawn from patient records.

(Column a) Patients by Race (Lines 1 through 8): report the number of patients in each race category on lines 1 through 8. Report Hispanic or Latino patients as a race category in line 6. Report patients selecting more than one race on line 7. Report the number of patients 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 patients on line 9 column (a) equal total patients on line 9 column (b).

(Column b) Patients by Ethnicity (Lines 1 through 4): report the number of patients in each ethnic category on lines 1 and 2. Report "Hispanic or Latino" patients on line 1 and all others as "Not Hispanic or Latino" on line 2. Report the number of patients where the ethnicity is unknown as "Unreported/Refused to Report" on line 3. 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 patients on line 4 column (b) equals total patients on line 9 column (a).

(Line 10) Patients Needing Interpretation Services: the number of total patients who would be better served in a language other than English. This is an estimate of all patients needing interpretation services. Include in the estimate those patients 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 patients who would require interpretation services if served in English. Include deaf patients as well as non-English speaking patients. The definition is meant to be inclusive rather than exclusive.

TABLE 2 PART C: PATIENTS BY INCOME LEVELS

The number of patients 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 patients. Samples may be drawn from patient records. The total number of patients is to be based upon actual data.

(Lines 1 through 5) Percent of Poverty Level: report the numbers of patients 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 by searching the Federal Register online under "notices" for the "Annual Update of the HHS Poverty Guidelines" at http://aspe.hhs.gov/poverty/11poverty.shtml. 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 patients making use of the discount policy, the most current patient income information available, and the current federal poverty guideline. Report the number of patients 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:
PATIENTS BY PRIMARY INSURANCE TYPE

The number of patients 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 patients. Samples may be drawn from patient records. The total number of patients is to be based upon actual data.

A patient 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 patient'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 patient's primary insurance, if any, for the services offered. Report the patient's primary health insurance even though it may not have covered the services rendered during the patient'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 patient has both Medicare and Medicaid because Medicare is billed before Medicaid.
>
> Report the employer plan as the primary insurance if a patient has both an employer plan and Medicare because the employer plan is billed first.

(Line 1) Medicare: patients 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: patients 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: patients 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. Patients 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 patients. Private insurance is earned and other public insurance is unearned. ***Patients 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: patients 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, patients 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 patients.

(Line 5) Self-Pay (no insurance): patients without any health insurance. As noted above, patients 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.

For Period: January 1, 2010 to December 31, 2010 Date Submitted: _____

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

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

Age Groups	Male Patients	Female Patients	Prenatal Patients
	(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 Patients			

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

Col (b), Lines 1-3: ☐ *Col (a), Lines 1-8:* ☐

Patients by Ethnicity		Patients by Ethnicity
		(b)
1.) Hispanic or Latino		
2.) Non-Hispanic		
3.) Unreported/Refused to report		
4.) Total Patients		

Patients by Race	Patients 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 Patients	
10.) Patients needing interpretation Services *(this line is a subset of*	

For Period: January 1, 2010 to December 31, 2010 Date Submitted: _____

TABLE 2- PART C PATIENTS BY INCOME LEVEL

Col (a), Lines1-3: ☐

(Not Completed by Prison, IHS, Section 638 or INS sites)

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

TABLE 2- PART D PATIENTS BY PRIMARY INSURANCE TYPE

Col (a), Lines1-5: ☐

(Not Completed by Prison, IHS, Section 638 or INS sites)

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

Note: Total patients in Tables 2A Cols (a) + (b), 2B Col (a), 2B col (b), 2C, and 2D are equal.

INSTRUCTIONS FOR TABLE 3: STAFFING AND UTILIZATION

This table profiles the personnel, visits, and patients 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). Visits and patients are defined in the General Instructions section beginning on page five. Visits and patients are reported in four major service classes including medical, dental, mental health and behavioral health, and other professional & other services. Visits 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 visits 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) Patients: the unduplicated number of patients seen during the reporting period within each of four major personnel service categories: medical care services; dental services; and mental health and behavioral health services; and other professional services. Patients are defined in the General

Instructions section of this manual. An actual count is of patients by service type is preferred but may be estimated based upon a sample of records. One method for estimating patients by service class is to divide actual visits for that service class by the visits per patient for that service class determined from a random sample of patient records. See the illustration in the General Instructions section on page 9.

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

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 visit, patient, 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 behavioral health 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 6) Physicians: (M.D. or D.O.): separate FTE and visit 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 7) Total Physicians: FTE and visit totals for medical services, lines 1 through 6.

(Line 8) Nurse Practitioners: FTE and visit totals for nurse practitioner staff performing medical services. Nurse practitioners include psychiatric nurse practitioners.

(Line 9) Physician Assistants: FTE and visit totals for physician assistant staff performing medical services.

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

(Line 11) Nurses: FTE and visit 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.

(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, visit, and patient 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 visits 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 visits are not reported.

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

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

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

(Line 19) Dental Hygienists: FTE and visit 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, visit, and patient totals for dental services, lines 18 through 20.

(Line 22) Mental Health and Behavioral Health Specialists: FTE and visit totals for individuals providing counseling or treatment services related to mental health or behavioral health 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 Behavioral Health 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 behavioral health specialists.

(Line 24) Total Mental Health and Behavioral Health Services: FTE, visit, and patient totals for mental health and behavioral health services, lines 22 and 23.

(Line 25) Total: FTE and visit grand totals. The total of unduplicated patients is reported on Table 2.

For Period: January 1, 2010 to December 31, 2010 Date Submitted: _____

TABLE 3
STAFFING AND UTILIZATION

Personnel by Major Service Categories	F.T.E.'s	Patients	Patients
	(a)	*(b)*	*(c)*
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 and Behavioral Health Services			
22.) Mental Health & Behavioral Health Specialists			
23.) Mental Health & Behavioral Health Support Personnel			
24.) Total MH & BH Services *(Lines 22 and 23, except Col. b)*			
25.) *Total* *(Lines 13, 17, 21, and 24)*			

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.

(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 visit, patient, 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 visit, 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) : charges and receipts related to services provided to Medicare beneficiaries payable by 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) Medicaid (Title XIX): charges and receipts related to services provided to Medicaid beneficiaries and payable by 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 3) Other Public: charges and receipts related to services provided to patients and payable by 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 4) Private Insurance: charges and receipts related to services provided to patients and payable by 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 5) 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 6) Total: the sum of lines 1 – 6.

(Line 7) 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 8) 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 9) Total Self-Pay Adjustments: the sum of lines 7 and 8.

For Period: January 1, 2010 to December 31, 2010 Date Submitted: _____

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)*
1.) Medicare		
2.) Medicaid		
3.) Other Public		
4.) Private Insurance		
5.) Self-Pay		
6.) Total *(Lines 1-5)*		

Self-Pay Adjustment Type	Adjustments
	(c)
7.) Self-Pay Sliding Fee Adjustments	
8.) Other Self-Pay Adjustments (Self-Pay Bad Debt and Charity Care)	
9.) Total Self-Pay Adjustments *(Lines 7 and 8)*	

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 Ryan White Part C HIV Early Intervention. 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 5. 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 5.

(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, behavioral health 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 behavioral health 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, behavioral health, 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, behavioral health, 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 non-staff 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 visit, patient, 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.

For Period: January 1, 2010 to December 31, 2010 Date Submitted: _____

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)*	

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

LINE	PERSONNEL BY MAJ O R 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	
8	Nurse Practitioner	X	
9	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	
12	Other Medical Support Personnel		X
12	Clinic Aide (Certified and Uncertified)		X
12	Medical Technologist (Certified and Uncertified)		X
12	Medical Assistant (Certified and Uncertified)		X

APPENDIX *A (continued)*

	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

APPENDIX A *(continued)*

LINE	PERSONNEL BY MAJ OR SERVICE CATEGORY	PROVIDER	NONPROVIDER
	MENTAL HEALTH AND BEHAVIORAL HEALTH STAFF		
22	Mental Health and Behavioral Health 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

Note: *All line numbers refer to Table 3 and only providers generate reportable visits.*