Public Burden Statement: An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. The OMB control number for this project is 0915-0061. Public reporting burden for this collection of information is estimated to average .25 hours per response, including the time for reviewing instructions, searching existing data sources, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to HRSA Reports Clearance Officer, 5600 Fishers Lane, Room 10-29, Rockville, Maryland, 20857.

**PERFORMANCE REPORT FOR GRANTS AND COOPERATIVE AGREEMENTS**

**FORM NAME: State Primary Care Offices (PCOs)**

SECTION A. Number of NHSC Site Application State Recommendation Forms Submitted.

**Block 1.** Indicate the Total Number of complete forms submitted by state PCO to NHSC within 21 calendar days (15 business days) from site submission date

**Block 2.** Total Number of complete forms submitted by state PCO to NHSC

SECTION B. Number of federal and state obligated health care providers addressing identified shortages in HPSAs.

Indicate the following for each obligated health care provider serving in a HPSA:

**Block 3.** Indicate primary care HPSA Name

**Block 4.** Indicate primary care HPSA ID#

**Block 5.** Indicate primary care provider discipline

**Block 6.** Indicate full-time equivalent hours for obligated providers per week.

**Block 7.** Indicate name of federal or state recruitment program supporting primary care FTE

**Block 8.** Indicate dental care HPSA Name

**Block 9.** Indicate dental care HPSA ID#

**Block 10.** Indicate dental care provider discipline

**Block 11.** Indicate full-time equivalent hours for obligated providers per week.

**Block 12.** Indicate name of federal or state recruitment program supporting dental care FTE

**Block 13.** Indicate mental health care HPSA Name

**Block 14.** Indicate mental health care HPSA ID#

**Block 15.** Indicate mental health care provider discipline

**Block 16.** Indicate full-time equivalent hours for obligated providers per week.

**Block 17.** Indicate name of federal or state recruitment program supporting mental health care FTE

(To Be Collected in Chart Format)

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Primary Care HPSA Name** | **HPSA ID#** | **Provider Discipline** | **Provider FTE/week** | **Federal or state program supporting FTE** |
|  |  |  |  |  |
| **Dental HPSA Name** | **HPSA ID#** | **Provider Discipline** | **Provider FTE/week** | **Federal or state program supporting FTE** |
|  |  |  |  |  |
| **Mental HPSA Name** | **HPSA ID#** | **Provider Discipline** | **Provider FTE/week** | **Federal or state program supporting FTE** |
|  |  |  |  |  |

SECTION C. Number of individuals and communities who received technical assistance by requestor type and topic.

**Block 18.** Indicate the type of clients who received technical assistance by requestor type and topic:

Types of Requestor:

Community

Provider

J-1 Waiver

CHC

Health Dept

State Agency

DRO

Medicaid

PCA

SLRP

RHC

NHSC

Other

Total

Topics of Technical Assistance:

NHSC   
Expansion   
Data Share   
Designation   
Needs Assessment   
Other TA Types (Specify)

(To Be Collected in Chart Format)

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | **TA Topic** | | | | | | |
| **TA Requestor** | **NHSC** | **Expansion** | **Data Share** | **Designation** | **Needs Assessment** | **Other TA Types** | **Specify Other Types** |
| **Community** |  |  |  |  |  |  |  |
| **Provider** |  |  |  |  |  |  |  |
| **J-1 Waiver** |  |  |  |  |  |  |  |
| **CHC** |  |  |  |  |  |  |  |
| **Health Dept** |  |  |  |  |  |  |  |
| **State Agency** |  |  |  |  |  |  |  |
| **DRO** |  |  |  |  |  |  |  |
| **Medicaid** |  |  |  |  |  |  |  |
| **PCA** |  |  |  |  |  |  |  |
| **SLRP** |  |  |  |  |  |  |  |
| **RHC** |  |  |  |  |  |  |  |
| **NHSC** |  |  |  |  |  |  |  |
| **Other** |  |  |  |  |  |  |  |
| **Total** |  |  |  |  |  |  |  |

SECTION D: Number of groups who received technical assistance by setting and type.  
**Block 19:** Technical Assistance Numbers by Setting:  
High school students  
Students in health professions training programs (undergraduate)  
Students in health professions training programs (graduate)  
Residency program participants  
Professional Meeting  
Community Meeting  
State sponsored Meeting  
Other Outreach (specify)

Numbers Reached by Technical Assistance Outreach:

Indicate number of group sessions conducted annually

Indicate number of individuals reached in all group sessions

Indicate brief description of setting

(To Be Collected In Chart Format)

|  |  |  |  |
| --- | --- | --- | --- |
| **Setting** | **# of sessions annually** | **Total #’s reached annually** | **Describe outreach setting\*** |
| High school students |  |  |  |
| Students in health professions training programs (undergraduate) |  |  |  |
| Students in health professions training programs (graduate) |  |  |  |
| Residency program participants |  |  |  |
| Professional Meeting |  |  |  |
| Community Meeting |  |  |  |
| State sponsored Meeting |  |  |  |
| Other Outreach (specify) |  |  |  |
| Total |  |  |  |

**INSTRUCTIONS**

**Purpose:** The State Primary Care Offices form captures information about activities conducted through BHW-funded grant programs. The State Primary Care Offices form is divided into four sections: Section A measures number of NHSC Site Application State Recommendation Forms Submitted within 21 days; Section B measures the impact of federal and state obligated health care providers on addressing identified shortages in HPSAs;

Section C captures information about number of individuals and communities who received technical assistance; Section D captures information about number of groups reached by technical assistance. Please complete the applicable sections and blocks using the instructions below.

**SECTION A**

Number of Site Application Recommendation State Recommendation Forms Submitted

**Block 1.** Indicate the total number of National Health Service Corps' (NHSC) Site application state recommendation forms submitted by the state Primary Care Office to the NHSC within 14 days (10 business days).

**Block 2.** Indicate the number of National Health Service Corps' (NHSC) Site application state recommendation forms submitted by the State Primary Care Office to the NHSC.

**SECTION B**

Number of federal and state obligated health care providers addressing identified shortages in HPSAs.

**Block 3.** Indicate primary care HPSA Name

**Block 4.** Indicate primary care HPSA ID#

**Block 5.** Indicate primary care provider discipline

**Block 6.** Indicate full-time equivalent hours for obligated providers per week.

**Block 7.** Indicate name of federal or state recruitment program supporting primary care FTE

**Block 8.** Indicate dental care HPSA Name

**Block 9.** Indicate dental care HPSA ID#

**Block 10.** Indicate dental care provider discipline

**Block 11.** Indicate full-time equivalent hours for obligated providers per week.

**Block 12.** Indicate name of federal or state recruitment program supporting dental care FTE

**Block 13.** Indicate mental health care HPSA Name

**Block 14.** Indicate mental health care HPSA ID#

**Block 15.** Indicate mental health care provider discipline

**Block 16.** Indicate full-time equivalent hours for obligated providers per week.

**Block 17.** Indicate name of federal or state recruitment program supporting mental health care FTE

Disciplines include:

Non-psychiatric Physician (MD or DO)

Dentist (DDS/DMD)

Nurse Practitioner (NP)

Nurse Midwife

(NM)

Physician Assistant (PA)

Dental Hygienist (DH)

Psychiatrist (MD&DO)

Clinical Psychologist (CP)

Licensed Clinical Social Worker (LCSW)

Psychiatric Nurse Specialist (PNS)

Other Mental Health Clinician (specify)

Licensed Professional Counselor (LPC)

Marriage and Family Therapist (MFT)

Other (specify)

Only count providers that were obligated as of September 30th each reporting year. This measure does not have a start and end data collection date. This measure ONLY has an end date.

**SECTION C**

Number of individuals and communities who received technical assistance reported by requestor type and topic

**Block 18.** Select the type of clients who received technical assistance from the type and requestor options below:

Types of Requestor:

Community

Provider

J-1 Waiver

CHC

Health Dept

State Agency

DRO

Medicaid

PCA

SLRP

RHC

NHSC

Other

Total

Topics of Technical Assistance:

NHSC   
Expansion   
Data Share   
Designation   
Needs Assessment   
Other TA Types (Specify)

**SECTION D**

Number of Groups who received technical assistance reported by setting and type.

**Block 19.** Indicate the number of clients who received technical assistance by setting and type from the options below:

Technical Assistance Numbers by Setting:

High school students

Students in health professions training programs (undergraduate)

Students in health professions training programs (graduate)

Residency program participants

Professional Meeting

Community Meeting

State sponsored Meeting

Other Outreach (specify)

Total

Numbers Reached by Technical Assistance Outreach:

Indicate number of group sessions conducted annually

Indicate number of individuals reached in each group session

Indicate brief description of group session setting

**When finished, click on "Save and Continue" to be routed to the appropriate form(s).**