DEPARTMENT OF HEALTH AND HUMAN SERVICES Health Resources and Services Administration FORM 5B: SERVICE SITES	FOR HRSA USE ONLY	
	Application Tracking Number	Grant Number

Site Qualification Criteria	
1. Is the site an A"admin-only" site? If Yes, the site is an Admin-only site, select 'Not Applicable' for questions a through d below. If No, the site is a Service Delivery site, answer questions a through d Yes or No.	[_] Yes [_] No
If 'No',	
a. a. Are/will health center encounters visits be generated by documenting in the patients' records face-to-face contacts between patients and providers?	[_] Yes [_] No [_] Not Applicable
b. Do/will providers exercise independent judgment in the provision of services to the patient?	[_] Yes [_] No [_] Not Applicable
c. Are/will services be provided directly by or on behalf of the grantee, whose governing board retains control and authority over the provision of the services at the location?	[_] Yes [_] No [_] Not Applicable
d. Are/will services be provided on a regularly scheduled basis (e.g., daily, weekly, first Thursday of every month)?	[_] Yes [_] No [_] Not Applicable
Choose Site Location Setting	
2. Is the sSite a Domestic Violence (Confidential) shelter? Select Yes for this question only if the site being added is a confidential site serving victims of domestic violence and the site address cannot be published due to the necessity to protect the location of the domestic violence shelter.	[_] Yes [_] No [_] Not Applicable

Site Information			
Name of Service Site Name		Service Site TypeSite Physical Address (Please ensure your address contains the appropriate unique suite, building, or other notation, if appropriate. If the address displayed does not contain this information, please select Change Physical Location and update as appropriate)	
LocationSite Type	[ ] Administrative/Service Delivery Site [ ] Service Delivery Site [ ] Administrative Site	Location Setting Site Phone Number	
Number of Contract Service Delivery Locations (Voucher Screening Only)		Number of Intermittent Sites (Intermittent Only)	
Web URL			

The following fields are required for "Service Delivery" and "Administrative/Service Delivery" site types:			
Location Type	[ ] Permanent [ ] Seasonal [ ] Mobile [ ] Migrant Voucher [ ] Intermittent	Site Setting	[ ] All Other Clinic Types [ ] Hospital [ ] School
Date Site was Added to Scope	mm/dd/yyyy	Site Operational Date	mm/dd/yyyy

FQHC Site Medicare Billing Number Status	[ ] This site is neither permanent nor seasonal per CMS (i.e., does not require unique FQHC Medicare Billing Number) [ ] Health center does not/will not bill under the FQHC Medicare system at this site [ ] Number is pending; application for this site has been submitted to CMS [ ] Application for this site has not yet been submitted to CMS [ ] This site has a Medicare billing number	FQHC Site Medicare Billing Number (Required if "This site has a Medicare billing number" is selected in 'FQHC Site Medicare Billing Number Status' field)	
FQHC Site National Provider Identification (NPI) Number (Optional field)		Total Hours of Operation (when Patients will be Served per Week)	
Months of Operation			
Service Area ZIP Codes			
Number of Contract Service Delivery Locations (Required for 'Migrant Voucher Screening' Site Type)		Number of Intermittent Sites (Required only for 'Intermittent Site' Type)	
Site Operated by	[ ] ~~Grantee~~ Health Center/Applicant [ ] Sub-~~R~~recipient [ ] Contractor		
Subrecipient or Contractor Information: (Required only if 'Subrecipient' or 'Contractor' is selected in 'Site Operated By' field)			
Subrecipient/Contractor Organization Name			
Subrecipient/Contractor Organization Physical Site Address			
Subrecipient/Contractor EIN			

~~If site is operated by sub-recipient or contractor, please provide the organization information below:~~

~~Organization~~	
~~Organization Name~~	-
~~Address (Physical)~~	-
~~Address (Mailing)~~	-
~~EIN~~	-
~~Comments~~	

~~Date Site was Opened~~	–	~~Date Site was Added to Scope~~	–
~~Site Operational By~~	–	~~Medicare Billing Number~~	–
~~Medicaid Billing Number~~	–	~~Medicaid Pharmacy Billing Number~~	
~~Site Phone Number~~	–	~~Site Fax Number~~	–
~~Site Physical Address~~	–		
~~Site Mailing Address (including Mailstop Code, Division/Department Name, Company, and Street/PO Box Address)~~	–		
~~Administration Phone Number~~		~~Service Area Population Type~~	~~[ ] Urban [ ] Rural [ ] Sparsely Populated~~
~~Service Area Zip Codes (include only those from which the majority of the patient population will come)~~			

Service Area Census Tracts (include only those from which the majority of the patient population will come)			
Operational Schedule	[_] Full-Time [_] Part-Time	Calendar Schedule	[_] Year-Round [_] Seasonal
Total Hours of Operation when Patients will be Served per Week (include extended hours)		Months of Operation (required for Permanent and Seasonal Locations)	

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 0915-0285. Public reporting burden for this collection of information is estimated to average 1 hour 45 minutes 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 10-3314N-39, Rockville, Maryland, 20857.