

Attachment A - Site Interest Form

Site Interest Form

Please complete the following form about your (organization). It should take no longer than 6 minutes. Our team will be in touch shortly to discuss this opportunity with you.

1. Site name:
2. Site main address:
3. Site telephone number:
4. Site Type (select one)
 - a. Ambulatory specialty clinic
 - b. Ambulatory primary clinic
 - c. FQHC
 - d. Adult hospital
 - e. Children's hospital
 - f. ER
5. Site characteristics/profit status

Select one:

☐ Government ☐ Non-government

Select one:

☐ For-profit ☐ Non-profit

Select one:

☐ Teaching ☐ Non-teaching

This survey is authorized under 42 U.S.C. 299a. This information collection is voluntary and the confidentiality of your responses to this survey is protected by Sections 944(c) and 308(d) of the Public Health Service Act [42 U.S.C. 299c-3(c) and 42 U.S.C. 242m(d)]. Information that could identify you will not be disclosed unless you have consented to that disclosure. Public reporting burden for this collection of information is estimated to average 6 minutes per response, the estimated time required to complete the survey. 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 data you provide will help AHRQ's mission to produce evidence to make health care safer, higher quality, more accessible, equitable, and affordable. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to: AHRQ Reports Clearance Officer Attention: PRA, Paperwork Reduction Project (0935-xxxx) AHRQ, 5600 Fishers Lane, Room #07W42, Rockville, MD 20857, or by email to the AHRQ MEPS Project Director at MEPSPROJECTDIRECTOR@ahrq.hhs.gov.

6. Urbanicity (select one)
 - a. Urban (Large Metropolitan)
 - b. Urban (Suburban)
 - c. Rural
7. Organization or Health System name:
8. Organization or Health System main address:
9. Organization or Health System main telephone number:
10. Point of Contact name:
11. Point of Contact email:
12. Point of Contact telephone number:
13. Alternate Contact name:
14. Alternate Contact email:
15. Alternate Contact telephone number:
16. CMS Region Location: (select one)
 - __ 1 (CT/ME/MA/NH/RI/VT)
 - __ 2 (NJ/NY/PR/VI)
 - __ 3 (DE/DC/MD/PA/VA/WV)
 - __4(AL/FL/GA/KY/MS/NC/SC/TN)
 - __5 (IL/IN/MI/MN/OH/WI)
 - __ 6 (AR/LA/NM/OK/TX)
 - __7 (IA/KS/MO/NE)
 - __8 (CO/MT/ND/SD/UT/WY)
 - __9 (AS/AZ/CA/GU/HI/NV)
 - __10 (AK/ID/OR/WA)

17. Interested in (check all that apply)
- a. Measure Dx
 - b. Calibrate Dx
 - c. Toolkit for Engaging Patients

18. Best time/way to contact: