COMMUNITY HEALTH CENTER SUPPLEMENTAL APPLICATION

This application must be completed in conjunction with
the CNA Allied Health Care Facilities Common Application.

Instructions:

1. Please read the instructions carefully. Complete and submit all requested information and/or required attachments. This application and all materials submitted shall be held in confidence.

2. All application questions must be fully answered. If a question does not apply, please write "N/A".

3. If you need more space, continue on a separate sheet of your letterhead and indicate the question number.

Name of Applicant: _____

1. Are you designated as a Federally Qualified Health Center (FQHC) ☐ yes ☐ no.

2. Type of Facility (check all that apply):

☐ Free Standing ☐ Critical Access Hospital Based

☐ Provider Based (unit of hospital, nursing home, or home health agency)

☐ Other (Describe): _____

3. What population do you service?

The Public Housing Primary Care Program (PHPC) _____%

Elderly _____% Migrant _____% Homeless _____% School based _____%

Other _____% Describe: _____

4. Current Number of Patients: _____

a. Typical % of pediatric patients _____%

b. Typical % of adult patients _____%

5. Indicate % of Gross Receipts by Type of Care and Visits. "Visits" are defined as the number of patients entering the facility for health related services per year.

Services Provided	% of Gross Receipts	Projected Annual Number of Visits/Revenue as noted
Adult Primary Health Care	%	#
Behavioral Health – indicate number of visits in sections below	%	N/A
Substance Abuse Counseling	N/A	#
Mental Health Counseling	N/A	#
Chronic Disease Management, e.g. asthma, obesity, diabetes	%	#
Clinical Trials	%	#

Services Provided	% of Gross Receipts	Projected Annual Number of Visits/Revenue as noted
Dental Care	%	#
Emergency Care/Urgent Care	%	#
Eye Care	%	#
Home Health Care	%	#
Imaging Services, e.g. x-ray, ultrasound	%	#
Immunizations, including tetanus diphtheria and influenza	%	#
Insurance Eligibility Screening and Enrollment	%	#
Invasive Procedures/Minor surgery(describe)	%	#
Laboratory Testing – indicate revenue		$
Medical Referral Services	%	#
Medical Social Services	%	#
Methadone Dispensing – indicate revenue		$
Nutritional Counseling	%	#
Pediatric Primary Health Care		#
Pre-employment physical exams	%	#
Social Services	%	#
TB Testing	%	#
Women's Health Care – Indicate number in sections below	%	
Abortions	N/A	#
Breast examination;	N/A	#
D&C's (dilatation and curettage)	N/A	#
Family planning services	N/A	#
Mammography Referral	N/A	#
Obstetrical Deliveries	N/A	#
Post-partum care	N/A	#
Prenatal care	N/A	#
Other (_____)	%	
Other (_____)	%	

6. **Do you have after hours coverage?** ☐ Yes ☐ No. If yes, please describe _____

_____

7. Do you provide a flu shot program? ☐ yes ☐ no

If "yes", what is the expected number of clients? _____

Do you provide a follow-up phone number to the patients in the event of a reaction to the vaccination? ☐ yes ☐ no

8. Do you use volunteers? ☐ yes ☐ no

If "yes", what type of services do they provide? _____

If "yes" do all volunteers undergo a criminal background check?

9. Do you operate a Pharmacy? ☐ yes ☐ no

a. If "yes", Receipts $ _____

b. If the Applicant is a distributor are the prescriptions: ☐ pre-packaged, or ☐ compound mixture

c. Is the Applicant ☐ packaging, ☐ compounding, or ☐ performing admixture?

d. Does the pharmacy compound medications? ☐ yes ☐ no

e. Does the pharmacy dispense controlled narcotics? ☐ yes ☐ no

10. Do you operate a CLIA approved laboratory? ☐ yes ☐ no

AUTHORIZATION

Signature in full Date

Name - please print

Agency Name and Address	Person submitting application	Telephone Number	E-Mail

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