OHIO PRACTICE SITE SUMMARY

Ohio Dental Hygienist Loan Repayment Program
Ohio Dentist Loan Repayment Program
Ohio Physician Loan Repayment Program
State Loan Repayment Program

Directions: Complete one Practice Site Summary form for each site where the applicant practices or will practice. This page *cannot* be completed by the applicant unless he or she is the owner of the practice.

I. Employer and Practice Site Information

Employer Name

Employer Address City, Zip+4

Practice Site Name

Practice Site Address City, Zip+4

II. Applicant (Clinician) Information

Applicant's Name Number of hours per week clinician practices at this practice site location?

Current Employment Contract (Start Date) to (End Date) Hours per Week

Number of hours per week clinician spends on each of the following job duties at this practice site per week: Patient Care Teaching Administration Other

III. Practice Site Profile

A. Does this practice participate in the Ohio Medicaid program? ☐ Yes ☐ No Medicaid #

B. Does this practice accept new Medicaid-eligible patients? ☐ Yes ☐ No

C. Does this practice accept assignment for Medicare? ☐ Yes ☐ No Medicare ID#

D. Does this practice see all patients regardless of their ability to pay? ☐ Yes ☐ No

E. Does this practice utilize a sliding fee scale (SFS) for uninsured patients whose incomes are at or below 200% of the Federal Poverty Guidelines? ☐ Yes* ☐ No *If yes, include a copy of SFS with the application

F. Is this practice not-for-profit? ☐ Yes ☐ No

G. What percentage of patients served by the practice are of racial and ethnic minorities? %

H. Provide the practice site's payer mix data for the most recent 12-month period. Provide actual numbers for unduplicated patients.
Reporting Period: to

Payer	Number of Unduplicated Patients	Percentage of Total Patients
Medicaid		0.00%
Medicare		0.00%
Sliding Fee Scale		0.00%
Full Fee Self-pay		0.00%
No Charge/No Payment by Client		0.00%
Private Insurance		0.00%
Other (explain)		0.00%
TOTALS	0	0.00%

I. Is this practice a Patient-Centered Medical Home? ☐ Yes* ☐ No

**If yes, through which of the following?* ☐ AACHC ☐ JC PCMH ☐ NCQA ☐ URAC

J. Does this practice provide integrated primary care and behavioral health care? ☐ Yes ☐ No

K. Does this practice utilize telehealth services? ☐ Yes* ☐ No

If yes,* ***through which of the following?* ☐ Originating Site ☐ Distant Site

IV. Practice Site Contact Person and Certification

Site contact person if applicant is awarded loan repayment:

Contact Person's Name

Contact Person's Position

Contact Person's E-Mail Address

Contact Person's Phone

☐ I certify that the information provided above is correct and can be verified with billing records.

Printed Name of Person Completing Survey

Title

Date

Signature of Person Completing Survey

E-Mail Address

Phone