



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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