

REQUEST FORM
CHANGE IN EMPLOYER/SERVICE SITE OR SERVICE HOURS

Request Date: _____

PRIMARY CARE PROVIDER INFORMATION

Name (Last, First): _____

Home Phone Number: _____ Daytime: _____

Email Address: _____

Reason for Request:

___ Change in service hours from full-time to half-time

Per R9-15-211 (F) Quarterly loan repayment amount will decrease in half effective the date of approval of the request.

___ Change in service hours from half-time to full-time

Per R9-15-211 (G)(1), No change in quarterly loan repayment amount until approval to renew contract.

___ Add a site or sites to an existing approved site(s)

___ Transfer to a new site (complete transfer where full services are going to be provided)

EMPLOYER INFORMATION

Name of Organization: _____

Executive director/manager's name: _____

Mailing Address: _____

Phone Number: _____ Email: _____

The employing organization is a ___ non-profit ___ for-profit organization.

The employing organization is a ___ public ___ private entity.

SERVICE SITE INFORMATION

Name of Current Approved Service Site: _____

Service Site Address: _____

Service Site Administrator Name: _____

Phone Number: _____ Email: _____ Fax Number: _____

Are the primary care provider's service hours at this site changing? ___ Yes ___ No

If yes, please check: ___ full-time to half-time or ___ half-time to full-time

If no, is the primary care provider's service site changing? ___ Yes ___ No

If yes, please check: ___ complete transfer to a new site ___ adding a site or sites

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Name of New/Additional Service Site: _____

Note: If requesting to add more than one service site, please fill out a request form for each additional site.

Service Site Address: _____

This site is in a _____ Rural _____ Urban area.

Primary Care Provider's Start Date of Service at the New/Added Site: _____

Primary Care Provider's End Date of Service at the Original Approved Site or N/A: _____

Expected number of primary care service hours at this site: _____

If applicable, number of telemedicine hours of the total primary care service hours at this site: _____

Practice Type

- Tribal/Indian Health Service Clinic
- CMS-Certified Federally Qualified Health Center (FQHC)
- CMS-Certified Federally Qualified Health Center Look –Alike (FQHC-LA)
- CMS Certified Rural Health Clinic
- State/Federal Prison
- Other
 - Please specify _____

Does this site accept Title XVIII (Medicare)? Yes No

If yes, provide Medicare identification number: _____

Does this site accept Title XIX (Medicaid/AHCCCS)? Yes No

If yes, AHCCCS provider number: _____

Does this site accept marketplace health insurance “qualifying health plan(s)? Yes No

If yes, qualifying health plan provider name and number: _____

Does this site implement a Sliding Fee Schedule (SFS)? Yes No

Note: Except for a free clinic or a state or federal prison, please attach the service site's SFS, SFS Policy and SFS Notice that is posted on the premises.

Distance from the next sliding fee scale clinic with the same type of service: _____

Link to Sliding Fee Scale Clinics locations: <http://www.azdhs.gov/hsd/sliding-fees/locations.htm>.

NOTE:

If the next nearest SFS clinic is an affiliated clinic of the service site, indicate the services site's distance to that affiliated clinic.

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Health Professional Shortage Area (HPSA) Designation in which the Service Site is Located

IMPORTANT NOTES:

Please list the HPSA Specific to the Primary Care Provider's Discipline.
Please print evidence of the service site's HPSA and attach with this document.

Find the HPSA information:

<http://datawarehouse.hrsa.gov/geoAdvisor/ShortageDesignationAdvisor.aspx> or
<http://datawarehouse.hrsa.gov/tools/analyzers/hpsafind.aspx>.

Census tract of service site (can be obtained from: <http://www.ffiec.gov/Geocode/default.aspx>):

Census Tract Number: _____

HPSA Name and Number: _____ HPSA Score: _____

Is this site's HPSA score different from the original approved site's HPSA score? ___ Yes ___ No.

If yes, list HPSA Name, Number and Score of the Original Approved Site

NOTE: Rural private practice sites that are not in a HPSA may submit evidence of AzMUA.

AzMUA information can be obtained from:

<http://www.azdhs.gov/hsd/data/documents/reports/azmuaannualrpt.pdf>

AzMUA Name: _____

Service Site Proof of Services to Underserved Populations

	<u>Last Two Calendar Years</u> (Please enter year)	
A. TOTAL # ENCOUNTERS ⁽¹⁾⁽²⁾ AT THE SERVICE SITE		
B. TOTAL # MEDICARE⁽³⁾ ENCOUNTERS		
C. TOTAL # MEDICAID⁽⁴⁾ ENCOUNTERS		
D. TOTAL # SFS⁽⁵⁾ ENCOUNTERS		
E. TOTAL # ENCOUNTERS FREE OF CHARGE		
F. C + D + E		
G. F / A * 100 (% of underserved patients served)		

- (1) An encounter is an office visit with a patient.
- (2) All encounters must have been at the specific facility referred to in this application.
- (3) Number of encounters where patients used Medicare as a method of payment.
- (4) Number of encounters where patients used AHCCCS as a method of payment.
- (5) Number of self-pay encounters using a Sliding Fee Schedule.

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If providing telemedicine, number of telemedicine hours of the total primary care service hours: _____

Note: Telemedicine hours is limited to 8 hours of the full-time 40 hours per week or 4 hours of the half-time 20 hours per week. The telemedicine site and the site where the patient is receiving telemedicine services must both be located in a Health Professional Shortage Area.

Name of Telemedicine Site _____

Street Address _____

Site Point of Contact Name _____

Phone _____ Email _____ Fax _____

HPSA Name _____ HPSA Number _____

PRIMARY CARE PROVIDER CERTIFICATON

I hereby certify that the Arizona Department of Health Services or its designee is authorized to verify all information provided in this form. _____ Initials

I hereby authorize the Arizona Department Health Services to request and obtain supplemental information from me regarding my application. _____ Initials

I hereby certify that all information provided in this request form is true and accurate. _____ Initials

When there is a change in employer, service site or service hours, a copy of the employment contract or employment letter is required to be submitted. I have attached a copy of the employment contract or letter that reflects this change request. _____ Initials

EMPLOYER/SERVICE SITE CERTIFICATION

(To be initialed and signed by the service site's licensee, employer, tribal authority or their designee)

Please check the appropriate boxes and fill in the blanks.

_____ A. The employer is a public, private non-profit or a rural, private practice and is eligible to participate in the LRP.

_____ B. This service site is in compliance with the LRP site eligibility requirements.

To be eligible to have a primary care provider participate in the LRP, a service site shall:

1. Provide primary care services in an area that is federally designated as a HPSA (Primary Care Provider Loan Repayment Program) or an AzMUA (Rural Private Primary Care Provider Loan Repayment Program);
2. Accept Medicare, Medicaid (AHCCCS) and qualifying health plan assignment;
3. Charge for services at the usual and customary rates prevailing in the primary care area, except that the service site shall have a policy providing that patients unable to pay the usual and customary rates shall be charged a reduced rate according to the service site's sliding-fee scale based on federal poverty level guidelines and meets [A.A.C. R9-1-504](#) 'Sliding See Schedule submission and content' except for a free clinic or a state or federal prison.
4. Not discriminate on the basis of a patient's ability to pay for care or the payment source,

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including Medicare, AHCCCS, or qualifying health plan.

- _____ C. This site has an employment contract/agreement with the provider or a letter of intent to hire the provider for the duration of the initial loan repayment contract and has the financial means available to support the primary care provider, including salary, benefits, and malpractice insurance expenses.
- _____ D. Except for a free clinic or a state/federal prison, this site is implementing a sliding fee scale program for patients without health insurance based on current federal poverty levels as dictated by the Federal Register. (I have attached a copy of the sliding fee scale, the sliding fee scale policy, and the sliding fee scale signage posted on the premises. _____ Initials)
- _____ E. The primary care provider awarded loan repayment funds will work full-time at least 40 hours per week, half-time at least 20 hours per week, or _____ hours in conjunction with service hours in a current approved site to a cumulative full-time or half-time hours as required in their profession per the LRP service hour requirements.
- _____ F. This site agrees to notify the Arizona Department of Health Services immediately when the employment status of the provider has changed i.e. termination, transfer to a different site, additional site, leave beyond 35 work days, change in work hours that is less than full-time or half-time, change in the scope of primary care services provided, etc.

I hereby certify that, to the best of my knowledge, the information contained in this form is accurate, and hereby authorize the Arizona Department of Health Services or its designee to verify all information presented.

Typed or Printed Name of Person Authorized to Sign on behalf of the licensee, employer, tribal authority or designee:

Signature of Authorized Person: _____ Date: _____

State of _____)

County of _____)

The foregoing instrument was acknowledged before me this _____ day of _____.

_____ My Commission Expires: _____
Notary Public