HOSPITAL-BASED FQHC IDENTIFICATION DATA	PROVIDER CCN: _____ COMPONENT CCN:	PERIOD: FROM: _____ TO: _____	WORKSHEET S-11 PART I

PART I - HOSPITAL-BASED FQHC IDENTIFICATION DATA

	1	Type of control (see instructions) 2	Date Decertified 3	V/I Decertification 4	Date of CHOW 5	
1	Site Name:					1
2	Street: P.O. Box:					2
3	City: State: ZIP Code: County: Designation - Enter "R" for rural or "U" for urban:					3
4	Is this hospital-based FQHC part of an entity that owns, leases or controls multiple FQHCs? Enter "Y" for yes or "N" for no. If yes, enter the entity's information below.					4
5	Name of Entity:					5
6	Street: P.O. Box: HRSA Award Number:					6
7	City: State: ZIP Code:					7

Consolidated Cost Report		Y/N 1	Date Requested 2	Date Approved 3	Number of FQHCs 4	
8	Is this hospital-based FQHC filing a consolidated cost report per CMS Pub. 100-04, chapter 9, §30.8? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, complete columns 2 through 4, and line 9 beginning with line 9.01. If column 1 is no, leave line 9 blank. (see instructions)					8

	1	CCN 2	CBSA 3	Date Requested 4	Date Approved 5	
9	List of Consolidated Providers:					9
9.01	Site Name:					9.01

Hospital-Based FQHC Operations		1	2	3	
10	What type of organization is this hospital-based FQHC? If you operate as more than one sub-type of an organization, enter only the applicable alpha characters in column 2. (see instructions)				10
11	Did this hospital-based FQHC receive a grant under §330 of the PHS Act during this cost reporting period? If this is a consolidated cost report, did the hospital-based FQHC reported on line 1, column 1, receive a grant under §330 of the PHS Act during this cost reporting period? Enter "Y" for yes or "N" for no. (complete line 12)				11
12	If the response to line 11 is yes, indicate in column 1, the type of HRSA grant that was awarded (see instructions). Enter the date of the grant award in column 2, and enter the grant award number in column 3. If you received more than one grant subscript this line accordingly.				12
Medical Malpractice					
13	Did this hospital-based FQHC submit an initial deeming or annual redeeming application for medical malpractice coverage under the FTCA with HRSA? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the effective date of coverage in column 2.				13
Interns and Residents					
14	Did this hospital-based FQHC receive a THC development grant authorized under Part C of Title VII of the PHS Act from HRSA? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2, the number of FTE residents that your hospital-based FQHC trained and received funding through your THC grant in this cost reporting period and in column 3, enter the total number of visits performed by residents funded by the THC grant in this cost reporting period. (see instructions)				14