

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

PROVIDER CCN:

PERIOD:

WORKSHEET S-8

COMPONENT CCN:

FROM _____
TO _____Check applicable box: ☐ Hospital-based RHC
☐ Hospital-based FQHC

Clinic Address and Identification:

1	Street:															1
2	City:	State:	Zip Code:	County:												2
3	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban															3

Source of Federal Funds:

		Grant Award	Date	
		1	2	
4	Community Health Center (Section 330(d), PHS Act)			4
5	Migrant Health Center (Section 329(d), PHS Act)			5
6	Health Services for the Homeless (Section 340(d), PHS Act)			6
7	Appalachian Regional Commission			7
8	Look-alikes			8
9	Other (specify)			9

		1	2	
10	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate the number of other operations in column 2.			10

Facility hours of operations¹

	Type Operation	Sunday		Monday		Tuesday		Wednesday		Thursday		Friday		Saturday		
		from	to	from	to	from	to	from	to	from	to	from	to	from	to	
11	Clinic	1	2	3	4	5	6	7	8	9	10	11	12	13	14	11

Enter clinic hours of operation on line 11 and other type operations on subscripts of line 11 (both type and hours of operation).
List hours of operation based on a 24 hour clock. For example: 8:00am is 0800, 6:30pm is 1830, and midnight is 2400.

		1	2	3	
12	Have you received an approval for an exception to the productivity standard?				12
13	Is this <i>worksheet prepared for</i> a consolidated <i>group</i> as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If <i>column 1 is Y</i> , enter in column 2 the number of providers included in <i>the group</i> . List the <i>provider name and provider number</i> of <i>each member</i> in the consolidated group on line 14. If <i>column 1 is Y</i> , in column 3, enter <i>G or N</i> to identify the grouping as grandfathered or non-grandfathered, respectively.				13
13.01	<i>Reserved</i>				13.01
14	RHC/FQHC name: CCN:				14

		Y/N	V	XVIII	XIX	Total Visits	
		1	2	3	4	5	
15	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)						15