

Quarterly Work Report

SHARP Program- Alaska Department of Health & Social Services

This report form is to be completed by each SHARP practitioner and his/her respective practice site (agency). The SHARP program must verify that each participant has been delivering healthcare services at the specified practice site during the past quarter: Please confirm this by completing this form electronically in Adobe Reader, saving, and sending it to SHARP program office via email to sharp.reports@alaska.gov.

Check one:	Reporting Period	Report Due
	January 1 – March 31	April 30
	April 1 – June 30	July 31
	July 1 – September 30	October 30
	October 1 – December 31	January 31

<i>Practitioner Information</i>	
Last Name	First Name
Email	Phone number
AK License number	Discipline Specialty

<i>Practice Information</i>			
Authorized FTE:	Full-Time	Half-Time	
Start date (effective date)			
Check one:	Full Quarter	Partial Quarter – Start date	End date
SHARP Program Component:		SHARP-I	SHARP-II SHARP-III
Number of practice sites:			
Do you currently have or anticipate having, a service obligation in addition to SHARP? <i>If yes, describe:</i>			Yes No

Practice Site 1 Name	
Site Street Address	
Site Phone	Site E-mail
Date SHARP practice began	
AK Medicaid No.	AK Medicare No.

Practice Site 2 Name	
Site Street Address	
Site Phone	Site E-mail
Date SHARP practice began	
AK Medicaid No.	AK Medicare No.

Please attach extra sheets if additional site information is necessary.

<i>Breakout of Duties</i>	
	% of Duties
Administrative	%
Direct Patient Care	%
Must add up to 100%	
	%

Clinician's Patient Payer Mix			
	Number of Patients	Number of Visits	<i>Pharmacists Only:</i> Number of prescriptions
Medicaid			
Medicare			
Patient Pay - Sliding Fee Scale			
Patient Pay - Full Fee			
No Charge or No Payment			
Private Insurance			
Indian Health Service			
VA or other Federal Program			
Other (explain)			
Total			
<i>Note: number of patients cannot exceed number of visits; unduplicated (each patient in one category)</i>			
Description of Case Load (Must add up to 100%)			
			% of Patients
Patients age years: 0-5			%
Patients age year: 6-18			%
Patients age year: 19-64			%
Patients age year: 65+			%
			%
Setting and Type of Care (May not add up to 100%)			
			% of Patients
In a hospital			%
In a Community Health Center			%
By use of telemedicine			%
Primary Care (also includes dental & behavioral health)			%
In a site that integrates primary care and behavioral health			%
In a Primary Care Medical Home clinic			%
To any patients in correctional facilities			%
To any patients on probation or parole			%
SHARP Clinician:			
I certify that all data contained in this report are accurate and can be substantiated by a record review. I hereby certify, under penalty of revocation of my Alaska SHARP agreement, that I personally delivered the type of health care services for which my SHARP award was approved.			
Yes	No	Date	
Authorized Site Representative (Administrator or Clinical Supervisor):			
As an authorized site (agency) representative, I certify via my signature that all data contained in this report are accurate and can be substantiated by a record review.			
<ul style="list-style-type: none"> The practitioner named above worked as a primary care clinician during the stated period, at the clinic site(s) listed above, and as in accordance with his/her SHARP contract. This site (agency) used the sliding fee scale or "no pay" policy for uninsured patients submitted with the sponsoring site's application. During reporting period, this practitioner was off work, including vacation, sick days, and holidays, for a total of days. 			
Yes	No	Date	
Printed name			
Title		Phone number	