

Part 2: Site Information

Site-1:

Practice Site Name	
Site Street Address	
Site email & phone	
Date SHARP practice began:	
AK Medicaid No.	
AK Medicare No.	

Site-2:

Practice Site Name	
Site Street Address	
Site email & phone	
Date SHARP practice began:	
AK Medicaid No.	
AK Medicare No.	

Site-3:

Practice Site Name	
Site Street Address	
Site email & phone	
Date SHARP practice began:	
AK Medicaid No.	
AK Medicare No.	

Clinician's Patient Payer Mix	A. Number of Patients	B. Number of Visits
Medicaid		
Medicare		
Patient Pay - Sliding Fee Scale		
Patient Pay - Full Fee Scale		
No Charge or No Payment		
Private Insurance		
Other (explain)		
Total		

- * Column A entries cannot exceed Column B entries
- * Categories are non-duplicative; each patient in one category

Site's Patient Payer Mix	A. Number of Patients	B. Number of Visits
Medicaid		
Medicare		
Patient Pay - Sliding Fee Scale		
Patient Pay - Full Fee Scale		
No Charge or No Payment		
Private Insurance		
Other (explain)		
Total		

* Column A entries cannot exceed Column B entries

* Categories are non-duplicative; each patient in one category

Comment(s): _____

Assertions:

As an authorized site (agency) representative, I certify via my signature that:

- A. This site (agency) used the sliding fee scale or “no pay” policy submitted with the sponsoring site’s application for uninsured patients.
- B. This here-listed practitioner worked as a primary care clinician during the here-stated period, at the clinic site(s) listed above, and as in accordance with his/her SHARP contract, in either a “Full-Time” or a “Half-Time” capacity. For definition of “Full-Time”, “Half-Time”, and related terms, see accompanying Report “Guidance” &/or the SHARP website at: <http://www.hss.state.ak.us/dph/healthplanning/sharp/default.htm> .
- C. During the here-stated quarterly reporting period, this practitioner was off work, including vacation, sick days and holidays, for a total of _____ days.
- D. All information here-provided is true and correct to the best of my knowledge and belief.

Signature of Authorized Site Representative - & Date (Administrator or Clinical Supervisor)	Printed Name of Authorized Signature (Administrator or Clinical Supervisor)
Phone number of signator	Title / Position of Signator