



National Health Service Corps Site Reference Guide

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U.S. Department of Health and Human Services
Health Resources and Services Administration
Bureau of Health Workforce
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PURPOSE

The purpose of the National Health Service Corps (NHSC) Site Reference Guide is to provide clarity on site eligibility requirements, qualification factors, compliance, roles and responsibilities associated with being an NHSC-approved site. The NHSC Site Reference Guide supplements the information contained in the online [NHSC Site Application](#).

It is strongly recommended that a site thoroughly review this document prior to completing an NHSC Site Application or becoming an NHSC-approved site. HRSA will update the [NHSC Site Reference Guide](#) periodically with updated web links, changes to the governing NHSC statute and regulations, and NHSC policies and procedures.

The 2020 NHSC Site Reference Guide contains changes related to the appropriation of specific funding for the NHSC to expand and improve access to quality opioid and substance use disorder (SUD) treatment in underserved areas. Under this initiative, Opioid Treatment Programs (OTPs), facilities in which office-based opioid treatment (OBOT) is provided by clinicians with a waiver granted under 21 U.S.C. § 823(g)(2), and non-opioid outpatient SUD treatment facilities may be eligible for the NHSC.

The requirements outlined in this document apply to applicant sites that submit an application in Calendar Year (CY) 2020 and all approved NHSC sites, including those required to recertify in CY 2020. Additional information and program changes applicable to NHSC sites, both current and those eligible to participate, are available on the [NHSC website](#) and in the [online application](#).

Paperwork Reduction Act Public Burden Statement

The purpose of this information collection is to obtain information through the National Health Service Corps (NHSC) Loan Repayment Program (LRP), NHSC Substance Use Disorder (SUD) Workforce LRP, and the NHSC Rural Community LRP applications, which are used to assess an LRP applicant's eligibility and qualifications for the LRP and to obtain information for NHSC site applicants. Clinicians interested in participating in a NHSC LRP must submit an application to the NHSC to participate in one of the NHSC programs, and health care facilities must submit an NHSC Site Application and Site Recertification Application to determine the eligibility of sites to participate in the NHSC as an approved service site. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. The OMB control number for this information collection is 0915-0127 and it is valid until 3/31/2023. This information collection is required to obtain or retain a benefit (Section 333 [254f] (a)(1) of the Public Health Service Act). Public reporting burden for this collection of information is estimated to average 0.5 hours per response, including the time for reviewing instructions, searching existing data sources, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to HRSA Reports Clearance Officer, 5600 Fishers Lane, Room 14N136B, Rockville, Maryland, 20857 or paperwork@hrsa.gov.

PROGRAM OVERVIEW

INTRODUCTION

The National Health Service Corps (NHSC) is a federal government program administered by the U.S. Department of Health and Human Services (HHS), Health Resources and Services Administration (HRSA) Bureau of Health Workforce (BHW). Since 1972, the NHSC has been building healthy communities, ensuring access to health care for everyone, preventing disease and illness, and caring for the most vulnerable populations who may otherwise go without care. NHSC programs provide scholarships and student loan repayment to health care professionals in exchange for a service commitment to practice in designated areas across the country with a shortage of health care professionals. Today, approximately 10,700 NHSC participants provide comprehensive primary medical, dental, and behavioral and mental health care at more than 5,900 NHSC-approved sites, serving over 11.4 million people who live in rural, urban, and tribal communities. NHSC participants work at NHSC-approved sites located in and serving Health Professional Shortage Areas (HPSAs), which are communities with limited access to care.

Clinicians at NHSC-approved sites may be eligible to apply to one of the five NHSC programs, including the NHSC Scholarship Program (SP), the NHSC Students to Service Loan Repayment Program (S2S LRP), the NHSC Loan Repayment Program (LRP), the NHSC Substance Use Disorder Workforce Loan Repayment Program (SUD Workforce LRP), and the NHSC Rural Community Loan Repayment Program (Rural Community LRP).

The Division of Regional Operations (DRO) serves as the regional component of HRSA BHW and supports the agency by:

- 1) Completing NHSC site visits and providing technical assistance to sites;
- 2) Reviewing and approving/disapproving NHSC Site applications and recertifications;
- 3) Providing support for recruitment and retention of primary health care providers in HPSAs;
- 4) Managing the scholar placement process; and
- 5) Coordinating with state-level partners to support HRSA programs.

ELIGIBILITY REQUIREMENTS AND QUALIFICATION FACTORS

Eligible Site Types for NHSC Approval

The following types of sites may be eligible to become an NHSC-approved site (see the [“Glossary”](#) section for complete descriptions of site types):

- 1) Federally-Qualified Health Centers (FQHCs) that are recipients of Public Health Service Act Section 330 grant funds);
 - a. Community Health Center
 - b. Migrant Health
 - c. Homeless Program

- d. Public Housing Program
- e. School-Based Program
- f. Mobile Clinic
- 2) Indian Health Service Facilities, Tribally-Operated 638 Health Programs, and Urban Indian Health Programs (ITUs);
 - a. Federal Indian Health Service (IHS)
 - b. Tribal/638 Health Facility
 - c. Dual-Funded (Tribal Health Clinic and FQHC 330 Funded)
 - d. Urban Indian Health Program
 - e. IHS Hospitals
- 3) FQHC Look-Alikes (LALs);
- 4) Correctional or Detention Facilities;
 - a. Federal Prison
 - b. State Prison
 - c. Immigration and Customs Enforcement (ICE) Health Service Corps
- 5) Centers for Medicare & Medicaid Services (CMS) Certified Rural Health Clinics (RHC);
 - a. Provider-Based
 - b. Independent
- 6) Critical Access Hospitals (CAH);
- 7) Community Mental Health Centers (CMHC);
- 8) State or Local Health Departments;
- 9) Community Outpatient Facilities;
 - a. Hospital Affiliated
 - b. Non-Hospital Affiliated
- 10) Private Practices;
 - a. Solo Practice
 - b. Group Practice
- 11) School-Based Clinics;
- 12) Mobile Units
- 13) Free Clinics; and
- 14) Substance Use Disorder Treatment Facilities
 - a. Substance Abuse and Mental Health Services Administration (SAMHSA)-certified OTPs
 - b. OBOTs
 - c. Non-opioid outpatient SUD treatment facilities

Ineligible Site Types for NHSC Approval

The following site types are not eligible to become NHSC-approved sites, even if they are located in, or serve, a HPSA:

- 1) Inpatient Hospitals (EXCEPT for Medicare-approved CAHs and some IHS Hospitals);
- 2) Clinics that limit care to veterans and active duty military personnel (including Veterans Health Administration Medical Centers, Hospitals, and Clinics; military bases, and civilian health care providers in the TRICARE Network);

- 3) Other types of Inpatient Facilities and Inpatient Rehabilitation Programs;
- 4) Residential Facilities;
- 5) Local/County/City Correctional Facilities;
- 6) Home-Based Health Care Settings of Patients or Clinicians; and
- 7) Specialty Clinics and/or service specific sites limited by gender identity, organ system, illness, categorical population or service (e.g., clinics that only provide STD/HIV/TB services).

Eligible Auto-Approved NHSC Site Types

Eligible auto-approved NHSC sites must apply to the NHSC by: a) contacting the DRO directly; b) providing necessary information for the NHSC to determine eligibility; c) reviewing and signing the NHSC Site Agreement (Appendix A); and d) remaining in compliance with their respective program requirements. Eligible auto-approved NHSC sites may submit an application to the NHSC at any point in the year and are not required to submit an application during the NHSC site application cycles, nor are they required to submit a recertification application every three years.

The following may be eligible Auto-Approved NHSC sites: 1) FQHCs; 2) FQHC LALs; 3) ITUs; 4) Federal Prisons; and 5) ICE Health Service Corps sites.

If an eligible auto-approved NHSC site has multiple eligible sites located in HPSAs, the NHSC must approve each site individually. Site administrators with sites that may be eligible for NHSC auto-approval must contact DRO in order for the site to be added to the BHW Customer Service Portal (see the [“Application and Recertification Process”](#) section).

In general, sites must meet **all** applicable requirements listed in the NHSC Site Agreement to be qualified to participate as an NHSC-approved site. Requirements that are not applicable to auto-approved NHSC sites are noted in the NHSC Site Agreement. The complete NHSC Site Agreement is available in Appendix A of this document.

HPSA Designation Requirement

HPSAs are designated by HRSA. These designations indicate shortages of primary medical care, dental, or mental health care professionals, and may be shortages in geographic areas (e.g., county), population groups (e.g., low-income), or facilities. Additional information about shortage areas, including HPSA scoring, can be found at [HRSA's Shortage Designation webpage](#). See also Section 332 of the Public Health Service Act (PHSA) and the implementing regulations at 42 C.F.R. Part 5 and appendices.

The NHSC uses HPSAs to determine priorities for assignment of NHSC clinicians. In order to recruit an NHSC clinician, NHSC-approved sites must be in and serve a designated HPSA for the specific category in which an NHSC clinician would serve. For example, an NHSC-approved site would need to have a primary care HPSA designation to recruit for an internal medicine physician; a mental health HPSA designation to recruit for a psychiatrist; a dental HPSA designation to recruit a dentist; etc.

Sites must contact their State Primary Care Office (PCO) when applying for, or inquiring about, a HPSA designation. The PCO will determine whether a site currently possesses a geographic area, population group, or facility HPSA designation for primary care, dental and/or mental health. To become NHSC-approved, the applicant site must have a HPSA designation as of the first day of the NHSC Site Application Cycle.

AUTOMATIC FACILITY HPSA DESIGNATIONS (Auto-HPSAs): Section 332(a) of the Public Health Service Act provides for the automatic designation of certain facility types as HPSAs. These facilities include FQHCs, FQHC LALs, ITUs, and RHCs that meet NHSC site requirements.

Note that “auto-HPSA designations” and NHSC “auto-approval” for sites are two separate processes. For example, Federal prisons and ICE facilities are eligible for NHSC “auto-approval,” but are not eligible for an “auto-HPSA designation.”

If a site is an RHC and it becomes NHSC-approved, then this site type is eligible for an “auto-HPSA designation.” The following RHC auto-HPSA designation process will be used:

- 1) RHC applies to become an eligible NHSC site by submitting a complete NHSC Site Application. Note that an NHSC Recertification Application is required from RHCs every three (3) years.
- 2) If the RHC is approved, HRSA calculates an auto-HPSA score and notifies the RHC Points of Contact and the State PCO.
- 3) The HPSA score is then published in the HRSA Data Warehouse. Note: The RHC will not be active for NHSC until the HPSA score is designated.

Comprehensive Primary Care (CPC) Requirement

All NHSC-approved sites must provide comprehensive primary care, whether medical, dental, or behavioral and mental health. The NHSC defines comprehensive primary care as a continuum of care not focused or limited to gender identity, organ system, a particular illness, or categorical population (e.g. developmentally disabled or those with cancer). Sites provide preventive, acute and chronic primary health services in an NHSC-approved discipline. Sites treat all patients fairly, regardless of disease or diagnosis, and offer a full range of primary care services when they walk in the door.

With the exception of substance use disorder treatment facilities, if sites do not offer all primary care services, they must offer an appropriate set of primary care services necessary for the community and/or populations they serve. For example, a site serving a senior population would need to provide geriatric primary care services. Sites that focus their efforts on a particular population defined by disease or diagnosis are ineligible for NHSC approval even if they provide comprehensive primary care to that population. NHSC does not consider them to be “serving” the HPSA because they are not open to all patients of the HPSA. For example, sites specializing in a limited set of services within a specialty (e.g., immunization clinics; STD/HIV/TB clinics), are ineligible for NHSC site approval.

In accordance with the NHSC Site Agreement item #5, sites must provide documentation (e.g., memoranda of understanding, exchange of letters, or other documentation) and meaningful demonstration of appropriate referral networks for other preventive, acute, and chronic primary health services with other NHSC-approved sites or providers. (See section on Proof of Access to Ancillary, Inpatient and Specialty Care. In accordance with the NHSC Site Agreement items #2a-e, all sites and referral networks for primary care should offer NHSC-approved discounts (see section on requirements for SFS discounts) to those with low income and agree to serve all patients regardless of their ability to pay (including those eligible for Medicaid, Medicare, or the CHIP).

The following example illustrates the application of an appropriate primary care referral network to ensure that a site seeking approval as an NHSC service site provides comprehensive primary care:

A pediatric clinic offers preventive, acute, and chronic primary health services to its clients. The clinic does not provide behavioral health services on-site, but instead refers to another clinic that offers behavioral health and adheres to NHSC site requirements (see [“Eligibility Requirements and Qualification Factors”](#)).

In this case, the pediatric clinic would be eligible to apply as an NHSC-approved site.

Requirements for Primary Behavioral and Mental Health Sites

Behavioral and mental health facilities must be located in and serve a mental health HPSA and must offer comprehensive primary behavioral health services to all residents of the defined mental health HPSA. For example, a mental health center that serves only individuals with developmental disabilities would be ineligible because they limit care to a specific population.

Sites that provide behavioral and mental health services must complete and submit the NHSC Comprehensive Behavioral Health Services Checklist and documents to demonstrate services provided on-site and services provided through all active formal affiliation agreements. You may view the NHSC Comprehensive Behavioral Health Services Checklist in [Appendix E](#).

EXCEPTION: *All auto-approved NHSC sites are EXEMPT and do not need to submit the NHSC Behavioral Health Services Checklist.*

All non-exempt NHSC behavioral health service sites must submit the NHSC Behavioral Health Services Checklist and supporting documentation to verify they offer comprehensive primary behavioral health care services. NHSC Comprehensive Behavioral Health Services include, but are not limited to, Core Comprehensive Behavioral Health Service Elements and Non-Core Behavioral Health Service Elements. NHSC-approved behavioral health sites must provide Core Comprehensive Behavioral Health Services **directly**, and not through an affiliation or referral.

If the site does not provide all of the non-Core Behavioral Health Services, the site must demonstrate a formal affiliation with a comprehensive community-based primary behavioral health setting or facility to provide these services. Affiliation agreements must be active and

accompany the NHSC Comprehensive Behavioral Health Services Checklist at time of application or recertification submission.

The definition of **Formal Affiliation Agreement** in the [“Glossary”](#) section includes required elements of a formal affiliation agreement. For examples of formal affiliation agreements, visit the [SAMHSA-HRSA Center for Integrated Health Solutions website](#) or [Appendix H](#).

The following example illustrates the application of an appropriate primary care referral network to ensure comprehensive primary behavioral health care for sites seeking eligibility by the NHSC:

A behavioral health clinic offers preventive, acute, and chronic primary health services to its clients. The clinic does not provide psychotropic medications on-site, and refers to another clinic that offers psychotropic medications and adheres to NHSC site requirements (see [“Eligibility Requirements and Qualification Factors”](#)).

Requirements for the Sliding Fee Discount Program

NHSC-approved sites are required to offer a Sliding Fee Discount Program and apply a sliding fee schedule (SFS), so that the amount owed for services by eligible patients is adjusted based on the patient’s ability to pay. The sliding fee discount program must include the following: (1) a schedule of fees for services; (2) a corresponding schedule of discounts for eligible patients based on the patient’s ability to pay; and (3) policies and operating procedures, including those concerning applying for the discount program. Eligibility for the SFS is based solely on family size and income under the HHS annual [Federal Poverty Guidelines](#) (FPG). You may view a sample Sliding Fee Discount Patient Application in Appendix C.

All aspects of an NHSC-approved site’s Sliding Fee Discount Program should be supported by written operating procedures and/or policies, based on the current FPG, and applied uniformly to all patients. The NHSC-approved site must define in policy, consistent with any Federal, State, or local laws and requirements, its definitions of “family” and “income.” In order to facilitate patient access and utilization, sites must ensure that eligibility for discounts is based on income and family size and no other factor (e.g., assets, insurance status, participation in the Health Insurance Marketplace, citizenship, population type).

All Sliding Fee Discount Programs must include the following elements:

- Applicable to all individuals and families with annual incomes at or below 200 percent of the most current FPG;
- Provide a full discount for individuals and families with annual incomes at or below 100 percent of the FPG, with allowance for a nominal charge only, consistent with site’s policy;
- Adjust fees (partial sliding fee discount) based on family size and income for individuals and families with incomes above 100 percent and at or below 200 percent of the FPG.

To the extent that a patient who otherwise meets the above criteria has insurance coverage from a third party (either public or private), an NHSC-approved site can charge for services to the extent that the third party will make payment.

A site has discretion regarding certain aspects of the Sliding Fee Discount Program. If an NHSC-approved site elects to include the following, then the items must be addressed in policies and supporting operating procedures:

- Alternative mechanisms for determining patient eligibility for the SFS for circumstances in which documentation/verification is unavailable (e.g., self-declaration, conditional SFS eligibility) and for making these mechanisms available to the entire patient population, regardless of income level, sliding fee discount pay class, or population type;
- Use of different SFS for medical, dental, and behavioral health services, if applicable, with appropriate justification(s);
- Billing and collections;
- Applicability of SFS or other discounts relative to supplies and equipment associated with services covered by the SFS (e.g., dentures or durable medical equipment);
- Provisions for waiving fee(s) and nominal charges for specific patient circumstances; and/or
- Other provisions related to billing and collections including payment incentives, grace periods, payment plans, or refusal to pay guidelines.

Staff at the NHSC-approved site should be familiar with the Sliding Fee Discount Program and routinely trained on the implementation of the program's policies and operating procedures. Front-line staff must be prepared to offer information and answer basic questions about the Sliding Fee Discount Program, and should present it as an option during a patient's initial visit. The NHSC encourages sites to have patient applications for the program readily available for patients at the front desk.

NHSC-approved sites must establish multiple methods of informing patients of the Sliding Fee Discount Program including prominently displaying notices about the discount program in common areas and on the site's website (if one exists). In addition, information about the Sliding Fee Discount Program must be available in appropriate languages and literacy levels for the patient population served. Sites interested in applying to the NHSC must have a Sliding Fee Discount Program in place for at least six (6) continuous months prior to applying to become an NHSC-approved site.

EXCEPTION: Free clinics, correctional facilities, and ITUs are EXEMPT from submitting certain required documents, including the SFS documents and required signage, due to their inability to bill and charge for services. However, the NHSC site needs to provide the NHSC with documentation that no one is charged or billed for services, and individuals are not denied service because of inability to pay.

Payment Incentives

NHSC-approved sites may elect to offer incentives through billing and collections policies. Such incentives are often referred to as "payment plans, grace periods, prompt or cash payment incentives," offered to patients who pay with cash, credit and/or who pay their bills within a specific, expedited timeframe as a method of increasing collections and reducing billing costs.

NHSC-approved sites should thoroughly research the potential consequences of implementing prompt payment/cash payment incentives for patients and conduct cost-benefit analyses in determining the amount of the payment incentive. The operating procedures that support such a policy must ensure that these incentives are accessible to all patients, regardless of income level or sliding fee discount pay class, and consistently applied without preferential treatment of any kind. In addition, sites must have a mechanism for communicating the availability of these incentives to all of their patients.

Refusal to Pay

There may be instances when patients refuse to pay the amount they owe the NHSC-approved site. If the site elects to establish policies to address these instances, including discharging patients from the site, they must establish supporting operating procedures that define:

- What constitutes “refusal to pay”;
- What individual circumstances are to be considered in making such determinations; and
- What collection efforts/enforcement steps are to be taken when these situations occur (e.g., offering grace periods, establishing payment plans, offering meetings with a financial counselor).

Establishing and Collecting Nominal Charges

Program regulations permit sites to adopt a nominal charge for services to patients at or below 100 percent of the Federal Poverty Guidelines. Electing to establish a nominal charge is at the discretion of the NHSC-approved site. Any NHSC-approved site that chooses to establish a nominal charge must ensure that patients are not impeded in accessing services due to an inability to pay. Specifically, a nominal charge must be a fixed fee that does not reflect the true value of the service(s) provided. As they are not intended to create a payment threshold for patients to receive care, nominal charges are not “minimum fees,” “minimum charges,” or “co-pays.” In addition, the nominal charge must be less than the fee paid by a patient in the first “sliding fee discount pay class” beginning above 100 percent of the Federal Poverty Guidelines.

Patients with Third Party Coverage who are Eligible for SFS

NHSC-approved sites may serve patients with third party insurance that does not cover or only partially covers fees for certain health center services. These patients may also be eligible for the SFS based on income and family size. In such cases, subject to potential legal and contractual limitations, the charge for each SFS pay class is the maximum amount an eligible patient in that pay class is required to pay for a certain service, regardless of insurance status.

EXAMPLE: John Doe, an insured patient, receives a service for which the site has established a fee of \$80, per its fee schedule. Based on John Doe’s insurance plan, the co-pay would be \$60 for this service. The health center has also determined, through an assessment of income and family size, that he is at 150 percent of the Federal Poverty Guidelines and thus qualifies for the site’s SFS. Under the SFS, a patient at 150 percent of the Federal Poverty Guidelines would receive a 50 percent discount off the \$80 fee, resulting in a charge of \$40 for this service. Rather than the \$60 co-pay, the site would charge John Doe no more than \$40 out-of-pocket, consistent with its SFS, as long as this is not precluded by the insurance contract terms.

As NHSC-approved sites are responsible for ensuring adherence to applicable laws and regulations and for following the terms and conditions of their contracts, they may wish to consult with their third party payors and/or private legal counsel regarding the permissibility of discounting patients' out-of-pocket costs relative to the terms and conditions of private payor contracts. The Medicare law requires clinicians to charge Medicare beneficiaries the same as they charge other patients. Waiving or discounting the Medicare co-pay on an ad-hoc or case-by-case basis is not allowed. Medicare will, however, accept a sliding fee discount schedule if appropriately designed and implemented. The key is to establish a discount policy that is uniformly applied to all patients based upon ability to pay. As long as the discount policy is uniformly applied to all patients, all the time, it is acceptable to discount deductibles and co-payments for Medicare beneficiaries if they qualify under the discount policy established by the clinic.

Multiple Sliding Fee Schedules

As discussed previously, sliding fee discounts must apply to all primary care services, regardless of the service type or mode of delivery (direct, by contract, or by formal referral agreement). NHSC-approved sites may elect to have multiple SFS based on services/mode of delivery.

CALCULATING SFS DISCOUNTS: Sites must base SFS discounts only on annual income and family size. NHSC sites must revise their SFS or discounted fee schedule annually with information from the updated FPG. All Sliding Fee Discount Program Documents – policy, SFS, and patient application – must be consistent and up-to-date. At the time of application, recertification and site visits, the NHSC will consider **NHSC-approved sites that deny or limit discounted services to individuals based on other factors, such as their assets or citizenship status, regardless of their eligibility for discounts under the FPG, to be noncompliant.**

CAHs and IHS hospitals must apply for site approval in conjunction with an affiliated, outpatient clinic by either submitting separate site applications during the same application cycle, or by demonstrating an affiliation with an outpatient clinic that has previously submitted a site application and has been approved. CAHs must utilize the NHSC-approved SFS, at a minimum, for low-income patients in both the emergency room and the affiliated outpatient clinic. The NHSC will consider **CAHs that deny or limit discounted services to individuals based on other factors such as their assets or citizenship status, regardless of their eligibility for discounts under the FPG, to be noncompliant.** This restriction does not extend to the CAH inpatient fee structure (i.e.: CAH in-house discounted fee schedule or charity care program for other settings) or for requirements necessary to meet Medicare certification requirements.

Requirements for the Non-Discrimination Policy, Posted Notice, and the Recruitment and Retention Plan

NHSC-approved sites must agree not to discriminate in the provision of services to an individual based on: the individual's inability to pay; whether payment for those services would be made under Medicare, Medicaid, or CHIP; the individual's race, color, sex, national origin, disability,

religion, age, sexual orientation, or gender identity. All NHSC-approved sites must have written policies for financial assistance in place that ensure that no one who is unable to pay will be denied access to services. All NHSC-approved sites must prominently display notices to patients—in common areas on-site and on the site’s website—stating that no one will be denied access to services due to inability to pay and that there a discounted/sliding fee schedule is available.

ITU EXCEPTION: At the request of a tribal health program (see the [“Glossary”](#) section), the services of an NHSC clinician may be limited to tribal members or other individuals who are eligible for services from that Indian Health Program. However, tribal health programs are required to respond to emergency medical needs as appropriate.

All sites must develop and maintain a plan to guide the recruitment and retention of clinicians to help ensure a viable NHSC-approved site. A recruitment and retention plan clearly states the policies and processes that a site will use to recruit and maintain clinical staffing levels needed to appropriately serve the community. A recruitment and retention plan must be submitted as part of the NHSC Site Application. NHSC-approved sites should keep a current copy of the plan on-site for review during NHSC site visits, and should periodically update the plan to address any factors that may have affected the management of the site.

Requirements to Opt-in to the NHSC SUD/Opioid Expansion

Outpatient SUD treatment facilities applying in FY 2020 as new sites must provide all required NHSC site application documentation, as well as certain SUD documentation depending on their site type. Also, new sites must complete and submit the NHSC Comprehensive Behavioral Health Checklist ([Appendix E](#)) and upload documents to demonstrate services provided to SUD patients on-site and services provided through formal affiliation agreements ([Appendix H](#)).

NHSC sites currently approved as primary care or behavioral health sites must provide additional SUD documentation to the NHSC in order to also opt-in as an SUD site. This step is required in order for providers at a site to be eligible to apply for the NHSC’s SUD-specific loan repayment programs.

Depending on the SUD services a site provides, the site’s point of contact must submit SUD documentation as a site inquiry via the BHW Portal in order for the site to be opted in with the NHSC as providing SUD. NHSC-approved sites that are opted in for SUD services allow for eligible clinicians of those sites to apply for either the NHSC SUD Workforce LRP or the NHSC Rural Community LRP. Please see [Appendix F: Substance Use Disorder Site Opt-in Instructions](#) for a list of required SUD documentation by SUD site type and for step-by-step instructions for opting in.

NOTE: BHW DRO can confirm the SUD status of FQHCs and FQHC LALs internally. If your site is an FQHC or FQHC LAL that is providing SUD services, please contact your [DRO state contact](#) via e-mail or submit a BHW Portal inquiry to opt in your site for SUD services/eligibility.

APPLICATION AND RECERTIFICATION PROCESS

Preparing for NHSC Approval

Before applying to be an NHSC-approved site, take the time to review all requirements carefully to ensure the site is operationally compliant with NHSC requirements. Sufficient time and attention should be allowed to prepare and complete required application documents. The following steps are a guide for submitting an NHSC application:

- 1) Determine if your site qualifies for NHSC Auto-Approval (see "[Eligible Automatically-Approved \(Auto-Approved\) NHSC site types](#)"):
- 2) Determine if your site is located in or serves a HPSA.
 - a. Contact your local [State PCO](#) for questions about your HPSA designation and the application.
 - b. Search the [HPSA Find tool by site address](#)
 - c. Search the [HPSA Find tool by state and county](#)
- 3) Determine if your site meets **all** applicable eligibility requirements listed in the NHSC Site Agreement in Appendix A (this may not, in its entirety, be applicable to all sites eligible for auto-approval).
- 4) If your site provides behavioral and mental health services, review the requirements described in the "[Requirements for Primary Behavioral and Mental Health Sites](#)" section.
- 5) Get your questions answered by contacting your State PCO, visiting the NHSC website, or contacting HRSA.
- 6) Gather **all** required documentation listed in the "[Required NHSC supporting documents](#)" section.
- 7) Apply online by creating an NHSC account via the [BHW Customer Service Portal](#).

Submitting the NHSC Online Site Application

Sites are required to complete each of the online sections (listed below) via the [BHW Customer Service Portal](#) *BEFORE* submitting an online application.

- 1) **Site Eligibility.** This section assesses a site's eligibility. If a site applicant does not pass the pre-screening portion of the online application, the applicant will not be able to continue with the Site Application. Refer to the "[Eligibility Requirements and Qualification Factors](#)" section to ensure that the site meets the appropriate requirements.
- 2) **General Information.** Answers to this section pertain to the site applicant's name, mailing and email addresses, and other contact information.
 - a. Points of Contact (POC) Information. Each site (with the exception of Solo Private Practices) is required to list two (2) site contacts in this section. Only POCs who have indicated that they own, oversee, or manage a significant portion of their organization and have the ability to answer questions about organization policies and operating procedures can submit a site application. If approved, the POC information will be visible to the public on the [Health Workforce Connector](#).

- 3) **Program Information.** In this section, site applicants will select the appropriate primary care services provided at their site, in addition to addressing questions regarding their SFS, accepted insurance, and the recruitment and retention plan.
- 4) **HPSA Score Suggestion.** A site applicant will determine their appropriate HPSA, and enter in their HPSA score based on verified information found in the [HPSA Find Tool](#). NHSC and State PCO staff will verify this information and add all applicable HPSA IDs to the application during the review process. This section is not required, but we recommend that sites consult with their State PCO to verify their HPSA ID and score.
- 5) **Supporting Documents.** Site applicants must upload **all** required supporting documents (refer to the [“Required NHSC supporting documents”](#) section) *PRIOR* to submission of the application. Required supporting documents cannot be submitted electronically once the application is submitted.
- 6) **Agreement for NHSC Sites.** In the last section of the Site Application, sites will review and certify their compliance with the NHSC Site Agreement. An agent for the organization with express authority must sign the application and the NHSC Site Agreement. Note that Auto-Approved NHSC sites must sign the NHSC Site Agreement. A copy of the NHSC Site Agreement is included in Appendix A.

The NHSC Site Application and Recertification Cycles

The NHSC generally opens one (1) New Site Application Cycle and one (1) Site Recertification Application Cycle every year. Each respective NHSC Site Application Cycle is generally open to accept submissions for approximately 6-8 weeks. The deadline submission time and the date of cycles for each fiscal year may be subject to change; however, each application cycle will close *at 11:59 p.m. ET*. Check the [NHSC website](#) for the most current opening and closing timeline for application cycles.

New sites, with the exception of Auto-Approved NHSC sites, can only apply during an open NHSC New Site Application Cycle. These include:

- Sites that have never applied for or been approved for NHSC; and
- Sites with a previously denied or cancelled site application on record.

Sites applying for recertification must apply during an open NHSC Site Recertification Application Cycle. These include:

- Active NHSC sites (with and without NHSC obligated participants) with an expiration date corresponding to the open recertification application cycle;
- Sites with an expired and/or Inactive NHSC status.

Each site administrator or designee is responsible for ensuring that **all** information reported on the NHSC Site Application is true and accurate. **If documentation is missing or not legible, the Site Application will be deemed incomplete and may render the Site Application disapproved.** Answers on the Site Application must match the supporting/supplemental documents and the documentation must accurately verify the answers provided.

An NHSC Site Application may not be altered after submission. If a site has application-related questions, they are encouraged to contact their State PCO or DRO representative *prior* to Site Application submission.

Required NHSC Supporting Documents

With the exception of eligible Auto-Approved NHSC sites, sites must upload all supporting documentation for the NHSC Site Application **before** the site can submit a complete application package. An NHSC Site Recertification Application follows the same process steps as the NHSC New Site Application.

A Site Application will not be considered complete, and may be disapproved, unless it contains each of the following required supporting documents:

- 1) **Policies on Non-Discrimination.** Upload a copy of the site’s policies on non-discrimination of patients based upon race, color, sex, national origin, disability, religion, age, sexual orientation or gender identity, in accordance with the NHSC Site Agreement item #2.

- 2) **Sliding Fee Discount Program Documents.** Upload documents (see list a-d below) that describe the site’s Sliding Fee Discount Program, in accordance with the NHSC Site Agreement items #2a-2e. Before submitting these documents, review the requirements and examples found in Appendix C.
 - a. **Site’s Policy on the Sliding Fee Discount Program.** These policies should describe:
 - i. Patient eligibility for the program, including definitions of income and family size and frequency of re-evaluation of eligibility. [Ensure that the site’s SFS applies to all residents of the site’s geographic, population and facility HPSA(s) groups.];
 - ii. Documentation and verification requirements and site procedures on determining patient eligibility;
 - iii. How the sliding fee discount program will be advertised to the patient population; and
 - iv. If the site chooses to collect a nominal charge, an explanation of the nominal charge.
 - v. If patients using the SFS will be sent to collections for outstanding debt, the site must submit a description of their collection policies.
 - b. **Sliding Fee Schedule (SFS).** This document outlines discounts offered based on family size and income:
 - i. Should be applicable to all individuals and families with annual incomes at or below 200 percent of the most current FPG;
 - ii. Provide a full discount for individuals and families with annual incomes at or below 100 percent of the FPG, with allowance for a nominal charge only, consistent with site’s policy;
 - iii. Should be adjusted for fees (partial sliding fee discount) based on family size and income for individuals and families with incomes above 100 percent and at or below 200 percent of the FPG; and

- iv. Although not required, attaching the schedule of fees or payments for basic services used at the site will help the review team in processing the Site Application.
 - c. **Copy of the Patient Application for the Sliding Fee Discount Program.**
 - d. **Posted Signage Notifying Patients about the Sliding Fee Discount Program:** Upload a photograph or copy of posted signage at the site that meets the requirements, in accordance with the NHSC Site Agreement item #2e. For an example of acceptable signage, reference Appendix B. ***Sites may not use the NHSC poster and/or logo until after they are approved by the NHSC.***
- 3) **Proof of Access to Ancillary, Inpatient and Specialty Care.** Upload proof of referral arrangements for ancillary, inpatient, and specialty care that are not available on-site, in accordance with the NHSC Site Agreement #5. Acceptable documents include signed Memorandums of Understanding (MOU), signed Memorandums of Agreement (MOA) or signed contracts with ancillary, inpatient, and specialty facilities. If formal referral arrangements do not exist, the site must provide a dated and signed description of how it ensures patient access to ancillary, inpatient, and specialty care.
- 4) **NHSC Site Data Tables.** Each individual site location must upload a completed NHSC Site Data Tables with up-to-date data for the preceding six (6) months. Site data helps to determine whether the site can meet the terms of the NHSC Site Agreement #13. The site data also demonstrates the site’s adherence to sound fiscal management policies and ability to support the clinical practice of potential NHSC clinicians in a full-time or half-time position of providing primary health services, as indicated in their NHSC LRP or SP contract.
- 5) **NHSC Comprehensive Behavioral Health Services Checklist and Supporting Documentation.** All non-exempt sites that provide behavioral and mental health services must certify that they provide comprehensive behavioral health services.
- a. Sites must prepare and submit the following:
 - i. [NHSC Comprehensive Behavioral Health Services Checklist](#), and
 - ii. Documentation that verifies all information included in the Checklist (which services provided on site and which through formal affiliation agreements).
 - b. Log in to the [BHW Customer Service Portal](#).
 - i. Upload the documentation into the NHSC New Site or Recertification Application verifying compliance with the NHSC Comprehensive Behavioral Health Services Requirement and all documents that verify checklist responses, including active formal affiliation agreements.
 - ii. Add as “Other Documentation Requested by the NHSC or State PCO.”
 - iii. In the *Comment* section, type “Comprehensive Behavioral Health Services Certification” and any other relevant comments.
- 6) **SUD Documentation.** Facilities providing opioid treatment and/or SUD treatment must provide the documentation listed in [Appendix F: Substance Use Disorder Site Opt-in Instructions](#).

- 7) **Clinician Recruitment and Retention Plan.** Upload documentation that clearly states the policies and processes that a site will use to recruit and maintain clinical staffing levels needed to appropriately serve the community, in accordance with the NHSC Site Agreement #6 and #7.

NHSC Site Application Review Process

After a site representative submits the NHSC Site Application, the State PCO and HRSA will review and evaluate the NHSC application. HRSA will make a final decision regarding the approval of the NHSC Site Application. The process generally takes 6-8 weeks to complete, but may take longer due to application volume, pre-approval site visit requirements, and the quality of submitted information. Additionally, HRSA will work closely with the State PCO and may coordinate a pre-approval site visit (see the [“Site Visits and Technical Assistance”](#) section) to evaluate and confirm all NHSC Site Application information and responses prior to approving the application.

SITES THAT REQUIRE A SITE VISIT PRIOR TO APPROVAL: Any NHSC-eligible site type, including private practices with solo or private practitioners, may require a site visit before the application review is completed.

Determining NHSC Site Approval

NHSC approval of a site is based on a site’s ability to meet the eligibility criteria set forth in the NHSC Site Application and Site Agreement, as determined by the State PCO and the DRO. The approval of the main/administrative site does not indicate approval for affiliated satellite sites. Each site must obtain approval from the NHSC, which is necessary for NHSC obligated participants to receive NHSC service credit for time spent at any site.

NHSC-approved sites will receive a notice from the NHSC through the [BHW Customer Service Portal](#) confirming their approval status. If a site has been approved, the site is encouraged to review information regarding how to post job vacancies on the [Health Workforce Connector](#) (see the [“Recruiting an NHSC Clinician”](#) section).

An NHSC site is considered ‘disapproved’ if the site fails to meet the NHSC statutory and programmatic eligibility requirements and does not receive approval by the NHSC.

NHSC Site Approval Expiration

With the exception of auto-approved NHSC sites, the NHSC Site Application approval is valid for three (3) years from the date of its approval, as long as the site remains in, and serves, a HPSA and continues to meet the NHSC eligibility requirements and qualification factors. Auto-approval of NHSC sites generally does not expire, unless they are no longer located in or serving a HPSA; are no longer meeting all NHSC requirements; or are found to be non-compliant with other HRSA/programmatic requirements (i.e.; Section 330 grants; ITUs).

NHSC Site Recertification

Once your site is approved, you can determine if your site will need to apply for recertification by logging into the [BHW Customer Service Portal](#). If there is an “Expiration Date” listed under the NHSC Approved Sites section, then your site will need to recertify. NHSC-approved sites are required to apply for recertification every three (3) years.

All sites with an approval expiration date **on or before December 31, 2020**, are required to submit an NHSC Site Recertification Application during the 2020 Site Recertification Application Cycle. Sites that fail to submit a complete and acceptable recertification application **PRIOR** to their expiration date, will become inactive after the site’s approval expiration date passes. Check the [NHSC website](#) for updates to the Site Application cycles. Refer to the [“Required NHSC Supporting Documents”](#) section for more details.

NHSC Site Recertification Application Instructions

To submit an NHSC Site Recertification Application:

- 1) Log into the [BHW Customer Service Portal](#) during the open NHSC Site Recertification Application Cycle.
- 2) Click on the name of the site for which you would like to submit an NHSC Site Recertification Application. You may submit an NHSC Site Recertification Application for an “Approved” OR “Inactive” site, but not a “Terminated” site.
- 3) In the “Need Assistance?” box, under “I need to...” click on “Recertify.”
- 4) Complete the NHSC Site Recertification Application, upload all required supporting documentation, and click “Submit.”

SITE ROLES & RESPONSIBILITIES

Responsibilities of NHSC-approved Sites

The mission of the NHSC is to increase access to primary care services for the nation’s underserved populations, and NHSC-approved sites are the cornerstone of this mission. NHSC-approved sites, including those that are auto-approved, must meet all site requirements listed in the NHSC Site Agreement in order to maintain NHSC approval. NHSC-approved sites are encouraged to continually review the NHSC Site Agreement and keep a copy for their reference.

In addition, all NHSC-approved sites must:

- 1) Activate and maintain a [BHW Customer Service Portal](#) account for a minimum of two (2) NHSC site Points of Contact (POCs). The portal account creation is a two-step process and is not considered active until the POC responds to an email prompt from the system.
 - a. All NHSC-approved sites, except for *solo* private practices, must identify a minimum of (2) NHSC POCs, with a minimum of one person serving in each of the following NHSC roles: Administrator, Personnel Verifier, and Recruiter.
 - i. Note that one POC can have multiple roles and a single organization may have multiple POCs. With the exception of solo private practices, **NHSC**

participants are highly discouraged from being a POC, as it may present a conflict of interest.

- ii. Only POCs who have indicated that they own, oversee, or manage a significant portion of their organization and have the ability to answer questions about organization policies and operating procedures can submit a site application. Specifically, these individuals must have express authority to act on behalf of the organization.
 - iii. To add a new POC, have them create and activate a BHW Customer Service Portal account. Next, log into your Portal account and click on the name of the site. Under “Self-Service,” click on “Manage Points of Contact” and then “Add Another Site POC.”
 - b. NHSC POCs should periodically update their roles at the site by clicking on “Update My Program Portal Profile” under the “Need Assistance?” section at the bottom of the home screen.
- 2) Complete and continually update the online NHSC [site profile](#) using the BHW Customer Service Portal. The site profile is a recruiting tool, providing prospective clinicians with a site-specific overview, while they search for jobs at NHSC-approved sites. Once the NHSC site profile is complete, the NHSC site can post open clinical vacancies through the BHW Customer Service Portal to be displayed on the [Health Workforce Connector](#).
 - 3) Post all NHSC-eligible clinical vacancies on the Health Workforce Connector. To post a vacancy, log into the BHW Customer Service Portal, click on the name of the site, and then under “Self Service” click on “Manage Current Job Openings.”
 - 4) Contact the NHSC through the BHW Customer Service Portal if there are any changes to the site including: NHSC points of contact, NHSC site location, ownership, or HPSA score. To notify the NHSC, log in to your BHW Customer Service Portal, click on the name of the site and under “Need Assistance,” and then click on “Ask a Question”.
 - 5) Download and display the NHSC-approved site decal/and or tabletop sign as well as the NHSC “We Promise To” site policy poster located at: [NHSC Member Sites Downloadable Resources](#).
 - 6) Participate in a site visit from the DRO.
 - 7) Submit an NHSC Site Recertification Application every three (3) years, with the exception of Auto-Approved NHSC sites.
 - 8) Support and appropriately use NHSC participants as illustrated in the section below. **As mandated by the NHSC statute, 42 U.S.C. § 254f, NHSC sites must make appropriate and efficient use of assigned NHSC clinicians. Evidence that the NHSC site has not made appropriate and efficient use of NHSC clinicians may be grounds for NHSC site disapproval and/or deactivation.**

Site Administrators are responsible for ensuring that the NHSC-approved site meets all NHSC site requirements and for reviewing and electronically signing the NHSC Site Agreement. These activities should not be delegated to an NHSC LRP, NHSC SP, or NHSC S2S LRP applicant or participant. The Site Agreement should be electronically signed by a designated official at the site.

NHSC-approved Site's Responsibility to the NHSC Participants

NHSC participants are responsible for meeting all NHSC requirements as a result of receiving their NHSC scholarship or loan repayment award contract. The NHSC LRP, NHSC SUD Workforce LRP, NHSC Rural Community LRP, NHSC S2S LRP, and the NHSC SP Application and Program Guidance, respectively, provide the details of the NHSC participant commitment. NHSC participants enter into a contractual agreement with the NHSC; thus, it is required that NHSC-approved sites afford NHSC participants the opportunity to fulfill this agreement.

The NHSC expects sites to support NHSC participants in fulfilling their service obligation by:

- 1) Completing NHSC Employment Verification forms (EVF) through the [BHW Customer Service Portal](#) for all NHSC sites.
- 2) Ensuring NHSC participants work at NHSC-approved and HPSA appropriate sites.
- 3) Ensuring each NHSC site is approved **prior** to the beginning of an NHSC participant assignment at that site.
- 4) Ensuring each NHSC participant is knowledgeable of the minimum HPSA score necessary for placement at an NHSC site.
- 5) Ensuring NHSC participants follow the NHSC minimum hourly and weekly NHSC clinical service requirements (the employment contract between the NHSC-approved site and NHSC participant may stipulate additional work hours).
- 6) Reporting leave on the NHSC online In-Service Verification forms (ISV). NHSC participants are allowed to spend no more than 7 weeks a year (35 full-time or 35 half-time workdays) away from clinical practice with the NHSC.
- 7) Verifying and reporting to the NHSC any time away from the site (e.g., vacation, holidays, continuing professional education, illness, or any other reason) taken by NHSC participants.
- 8) Allowing NHSC participants to participate in NHSC Continuing Education and NHSC program webinars and/or conferences.
- 9) Providing appropriate supervision to NHSC participants, as well as needed orientation, training and mentorship regarding the NHSC site's processes and procedures, client population, and primary care practice.
- 10) Facilitating an NHSC participant site transfer request, if applicable, by completing an online EVF through the [BHW Customer Service Portal](#). **Prior to leaving a site, NHSC participants submit a transfer request via the [BHW Customer Service Portal](#) to change his or her current site to another NHSC-approved site.** To ensure that NHSC-approved sites can continue to meet the needs of patients, the NHSC strongly encourages NHSC participants to discuss their plans with the NHSC site first. As part of the transfer process, the NHSC participant's current NHSC service site may submit an email that includes:
 - a) Any clinical competency issues related to the NHSC participant while employed at the NHSC-approved site;
 - b) Any disciplinary action related to the NHSC participant while employed at the NHSC-approved site; and
 - c) Confirmation of the NHSC participant's last employment date at the NHSC-approved site.

- d) Upon approval of the transfer request, the NHSC-approved site is responsible for reviewing online and confirming the NHSC participant reported leave for the period of time that the NHSC participant has been employed at the NHSC-approved site.
- 11) Making available for NHSC review, a participant's personnel documents, communications, and/or practice related documents as needed so that the NHSC can monitor an NHSC participant's compliance with NHSC service requirements. Such documents should be made available to the NHSC both during an NHSC participant's service obligation and after their obligation has ended.

NHSC Participants' Clinical Service Requirements for Full-time and Half-time Service

In order to maintain a successful partnership, NHSC participants and NHSC-approved sites should possess a firm understanding of the NHSC clinical service requirements. For a more detailed explanation of the full-time and half-time clinical practice requirements, including requirements for participants working in CAHs and IHS Hospitals, refer to the [NHSC website](#) and review the respective NHSC LRP, SUD Workforce LRP, Rural Community LRP, S2S LRP and/or SP Application and Program Guidance.

NOTE:

- *Full-time NHSC participants serving at a CMS approved CAH or IHS Hospital must spend at least 16 hours/week (8 hours/week for half-time NHSC participants) providing patient care at the CAH-affiliated outpatient clinic.
- *Clinical time spent "on call" will not be counted towards the service commitment, except to the extent the provider is directly treating patients during that period.
- *NHSC participants exercising the Private Practice Option (PPO) **ARE NOT** eligible for half-time service.

Notifying the NHSC of Changes to a Participant's Employment or to Site Information

All NHSC-approved sites are expected to maintain current, active status as a comprehensive primary care, dental, or mental health service delivery site by continually meeting the NHSC requirements outlined in the NHSC Site Agreement (located in Appendix A).

In addition, NHSC-approved sites are required to notify the NHSC if there are any changes to the NHSC participant's employment status with the NHSC-approved site (e.g., termination, resignation, change in work hours or site allocation), and to verify the NHSC participant's last employment date seeing patients.

Participants who are asked to work at a clinic that is not listed in the participant's profile on the [BHW Customer Service Portal](#) must immediately notify the NHSC through the Customer Service Portal. Time spent at unapproved clinics will not count towards the participant's service commitment.

As indicated in the "[Application and Recertification Process](#)" section, all NHSC-approved sites must contact the NHSC through the [BHW Customer Service Portal](#) if there are any changes to the

site including: NHSC points of contact, NHSC site location, or ownership. The DRO can provide technical assistance; for example:

If an established site changes ownership:

The site must submit a new application in order to verify that the site and its new owners understand and are able to meet the NHSC program requirements. In addition, if a site has changed its name, the site may be required to provide documentation if site ownership has also changed. Sites are encouraged to contact the DRO for additional assistance.

If there is a change in site information:

Generally, a new application does not need to be submitted when a site changes its physical location but remains in (or serving) the same HPSA, or adds a change in scope to its services (e.g., adds dental services to a primary care site). However, the site should report such changes to the NHSC so that the DRO can modify/update site records as necessary.

If a site moves to a new location and the DRO determines that the previous HPSA designation and/or score no longer applies, the site's approval status may be affected. In addition, a change in HPSA status or score could mean that NHSC participants currently serving at the site will not be eligible for a continuation award.

Inactivating or Terminating an NHSC-approved Site

Inactivation of an NHSC-approved site can occur under the following situations:

- 1) When an approved NHSC site no longer meets the established eligibility requirements;
- 2) When a site elects not to continue as an NHSC site; and
- 3) When a site misses the recertification deadline.

If HRSA determines that an approved NHSC site no longer meets established eligibility requirements, they will be given formal notice of the reasons for inactivation and an opportunity to address the eligibility concerns. Inactivated sites may reapply to become an NHSC-approved site during an open NHSC Site Recertification application cycle.

A site that is no longer operational will have its NHSC status terminated. The site should report such changes to the NHSC so that the DRO can modify/update the site record(s) as necessary. If the terminated site reopens under new ownership, the site must apply as a new site during an open NHSC New Site application cycle to become NHSC-approved.

If a participant is working at an inactivated or terminated site, he/she is required to transfer to another NHSC-approved site. The participant must request a transfer through the Customer Service Portal. The site change must be approved and processed by the NHSC prior to the participant beginning work at the new site. If a participant begins employment at a site before obtaining NHSC approval, he/she may not receive service credit for the time between his/her last

day providing patient care at the prior service site and resumption of service at the transfer site following NHSC approval. If the proposed site is disapproved by the NHSC and the participant refuses assignment to another NHSC-approved service site, he/she may be placed in default.

RECRUITING AN NHSC CLINICIAN

National Practitioner Data Bank (NPDB)

As part of its mission to improve health care quality, protect the public, and reduce health care fraud and abuse in the United States, HRSA maintains the [NPDB](#).

In accordance with the NHSC Site Agreement item #4, **the NHSC requires that all NHSC-approved sites use, at a minimum, a clinician credentialing process including reference review, licensure verification, and a query of the NPDB of those clinicians for whom the NPDB maintains data.**

This is especially important during the employment verification of a new NHSC LRP-applicant and those NHSC S2S participants or NHSC scholars with whom the NHSC has helped identify an NHSC-approved site where the individual will complete his/her service commitment.

The NPDB is primarily a flagging system that serves to alert an NHSC-approved site that there may be a problem with the competency or conduct of an NHSC participant. When the NHSC-approved site receives a report from the NPDB, it is prudent that the NHSC-approved site use this alert to complete a more comprehensive review of the qualifications and background of the NHSC clinician. The NHSC strongly encourages NHSC-approved sites to utilize the NPDB information in combination with other sources in making determinations on employment, affiliation, clinical privileges, certification, or other decisions.

Hiring an NHSC Participant

Once an NHSC site is approved, the NHSC site can post job vacancies on the [Health Workforce Connector](#) in order to recruit and hire a clinician. NHSC-approved sites and NHSC participants should both be aware that if the NHSC participant begins his/her employment at an **unapproved** site, the time served will **NOT** count toward the NHSC participant's service obligation. NHSC creditable service time may begin only after both the NHSC eligible site has been approved and the NHSC participant has been approved for participation in an NHSC program. It is important to remember that the approval of an NHSC site does not automatically guarantee a staff member's eligibility for an NHSC LRP, S2S or SP award. The approval of a site with the NHSC is separate and independent from the participant's NHSC award eligibility requirements, selection factors, and funding preferences.

In order for the NHSC-approved site to qualify specifically for an NHSC Scholar or NHSC S2S LRP participant, the NHSC-approved site must meet the published HPSA score threshold for the Scholar's or S2S LRP participant's applicable placement year. Each year, the NHSC will notify sites what the minimum required HPSA score is to recruit an NHSC scholar. Refer to the [NHSC website](#) for updates regarding this information.

If an NHSC site offers a job to an NHSC Scholar or NHSC S2S LRP participant, the site job offer letter must:

- 1) Be printed on company letterhead;
- 2) Be signed by the NHSC site or personnel representative;
- 3) Include the name and address of the NHSC site(s) where the NHSC participant will be working;
- 4) Indicate the number of hours the NHSC participant will work at each NHSC site;
- 5) Include the anticipated start of employment date; and
- 6) State whether the NHSC site will pay for the NHSC clinician's malpractice and tail coverage for the duration of employment.

Hiring Limitations of NHSC scholars or NHSC S2S LRP Participants

The NHSC SP allows one (1) NHSC Scholar **per discipline** to serve at a given NHSC-approved site within a yearly placement cycle. The NHSC S2S LRP program allows one (1) S2S LRP participant to serve at a given NHSC-approved site within a yearly placement cycle. There are no limitations to the number of NHSC LRP participants at a given NHSC-approved site. NHSC scholars do not count against the number of allowed NHSC S2S LRP participants at a given site. Likewise, NHSC S2S LRP participants do not count against the number of NHSC scholars allowed at any given site. For more information and to request an additional NHSC Scholar or NHSC S2S LRP participant, visit the [NHSC Sites webpage](#) and submit the [Additional Clinician Request Form](#).

Health Workforce Connector

The Health Workforce Connector is a quick and easy way to advertise job vacancies at NHSC-approved sites. This online platform allows sites to reach thousands of clinicians who are actively seeking employment in underserved communities. NHSC-approved sites may update their [site profile](#) on the [Health Workforce Connector](#) through the [BHW Customer Service Portal](#). For more information on creating and managing the site profile, refer to the [Site POC Portal User Guide](#). Additionally, review the Health Workforce Connector [FAQs](#) and [Instructions](#).

SITE VISITS AND TECHNICAL ASSISTANCE

NHSC Site Visit

An NHSC site visit is an evaluation of a site's understanding and implementation of the NHSC site and participant requirements as outlined in the NHSC Site Agreement (Appendix A). DRO staff conduct site visits in collaboration with the State PCO to provide technical assistance to site administrators or NHSC participants, to promote BHW and HRSA programs, and to improve NHSC program compliance.

Expectations During a Site Visit

Along with an evaluation of the site's understanding and implementation of the NHSC site and NHSC participant requirements, the site visit also provides the following:

- A setting where DRO staff and State PCO staff can provide site-specific technical assistance on NHSC program requirements;

- An opportunity for DRO staff to share NHSC recruitment and retention resources available to NHSC sites; and
- A venue where DRO staff can meet with NHSC clinicians to assess any technical assistance needs and receive feedback about the clinicians’ participation in the NHSC program.

DRO staff will request the list of required supporting documents as noted in the section entitled, [“Required NHSC Supporting Documents”](#) DRO reserves the right to request access to (or copies of) additional documents during the NHSC site visit. These materials may also be reviewed by DRO staff in advance of the actual site visit. More information to prepare for a site visit can be found on the [NHSC Sites webpage](#).

Frequency of NHSC Site Visits

For applicant sites, DRO staff will conduct pre-decisional site visits as determined necessary to ensure compliance with NHSC program requirements and as travel resources are available. Existing NHSC-approved sites should anticipate periodic site visits while participating in the NHSC program to confirm adherence to all NHSC site requirements.

Addressing NHSC Site Eligibility Concerns

NHSC site eligibility concerns can arise for sites at the time of NHSC new site application, recertification, or during an NHSC site visit. In addition, site eligibility concerns for existing NHSC-approved sites can be raised from NHSC participants, State PCOs, other BHW Divisions, HRSA Bureaus and Offices, or other external stakeholders at any point during the site’s three-year approval period. There are two separate processes to address NHSC site eligibility concerns, depending on whether the site is an applicant site or an existing site. Note that the term “applicant site” includes both new and recertifying sites.

- ***Process for Addressing NHSC Site Eligibility for New and Recertifying Applicant Sites.***
HRSA BHW DRO renders the final decision for NHSC site approval and a disapproval is determined if: 1) an applicant site does not meet the NHSC site eligibility requirements as set forth in the NHSC Site Reference Guide and NHSC Site Agreement, or 2) the NHSC site application is incomplete or contains illegible documents. Disapproved sites will receive an email notification from the BHW Customer Service Portal of the final decision. A copy will also be sent to the State PCO. Disapproved sites are encouraged to discuss their disapproved site application with HRSA BHW DRO staff in their respective regional office in order to obtain guidance on how to meet the NHSC site eligibility requirements for the next application cycle.
- ***Process for Addressing NHSC Site Eligibility in Existing NHSC-Approved Sites.***
If HRSA BHW DRO determines that an existing NHSC-approved site does not meet the NHSC Site Eligibility requirements set forth in the NHSC Site Reference Guide and NHSC Site Agreement, the following steps will take place:
 1. HRSA BHW DRO will contact the existing site via e-mail to identify the specific violation of the NHSC Site Reference Guide or NHSC Site Agreement, the specific requested remedy to that violation, and a thirty (30) calendar day timeframe for submitting sufficient documentation demonstrating that the site addressed and fulfilled the requisite remedy to HRSA BHW DRO.

2. A “flag” may be placed in the BMISS site record for the existing site to alert HRSA BHW staff that there is an eligibility concern. The “flag” may be considered by HRSA BHW staff in relation to placing additional NHSC participants at the existing site.
3. HRSA BHW DRO will provide all necessary technical assistance to the existing site to assist with the remedy. The technical assistance may include a site visit or phone audit by HRSA BHW DRO.
4. If the existing site fails to provide an acceptable response to DRO within thirty (30) calendar days, the site will be disapproved. The reviewing DRO staff member will email the decision letter to the site and send a copy to the State PCO. The existing site will be placed in an inactive status in BMISS. A site inquiry will be sent via BMISS to the HRSA BHW Division of Participant Support and Compliance (DPSC) to notify them of the site inactivation in the event there are NHSC participants present at the site. *(NOTE: On rare occasions as deemed necessary by BHW DRO, the site may be granted a thirty (30) day extension if the site demonstrated due diligence in trying to meet NHSC site eligibility requirements.)*
5. If the existing site provides an acceptable response to HRSA BHW DRO within the initial or final thirty (30) calendar days, the site recertification will be approved and the decision is automatically emailed to the site through the BHW Customer Service Portal, and copied to the State PCO. The existing site will remain active in BMISS and the “flag” will be removed from the BMISS site record.

Addressing Site Concerns Unrelated to the NHSC

Occasionally, HRSA BHW will receive concerns about NHSC approved sites that are outside of its program authority and the terms of the NHSC Site Agreement (e.g., contractual disputes with site, allegations of Medicaid fraud, workplace discrimination). In these situations, HRSA BHW DRO may refer complainants to the appropriate program authority (e.g., the site’s Board of Directors, HHS Office of Inspector General, the HRSA Office of Civil Rights, Diversity, and Inclusion) to address the concerns.

GLOSSARY

For an expanded list of terminologies, refer to the [BHW Health Workforce Glossary](#).

Centers for Medicare and Medicaid Services (CMS) – An operating agency of HHS. For more information, click [here](#).

CMS Certified Rural Health Clinic (RHC) – A facility certified by the CMS under section 1861(aa)(2) of the Social Security Act that receives special Medicare and Medicaid reimbursement. RHCs are located in a non-urbanized area with an insufficient number of health care practitioners and provide outpatient primary care services, routine diagnostic, and clinical laboratory services. RHCs have a nurse practitioner, a physician assistant, or a certified nurse-midwife available to furnish patient care services not less than 50 percent of the time the clinic operates. For more information, click [here](#).

Clinical-Related Administrative, Management or Other Activities – May include charting, training, laboratory follow-up, patient correspondence, attending staff meetings, activities related to maintaining professional licensure, and other non-treatment related activities pertaining to the participant’s approved NHSC practice. Any time spent in a management role is also considered an administrative activity. The duties of a medical director are considered primarily administrative, and NHSC participants serving in such a capacity should keep in mind that they cannot count more than 8 hours per week of administrative and/or management time if serving full-time (4 hours if serving half-time) toward the total required 40 hours per week (or 20 hours per week in the case of half-time service).

Community Mental Health Center (CMHC) – An entity that meets applicable licensing or certification requirements for CMHCs in the state in which it is located. Effective March 1, 2001, in the case of an entity operating in a state that by law precludes the entity from providing the screening services, the entity may provide for such service by contract with an approved organization or entity (as determined by the Secretary) that, among other things, meets applicable licensure or certification requirements for CMHCs in the state in which it is located. A CMHC may receive Medicare reimbursement for partial hospitalization services only if it demonstrates that it provides such services.

Comprehensive Community-Based Primary Behavioral Health Setting or Facility – A site that provides comprehensive primary behavioral health care services as defined by NHSC. The site must function as part of a system of care to ensure continuity of patient-centered, comprehensive, and coordinated care. The site must offer or ensure access to ancillary, inpatient, and specialty referrals.

Comprehensive Primary Behavioral/Mental Health Services – Services that include, but are not limited to: screening and assessment; diagnosis; treatment plans; therapeutic services (including access to psychiatric medication prescribing and management, chronic disease management, and

substance use disorder treatment); crisis care (including 24-hour crisis call access); case management; consultative services; and care coordination. Sites providing such services must function as part of a system of care to ensure continuity of patient-centered, comprehensive, and coordinated care. The site must also offer or ensure access to ancillary, inpatient, and specialty referrals. Refer to [NHSC Comprehensive Behavioral Health Checklist](#) for detailed definitions.

Core Comprehensive Primary Behavioral Health Services – NHSC sites must provide the following services on-site and not through affiliation agreements: screening and assessment, treatment plans, and care coordination.

Correctional Facility – The NHSC recognizes state and Federal prisons. State prisons are clinical sites administered by the state. Federal prisons are designated institutions and/or facilities from the U.S. Department of Justice, Federal Bureau of Prisons. Federal prisons may be eligible as auto-approved if these facilities continue to provide comprehensive primary medical, dental, and behavioral and mental health care services, and meet the NHSC requirements. For more information about Federal prisons, click [here](#). **Clinical sites within city, county and local correctional facilities are not eligible as an NHSC-approved site.**

Critical Access Hospital (CAH) –The NHSC recognizes the entire CAH as a service delivery site (to include the Emergency Room (ER), swing bed unit, and skilled nursing facility (SNF)). The CAH must provide comprehensive primary care and related inpatient services. CAHs must apply for site approval in conjunction with an affiliated, outpatient clinic by either submitting separate site applications during the same application cycle, or by demonstrating an affiliation with an outpatient clinic that has previously submitted a site application and has been approved. The CAH must also demonstrate an affiliation (either through direct ownership or affiliation agreements) with an outpatient, primary care clinic. NHSC clinical practice requirements vary for NHSC clinicians working at CAHs. For a more detailed explanation of the full-time and half-time clinical practice requirements, including requirements for participants working in CAHs, refer to the [NHSC website](#) and review the respective NHSC LRP, S2S LRP and/or SP Application and Program Guidance. For more information about CAHs, click [here](#).

DATA 2000 Waiver – A waiver obtained under the Controlled Substances Act (CSA), 21 U.S.C 823(g)(2), as amended by the Drug Addiction Treatment Act of 2000 (DATA 2000), and the Comprehensive Addiction and Recovery Act of 2016, that permits physicians, nurse practitioners and physician assistants who meet certain qualifications to treat opioid use disorder with Schedule III, IV, and V narcotic medications, including buprenorphine, or combinations of such medications, that are approved by the Food and Drug Administration (FDA) in treatment settings other than opioid treatment programs (OTPs).

Disapproved Site – A site that fails to meet the NHSC statutory and programmatic eligibility requirements and does not receive approval by the NHSC.

Division of Policy and Shortage Designation (DPSD) – One of several divisions within BHW; consists of two branches that serve as the focal point for the development of BHW programs and

policies by leading and coordinating the analysis, development, and drafting of policies impacting BHW programs, recommending and approving shortage designation requests, overseeing cooperative agreements to State PCOs, and supporting other BHW activities. Learn more information about [shortage designation](#).

Division of Regional Operations (DRO) – One of several divisions within BHW; consists of 10 regional HRSA offices that are primarily responsible for promoting BHW programs, conducting NHSC site visits, approving NHSC Site Applications, providing NHSC scholar support, and supporting other BHW activities. Contact a [DRO representative](#).

Federal Poverty Guidelines (FPG) – The [Federal Poverty Guidelines](#) are issued each year in the *Federal Register* by HHS. The Guidelines are a simplification of the poverty thresholds for use for administrative purposes — for instance, determining financial eligibility for certain Federal programs.

Federally-Qualified Health Centers (FQHC) – For more information, visit the [Bureau of Primary Health Care website](#).

Fiscal Year (FY) – October 1 through September 30.

Formal Affiliation Agreement – Written agreement that sets forth the terms and conditions under which two organizations agree to furnish integrated services to better meet patient and client needs. All affiliated entities for primary behavioral health care should accept applicable public insurance and offer NHSC-approved discounts to those with low incomes and agree to see all patients regardless of their ability to pay. Affiliation agreements must include the following:

- 1) Signatures from both parties and a description of the formal relationship.
- 2) Process for sharing pertinent medical information through a shared electronic health record or other administrative process. Entities should utilize signed authorizations for release of information.
- 3) Demonstration of continuity of care through: a) Written procedures and/or assigned personnel for care coordination and case management; b) Processes for tracking and follow-up of referral appointments; and c) Processes for scheduling consultation or care coordination meetings with affiliated site providers.
- 4) Assurance that the affiliated entity is accessible to clients of the site (affordability, accepting new patients, etc.).

For examples of formal affiliation agreements, visit the [SAMHSA-HRSA Center for Integrated Health Solutions website](#) or Appendix G.

Free Clinic – A medical facility offering community health care on a free or very low-cost basis. Care is generally provided in these clinics to persons who have lower or limited income and no health insurance, including persons who are not eligible for Medicaid or Medicare. Almost all free

clinics provide care for acute, non-emergent conditions. Many also provide a full range of primary care services (including preventive care) and care for chronic conditions.

Health Workforce Connector – The [Health Workforce Connector](#) is a searchable database of open job opportunities and information on NHSC sites.

Immigration and Customs Enforcement (ICE) Health Service Corps sites – Clinical sites administered by the U.S. Immigration, Customs, and Enforcement Agency with the Department of Homeland Security. [ICE Health Service Corps](#) sites may be eligible as auto-approved if these sites provide comprehensive primary medical, dental and behavioral and mental health care services, and meet the NHSC requirements.

Indian Health Service (IHS) Hospitals – A collective term that includes hospitals that are both IHS-owned and IHS-operated, or IHS-owned and tribally-operated (i.e., a federal facility operated by a tribe or tribal organization contracting with the IHS pursuant to the Indian Self-Determination and Education Assistance Act), which provide both inpatient and outpatient clinical treatment services to eligible American Indians and Alaska Natives. This term does not include hospitals that are both tribally-owned and tribally-operated. The NHSC recognizes the entire IHS Hospital as a service delivery site (to include the Emergency Room (ER), swing bed unit, and skilled nursing facility (SNF)). IHS Hospitals must provide comprehensive primary care and related inpatient services. IHS hospitals must apply for site approval in conjunction with an affiliated, outpatient clinic by either submitting separate site applications during the same application cycle, or by demonstrating an affiliation with an outpatient clinic that has previously submitted a site application and has been approved. IHS Hospitals must also demonstrate an affiliation (either through direct ownership or affiliation agreements) with an outpatient, primary care clinic. NHSC clinical practice requirements vary for NHSC clinicians working at IHS Hospitals. For a more detailed explanation of the full-time and half-time clinical practice requirements, including requirements for participants working in IHS Hospitals, refer to the [NHSC website](#) and review the respective NHSC LRP, S2S LRP and/or SP Application and Program Guidance.

Indian Health Service, Tribal or Urban Indian Health Clinic (ITU) – A health care facility (whether operated directly by the IHS or by a tribe or tribal organization contracting with the IHS pursuant to the Indian Self-Determination and Education Assistance Act, codified at 25 U.S.C. 450 et seq.; or by an urban Indian organization receiving funds under Subchapter IV of the Indian Health Care Improvement Act, codified at 25 U.S.C. 1651 et seq.), which provides clinical treatment services to eligible American Indians and Alaska Natives on an outpatient basis. Visit the [Indian Health Service website](#) to learn more.

Medication-Assisted Treatment (MAT) – The use of FDA-approved medications, in combination with counseling and behavioral therapies, to provide a “whole-patient” approach to the treatment of substance use disorders.

Mobile Units/Clinics – The NHSC recognizes Mobile Units/Clinics as medical vehicles (e.g., mobile health vans) that travel to underserved rural and urban communities, providing a majority (>50%)

of primary care services to individuals located in a HPSA. NHSC participants working within a mobile unit that functions as part of an NHSC-approved site or through an alternative care setting (e.g., hospitals, nursing homes, shelters) will receive service credit for patient care, so long as the mobile unit is affiliated with an NHSC-approved site and provides a majority (>50%) of services to only the approved HPSA area and/or residents of a HPSA.

National Health Service Corps (NHSC) – “The Emergency Health Personnel Act of 1970,” Public Law 91-623, established the NHSC on December 31, 1970. The [NHSC](#), within the Department of Health and Human Services, was created to eliminate health professional shortages through the assignment of trained health professionals to provide primary health services in HPSAs. The NHSC seeks to improve the health of underserved Americans by bringing together communities in need with qualified primary health care professionals.

NHSC-Approved Site – Sites interested in NHSC approval must submit an NHSC application to become an [NHSC-approved service site](#). In order for a site to be eligible for NHSC approval, it must: be located in and be provide service to a federally-designated HPSA; provide comprehensive primary medical care, behavioral/mental health, and/or dental services; provide ambulatory care services (no inpatient sites, except CAHs and IHS hospitals); ensure access to ancillary, inpatient, and specialty referrals; charge fees for services consistent with prevailing rates in the area; discount or waive fees for individuals at or below 200% of the federal poverty level; accept assignment for Medicare beneficiaries; enter into agreements with Medicaid and the Children’s Health Insurance Program (CHIP), as applicable; not discriminate in the provision of services based on an individual’s inability to pay for services or the source of payment (Medicare/Medicaid/CHIP); prominently post signage that no one will be denied access to services due to inability to pay; agree not to reduce clinician’s salary due to NHSC support; provide sound fiscal management; and maintain a recruitment and retention plan, as well as a credentialing process, for clinicians. If the site application is approved, the community site becomes an NHSC-approved site. All NHSC sites must continuously meet the above requirements.

NHSC Loan Repayment Program (LRP) – Under the NHSC LRP, participants provide full-time or half-time primary health services in HPSAs in exchange for funds for the repayment of their qualifying educational loans. The NHSC LRP selects fully trained and licensed primary health care professionals dedicated to meeting the health care needs of medically underserved HPSA communities.

NHSC Rural Community Loan Repayment Program (NHSC Rural Community LRP) – The NHSC Rural Community LRP is authorized by Section 338B of the Public Health Service (PHS) Act (42 United States Code Section 254I-1), as amended; Section 331(i) of the PHS Act (42 United States Code Section 254d(i)), as amended by the Consolidated Appropriations Act of 2018 (P.L. 115-141); Consolidated Appropriations Act, 2018, Title II (Public Law No. 115-141, Title II); Department of Defense and Labor, Health and Human Services, and Education Appropriations Act, 2019 and Continuing Appropriations Act, 2019 (P.L. 115-245). The NHSC Rural Community LRP recruits and retains medical, nursing, and behavioral/mental health clinicians with specific training and credentials to provide evidence-based SUD treatment in rural communities designated as HPSAs.

NHSC Scholarship Program (SP) – The [NHSC SP](#) is a competitive federal program that awards scholarships to students pursuing primary care health professions training. In return for each school year or partial school year of NHSC scholarship support received, students agree to provide full-time primary care services for one (1) year in an NHSC-approved service site located in or serving a HPSA. For each school year or partial school year of scholarship support received, there is a minimum 2-year service commitment with a maximum 4-year commitment.

NHSC Site Data Tables – A site reporting tool - [Site Data Tables \(Appendix D\)](#) used by the NHSC to collect the required information from sites at time of application, recertification, and NHSC site visits.

NHSC Students to Service Loan Repayment Program (S2S LRP) – The [NHSC S2S LRP](#) is a competitive federal program that provides loan repayment awards to medical and dental students in their final year of school. In exchange for loan repayment, these individuals agree to provide primary health care services for a 3-year service commitment at NHSC-approved service sites located in or serving HPSAs.

NHSC Substance Use Disorder (SUD) Workforce LRP – The NHSC SUD Workforce LRP recruits and retains medical, nursing, and behavioral/mental health clinicians with specific training and credentials to provide evidence-based SUD treatment and counseling in eligible communities of need designated as HPSAs. Participants receive loan repayment to reduce their educational financial debt in exchange for a service obligation to work at NHSC-approved SUD Treatment Sites.

National Practitioner Data Bank (NPDB) – The [NPDB](#) is a confidential information clearinghouse created by Congress with the primary goals of improving health care quality, protecting the public, and reducing health care fraud and abuse in the United States. This health workforce tool provides eligible health care entities information on medical malpractice payments and certain adverse actions related to health care practitioners, entities, providers, and suppliers.

Non-Opioid Outpatient Substance Use Disorder (SUD) Treatment Facility – Sites other than Opioid Treatment Programs (OTPs) and Office-based Opioid Treatment (OBOT) practices that provide outpatient SUD treatment services to patients with SUD needs.

Office-based Opioid Treatment (OBOT) Facility – Clinical practice, other than SAMHSA certified Opioid Treatment Programs, that provides office-based medication-assisted treatment services to patients with opioid use disorder by a provider with a waiver granted under 21 U.S.C. § 823(g)(2), otherwise known as a Drug Addiction Treatment Act of 2000 (DATA 2000) waiver.

Opioid Treatment Program (OTP) – Sites that provide medication-assisted treatment (MAT) for people diagnosed with opioid-use disorder that are certified by the Substance Abuse and Mental Health Services Administration (SAMHSA), in accordance with 42 C.F.R. Part 8. OTPs must also be accredited by an independent, SAMHSA-approved accrediting body to dispense opioid treatment

medications, licensed by the state in which they operate, and must register with the Drug Enforcement Agency (DEA) through a local DEA office.

Patient Care for Behavioral Health Providers – Time spent providing one or more of the comprehensive behavioral health services as defined under “**Comprehensive Primary Behavioral/Mental Health Services.**”

Primary Health Services – Health services including family medicine, internal medicine, pediatrics, obstetrics and gynecology, dentistry, or mental health, that are provided by physicians or other health professionals, and for purposes of the NHSC SUD Workforce LRP, includes clinical substance use disorder treatment services.

Public Health Department Clinic – Primary or mental health clinics operated by a state, county or local health department.

School-Based Programs and School-Based Clinics – All school-based clinics must be NHSC-approved service sites. Participants serving at school-based clinics as their primary service site(s) must provide required documentation (e.g., ISV Forms) that demonstrates they are meeting their NHSC service obligation at that facility. For participants serving at an NHSC-approved school-based clinic, the NHSC understands that the school-based clinic may not be open year-round. Providers who work at school-based clinics that are not open year-round will not receive NHSC service credit in accordance with their NHSC service contract for any period of time they are not serving at a school-based clinic. In order to meet the NHSC’s clinical practice requirements, participants who are working at school-based clinics that are not open for a minimum of 45 weeks per service year have the option to work at an additional NHSC-approved site (or sites). The additional NHSC-approved site (or sites) must satisfy the HPSA requirements identified in the participant’s initial NHSC service contract.

If the school is closed for a portion of the year, and the participant does not have an alternate NHSC-approved site that will enable the participant to fulfill the NHSC’s annual clinical practice requirements, the participant’s service obligation will be extended. Participants who fail to maintain compliance with NHSC clinical practice requirements may be in breach of their current NHSC service contract.

Site Points of Contact (POC) – A POC is a person who serves as the coordinator or focal point of information concerning Bureau of Health Workforce (BHW) programs and activities at an organization. The organization typically has employees interested in or actively participating in one or more BHW programs (e.g., National Health Service Corps). The BHW utilizes POCs in cases where information is time-sensitive and accuracy is important. A single organization may have multiple POCs depending on the programs the organization is involved in and the role of the identified POCs. Specifically, the BHW is interested in POCs who are:

- 1) Administrators – own oversee, or manage a significant portion of their organization and/or understand and have the ability to answer questions about organization policies and operating procedures;

- 2) Personnel Verifiers – manage and can confirm employment status, work schedules, and/or absences of employees within their organization;
- 3) Recruiters – hire and/or recruit new employees for the organization.

Sliding Fee Scale (SFS) or Discounted Fee Schedule – A SFS or discounted fee schedule is a set of discounts that are applied to a practice’s schedule of charges for services, based upon a written policy that is non-discriminatory.

Solo or Group Private Practice – A clinical practice that is made up of either one or many providers in which the providers have ownership or an invested interest in the practice. Private practices can be arranged to provide primary medical, dental and/or mental health services and can be organized as entities on the following basis: fee-for-service; capitation; a combination of the two; family practice group; primary care group; or multi-specialty group.

State Primary Care Offices (PCOs) – [State-based primary care offices](#) provide assistance to communities seeking HPSA designations and recruitment assistance as NHSC-approved sites. PCOs work collaboratively with PCAs and the NHSC Program to increase access to primary and preventive health care and improve the health status of underserved and vulnerable populations. The primary responsibilities of PCOs include the following:

- 1) Improving organizational effectiveness among stakeholders and fostering collaboration with Primary Care Associations, State Offices of Rural Health, Area Health Education Centers, and other entities to address primary care needs;
- 2) Providing technical assistance to organizations and communities wishing to expand access to primary care for underserved populations;
- 3) Assessing needs and sharing data with the public;
- 4) Conducting workforce development activities for the NHSC and the safety net and health center network; and
- 5) Coordinating HPSA and Medically Underserved Areas and Populations (MUA/P) designation process within states, including the data collection on primary care, dental, and mental health providers in their states.

Substance Use Disorder (SUD) – Involves the overuse of, or dependence on, one or more substances leading to a clinically significant impairment whose effects are detrimental to the individual’s physical and mental health, or the welfare of others.

Substance Use Disorder Treatment – Refers to SUD-related care that is delivered based on a standardized assessment of SUD treatment needs.

Substance Use Disorder Treatment Facility – A collective term used to refer to OTPs, OBOT facilities, and non-opioid outpatient SUD treatment facilities. NHSC SUD Workforce LRP applicants must work at an SUD Treatment Facility.

Telemedicine/Telehealth – The practice of medicine in accordance with applicable federal and state laws by a practitioner (other than a pharmacist) who is at a location remote from the

patient; and is communicating with the patient, or health care professional who is treating the patient, using a telecommunications system referred to in regulation. The patient must be either:

- Treated by, and physically located in, a DEA-registered hospital (for purposes of NHSC, only CAHs or IHS Hospitals) or clinic by a practitioner who is: a) acting in the usual course of professional practice; b) who is acting in accordance with applicable state law; and c) is registered with the DEA state in which the patient is located.

--OR--

- Treated by, and in the physical presence of a DEA-registered practitioner who is: a) acting in the usual course of professional practice; b) acting in accordance with applicable state law; and c) registered with DEA in the state in which the patient is located.

Importantly, remote practitioners engaged in the practice of telemedicine must be registered with the DEA in the state where they are physically located and in every state where their patient(s) is (are) physically located. All records for prescribing of an FDA approved narcotic for the treatment of opioid addiction need to be kept in accordance with Federal regulations.

Tribal Health Program – An Indian tribe or tribal organization that operates any health program, service, function, activity, or facility funded, in whole or part, by the IHS through, or provided for in, a contract or compact with the IHS under the Indian Self-Determination and Education Assistance Act (25 USC 450 et. seq.).

APPENDIX A: NHSC Site Agreement



National Health Service Corps

SITE AGREEMENT

National Health Service Corps (NHSC) approved sites must meet all requirements stated below at the time of application and must continue to meet the requirements in order to maintain status as an NHSC-approved site.

1. Is located in and treats patients from a federally designated [Health Professional Shortage Area \(HPSA\)](#).
2. Does not discriminate in the provision of services to an individual (i) because the individual is unable to pay; (ii) because payment for those services would be made under Medicare, Medicaid, or the Children's Health Insurance Program (CHIP); or (iii) based upon the individual's race, color, sex, national origin, disability, religion, age, sexual orientation, or gender identity. *[May or may not be applicable to Indian Health Service, Tribal or Urban Indian Health Clinics (ITUs), free clinics, or correctional facilities].*
 - a. Uses a schedule of fees or payments for services consistent with locally prevailing rates or charges and designed to cover the site's reasonable costs of operation. *(May or may not be applicable to ITUs, free clinics, or correctional facilities.)*
 - b. Uses a [discounted/sliding fee schedule](#) to ensure that no one who is unable to pay will be denied access to services, and the discount must be applicable to all individuals and families with annual incomes at or below 200 percent of the most current Federal Poverty Guidelines (FPG). The sliding fee schedule must also provide a full discount for individuals and families with annual incomes at or below 100 percent of the FPG, with allowance for a nominal charge only, consistent with site's policy; Must adjust fees (partial sliding fee discount) based on family size and income for individuals and families with incomes above 100 percent and at or below 200 percent of the FPG. *(May or may not be applicable to ITUs, free clinics, or correctional facilities.)*
 - c. Makes every reasonable effort to secure payment in accordance with the schedule of fees or schedule of discounts from the patient and/or any other third party. *(May or may not be applicable to ITUs, free clinics, or correctional facilities.)*

- d. Accepts assignment for Medicare beneficiaries and has entered into an appropriate agreement with the applicable state agency for Medicaid and CHIP beneficiaries. *(May or may not be applicable to ITUs, free clinics, or correctional facilities.)*
 - e. Prominently displays a statement in common areas and on site's website (if one exists) that explicitly states that (i) no one will be denied access to services due to inability to pay; and (ii) there is a discounted/sliding fee schedule available. When applicable, this statement should be translated into the appropriate language/dialect. *(May or may not be applicable to free clinics, or correctional facilities.)*
3. Provides culturally competent, comprehensive primary care services (medical, dental, and/or behavioral), which correspond to the designated HPSA type. For a detailed description of culturally and linguistically appropriate services in health, visit the [Office of Minority Health](#) website.
 4. Uses a credentialing process that, at a minimum, includes reference review, licensure verification, and a query of the [National Practitioner Data Bank \(NPDB\)](#) of those clinicians for whom the NPDB maintains data.
 5. Functions as part of a system of care that either offers or ensures access to ancillary, inpatient, and specialty referrals.
 6. Adheres to sound fiscal management policies and adopts clinician recruitment and retention policies to help the patient population, the site, and the community obtain maximum benefits.
 7. Maintains a clinician recruitment and retention plan, keeps a current copy of the plan on-site for review, and adopts recruitment policies to maintain appropriate clinical staffing levels needed to serve the community.
 8. Does not reduce the salary of NHSC clinicians because they receive or have received benefits under the NHSC Loan Repayment or Scholarship programs.
 9. Allows NHSC clinicians to maintain a primary care clinical practice (full-time or half-time) as indicated in their contract with NHSC and described in part below. **The site administrator must review and know the clinician's specific NHSC service requirements.** Time spent on call will not count toward a clinician's NHSC work hours. Participants do not receive service credit hours worked over the required hours per week, and excess hours cannot be applied to any other work week. Clinicians must apply for a suspension of their service obligation if their absences per year are greater than those allowed by NHSC. If a suspension is requested and approved, the participant's service obligation end date will be extended accordingly. For a more detailed explanation of the full-time and half-time clinical practice requirements, including requirements for participants working in CAHs and IHS Hospitals, refer to the [NHSC website](#) and review the respective NHSC Loan Repayment Programs (LRP, SUD Workforce LRP, Rural Community LRP), Students to Service Loan Repayment Program and/or Scholarship Program Application and Program Guidance.
 10. Communicates to the NHSC any change in site or clinician employment status for full-time and half-time, including moving an NHSC clinician to a satellite site for any or all of their hour work week, termination, etc.
 11. Supports clinicians with funding and arrangements, including clinical coverage, for their time away from the site to attend NHSC-sponsored meetings, webinars, and other continuing education programs.
 12. Maintains and makes available for review by NHSC representatives all personnel and practice records associated with an NHSC clinician including documentation that contains such information that the Department may need to determine if the individual and/or site has complied with NHSC requirements.

13. Completes and submits NHSC Site Data Tables (requires up-to-date data for the preceding six months) to NHSC at the time of the site application, recertification, and NHSC site visits. The following eligible Auto-Approved NHSC Sites ARE NOT required to submit the NHSC Site Data Tables: 1) Federally Qualified Health Centers, and 2) Federally Qualified Health Center Look-Alikes. The standard Health Resources and Services Administration/Bureau of Primary Health Care Uniform Data System (UDS) report will be reviewed in place of the data tables. The following eligible Auto-Approved NHSC sites must provide NHSC Site Data Tables upon request if HRSA needs them to determine NHSC site eligibility: 1) ITUs, 2) Federal Prisons, 3) State Prisons, and 4) Immigration and Customs Enforcement Health Service Corps sites.
14. Complies with requests for a site visit from NHSC or the State Primary Care Office with adherence to all NHSC requirements.

By signing below, you hereby affirm your compliance with the NHSC Site Agreement, and that the information submitted is true and accurate. You further understand that this information is subject to verification by the NHSC.

Name of Site (Print): _____

Site Official's Name (Print): _____

Site Official's Name (Signature): _____

Site Official's Title: _____

Date: _____



APPENDIX B: NHSC Public Notice Signage

Sample Public Notice Signage

NHSC-approved service sites are required to inform patients of the Sliding Fee Discount Program. The following examples illustrate language to be posted prominently online and at the physical site. NHSC encourages sites to establish multiple methods of informing patients. Sites can obtain more information by accessing the [Current Member Sites page](#) on the NHSC website.

Public Notice Signage Example One

NOTICE TO PATIENTS:

This practice serves all patients regardless of inability to pay.

Discounts for essential services are offered based on family size and income.

For more information, ask at the front desk or visit our website.

Thank you.

AVISO PARA PACIENTES:

Esta práctica sirve a todos los pacientes, independientemente de la incapacidad de pago.

Descuentos para los servicios esenciales son ofrecidos dependiendo de tamaño de la familia y de los ingresos.

Usted puede solicitar un descuento en la recepción o visita nuestro sitio web.

Gracias.





AS A NATIONAL HEALTH SERVICE CORPS SITE, WE PROMISE TO

- Serve all patients**
- Offer discounted fees for patients who qualify**
- Not deny services based on a person's:**

- Race
- Color
- Sex
- Age
- National Origin
- Disability
- Religion
- Gender identity
- Sexual orientation
- Inability to pay

- Accept insurance, including:**

- Medicaid
- Medicare
- Children's Health Insurance Program (CHIP)

This facility is a member of the National Health Service Corps: NHSC.hrsa.gov.



APPENDIX C: Sample Sliding Fee Discount Patient Application, Program Policy, and Schedule

Sample Sliding Fee Discount Application

ABC HEALTHCARE CLINIC

Sliding Fee Discount Information

It is the policy of ABC Healthcare Clinic to provide essential services regardless of the patient's ability to pay. ABC offers discounts based on family size and annual income.

Please complete the following information and return to the front desk to determine if you or members of your family are eligible for a discount.

The discount will apply to all services received at this clinic, but not those services or equipment purchased from outside, including reference laboratory testing, drugs, and x-ray interpretation by a consulting radiologist, and other such services. You must complete this form every 12 months or if your financial situation changes.

NAME OF HEAD OF HOUSEHOLD			PLACE OF EMPLOYMENT	
STREET	CITY	STATE	ZIP	PHONE

Please list spouse and dependents under age 18.

Name	Date of Birth	Name	Date of Birth
SELF		DEPENDENT	
SPOUSE		DEPENDENT	
DEPENDENT		DEPENDENT	
DEPENDENT		DEPENDENT	



Source	Self	Spouse	Other	Total
Gross wages, salaries, tips, etc.				
Income from business, self-employment, and dependents				
Unemployment compensation, workers' compensation, Social Security, Supplemental Security Income, public assistance, veterans' payments, survivor benefits, pension or retirement income				
Interest, dividends, rents, royalties, income from estates, trusts, educational assistance, alimony, child support, assistance from outside the household, and other miscellaneous sources				
Total Income				

NOTE: Copies of tax returns, pay stubs, or other information verifying income may be required before a discount is approved.

I certify that the family size and income information shown above is correct.

Name (Print)

Signature

Date

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Office Use Only

Patient Name: _____

Approved Discount: _____

Approved by: _____

Date Approved: _____

Verification Checklist	Yes	No
Identification/Address: Driver's license, utility bill, employment ID, or other		
Income: Prior year tax return, three most recent pay stubs, or other		
Insurance: Insurance Cards		



Sample Sliding Fee Discount Program Policy

ABC HEALTHCARE CLINIC BUSINESS OFFICE POLICIES

SUBJECT: Sliding Fee Discount Program

EFFECTIVE DATE: April 1, 2020

POLICY: To make available discount services to those in need.

PURPOSE: This program is designed to provide free or discounted care to those who have no means, or limited means, to pay for their medical services (Uninsured or Underinsured).

In addition to quality healthcare, patients are entitled to financial counseling by someone who can understand and offer possible solutions for those who cannot pay in full. The Patient Account Representative's role is that of patient advocate, that is, one who works with the patient and/or guarantor to find reasonable payment alternatives.

ABC HEALTHCARE CLINIC will offer a Sliding Fee Discount Program to all who are unable to pay for their services. ABC HEALTHCARE CLINIC will base program eligibility on a person's ability to pay and will not discriminate on the basis of an individual's race, color, sex, national origin, disability, religion, age, sexual orientation, or gender identity. The [Federal Poverty Guidelines](#) are used in creating and annually updating the sliding fee schedule (SFS) to determine eligibility.

PROCEDURE:

The following guidelines are to be followed in providing the Sliding Fee Discount Program.

1. Notification: ABC HEALTHCARE will notify patients of the Sliding Fee Discount Program by:
 - Payment Policy Brochure will be available to all uninsured patients at the time of service.
 - Notification of the Sliding Fee Discount Program will be offered to each patient upon admission.
 - Sliding Fee Discount Program application will be included with collection notices sent out by ABC HEALTHCARE.
 - An explanation of our Sliding Fee Discount Program and our application form are available on ABC HEALTHCARE's website.
 - ABC HEALTHCARE places notification of Sliding Fee Discount Program in the clinic waiting area.



2. All patients seeking healthcare services at ABC HEALTHCARE are assured that they will be served regardless of ability to pay. No one is refused service because of lack of financial means to pay.
3. Request for discount: Requests for discounted services may be made by patients, family members, social services staff or others who are aware of existing financial hardship. The Sliding Fee Discount Program will only be made available for clinic visits. Information and forms can be obtained from the Front Desk and the Business Office.
4. Administration: The Sliding Fee Discount Program procedure will be administered through the Business Office Manager or his/her designee. Information about the Sliding Fee Discount Program policy and procedure will be provided and assistance offered for completion of the application. Dignity and confidentiality will be respected for all who seek and/or are provided healthcare services.
5. Alternative payment sources: All alternative payment resources must be exhausted, including all third-party payment from insurance(s), federal and state programs.
6. Completion of Application: The patient/responsible party must complete the Sliding Fee Discount Program application in its entirety. By signing the Sliding Fee Discount Program application, persons authorize ABC HEALTHCARE access in confirming income as disclosed on the application form. Providing false information on a Sliding Fee Discount Program application will result in all Sliding Fee Discount Program discounts being revoked and the full balance of the account(s) restored and payable immediately.

If an application is unable to be processed due to the need for additional information, the applicant has two weeks from the date of notification to supply the necessary information without having the date on his/her application adjusted. If a patient does not provide the requested information within the two-week time period, his/her application will be re-dated to the date on which s/he supplies the requested information. Any accounts turned over for collection as a result of the patient's delay in providing information will not be considered for the Sliding Fee Discount Program.

7. Eligibility: Discounts will be based on income and family size only. ABC HEALTHCARE uses the [Census Bureau](#) definitions of each.
 - a. Family is defined as: a group of two people or more (one of whom is the householder) related by birth, marriage, or adoption and residing together; all such people (including related subfamily members) are considered as members of one family.
 - b. Income includes: earnings, unemployment compensation, workers' compensation, Social Security, Supplemental Security Income, public assistance, veterans' payments, survivor benefits, pension or retirement income, interest, dividends, rents, royalties, income from estates, trusts, educational assistance, alimony, child support, assistance from outside the household, and other miscellaneous sources.



8. Income verification: Applicants must provide one of the following: prior year W-2, two most recent pay stubs, letter from employer, or Form 4506-T (if W-2 not filed). Self-employed individuals will be required to submit detail of the most recent three months of income and expenses for the business. Adequate information must be made available to determine eligibility for the program.

Self-declaration of Income may only be used in special circumstances. Specific examples include participants who are homeless. Patients who are unable to provide written verification must provide a signed statement of income, and why they are unable to provide independent verification. This statement will be presented to ABC HEALTHCARE's CEO or his/her designee for review and final determination as to the sliding fee percentage. Self-declared patients will be responsible for 100% of their charges until management determines the appropriate category.

9. Discounts: Those with incomes at or below 100% of poverty will receive a full 100% discount. Those with incomes above 100% of poverty, but at or below 200% of poverty, will be charged according to the attached sliding fee schedule. The sliding fee schedule will be updated during the first quarter of every calendar year with the latest [Federal Poverty Guidelines](#).
10. Nominal Fee: Patients receiving a full discount will be assessed a \$10 nominal charge per visit. However, patients will not be denied services due to an inability to pay. The nominal fee is not a threshold for receiving care and thus, is not a minimum fee or co-payment.
11. Waiving of Charges: In certain situations, patients may not be able to pay the nominal or discount fee. Waiving of charges may only be used in special circumstances and must be approved by ABC HEALTHCARE's CEO, CFO, or their designee. Any waiving of charges should be documented in the patient's file along with an explanation (e.g., ability to pay, good will, health promotion event).
12. Applicant notification: The Sliding Fee Discount Program determination will be provided to the applicant(s) in writing, and will include the percentage of Sliding Fee Discount Program write off, or, if applicable, the reason for denial. If the application is approved for less than a 100% discount or denied, the patient and/or responsible party must immediately establish payment arrangements with ABC HEALTHCARE. Sliding Fee Discount Program applications cover outstanding patient balances for six months prior to application date and any balances incurred within 12 months after the approved date, unless their financial situation changes significantly. The applicant has the option to reapply after the 12 months have expired or anytime there has been a significant change in family income. When the applicant reapplies, the look back period will be the lesser of six months or the expiration of their last Sliding Fee Discount Program application.
13. Refusal to Pay: If a patient verbally expresses an unwillingness to pay or vacates the premises without paying for services, the patient will be contacted in writing regarding their payment obligations. If the patient is not on the sliding fee schedule, a copy of the sliding fee discount program application will be sent with the notice. If the patient does not make effort to pay or fails to respond within 60



days, this constitutes refusal to pay. At this point in time, ABC HEALTHCARE can explore options not limited, but including offering the patient a payment plan, waiving of charges, or referring the patient to collections.

14. Record keeping: Information related to Sliding Fee Discount Program decisions will be maintained and preserved in a centralized confidential file located in the Business Office Manager's Office, in an effort to preserve the dignity of those receiving free or discounted care.
 - a. Applicants that have been approved for the Sliding Fee Discount Program will be logged in a password protected document on ABC HEALTHCARE shared directory, noting names of applicants, dates of coverage and percentage of coverage.
 - b. The Business Office Manager will maintain an additional monthly log identifying Sliding Fee Discount Program recipients and dollar amounts. Denials will also be logged.
15. Policy and procedure review: Annually, the amount of Sliding Fee Discount Program provided will be reviewed by the CEO and/or Comptroller. The SFS will be updated based on the current Federal Poverty Guidelines. Pertinent information comparing amount budgeted and actual community care provided shall serve as a guideline for future planning. This will also serve as a discussion base for reviewing possible changes in our policy and procedures and for examining institutional practices which may serve as barriers preventing eligible patients from having access to our community care provisions.
16. Budget: During the annual budget process, an estimated amount of Sliding Fee Discount Program service will be placed into the budget as a deduction from revenue. Board approval for Sliding Fee Discount Program will be sought as an integral part of the annual budget.

ATTACHMENTS:

APPROVAL: 04-01-2011

2020 Sliding Fee Schedule

REVISED: 04-01-2020

Patient Application for the Sliding Fee Discount Program

REVIEWED BY: _____



Sliding Fee Schedule (SFS) Example One

Annual Income Thresholds by Sliding Fee Discount Pay Class and Percent Poverty						
Poverty Level*	At or Below 100%	125%	150%	175%	200%	Above 200%
Family Size	Charge					
	Nominal Fee (\$5)	20% pay	40% pay	60% pay	80% pay	100% pay
1	0-\$12,760	\$12,761-\$15,950	\$15,951-\$19,140	\$19,141-\$22,330	\$22,331-\$25,520	\$25,521+
2	0-\$17,240	\$17,241-\$21,550	\$21,551-\$25,860	\$25,861-\$30,170	\$30,171-\$34,480	\$34,481+
3	0-\$21,720	\$21,721-\$27,150	\$27,151-\$32,580	\$32,581-\$38,010	\$38,011-\$43,440	\$43,441+
4	0-\$26,200	\$26,201-\$32,750	\$32,751-\$39,300	\$39,301-\$45,850	\$45,851-\$52,400	\$52,401+
5	0-\$30,680	\$30,681-\$38,350	\$38,351-\$46,020	\$46,021-\$53,690	\$53,691-\$61,360	\$61,361+
6	0-\$35,160	\$35,161-\$43,950	\$43,951-\$52,740	\$52,741-\$61,530	\$61,531-\$70,320	\$70,321+
7	0-\$39,640	\$39,641-\$49,550	\$49,551-\$59,460	\$59,461-\$69,370	\$69,371-\$79,280	\$79,281+
8	0-\$44,120	\$49,121-\$55,150	\$55,151-\$66,180	\$66,181-\$77,210	\$77,211-\$88,240	\$88,241+
For each additional person, add	\$4,480	\$5,600	\$6,720	\$7,840	\$8,960	\$8,960

*Based on the 2020 [Federal Poverty Guidelines \(FPG\) for the 48 contiguous states and the District of Columbia](#). Please note that there are separate guidelines for Alaska and Hawaii, and that the thresholds would differ for sites in those two states. Sites in Puerto Rico and other outlying jurisdictions would use the above guidelines.



Sliding Fee Schedule (SFS) Example Two

Maximum Annual Income Amounts for each Sliding Fee Percentage Category (except for 0% discount)

Poverty Level ⁱ	100%	110%	120%	130%	140%	150%	160%	170%	180%	190%	200%	>200%
Family Size	Discount 100%	Discount 100%	Discount 90%	Discount 80%	Discount 70%	Discount 60%	Discount 50%	Discount 40%	Discount 30%	Discount 20%	Discount 10%	Discount 0%
1	12,760	14,036	15,312	16,588	17,864	19,140	20,416	21,692	22,968	24,244	25,520	25,521+
2	17,240	18,964	20,688	22,412	24,136	25,860	27,584	29,308	31,032	32,756	34,480	34,481+
3	21,720	23,892	26,064	28,236	30,408	32,580	34,752	36,924	39,096	41,268	43,440	43,441+
4	26,200	28,820	31,440	34,060	36,680	39,300	41,920	44,540	47,160	49,780	52,400	52,401+
5	30,680	33,748	36,816	39,884	42,952	46,020	49,088	52,156	55,224	58,292	61,360	61,361+
6	35,160	38,676	42,192	45,708	49,224	52,740	56,256	59,772	63,288	66,804	70,320	70,321+
7	39,640	43,604	47,568	51,532	55,496	59,460	63,424	67,388	71,352	75,316	79,280	79,281+
8	44,120	48,532	52,944	57,356	61,768	66,180	70,592	75,004	79,416	83,828	88,240	88,240+
For each additional person, add	4,480	4,928	5,376	5,824	6,272	6,720	7,168	7,616	8,064	8,512	8,960	8,960

¹ Based on [2020 Federal Poverty Guidelines](#).



APPENDIX D: NHSC Site Data Tables

Site Data Tables

Site Name: _____

Site Address: _____

Site Address: _____

Date Prepared: _____

Prepared By: _____

6-Month Reporting Period (from mm/yy to mm/yy): ____/____ - ____/____

Total Patients: _____

Total Patient Visits: _____

TABLE 1: PATIENTS OR VISITS BY PRIMARY INSURANCE TYPE

Complete data for “Number of Patients” OR “Number of Patient Visits”

Primary Insurance	Number of Patients	Percentage (Patients)	Number of Patient Visits	Percentage (Visits)
1) Medicare		0%		0%
2) Medicaid		0%		0%
3) Other Public Insurance		0%		0%
4) Private Insurance		0%		0%
5) Sliding Fee Schedule (SFS)		0%		0%
6) Self-Pay (No Insurance and not on SFS)		0%		0%
7) Total		100%		100%



TABLE 2: PATIENT SERVICE CHARGES, COLLECTIONS, AND SELF-PAY ADJUSTMENT

Payment Source	Full Charges (a)	Amount Collected (b)
1) Medicare		
2) Medicaid		
3) Other Public Insurance		
4) Private Insurance		
5) Self-Pay		
6) Total (lines 1-5)	\$0.00	\$0.00

Self-Pay Adjustment Type	Adjustments (c)
7) Self-Pay Sliding Fee Adjustments	
8) Other Self-Pay Adjustments (e.g., Self-Pay Bad Debt)	
9) Total Self-Pay Adjustments (lines 7 and 8)	\$0.00

TABLE 3: PATIENT APPLICATIONS FOR SLIDING FEE SCHEDULE (SFS)

Patient Applications for the Sliding Fee Schedule	Number of Applications
1) SFS Applications Approved	
2) SFS Applications Not Approved	
3) Total SFS Applications Received	\$0.00



TABLE 4: SERVICE SITE STAFFING

Personnel by Major Service Categories	FTEs
Medical Services	
1) Family Practitioners	
2) General Practitioners	
3) Internists	
4) Obstetrician/Gynecologists	
5) Pediatricians	
6) Psychiatrists	
7) Other Physician Specialists	
8) Total Physicians (lines 1-7)	0
9) Nurse Practitioners/Physician Assistants	
10) Certified Nurse Midwives	
11) Nurses	
12) Other Medical Support Personnel	
13) Total Medical Services (lines 8-12)	0
Ancillary Services	
14) Laboratory Services Personnel	
15) X-Ray Services Personnel	
16) Pharmacy Personnel	
17) Total Ancillary Services (lines 14-16)	0
Dental Services	
18) Dentists	
19) Dental Hygienists	
20) Dental Assistants, Aides, Technicians, and Support Personnel	
21) Total Dental Services (lines 18-20)	0
Mental Health (MH) and Behavioral Health (BH) Services	
22) Mental Health & Behavioral Health Specialists	
23) Mental Health & Behavioral Health Support Personnel	
24) Total MH & BH Services (lines 22-23)	0
25) TOTAL (lines 13, 17, 21, and 24)	0

NOTES:



General Instructions

Reporting Period

The reporting period should include up-to-date data for the preceding six months. Please indicate the start and end dates of the six months for which the site is reporting.

Scope of Activity Reported

The NHSC Site Data Tables are site specific (one per physical address). Activity at other sites owned or operated by the applicant site is to be excluded.

All related activity of all providers at the site is to be reported, including activity of all NHSC and non-NHSC providers at the site. Related activity includes all primary care services and related supplemental services, which support the primary health care activity.

These services are an integral part of the primary care delivery system:

Under direction and control of the applicant site; and

Provided by the site's providers to the applicant site's patients.

The services are provided at the approved site location or by the site's providers to the applicant site's patients at approved off-site locations such as the patient's home, nursing home, emergency room or hospital.

Sites may elect to include or exclude all or some portion of referred care services paid by the applicant site which are rendered to the site's patients at off-site locations. This election may be based upon the ability or ease of reporting this information on a site specific basis. The same scope of off-site referred care should be used to complete the visit, patient, charge, and cost tables.

Institutional or large provider organizations may opt to limit the scope of reportable activity to the smallest set of common primary care services that can readily be reported at the site.

Who Submits Site Data Tables

The NHSC Site Data Tables are to be filed by those parties which enter into an agreement with the Secretary of the Department of Health and Human Services to participate as an NHSC member site and which are not currently receiving grant support from the Health Resources and Services Administration's Bureau of Primary Health Care (HRSA/BPHC). The NHSC Site Data Tables are to be completed prior to an NHSC Site Visit. Only one report per site is to be filed.

The following eligible Auto-Approved NHSC Sites ARE NOT required to submit the NHSC Site Data Tables: 1) FQHCs, and 2) FQHC Look-Alikes. The standard HRSA/BPHC Uniform Data System (UDS) report will be reviewed in place of the data tables.

The following eligible Auto-Approved NHSC sites must provide NHSC Site Data Tables upon request if HRSA needs to determine NHSC site eligibility: 1) ITUs, 2) Federal Prisons, 3) State Prisons, and 4) ICE Health Service Corps site.

Detailed Table Instructions

Table 1: Patients or Visits by Primary Insurance Type

The number of patients or patient visits by primary insurance type may be actual or



estimated. Estimates are to be based upon a sample. The minimum sample size is 200 records of randomly selected patients or visits. The total number of patients and the total number of visits should be based upon actual data.

A patient may have coverage under more than one insurance plan, different coverage for different services and this coverage may change over the course of a year. When medical services are provided, report the patient's **primary health insurance covering primary medical care**, if any, **as of the last visit during the reporting period**. If medical services are not provided, report the patient's primary insurance, if any, for the services offered. Report the patient's primary health insurance even though it may not have covered the services rendered during the patient's last visit.

Primary insurance is defined as the insurance plan or program that the site would **bill first** for services rendered.

Example: Report Medicare as the primary insurance if a patient has both Medicare and Medicaid because Medicare is billed before Medicaid. Report the employer plan as the primary insurance if a patient has both an employer plan and Medicare because the employer plan is billed first.

(Line 1) Medicare: patients whose primary insurance is a plan for Medicare beneficiaries including Rural Health Clinic (RHC), managed care, Federally Qualified Health Center (FQHC), and other reimbursement arrangements administered by Medicare or by a fiscal intermediary.

(Line 2) Medicaid: patients whose primary insurance is a plan for Medicaid beneficiaries including RHC, managed care, FQHC, Early Periodic Screening, Diagnosis, and Treatment (EPSDT) Program, Child Health Insurance Program (CHIP) and other reimbursement arrangements administered either directly by the state agency or by a fiscal intermediary

(Line 3) Other Public Insurance: patients whose primary insurance is provided by federal, state, or local governments that is not reported elsewhere such as, state indigent care programs, city welfare, and similar government plans. A CHIP operated independently from the Medicaid program is an example of other public insurance. Patients with health benefit plans offered to government employees, retirees and dependents such as TRICARE, the federal employees health benefit program, state employee health insurance benefit programs, teacher health insurance and similar plans are to be classified as private insurance patients. Private insurance is earned and other public insurance is unearned.

Patients with no insurance but who have public categorical or other grant funds applied to their accounts for services received are to be classified as self-pay. The National Breast and Cervical Cancer Early Detection Program is an example of a categorical grant program, which is not insurance.

(Line 4) Private Insurance: patients whose primary insurance is a private insurance plan, managed care plan, or a contractual arrangement. This includes plans such as Blue Cross and Blue Shield, commercial insurance, managed care plans, self-insured employer plans, group contracts with unions and employers, and service contracts with employers and others. As noted above, patients with health benefit plans offered to government employees, retirees and dependents such as TRICARE, the federal employees' health benefit program, state employee health insurance benefit programs, teacher health insurance and similar plans are to be classified as private insurance patients.



(Line 5) Sliding Fee Schedule (SFS): patients participating in the site's sliding fee discount program who do not have other coverage. NHSC sites are expected to make services available through the use of a sliding fee discount schedule or other documented means of eliminating financial barriers for those at or below 200 percent of the federal poverty income guidelines. All Sliding Fee Discount Programs must include the following elements:

Applicable to all individuals and families with annual incomes at or below 200 percent of the most current FPG; and

Provide a full discount for individuals and families with annual incomes at or below 100 percent of the FPG, with allowance for a nominal charge only, consistent with site's policy; and

Adjust fees (partial sliding fee discount) based on family size and income for individuals and families with incomes above 100 percent and at or below 200 percent of the FPG.

The most current poverty guidelines can be found at [ASPE: Poverty Guidelines](#). The data reported here should be based upon the number of patients making use of the sliding fee discount policy as their primary source of coverage.

(Line 6) Self-Pay (no insurance and not on SFS): patients without any health insurance and not participating in the site's sliding discount fee schedule program. As noted above, patients with no insurance but who have categorical or other grant funds applied to their accounts for services received are to be classified as self-pay.

(Line 7) Total: the sum of lines 1-6.

Table 2: Patient Service Charges, Collections, and Self-Pay Adjustment

This table shows the patient service charges, receipts, and sliding fee discounts by payment source for all related activity of all providers at the site to which the NHSC provider is assigned. See the General Instructions for a definition of the scope of activity to be reported. Report in whole dollars.

Charges and collections are to be reported in **five pay classes:** Medicare, Medicaid, other public insurance, private insurance, and self-pay. Charges and receipts are to be identified with the payer, which is the responsible party. For instance, Medicare receipts are attributable to Medicare even though the receipts were made by an intermediary such as Blue Shield. Similarly, charges and receipts for which a Medicare beneficiary is personally responsible such as deductibles and copayments are self-pay rather than Medicare charges and receipts.

(Column a) Full Charges: the gross charges as established by the site for the services rendered during the reporting period. Charges are reported at their full value for all services prior to any adjustments. Fee-for-service charges are uniformly reported at the full charge rate from the site's fee schedule. Site's with capitation contracts or who are reimbursed on a cost based flat fee, such as a RHC rate or FQHC rate are to report the normal full charge from the site's fee schedule rather than the negotiated visit, capitation, or contract rate.

Charges are to reflect the amount for which the payer is responsible. **Deductibles, copayments, and uncovered services for which the patient is personally responsible should be reclassified and reported as self-pay. Similarly, any charges not payable by a third party payer that are due from the patient or another third party**



should be deducted from the payer's charges and added to the account of the secondary payer. The reclassification of charges to secondary and subsequent payers may be estimated based upon a sample.

Sites may elect to include or exclude all or some portion of paid referred care services rendered to the site's patients at off-site locations. This election may be based upon the ability or ease of reporting this information on a site-specific basis. The same scope of off-site referred care should be used to complete the visit, patient, charge, and cost tables.

(Column b) Amount Collected: the actual cash received during the period for services rendered, regardless of the date of service. This includes RHC and FOHC settlement receipts, case management fee receipts, incentive receipts from managed care plans, and other similar receipts.

Amounts collected are the amounts collected from the payer. If there is more than one payer involved in a given visit, the charges due from the primary payer and the amount collected from the primary payer are reported on the primary payer line. The charges due from the secondary payer are reported on the secondary payer line along with any amounts collected from the secondary payer. The reclassification of charges and collections to secondary and subsequent payers may be estimated based upon a sample of accounts.

(Column c) Adjustments: the difference between the full charges and the amount actually received or expected. The only adjustments to be reported here are self-pay adjustments.

(Line 1) Medicare (Title XVIII): charges and receipts related to services provided to Medicare beneficiaries that are payable by insurance plans operated under Title 18 of the Social Security Act including FQHC, RHC, or any other reimbursement arrangement excluding capitated managed care administered by Medicare or its fiscal intermediaries.

(Line 2) Medicaid (Title XIX): charges and receipts related to services provided to Medicaid beneficiaries and payable by insurance plans operated under Title 19 of the Social Security Act, including FQHC, RHC, case management, fee-for-service managed care, EPSDT Program, CHIP and any other reimbursement arrangement, excluding capitated managed care, administered either directly by the state agency or by its fiscal intermediaries.

(Line 3) Other Public Insurance: charges and receipts related to services provided to patients and payable by insurance plans operated by federal, state, or local governments that are not reported elsewhere such as separately administered CHIP, state or county indigent care programs, city welfare, and similar plans. This may also include that portion of charges and receipts from public categorical service grants, which are directly applied to a self-pay or insured patient's account. The National Breast and Cervical Cancer Early Detection Program is one example of a public categorical service grant program whose charges and receipts are classifiable as other public.

(Line 4) Private Insurance: charges and receipts related to services provided to patients and payable by insurance plans other than those reported above such as a private insurance plan, managed care plan, or a contractual arrangement. This includes plans such as Blue Cross and Blue Shield, commercial insurance, managed care plans, self-insured employer plans, group contracts with unions and employers, and service contracts with employers, schools, health departments, and others. Health benefit plans offered to government employees, retirees and dependents such as TRICARE, the federal employees health benefit



program, state employee health insurance benefit programs, teacher health insurance and similar plans are to be classified as private insurance.

(Line 5) Self-Pay: charges and receipts related to services provided to patients without any principal health insurance or to patients with insurance but only that portion for which the patient is personally liable such as deductible, copayments, and uncovered charges. Charges not paid by a third party payer and due from the patient should be deducted from the full charges of the third party payer and added to the full charges for the self-pay patients.

(Line 6) Total: the sum of lines 1–5.

(Line 7) Self-Pay Sliding Fee Adjustments: the value of charge discounts granted to patients prior to service and based upon financial hardship. It does not include professional courtesy, staff, service incentive, or similar discounts. Also, it does not include bad debt adjustments related to patients who were initially charged full fee but unable to pay because of financial hardship or other reasons. If a hardship fund is used to pay for the referred lab, x-ray, pharmacy or other care for sliding fee patients, report the charge value of those services in column (a) and an offsetting sliding fee adjustment in column (c). Sliding fee discounts reflect the site's compliance with its assurance to the NHSC that there are no financial barriers to care for those at or below 200 percent of the current federal poverty income guideline.

(Line 8) Other Self-Pay Adjustments: the value of all self-pay adjustments other than sliding fee adjustments. This includes bad debt and charity adjustments taken or granted to self-pay patients who were initially charged a full, discounted, or partial fee but who subsequently were either unwilling or unable to pay the amounts charged. It does not include bad debt related to other pay sources, which may be caused by a failure to file timely claims, payer bankruptcy or similar reasons.

(Line 9) Total Self-Pay Adjustments: the sum of lines 7 and 8. Compliance with its assurance to the NHSC that there are no financial barriers to care for those at or below 200 percent of the current federal poverty income guideline.

Table 3: Patient Applications for the Sliding Fee Schedule

This table provides information on the number of unique sliding fee schedule applications submitted by patients/clients during the reporting period.

(Line 1) SFS Applications Approved: the number of patient applications for the sliding fee schedule received during the reporting period that were approved for discounted service.

(Line 2) SFS Applications Not Approved: the number of patient applications for the sliding fee schedule received during the reporting period that were not approved for discounted services for any reason (e.g., incomplete application, patient did not meet poverty guideline requirements, application not processed).

(Line 3) Total SFS Applications Received: the total number of patient applications for the sliding fee schedule received during the reporting period. This should be equal to the sum of lines 1-2.



Table 4: Service Site Staffing

This table profiles the personnel by major service category. The number of staff is reported in full time equivalents (FTEs).

Staff: salaried full-time or part-time employees of the applicant site who work on behalf of the site and non-salaried individuals paid by the applicant site who work **for the site on a regular schedule that is controlled by the site** under any of the following compensation arrangements: contract, NHSC assignment, retainer, capitation, block time, fee-for-service, and **donated time**. Provider staff work at the NHSC approved site. Support staff may work for the site at other locations. Regularly scheduled means a pre-assigned number of work hours devoted to the site's activities.

FTEs are reported for staff and are not reported for non-staff individuals. Some examples of staff and non-staff personnel are noted below:

- NHSC providers are considered staff.
- Providers working on-site under contract on a scheduled basis are considered staff.
- Referral providers who are paid by the applicant site are considered non-staff when working independently at unapproved off-site locations such as the referral provider's office.
- Contracted support staff working under a contract which replaces personnel the site would otherwise have hired, who work directly for the site, who may work either on or off-site, and **who work for the site on a regularly scheduled basis** are considered "staff" whose time or FTE value is to be reported. This might include personnel employed by a practice management company, a management services organization, billing service company, or similar contractor. If individuals under these arrangements work on an irregular, unscheduled or indirect basis, they are considered non-staff and their FTEs are not counted.
- Professionals working for the site under legal, audit, actuarial, management consulting, and similar contracts for services provided on a one-time, sporadic, or unscheduled basis are considered non-staff.
- Consulting pathologists, radiologists, and other consulting providers who provide services on an unscheduled or sporadic basis are considered non-staff.

FTEs: full time equivalents for **all staff**. Full time equivalents are computed on an individual basis by dividing the total number of hours in the reporting period for which a person was compensated by the total number of hours in the year considered by the site to be full-time. The total number of hours for which an individual was compensated includes the number of hours a person was present for work and paid for their time, as well as paid leave time including vacation, sick leave, continuing education trips, etc. An annual hours pay base of 2,080 (40 hours/week x 52 weeks/year) is typical but the base may vary by organization and by class of employee. Employees who work less than the annual hour's base are normally considered part time. An individual staff member is not to be reported as more than 1.00 full time equivalents regardless of any overtime hours worked or compensation paid. Round FTEs to the second decimal place.

Salaried provider staff FTEs are to be calculated based upon the number of paid hours, not the number of scheduled hours. A provider who schedules 32 hours per week to see patients but who is paid for a 40-hour week is considered full time or 1.00 FTE.

Contract provider and support staff FTEs are to be calculated by dividing the hours the staff



worked by the hours a full time employee of that type would be expected to work. The time worked in the numerator is to be taken from contracts, invoices, schedules or similar sources. The denominator or base of hours considered full-time for these arrangements should not include leave time unless leave is directly charged or the time salaried clinicians of that type are ordinarily not scheduled to see patients. For example, if full time salaried providers are expected to schedule 32 hours of patient care per week, a contract provider who was paid for 16 hours of scheduled patient care per week would be considered half time or 0.50 FTE. The annual scheduled hour's base considered full-time for contract providers is likely to vary by clinical specialty.

Time for personnel performing more than one function should be allocated as appropriate among the major personnel service categories. For example, the time of a physician who is also a medical director should be allocated between medical care services and administration. Time for nurses who also provide case management services should be allocated between medical care and case management.

Personnel by Major Service Category: FTEs are classified into four service categories. The categories are: medical care services; ancillary services, dental services; and mental health and behavioral health services.

(Lines 1 through 7) Physicians: (M.D. or D.O.): separate FTE totals for family practitioners, general practitioners, internists, obstetrician/gynecologists, pediatricians, psychiatrists, and all other specialists. Use board certification to classify physicians by specialty. Classify physicians with more than one board certification in the specialty representing the service the physician provides most, or allocate based upon time spent.

(Line 8) Total Physicians: FTE total for medical services, lines 1-6.

(Line 9) Nurse Practitioners and Physician Assistants: FTE total for nurse practitioner staff performing medical services. Nurse practitioners include psychiatric nurse practitioners. FTE total for physician assistant staff performing medical services.

(Line 10) Certified Nurse Midwives: FTE total for nurse midwives performing medical service.

(Line 11) Nurses: FTE total for nurses that are involved in provision of medical services, including registered nurses, licensed practical nurses, home health and visiting nurses, clinical nurse specialists, and public health nurses. If an individual's time is divided between medical and nonmedical services, allocate the FTEs to reflect this division of time. For example, nurses who provide case management or education/counseling services in addition to medical care should be allocated between medical services and other services.

(Line 12) Other Medical Support Personnel: FTE total for medical assistants, nurse aides, and all other personnel providing services together with or in direct support of services provided by a physician, nurse practitioner, physician assistant, certified nurse midwife, or nurse. **FTEs for registration, reception, appointments, transcription, patient records, and other support personnel are not reported.**

(Line 13) Total Medical Services: FTE total for medical services, lines 8-12.

(Line 14) Laboratory Services Personnel: FTE total for pathologists, medical technologists, laboratory technicians and assistants, phlebotomists. This **refers exclusively**



to medical personnel not dental personnel. Dental personnel performing laboratory services are reported on lines 18-20. Lab visits are not reported.

(Line 15) X-ray Services Personnel: FTE total for radiologists, X-ray technologists, X-ray technicians and ultrasound technicians. **Only report medical personnel not dental personnel.** Dental personnel performing x-ray services are reported on lines 18-20. X-ray visits are not reported.

(Line 16) Pharmacy Personnel: FTE total for pharmacists and pharmacist assistants.

(Line 17) Total Ancillary Services: FTE total for ancillary services, lines 14 through 16.

(Line 18) Dentists: FTE total for general practitioners and specialists including oral surgeons, periodontists, and pedodontists.

(Line 19) Dental Hygienists: FTE total for dental hygienists.

(Line 20) Dental Assistants, Aides, Technicians & Support Personnel: FTE total for other dental personnel including dental assistants, aides, and technicians.

(Line 21) Total Dental Services: FTE total for dental services, lines 18-20.

(Line 22) Mental Health and Behavioral Health Specialists: FTE total for individuals providing counseling or treatment services related to mental health or behavioral health including clinical psychologists, clinical social workers, psychiatric social workers, psychiatric nurses, mental health nurses, and family therapists. **Report psychiatrists on line 6 under physicians and psychiatric nurse practitioners on line 9 under nurse practitioners, not in this category.**

(Line 23) Mental Health and Behavioral Health Support Personnel: FTE total for assistants, aides, and all other personnel providing services in conjunction with or in direct support of services provided by mental health and behavioral health specialists.

(Line 24) Total Mental Health and Behavioral Health Services: FTE total for mental health and behavioral health services, lines 22 and 23.

(Line 25) Total: FTE grand total, lines 13, 17, 21, and 24.



APPENDIX E: NHSC Comprehensive Behavioral Health Services Checklist

OMB No. 0915-0127
Form Approved Exp.
Date 03/31/2023

NHSC COMPREHENSIVE BEHAVIORAL HEALTH SERVICES CHECKLIST

Attach all signed affiliation agreements for any service elements not provided on-site.

****Only NHSC Site Administrators are permitted to submit certification documents****

Site Name _____

Address _____

Section I. Core Comprehensive Behavioral Health Service Elements

The following three sets of services *must* be provided on-site; these services cannot be offered through affiliation.

Service	Provided On-site	
	(Select One)	
	Yes	No
<p>1. Screening and Assessment: <i>Screening</i> is the practice of determining the presence of risk factors, early behaviors, and biomarkers which enables early identification of behavioral health disorders (e.g., warning signs for suicide, substance abuse, depression) and early access to care. <i>Assessment</i> is a structured clinical examination that analyzes patient bio-psych-social information to evaluate a behavioral health complaint.</p>	<input type="checkbox"/>	<input type="checkbox"/>
<p>2. Treatment Plan: A formalized, written document that details a patient's current clinical symptoms, diagnosis, and outlines the therapeutic strategies and goals that will assist the patient in reducing clinical symptoms and overcoming his or her behavioral health issues. The plan also identifies, where indicated, clinical care needs and treatment(s) to be provided by affiliated health and behavioral health care providers and settings.</p>	<input type="checkbox"/>	<input type="checkbox"/>
<p>3. Care Coordination: <i>Care Coordination</i> is the practice of navigating and integrating the efforts primary care, specialty health care and social service providers to support a patient's health, wellness and independence.</p>	<input type="checkbox"/>	<input type="checkbox"/>



Section II. Additional Comprehensive Behavioral Health Service Elements

The following five sets of services *may* be provided on-site or through formal affiliation. Signed affiliation agreements must be uploaded to the [BHW Customer Service Portal](#) for any services not provided on-site.

Service	Provided On-site	
	(Select One)	
	Yes	No
<p>1. Diagnosis: The practice of determining a patient’s emotional, socio-emotional, behavioral or mental symptoms as a diagnosable disorder in accordance with the Diagnostic and Statistical Manual of Mental Disorders (DSM; most current edition) and International Classification of Disease (ICD; most current edition).</p>	<input type="checkbox"/>	<input type="checkbox"/>
<p>2. Therapeutic Services (including, but not limited to, psychiatric medication prescribing and management, chronic disease management, and Substance Use Disorder Treatment): Broad range of evidence-based or promising behavioral health practice(s) with the primary goal of reducing or ameliorating behavioral health symptoms, improve functioning, and restore/maintain a patient’s health (e.g., individual, family, and group psychotherapy/ counseling;</p>	<input type="checkbox"/>	<input type="checkbox"/>
<p>a. Psychiatric Medication Prescribing and Management</p> <p>b. Substance Use Disorder Treatment</p> <p>c. Short/long-term hospitalization</p> <p>d. Other (Please list)</p> <p>e. Other (Please list)</p>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
<p>3. Crisis/Emergency Services (including, but not limited to, 24-hour crisis call access): The method(s) used to offer immediate, short-term help to individuals who experience an event that produces emotional, mental, physical, and behavioral distress or problems. In some instances, a crisis may constitute an imminent threat or danger to self, to others, or grave disability. (Note: generic hotline, hospital emergency room referral, or 911 is not sufficient).</p>	<input type="checkbox"/>	<input type="checkbox"/>
<p>4. Consultative Services: The practice of collaborating with health care and other social service providers (e.g., education, child welfare, and housing) to identify the biological, psychological, medical and social causes of behavioral</p>	<input type="checkbox"/>	<input type="checkbox"/>



health distress, to determine treatment approach(s), and to improve patient functioning.		
5. Case Management: The practice of assisting and supporting patients in developing their skills to gain access to needed health care, housing, employment, social, educational and other services essential to meeting basic human needs and consistent with their health care treatment, symptom management, recovery and independent functioning.	<input type="checkbox"/>	<input type="checkbox"/>

Section III. Affiliation Agreements for Off-Site Behavioral Health Services

For *each* of the services under Section II that are provided off-site, a formal affiliation agreement(s) must be uploaded to the [BHW Customer Service Portal](#). Under this section, the NHSC-approved site must provide basic information for each entity with which a formal affiliation is in place.

Affiliated Entity: _____ Address: _____ Services Covered Under Affiliation: _____ Date Affiliation Agreement Executed: _____ Services available under this agreement are offered to all without regard for the ability to pay? Yes <input type="checkbox"/> No <input type="checkbox"/>	Affiliated Entity: _____ Address: _____ Services Covered Under Affiliation: _____ Date Affiliation Agreement Executed: _____ Services available under this agreement are offered to all without regard for the ability to pay? Yes <input type="checkbox"/> No <input type="checkbox"/>
Affiliated Entity: _____ Address: _____ Services Covered Under Affiliation: _____ Date Affiliation Agreement Executed: _____ _____ _____ Services available under this agreement are offered to all without regard for the ability to pay? Yes <input type="checkbox"/> No <input type="checkbox"/>	Affiliated Entity: _____ Address: _____ Services Covered Under Affiliation: _____ Date Affiliation Agreement Executed: _____ _____ _____ Services available under this agreement are offered to all without regard for the ability to pay? Yes <input type="checkbox"/> No <input type="checkbox"/>

Section IV. Certification of Compliance with Behavioral Health Clinical Practice Requirements

Certify that the behavioral health site adheres to the clinical practice requirements for behavioral health providers under the NHSC and supports NHSC participants in meeting their obligation related to the clinical



practice requirements.

	Provided On-site	Not Provided On-site
<p>Full-time: The site offers employment opportunities that adhere to the NHSC definition of full-time clinical practice. Full-time clinical practice for behavioral health providers means a minimum of 40 hours/week, for a minimum of 45 weeks/service year. At least 20 hours/week must be spent providing patient care at the approved service site(s). Of the minimum 20 hours spent providing patient care, no more than 8 hours/week may be spent in a teaching capacity, performing clinical-related administrative activities, or in an alternative setting (e.g., hospitals, nursing homes, and shelters) as directed by the approved sites. The remaining 20 hours/week must be spent providing patient care at the approved service site(s) or performing service as a behavioral or mental health professional in schools or other community-based settings when directed by the approved sites(s).</p>	<input type="checkbox"/>	<input type="checkbox"/>
<p>Half-time: The site offers employment opportunities that adhere to the NHSC definition of half-time clinical practice. Clinicians must work a minimum of 20 hours/week, for a minimum of 45 weeks/service year. At least 10 hours/week are spent providing patient care at the approved service site(s). Of the minimum 10 hours spent providing patient care, no more than 4 hours per week may be spent in a teaching capacity, performing clinical-related administrative activities, or in an alternative setting (e.g., hospital, nursing home, and shelter), as directed by the approved site(s). The remaining 10 hours/week may be spent providing patient care at the approved service site(s) or performing service as a behavioral or mental health professional in schools or other community-based settings when directed by the approved site(s).</p>	<input type="checkbox"/>	<input type="checkbox"/>

Section V. Site Certification:

By signing below, you (the NHSC Site Administrator) are affirming the truthfulness and accuracy of the information in this document.

I, _____, hereby certify that the information provided above, and all supporting information, is true and accurate. I understand that this information is subject to verification by the NHSC.

 Signature _____ Date _____



OFFICIAL NHSC USE ONLY

Recommended By: _____

COMMENTS

Certified	Not Certified
<input type="checkbox"/>	<input type="checkbox"/>



APPENDIX F: Substance Use Disorder Site Opt-in Instructions

Existing NHSC sites must add Substance Use Disorder (SUD) to their list of services provided in order for their staff to then apply for the NHSC's SUD loan repayment programs. To document with the NHSC that your site is providing SUD services, please follow the guidance below.

If your site is...	What to Submit	How to Submit
<p>Providing non-opioid, outpatient SUD services</p>	<p>1) Documentation of the SUD services that are provided on-site, which should include one or more of the following:</p> <ul style="list-style-type: none"> - An SUD operating certificate from your state, county, etc.; - A brochure listing the SUD services provided on-site; - Website documentation outlining the SUD services provided on-site; and/or - A policy document outlining the SUD services provided on-site. <p>2) A completed NHSC Comprehensive Behavioral Health Services Checklist.</p>	<p>As a site inquiry via the BHW Portal.</p> <ul style="list-style-type: none"> - Select Category: Substance Use Disorder (SUD) Documentation - Use the description: "Opt-in SUD Expansion" - List all SUD services provided at the site and upload required documentation
<p>An Office-Based Opioid Treatment (OBOT) facility</p>	<p>1) Documentation of services provided on-site (e.g., brochure, website documentation, or policy document outlining services provided, as described above).</p> <p>2) Verification of on-site medication assistance treatment (MAT) in the form of an attestation from the site CEO or Medical Director.</p> <ul style="list-style-type: none"> - This letter must state that the site offers MAT and must also describe the size of MAT patient panel for the most recent 6 month period for which data are available. (For a letter template, please see Appendix G: MAT Attestation Letter Template) <p>3) A completed NHSC Comprehensive Behavioral Health Services Checklist.</p>	<p>As a site inquiry via the BHW Portal.</p> <ul style="list-style-type: none"> - Select Category: Substance Use Disorder (SUD) Documentation - Use the description: "Opt-in SUD Expansion" - List all SUD services provided at the site and upload all required documentation



<p>A SAMHSA-certified Opioid Treatment Program (OTP)</p>	<p>1) A current, SAMHSA-issued OTP certificate.</p> <p>2) A completed NHSC Comprehensive Behavioral Health Services Checklist.</p>	<p>As a site inquiry via the BHW Portal.</p> <ul style="list-style-type: none"> - Select Category: Substance Use Disorder (SUD) Documentation - Use the description: "Opt-in SUD Expansion" - List all SUD services provided at the site and upload all required documentation
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APPENDIX G: MAT Attestation Letter Template

ORGANIZATION LETTERHEAD

DATE:

FROM:

RE: Attestation to provision of Medication-Assisted Treatment

TO: National Health Service Corps

[INSERT BRIEF OVERVIEW OF SITE (AND ORGANIZATION IF APPLICABLE) AND SERVICES PROVIDED AND PATIENT POPULATION].

This letter is to certify that [SITE NAME] located at [SITE ADDRESS] provides medication-assisted treatment (MAT) to patients with opioid use disorder in an outpatient clinical setting. MAT services are available to patients [INSERT DAYS AND HOURS OF OPERATION FOR MAT]. At this clinical service site, the MAT patient panel for the six-month period beginning [START DATE] and ending [END DATE] included [# OF PATIENTS RECEIVING MAT].

[INK OR E-SIGNATURE OF CEO AND/OR MEDICAL DIRECTOR]

[PRINTED SIGNATOR NAME]

[POSITION/TITLE]

[ORGANIZATION]



APPENDIX H: Sample Affiliation Agreement

AFFILIATION AGREEMENT

(NHSC Site)	(Affiliate Agency)
Name	Name
Address	Address
City, State, Zip	City, State, Zip

(NHSC Site) provides mental health services to everyone in the mental health HPSA they serve regardless of the patient's ability to pay. **(Affiliate Agency)** is a behavioral healthcare organization that can provide these additional services:

- 1. Diagnosis
- 2 a. Psychiatric Medication Prescribing and Management
- 2 b. Substance Use Disorder Treatment
- 2 c. Short/long-term hospitalization
- 2 d. Other (Please list)
- 3. Crisis/Emergency Services 24/7 access
- 4. Consultative Services
- 5. Case Management

Both agencies will comply with the following:

- 1) Individually maintain full responsibility for all clinical services delivered by their employees or contract providers and carry professional liability insurance.
- 2) Provide services to all patients, regardless of ability to pay, race, color, sex, national origin, disability, religion, age, sexual orientation, or gender identity.
- 3) Orient and train their respective staff on any issue(s) deemed relevant to this affiliation.
- 4) Have a process for sharing pertinent medical information through shared health records or other administrative processes through authorizations for release of information.
- 5) Demonstrate continuity of care with patients referred by following written



procedures and/or assigning personnel for care coordination and case management as outlined below:

- a. [NHSC Site] will: _____
 - b. [Affiliate Agency] will: _____
- 6) Personnel at [INSERT NHSC Site and/or Affiliate Agency][INSERT NHSC Site and/or Affiliate Agency][INSERT NHSC Site and/or Affiliate Agency] involved in care coordination will track and follow up on referral appointments and will schedule consultation or care coordination meeting between providers involved in referred patient care.
- 7) If there is a professional liability claim that involves services provided under the auspices of this Agreement, then each party will cooperate in any investigation into such matter by providing access to records, documents and witnesses.
- 8) The parties (and their employees, agents, and contractors) shall maintain the confidentiality of all patient and/or individual party information in accordance with all applicable state and federal laws including HIPPA and regulations regarding the confidentiality of such information. The parties (and their employees, agents, and contractors) shall not divulge such confidential information to any third parties without the patient's or party's prior written consent, except, as to patients, unless required by law or as necessary to treat such patient.
- 9) This Agreement may be terminated immediately upon written notice to all parties of the Agreement.
- 10) The parties shall attempt to resolve any dispute arising under this Agreement by engaging in an informal discussion.

This Agreement is effective _____ and shall be automatically renewed from year to year under the same terms and conditions.

NHSC Site

Affiliate Agency

Date

Date

Click or tap here to enter text.

