



# 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.

HRSA expects sites to thoroughly review this document prior to completing an NHSC Site Application or Recertification. HRSA will update the [NHSC Site Reference Guide](#) periodically with updated web links, changes to the governing NHSC statute and regulations, and revised NHSC policies and procedures.

The 2022 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 USC. 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) 2022 and all approved NHSC sites, including those required to recertify in CY 2022. 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 for NHSC site applicants. 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.

## 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, more than 22,700 NHSC participants provide comprehensive primary medical, dental, and behavioral and mental health care at more than 19,600 NHSC-approved sites, serving over 23.6 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 and S2S placement process; and
- 5) Coordinating with health care partners to promote and 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 online to the NHSC by taking the following steps:

- 1) Login to the [BHW Customer Service Portal](#);
- 2) If the site is already listed under “My Sites” click on the site name, and then click “Start a NHSC Site App”;
- 3) If the site is not already listed under “My Sites” click “Create a New Site” on the left-hand sidebar. Once the site is created, click “Start a NHSC Site App”;
- 4) Complete the Site Application. Refer to the [Submitting the NHSC Online Site Application](#) section for more information about completing applicable sections of the online application;
- 5) Review and sign the NHSC Site Agreement; and
- 6) Submit the Site Application for review and approval.

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. NHSC auto-approval is not guaranteed, and sites seeking auto-approval of a site location must submit an online NHSC Site Application in order to receive a final determination of their eligibility as an auto-approved site.

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](#).

### **HPSA Designation Requirement**

HPSAs are designated by HRSA. These designations indicate shortages of primary care health professionals (medical, dental, or mental health care), 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.

To become NHSC-approved, the applicant site (except auto-approved sites) must have a HPSA designation as of the first day of the NHSC Site Application Cycle. This HPSA requirement does not apply to RHCs, as they are approved for the NHSC prior to auto-HPSA designation. Refer to the RHC site approval and auto-HPSA designation section below. 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.

**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 HPSA designation and NHSC site approval are two separate processes. The location of a site in a HPSA does not guarantee NHSC site approval. This also applies to “auto-HPSA designations” and NHSC “auto-approval.” For example, federal prisons and ICE facilities are eligible for NHSC “auto-approval,” but are not eligible for an “auto-HPSA designation.” Conversely, RHCs are eligible for “auto-HPSA designation,” but are not eligible for NHSC “auto-approval.”

Correctional facilities, including federal prisons, state prisons, and ICE Health Service Corps sites, can only utilize facility HPSAs designated specifically for that facility. Correctional facilities do not see patients of the general population, and therefore cannot utilize any geographic or population HPSAs. Correctional facility HPSAs are not eligible for “auto-HPSA designation.”

#### ***RHC Site Approval and 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) An RHC applies to become an NHSC-approved site by submitting a complete NHSC Site Application. The Site Application must include the RHC’s six-digit, federally-assigned CMS Certification Number (CCN). 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, unless the site has a valid Geographic/Population HPSA available to use.

### **Requirements for the Sliding Fee Discount Program**

NHSC-approved sites are required to offer a Sliding Fee Discount Program to ensure that patients have access to all primary health services regardless of their ability to pay. Through use of a sliding fee schedule, or schedule of discounts, sites apply a discount to service fees charged to eligible patients. Eligibility for the Sliding Fee Discount Program in NHSC-approved sites must be based solely on family size and income.

The Sliding Fee Discount Program must be offered to all patients with annual incomes at or below 200 percent of the most current [Federal Poverty Guidelines \(FPG\)](#). For individuals with annual incomes at or below 100 percent of the FPG, NHSC-approved sites must provide services at no charge, or at a nominal charge. For individuals with incomes above 100 percent, but at or below 200 percent of the FPG, NHSC-approved sites must provide services at a nominal charge, which can be in the form of a sliding fee, or schedule of discounts.

The required components of a site's Sliding Fee Discount Program are a schedule of fees for services; a corresponding schedule of discounts for eligible patients; and supporting policies and operating procedures. The implementation of a Sliding Fee Discount Program is intended to minimize financial barriers to care for patients at or below 200 percent of the current FPG. Therefore, the required fees and the process of assessing patient eligibility and collecting payment must not create barriers to care.

All Sliding Fee Discount Program Documents – sliding fee schedule (SFS), application, program signage, and policy – are reviewed at the time of NHSC new site application, site recertifications and site visits. NHSC will consider sites that deny or limit discounted services to individuals based on factors other than family size and income to be noncompliant. Sites must have a Sliding Fee Discount Program in place for at least six continuous months prior to applying to become an NHSC-approved site, and continuously thereafter.

### **Sliding Fee Discount Program Policy**

All aspects of an NHSC-approved site's Sliding Fee Discount Program must be based on written policies, applied uniformly to all patients (including both uninsured and underinsured), and supported by operating procedures.

At a minimum, the following areas must be addressed in a site's Sliding Fee Discount Program policy:

- Patient eligibility, including definitions of income and family size and frequency of re-evaluation of eligibility.
- Documentation and verification requirements to determine patient eligibility.

- How the Sliding Fee Discount Program will be advertised to the patient population.
- An explanation of the nominal charge and policies concerning establishing and collecting nominal charges.
- If any patient using the Sliding Fee Discount Program will be sent to collections for outstanding debt, the site must submit a description of their collection policies.

[SEE SAMPLE POLICY IN APPENDIX C](#)

***Determining Eligibility for Sliding Fee Discounts***

In order to facilitate patient access and use, sites must ensure that eligibility for Sliding Fee Scale Discount Program is based solely on income and family size. No other factor (e.g., assets, insurance application and/or coverage, citizenship, population type) can be used to assess eligibility. Sites must not require Medicare, Medicaid, or Children’s Health Insurance Program (CHIP) application or proof of denial before allowing a patient to apply and be eligible for the Sliding Fee Discount Program.

An NHSC-approved site must define in policy its definitions of “income” and “family size.” Sites may consider adapting definitions from other sources for their use, such as the definition of income used by the Census Bureau or other federal programs. Sites must also have supporting operating procedures in place for assessing income and family size for all patients, both for NHSC reporting purposes and to assist patients in determining whether they are eligible for sliding fee discounts.

Programmatic operating procedures should include the development and use of an ***SFS application***. The SFS application should be limited to questions related to family size and income. Note: income is distinct from assets, as assets are a fixed economic resource while income is comprised of earnings. Questions about assets – including retirement accounts, interest-earning assets, and other income-generating assets – should not be included in the SFS application.

Additional questions that should not be included in the SFS application include those related to a patient’s social security number, citizenship status, housing status or marital status. Sites also must not use credit checks, payment history, Medicaid denial letters, asset tests, or “net worth” (combining assets and income) tests when determining eligibility.

[SEE SAMPLE SFS APPLICATION IN APPENDIX C](#)

A patient who meets the income guidelines, as assessed by the application process, would receive a discount based on the SFS. The site’s eligibility determination process must be documented, and its implementation periodically reviewed for compliance and effectiveness. Individual patient eligibility for the SFS should be renewed/reviewed at least once a year or upon the patient’s next visit to the site (if more than 12 months have passed since renewal/review).

The unique characteristics of HPSA populations (e.g., low-income or homeless) must be considered in developing policies and supporting operating procedures to ensure that these

elements do not become a barrier to care. Once established, these policies and supporting operating procedures must be applied uniformly across the patient population.

A site may choose to use 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.

### **Sliding Fee Schedule**

Sites must use a schedule of fees or payments for services that is consistent with locally prevailing rates or charges and designed to cover the site's reasonable costs of operation. Once the site has established its fee schedule, it must establish a corresponding sliding fee schedule based on a patient's annual income and family size. All primary care services for the site type must be covered by the SFS.

The SFS is established and implemented to ensure that uniform and reasonable fees and discounts are consistently and appropriately applied to all eligible patients. While the fee schedule is designed to cover reasonable costs for providing services, the purpose of the SFS is to address financial barriers to care. Therefore, the SFS enables the provision of services to individuals consistent with their ability to pay for such services.

Once established, NHSC sites must revise their SFS or discounted fee schedule annually, at a minimum, to reflect annual updates to the FPG.

As long as the complexity of its structure does not create a barrier to care, each site has discretion regarding how it structures the SFS, including the number of discount pay classes and the types of discounts (percentage of fee or fixed/flat fee for each discount pay class) it offers.

Sites may also determine 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).

### ***Establishing and Collecting Nominal Charges***

NHSC regulations require sites to fully discount or adopt a nominal charge for services to patients at or below 100 percent of the FPG; and requires sites to adopt a nominal charge for services to patients above 100 percent and at or below 200 percent of the FPG. All NHSC-approved sites must ensure that patients are not impeded in accessing services due to an inability to pay. Specifically, the charge must be at a level that does not reflect the true value of the service being 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," and must not be referred to as such. For patients at or below 100 percent of the FPG, 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 FPG.

### ***Patients with Third Party Coverage who are Eligible for SFS***

NHSC-approved sites must apply the SFS for eligible patients with third party insurance coverage unless the third party insurance contract prohibits the application of the SFS. These patients may also be eligible for the SFS based on income and family size. For example, the Medicare law requires clinicians to charge Medicare beneficiaries the same as they charge other patients. Medicare will accept SFS discounts as long as the SFS discount policy is uniformly applied to all patients.

### ***Multiple Sliding Fee Schedules***

Sliding fee discounts must apply to all primary care services, regardless of the service type (medical, dental, or behavioral health) 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; each SFS must meet all NHSC requirements.

### ***Payment Incentives***

NHSC-approved sites may elect to offer incentives through billing and collections policies. Such incentives, often referred to as payment plans, grace periods, or prompt or cash payment incentives, are offered to patients who pay with cash or credit, 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 charged by the NHSC-approved site. If the site elects to establish policies to address these instances, 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).

### ***Sliding Fee Discount Program Requirements for [Critical Access Hospitals \(CAHs\)](#)***

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 SFS requirements do 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.

## **Implementation**

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 SFS applications 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 "No one will be denied access to services due to inability to pay, and that a discounted/sliding fee schedule is available based on family size and income" notices in common areas, and publishing the information on the site's official website (if one exists) and social media platforms (if applicable). The statements on websites and social media platforms should be user-friendly and easily accessible to ensure transparency and support patient access needed to make informed decisions. In addition, information about the Sliding Fee Discount Program must be available in the appropriate languages and literacy levels for the patient population served.

It is important that the eligibility determination process be conducted in an efficient, respectful, and culturally appropriate manner to ensure that the process itself does not present a barrier to care. Patient privacy and confidentiality must be protected throughout the process. Some patients may choose not to provide information that the site requires for assessing income and family size, even after being informed that they may qualify for sliding fee discounts. If the site has followed its policies and supporting operating procedures and the patient declines to be considered for the SFS, the site may consider the patient ineligible for such discounts. The site must document that the offer was made in these cases, even if it was not accepted.

## **Site Exemptions for Sliding Fee Discount Programs**

The following site types are EXEMPT from submitting certain required documents, including Sliding Fee Discount Program documents and required signage, due to their inability to bill and charge for services:

- Free Clinics
- Correctional or Detention facilities
- Indian Health Service, Tribal Clinic, and Urban Indian Health Clinic (ITU)

However, these sites need 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.

## **Requirements for the Non-Discrimination Policy and Posted Notice**

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 official website and social media platforms (if one exists) — stating that no one will be denied access to services due to inability to pay; and there is a discounted/sliding fee schedule available based on family size and income.

**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.

### **Requirements for the Clinician Recruitment and Retention Plan**

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, *and should contain specific strategies aimed at promoting clinician resiliency and reducing burnout*. 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.

### **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 SUD 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 – signed Memorandums of Understanding (MOU), signed Memorandums of Agreement (MOA) or signed contracts with ancillary, inpatient, and specialty care facilities – and meaningful demonstration of appropriate referral networks for other preventive, acute, and chronic primary health services, preferably with 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 for NHSC site approval.

### **Requirements for Primary Behavioral and Mental Health Sites**

Facilities offering comprehensive primary behavioral/mental health services must be located in and serve the 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.

Primary behavioral health service sites must complete and submit the [NHSC Comprehensive Behavioral Health Services Checklist](#) (Appendix E). Sites must provide documentation demonstrating the provision of Core Comprehensive Behavioral Health Services on-site. NHSC Core Comprehensive Behavioral Health Service Elements include: screening and assessment; treatment plan; and care coordination. Sites must also provide documentation demonstrating patient access to Additional Comprehensive Behavioral Health Services Elements (i.e. Non-Core Elements), which include: diagnosis; therapeutic services; crisis/emergency services; consultative services; and case management. These Additional Comprehensive Behavioral Health Service Elements must be provided on-site, off-site, through referral, affiliation or contract. Acceptable documentation includes: affiliation agreements; memorandums of understanding/agreement; contracts; letters of referral; letters of support/commitment; or referral and follow-up policy statements.

**EXCEPTION (i.e. exempt sites):** *The following sites are EXEMPT and do not need to submit the NHSC Comprehensive Behavioral Health Services Checklist: FQHCs (Health Center Grantees), FQHC LALs, American Indian Health Service Facilities (including Indian Health Service facilities, Tribally-operated 638 Health Programs, and Urban Indian Health programs, commonly referred to as ITUs), and correctional facilities [Federal prisons, state prisons, and Immigration and Customs Enforcement (ICE) Health Service Corps (IHSC) sites].*

### **Substance Use Disorder (SUD) Eligibility and Opt-in Requirements for NHSC Sites**

Facilities interested in becoming an NHSC-approved SUD service site must provide specific documentation to the NHSC during New Site Application or Site Recertification cycles. Sites

already approved for the NHSC can submit SUD documentation at any time to request to opt-in for SUD eligibility. Sites must receive approval from NHSC to opt-in to become NHSC-approved SUD service sites for their clinicians to be eligible to apply for the NHSC’s SUD-specific loan repayment programs, such as the NHSC SUD Workforce LRP and the NHSC Rural Community LRP.

- **SUD Documentation Process during Application Cycles:** Facilities may apply to become an SUD service site during the New Site Application or Site Recertification cycles by submitting required NHSC site application documents; as well as, SUD and Comprehensive Primary Behavioral Health Service documentation to NHSC.
- **Opt-in Process Off-Cycle for Existing NHSC-Approved Sites:** Current NHSC-approved primary care medical or behavioral health sites can request to opt-in as SUD service sites at any time by submitting required SUD documentation to NHSC. Primary care medical sites also must complete and submit Comprehensive Primary Behavioral Health Service documentation. If your site is currently NHSC-approved and is eligible for SUD opt-in, submit a separate inquiry for each site via the BHW Customer Service Portal to request opt-in for SUD eligibility for your site(s) providing SUD services.
  - In the [BHW Customer Service Portal](#), select “ask a question,” and enter the category “Substance Use Disorder (SUD) Documentation,” and use the description “Opt-in SUD Expansion.” Within each inquiry, list the site name and address, list all SUD services provided at the site, and upload all required SUD documentation.

**EXCEPTION (No SUD documentation required):** 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, submit an inquiry via the BHW Customer Service Portal to request opt-in for SUD eligibility for the site(s) providing SUD services. Within each inquiry, list the site name and address, and list all SUD services provided at the site.

**SUD Documentation:** Depending on the type of SUD service provided, NHSC requires the following documentation to verify the site for SUD service eligibility.

- **Sites providing non-opioid, outpatient SUD services** must provide documentation of the SUD services that are provided on-site in the form of one or more of the following:
  - SUD operating certificate from your state, county, etc.;
  - Brochure listing the SUD services provided on-site;
  - Website documentation outlining the SUD services provided on-site; and/or
  - Policy/process document outlining the SUD services provided on-site.
  - Complete NHSC Comprehensive Behavioral Health Services Checklist (Appendix E) with supporting documentation.
- **Office-Based Opioid Treatment (OBOT) facilities** are clinical practices, other than SAMHSA certified OTPs, that provide medication-assisted treatment (MAT) services to patients with opioid use disorder by a provider with a waiver granted under 21 USC 823(g)(2), otherwise known as a Drug Addiction Treatment Act of 2000 (DATA 2000) waiver. OBOTs must provide the following:



- Documentation of services provided on-site (e.g., brochure, website documentation, or policy/process document outlining services provided, as described above); and
  - Verification of on-site MAT in the form of an attestation letter from the site CEO or Medical Director.
    - This letter must state that the site offers MAT, the days and hours when MAT services are offered, 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 F: MAT Attestation Letter Template).
  - Complete NHSC Comprehensive Behavioral Health Services Checklist (Appendix E) with supporting documentation.
- **SAMHSA-Certified Opioid Treatment Programs (OTPs)** provide MAT for people diagnosed with opioid-use disorder and are certified by SAMHSA, in accordance with 42 C.F.R. Part 8. Visit the OTP directory to verify participation. Sites providing OTP will be verified through the [SAMHSA Opioid Treatment Program Directory](#) and must submit a NHSC Comprehensive Behavioral Health Services Checklist (Appendix E) with supporting documentation.

### **Health Professional Shortage Area (HPSA) Requirement**

Sites providing SUD services must be located in a designated Mental Health or Primary Care HPSA. For the purpose of the NHSC SUD Workforce LRP and the NHSC Rural Community LRP, an NHSC site approved for SUD services may use either the Primary Care or the Mental Health HPSA scores, even if it does not provide primary care (medical).

### **Rural Designation**

Only clinicians working at a rural NHSC-approved SUD service site are eligible to apply for the NHSC Rural Community LRP. Rural NHSC-approved sites are located in a Rural-Urban Commuting Area (RUCA) Census Tract designated by HRSA. To determine if an applicant’s site is considered “rural” for purposes of the NHSC Rural Community LRP, sites may use the [Rural Health Grants Eligibility Analyzer](#).

## APPLICATION AND RECERTIFICATION PROCESS

### **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 for approximately 6-8 weeks. The deadline submission time and the date of cycles for each 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, and [sign-up here](#) to receive updates from the NHSC via e-mail.

All sites that are *currently NHSC-approved* must submit a Recertification Application during an open NHSC Site Recertification Application Cycle that coincides with their expiration date. *All*

other sites should apply for NHSC approval during an open NHSC New Site Application cycle. If you do not know the status of your site, please contact your [DRO](#) State/Territory Lead for clarification.

NHSC New Site Application Cycle	NHSC Site Recertification Application Cycle
<ul style="list-style-type: none"> <li>• Sites that have <b>never</b> been approved for NHSC, including sites that have applied and had their application denied or cancelled.</li> <li>• Sites that are currently <b>inactive</b> for NHSC due to expiration or past compliance issues.</li> </ul>	<p><b>Active</b> NHSC sites with an expiration date corresponding to the open recertification application cycle.</p>

### Preparing for NHSC Approval

Before applying to be an NHSC-approved site, ensure the site is operationally compliant with NHSC requirements, as set forth in this NHSC Site Reference Guide and the NHSC Site Agreement ([Appendix A](#)). An application that is deemed incomplete or contains illegible documents may be disapproved. The following steps are a guide for submitting an NHSC Site 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.
  - b. Search by site address using the [HPSA Find Tool](#)
- 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. Additionally, if your site provides SUD services, review the requirements described in the [“Substance Use Disorder \(SUD\) Eligibility and Opt-in Requirements for NHSC Sites”](#) section.
- 5) Get your questions answered by visiting the [NHSC website](#), contacting your [State PCO](#), or [contacting DRO](#).
- 6) Gather **all** required documentation listed in the [“Required NHSC supporting documents”](#) section.
- 7) Create an NHSC account in the [BHW Customer Service Portal](#), and submit an NHSC site application online. You will receive a confirmation email once the application is successfully submitted.
- 8) Reference the [Site POC Portal User Guide](#) at any time for help navigating the BHW Customer Service Portal and the online application process.

### 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) **Check 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) **Confirm Site Details.** This section asks the site applicant to confirm general information such the site name, location, mailing and email addresses, and other contact information.
- 3) **Check for Existing Sites.** This section provides details regarding any similar or potential duplicate sites that already have a BHW site record. This section should be reviewed carefully to ensure duplicate site records are not created. If you previously submitted an application, please use the same site record. Do not create a duplicate site record.
- 4) **Services and Staffing.** In this section, applicant sites will select the type of comprehensive primary medical care, mental/behavioral health care (including type of SUD service) and/or dental care services provided on-site. In addition, the applicant site will need to fill out information in regards to the service site staffing full-time equivalents. The information collected in this section is part of the [NHSC Site Data Tables](#).
- 5) **Behavioral Health** (applicable only for sites that provide mental/behavioral health and/or SUD services). If the applicant site provides behavioral health services, the site is required to complete the NHSC Comprehensive Behavioral Health Services Checklist. Refer to the [“Requirements for Primary Behavioral and Mental Health Sites”](#) section of this guide to ensure that the site meets the appropriate requirements.
- 6) **Payments and Insurance.** This section addresses questions and requires data regarding accepted insurance, payment types, and sliding fee schedule. Note in this section that the Medicare ID number refers to the site’s six-digit, federally-assigned CMS Certification Number (CCN). The information collected in this section is part of the [NHSC Site Data Tables](#).\*\*NOTE: The NHSC Site Data Tables were updated in 2021 and include new instructions. Review the updated tables and instructions to ensure accurate data submission.\*\*
- 7) **Telehealth.** This section asks questions regarding the applicant site’s utilization of telehealth services.
- 8) **Identify Points of Contact (POC).** 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](#).
- 9) **Review HPSAs.** Site applicants will enter in the appropriate HPSA score based on verified information found in the [HPSA Find Tool](#). [DRO](#) 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.
- 10) **Upload 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.

- 11) **Finalize NHSC Site Agreement.** In the last section of the online 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. A copy of the NHSC Site Agreement is included in Appendix A for reference. Note that eligible auto-approved NHSC sites must have a signed NHSC site agreement on file, and are required to submit an online application.

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**

Sites must upload all applicable supporting documentation for the NHSC Site Application **before** the site can submit a complete application package. Both NHSC Site Recertification Applications and NHSC New Site Applications follow the same requirements and process steps but during different application cycles.

A Site Application is considered incomplete, and may be disapproved, if it does not contain each of the following required supporting documents, as applicable:

- 1) **Policies on Non-Discrimination.** Upload a copy of the site's policies on non-discrimination of patients based upon the individual's inability to pay; whether payment for services would be made under Medicare, Medicaid, or CHIP; and the individual's race, color, sex, national origin, disability, religion, age, sexual orientation, or gender identity, in accordance with the NHSC Site Agreement item #2. Refer to [Appendix A](#).
- 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. Policy must ensure eligibility for the program is based solely on income and family size. No other factor (e.g., assets, insurance application

- and/or coverage, citizenship, population type) can be used to assess eligibility;
- 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. An explanation of any 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. Must be adjusted for fees (partial sliding fee discount) based on family size and income, and should reflect nominal charges for individuals and families with incomes above 100 percent and at or below 200 percent of the FPG; and
  - iv. In addition to submitting a copy of the SFS, sites may attach the schedule of fees for the entity's services, consistent with locally prevailing rates or charges and designed to cover the entity's reasonable operating cost. A schedule of fees is a complete listing of full-price cost or fees for services, and the site shall have this available for review upon request.
- c. **Copy of the Patient Application for the Sliding Fee Discount Program.** The SFS application should be limited to questions related to income and family size, and should not include questions related to a patient's assets, social security number, citizenship status, housing status or marital status.
- d. **Posted [Signage](#) Notifying Patients about the Sliding Fee Discount Program:**
- i. Upload *two photographs* of the posted signage. The sign must explicitly state that "no one will be denied access to services due to inability to pay; and there is a discounted/sliding fee schedule available based on family size and income," in accordance with the NHSC Site Agreement item #2e. The first photograph must show the sign prominently displayed in a common area visible to patients. The second photograph must be a close-up photo so the text is legible. For an example of acceptable signage, refer to [Appendix B](#). ***Sites may not use the NHSC poster and/or logo until after they are approved by the NHSC.***
  - ii. Upload *a document with the screenshot and link to the published online statement* on the site's official website (if one exists) and social media platforms (if applicable.)
- 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, signed Memorandums of Agreement or signed contracts with ancillary, inpatient, and specialty facilities. For primary medical and dental sites, 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. Behavioral health sites must submit documents outlined in item #4 below.

- 4) **NHSC Comprehensive Behavioral Health Services Checklist and Supporting Documentation.** Sites offering Comprehensive Primary Behavioral Health Services must certify that they provide comprehensive behavioral health services. *Note: The NHSC Comprehensive Behavioral Health Services Checklist is available for direct data entry on the NHSC Site Application online.*
- 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. Site policies or other internal documents must be uploaded to reflect services provided directly on-site or within their own network. In addition, facilities must provide documentation demonstrating patient access to “Additional Comprehensive Behavioral Health Service Elements” (i.e. Non-Core Elements), which are provided on-site, off-site, through referral, affiliation or contract. Acceptable documentation includes: affiliation agreements; memorandums of understanding/agreement; contracts; letters of referral; letters of support/commitment; or referral and follow-up policy.
  - 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 documents as outlined above in a.ii.
    - ii. Select document type as “Formal Affiliation Agreement,” “Other Behavioral Health Document,” or “On-Site Services Documents.”
    - iii. In the *Comments* section, type “Comprehensive Behavioral Health Services Certification” and any other relevant comments.
- 5) **[NHSC Site Data Tables](#).** Each individual site location must upload completed NHSC Site Data Tables with up-to-date data for the preceding six (6) months (one per physical address). Activity at other non-NHSC sites owned or operated by the applicant site is to be excluded. Site data helps to determine whether the site can meet the terms of the NHSC Site Agreement #13 and if the site implemented the Sliding Fee Discount Program. 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. *Note: The NHSC Site Data Tables are available for direct data entry on the NHSC*

*Site Application online. The data tables are updated and contain new instructions. Refer to [Appendix D](#) for instructions to complete the NHSC Site Data Tables.*

- 6) **SUD Documentation.** Facilities providing opioid treatment and/or SUD treatment must provide the required documentation listed in the “[Substance Use Disorder \(SUD\) Eligibility and Opt-in Requirements for NHSC Sites](#)” section of this document.
  
- 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, *including specific strategies aimed at promoting clinician resiliency and reducing burnout.*

### **NHSC Site Application Review Process**

After a site representative submits the NHSC Site Application, the [State PCO](#) and DRO will review and evaluate the NHSC application. DRO 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, DRO 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 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 demonstrate it meets 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. This means, if a site has several offices at different addresses, or multiple offices at the same address (for instance different suite numbers for a dental, primary care, and mental health clinic), the site must submit separate applications for each site. If submitting more than one new site application, please provide a different site name for each site. For instance, do not list all sites as “ABC Clinic”. Please differentiate the sites, for instance “ABC Clinic - Rockville” and “ABC Clinic - Gaithersburg.”

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 a “disapproved site” 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 applicable NHSC requirements; or are found to be non-compliant with other HRSA/programmatic requirements (i.e.; Section 330 grants; ITUs).

### **NHSC Site Recertification**

Once a site is approved, the site POC can determine if the 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 the 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, 2022**, are required to submit an NHSC Site Recertification Application during the 2022 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 the list of required documents a site must upload when submitting an NHSC site application.

### **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) In the “my sites” section of your portal, click on the name of the site for which you would like to submit an NHSC Site Recertification Application. Note: you may submit an NHSC Site Recertification Application only for an “Approved” site with an expiration date corresponding to the open Site Recertification Application Cycle.
- 3) Click on the “Recertify” button on the top left section of the site page. Additional technical assistance on maneuvering the recertification application is available in the [Site POC Portal User Guide](#).
- 4) Complete the NHSC Site Recertification Application, upload all required supporting documentation, review and sign the NHSC Site Agreement, and click “Submit.” Refer to the [“Required NHSC Supporting Documents”](#) section for the list of required documents sites must upload.



## 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 applicable 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 BHW Customer Service 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 site 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 BHW Customer Service 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.
- 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 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 USC 254f, NHSC sites must make appropriate and efficient use of assigned NHSC clinicians. An NHSC determination 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 applicable 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, or consultant. 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. Additional information on completing the EVF is available in the [Site POC Portal User Guide](#).
- 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 or hours that do not meet the NHSC’s definition of full-time or half-time service).
- 6) Refraining from reducing the salary of NHSC clinicians because they receive or have received benefits under the NHSC Loan Repayment or Scholarship programs, in accordance with item #8 of the NHSC Site Agreement.

- 7) 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.
- 8) 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.
- 9) Allowing NHSC participants to participate in NHSC Continuing Education and NHSC program webinars and/or conferences.
- 10) 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.
- 11) 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.
- 12) 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 LRP](#) and [SP](#) websites 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 medical, dental, or behavioral/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 BHW 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 owner understands 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 medical 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 NHSC site 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, the site 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 New Site 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 will be referred to HRSA's Division of Participant Support and Compliance to determine impact on NHSC service contract. The participant may be required to transfer to another NHSC-approved site. If so, the participant must request a transfer through the BHW 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 AND RETAINING AN NHSC CLINICIAN**

### **Clinician Recruitment and Retention Plan**

Establishing a recruitment and retention plan is critical for a site's financial sustainability and for ensuring that patients from underserved communities have access to needed care. Recruitment and retention plans should contain strategies aimed at promoting clinician resiliency and reducing burnout so sites can maintain optimal care for patients, improve patient satisfaction, and prevent unnecessary expenses related to repeated recruitment. For additional technical assistance and examples of clinician recruitment and retention plans, please contact your [DRO](#) State/Territory Lead.

## **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, licensure, 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 and S2S participant. Refer to the NHSC website for [scholar](#) and [S2S](#) 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 an official letter on organization letterhead;
- 2) Include written confirmation of full-time or half-time employment and list the discipline, specialty, and number of hours the participant will work per week;

- 3) Include the name and full address of the NHSC site(s) where the participant will be working (if multiple sites, include information for each site and number of hours the participant will work per week);
- 4) Include the anticipated employment start date;
- 5) State whether the NHSC site will pay for the NHSC clinician's malpractice insurance and tail coverage for the duration of employment; and
- 6) Include the site representative's contact information, title, and signature.

### **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) and the NHSC Site Reference Guide. [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.***  
[DRO](#) renders the final decision for NHSC site approval and a disapproval may be determined if: 1) an applicant site does not meet the NHSC site eligibility requirements as set forth in the most current 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 [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 DRO determines that an existing NHSC-approved site does not meet the NHSC site eligibility requirements as set forth in the NHSC Site Reference Guide and NHSC Site Agreement *outside of the NHSC Site Recertification Application Cycle*, the following steps will take place:
  1. 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 DRO.



2. A “flag” may be placed in the BMISS site record for the existing site to alert BHW staff that there is an eligibility concern. The “flag” may be considered by BHW staff in relation to placing additional NHSC participants at the existing site.
3. 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 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 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 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 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 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 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](#).

**Additional Comprehensive Behavioral Health Service Elements** (i.e. Non-Core Elements) – NHSC-approved Comprehensive Primary Behavioral Health/Mental Health Service sites must demonstrate patient access to Diagnosis, Therapeutic Services, Short/long-term hospitalization, Crisis/Emergency Services, Consultative Services, and Case Management. Non-core element services may be provided on-site, off-site, through referral, affiliation or contract.

**Approved Alternative Setting** – Alternative settings include any setting in a HPSA at which the clinician is directed to provide care by the NHSC-approved site (e.g., hospitals, nursing homes and shelters). The alternative sites must provide services that are appropriate for the discipline and specialty of the clinician and the services provided. Services at alternative sites must be an extension of the comprehensive primary care provided at the NHSC-approved site.

**Automatically-Approved NHSC Site** – Eligible auto-approved NHSC sites are those sites that may be recognized by the NHSC as meeting all NHSC site requirements, and have reviewed and signed the NHSC Site Agreement, while remaining in compliance with their respective program requirements. The following may be eligible auto-approved NHSC sites: 1) FQHCs, 2) FQHC Look-Alikes, 3) Indian Health Service (IHS) Facilities, 4) Tribally-Operated 638 Health Programs, 5) Urban Indian Health Programs, 6) Federal prisons, and 7) Immigration and Customs Enforcement (ICE) Health Service Corps sites.

**Centers for Medicare & Medicaid Services (CMS)** – An operating agency of HHS. Visit the [CMS website](#) 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. View the [Rural Health Clinic fact sheet](#) for more information. To search for a Rural Health Clinic, 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 Services Checklist](#) for detailed definitions.

**Comprehensive Primary Care** – 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).

**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. Visit the [Federal Bureau of Prisons website](#) for more information. **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. Learn more about [CAHs](#).

**DATA 2000 Waiver** – A waiver obtained under the Controlled Substances Act (CSA), 21 USC 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.).

**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.

**Health Professional Shortage Area (HPSA)** – A HPSA is a geographic area, population group, public or nonprofit private medical facility or other public facility determined by the Secretary of HHS to have a shortage of primary medical care, dental, or mental health professionals based on criteria defined in regulation. Information considered when designating a primary care HPSA includes health provider to population ratios, rates of poverty, and access to available primary health services. HPSAs are designated by the Shortage Designation Branch, within HRSA’s Bureau of Health Workforce, pursuant to Section 332 of the PHS Act (42 USC 254e), and implementing regulations (42 CFR Part 5).

**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 USC 450 et seq.; or by an urban Indian organization receiving funds under Subchapter IV of the Indian Health Care Improvement Act, codified at 25 USC 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** – Each health care site must submit an NHSC Site Application to become an [NHSC-approved site](#). In order for a site to be eligible for NHSC approval, it must meet all

applicable eligibility requirements as set forth in the NHSC Site Agreement and NHSC Site Reference Guide. If the site application is approved, the site becomes an NHSC-approved site. All NHSC-approved sites must continuously meet NHSC 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 recruits and retains medical, nursing, and behavioral/mental health clinicians with specific training and credentials to provide evidence-based SUD treatment in communities designated as “rural” by HRSA and in 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 USC 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 CFR 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 Care** – The provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community.

**Primary Health Services** – Health services including family medicine, internal medicine, pediatrics, geriatrics, 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 and the NHSC Rural Community 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.

**Rural** – A geographical area located in a non-metropolitan county, or an area located in a metropolitan county designated by the Federal Office of Rural Health Policy as being considered rural. *Note:* To determine whether a geographical area is considered rural as determined by the Federal Office of Rural Health Policy, use the [Rural Health Grants Eligibility Analyzer](#).

**School** – A public or private institution (including home schools), providing instruction to children of compulsory school age in kindergarten, grades 1-12, or their equivalent. The operation and administration of the school must meet applicable federal, state and local laws, and services provided by NHSC participants in a school must be an extension of the comprehensive primary care provided at the NHSC-approved site.



**School-Based Clinics** – A part of a system of care located in or near a school facility of a school district or board or of an Indian tribe or tribal organization; organized through school, community, and health provider relationships. This facility provides - through health professionals - primary health services to school aged children and adolescents in accordance with federal, state and local law, including laws relating to licensure and certification. In addition, this site satisfies such other requirements as a state may establish for the operation of such a clinic.

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 participant's 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.

**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 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.

NHSC participants must comply with all applicable telemedicine policies of their site, as well as, all-applicable federal and state rules and policies regarding telemedicine services. NHSC participants who are performing telehealth are encouraged to utilize HRSA’s [Telehealth Resource Centers \(TRCs\)](#). These centers provide free telehealth technical assistance and training for providers using telehealth.

Subject to the restrictions below, the NHSC will consider telehealth as patient care when both the **originating site** (location of the patient) and the **distant site** (location of the NHSC participant) are located in a HPSA and are NHSC-approved.

- a. The NHSC participant must be practicing in accordance with applicable licensure and professional standards.
- b. NHSC participants must be available, at the discretion of the NHSC-approved site, to provide in-person care at the direction of each telehealth site on the NHSC service contract regardless of whether such sites are distant or originating.
- c. Telehealth may be conducted to or from an approved **alternative setting** as directed by the participant's NHSC-approved site. All service completed in an approved alternative setting are restricted to the program guidelines.
- d. Self-employed clinicians are not eligible to earn NHSC service credit for telehealth services.
- e. If telehealth services are provided to patients in another state, the clinician must be licensed to practice (including compacts) in both the state where the clinician is located (i.e., the distant site) and the state where the patient is physically located (i.e., the originating site).
- f. Telehealth services must be furnished using an interactive telecommunications system, defined as multimedia communications equipment that includes, at a minimum, audio and video equipment permitting two-way, real time interactive communication between the patient at the originating site and the NHSC participant at the distant site. Telephones, facsimile machines, and electronic mail systems do not meet the definition of an interactive telecommunications system.

**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 an eligible site type for NHSC approval, and 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), reflecting nominal charges, based solely on family size and income and no other factors 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 official website and social media platforms (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 based on family size and income. 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 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. All other eligible NHSC site types must submit NHSC Site Data Tables at the time of site application, recertification, and NHSC Site Visit.
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 example illustrates 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

#### NOTICE TO PATIENTS:

This practice serves all patients regardless of ability 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 capacidad 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.



## **Sample Sliding Fee Discount Program Policy:**

### **ABC HEALTH CARE CLINIC BUSINESS OFFICE POLICIES**

**SUBJECT:** Sliding Fee Discount Program

**EFFECTIVE DATE:** March 1, 2022

**POLICY:** To make available free or discounted services to those in need.

**PURPOSE:** All patients seeking health care services at ABC HEALTH CARE 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. 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).

ABC HEALTH CARE CLINIC will offer a Sliding Fee Discount Program to all who are unable to pay for their services. ABC HEALTH CARE 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 HEALTH CARE will notify patients of the Sliding Fee Discount Program by:
  - Payment Policy Brochure will be available to all 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 HEALTH CARE.
  - An explanation of our Sliding Fee Discount Program and our application form are available on ABC HEALTH CARE's website.
  - ABC HEALTH CARE places notification of Sliding Fee Discount Program in the clinic waiting area.
2. 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.
3. 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 to patients. Staff are to offer assistance for completion of





the application. Dignity and confidentiality will be respected for all who seek and/or are provided health care services.

4. Completion of Application: The patient/responsible party must complete the Sliding Fee Discount Program application in its entirety. Staff will be available, as needed, to assist patient/responsible party with applications. By signing the Sliding Fee Discount Program application, persons are confirming their income to ABC HEALTH CARE as disclosed on the application form.
5. Eligibility: Discounts will be based on income and family size only.
  - 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. ABC HEALTH CARE will also accept non-related household members when calculating family size.
  - b. Income includes: gross wages; salaries; tips; income from business and self-employment; unemployment compensation; workers' compensation; Social Security; Supplemental Security Income; veterans' payments; survivor benefits; pension or retirement income; interest; dividends; royalties; income from rental properties, estates, and trusts; alimony; child support; assistance from outside the household; and other miscellaneous sources.
6. Income verification: Applicants may 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 be used. Patients who are unable to provide written verification may provide a signed statement of income.
7. Discounts: Those with incomes at or below 100% of poverty will receive a full 100% discount for health care services. Those with incomes above 100% of poverty, but at or below 200% of poverty, will be charged a nominal fee 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 [FPL Guidelines](#).
8. Nominal Fee: Patients with incomes above 100% of poverty, but at or below 200% poverty will be charged a nominal fee according to the attached sliding fee schedule and based on their family size and income. 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.
9. Waiving of Charges: In certain situations, patients may not be able to pay the nominal or discount fee. Waiving of charges must be approved by ABC HEALTH CARE's designated official. Any waiving of charges should be documented in the patient's file along with an explanation.
10. 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, ABC HEALTH CARE will work with the patient and/or responsible party to establish payment arrangements. 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



11. 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.
12. 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 HEALTH CARE can explore options not limited to, but including offering the patient a payment plan, waiving of charges, or referring the patient to collections.
13. 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 ABC HEALTH CARE's practice management system, 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 and applications not returned will also be logged.
14. Policy and procedure review: The SFS will be updated based on the current Federal Poverty Guidelines. ABC HEALTH CARE will also review 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.
15. 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.

**ATTACHMENTS:**

**2022 Sliding Fee Schedule**

**Patient Application for the Sliding Fee Discount Program**

APPROVAL: \_\_\_\_\_

REVISED: \_\_\_\_\_

REVIEWED BY: \_\_\_\_\_



## Sample SFS Application

### ABC HEALTH CARE CLINIC

#### Sliding Fee Discount Information

It is the policy of ABC Health Care 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, 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				
STREET	CITY	STATE	ZIP	PHONE

**Please list all household members, including those under age 18.**

	Name	Date of Birth
<b>SELF</b>		
<b>OTHER</b>		
<b>OTHER</b>		
<b>OTHER</b>		



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

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

Name (Print)

Signature

Date



---

**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		

Self-declaration of income may also be used.



## Sliding Fee Schedule (SFS) Example

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

Poverty Level	100%	110%	120%	130%	140%	150%	160%	170%	180%	190%	200%	>200%
Family Size	Discount 100%	Discount 90%	Discount 80%	Discount 70%	Discount 60%	Discount 50%	Discount 40%	Discount 30%	Discount 20%	Discount 15%	Discount 10%	Discount 0%
1	\$13,590	14,949	16,308	17,667	19,026	20,385	21,744	23,103	24,462	25,821	27,180	27,181+
2	\$18,310	20,141	21,972	23,803	25,634	27,465	29,296	31,127	32,958	34,789	36,620	36,621+
3	\$23,030	25,333	27,636	29,939	32,242	34,545	36,848	39,151	41,454	43,757	46,060	46,061+
4	\$27,750	30,525	33,300	36,075	38,850	41,625	44,400	47,175	49,950	52,725	55,500	55,501+
5	\$32,470	35,717	38,964	42,211	45,458	48,705	51,952	55,199	58,446	61,693	64,940	64,941+
6	\$37,190	40,909	44,628	48,347	52,066	55,785	59,504	63,223	66,942	70,661	74,380	74,381+
7	\$41,910	46,101	50,292	54,483	58,674	62,865	67,056	71,247	75,438	79,629	83,820	83,821+
8	\$46,630	51,293	55,956	60,619	65,282	69,945	74,608	79,271	83,934	88,597	93,260	93,261+
For each additional person, add	\$4,720	5,192	5,664	6,136	6,608	7,080	7,552	8,024	8,496	8,968	9,440	9,440

\*Based on the 2022 [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.



**APPENDIX D: NHSC Site Data Tables**

**Site Data Tables**

Site Name: \_\_\_\_\_  
 \_\_\_\_\_

Site Address: \_\_\_\_\_  
 \_\_\_\_\_

Date Prepared: \_\_\_\_\_  
 \_\_\_\_\_

Prepared By: \_\_\_\_\_  
 \_\_\_\_\_

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

Total Patients: \_\_\_\_\_

Total Patient Visits: \_\_\_\_\_

**TABLE 1: PATIENTS AND VISITS BY PRIMARY INSURANCE TYPE**

**Complete data for "Number of Patients" AND "Number of Patient Visits"**

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



**TABLE 2: PATIENT SERVICE CHARGES, COLLECTIONS, AND ADJUSTMENTS**

Payment Source	Full Charges (a)	Amount Collected (b)	Adjustments (c)
1) Medicare			
2) Medicaid			
3) Other Public/Private Funds			
4) Private Insurance			
5) Sliding Fee			
6) Self-Pay (Other than Sliding Fee)			
<b>7) Total (lines 1-6)</b>	<b>\$0.00</b>	<b>\$0.00</b>	

**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	
<b>3) Total SFS Applications Received</b>	

**TABLE 4: SERVICE SITE STAFFING**

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





## 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. The total number of patients and the total number of patient visits should be based upon actual data.

### 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 comprehensive primary care—whether medical, dental or behavioral and mental health—and ancillary service provided onsite.

These services are an integral part of the comprehensive 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.

### 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: Federally Qualified Health Centers (FQHCs) and FQHC Look-Alikes. The standard HRSA/BPHC Uniform Data System (UDS) report will be reviewed in place of the site data tables.

The following eligible 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. All other eligible NHSC site types must submit NHSC Site Data Tables at time of site application, recertification, and NHSC Site Visit.



## Detailed Table Instructions

**Table 1: Patients or Visits by Primary Insurance Type**

This table reflects the number of patients and patient visits by primary insurance type and/or payer source for the reporting period. 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/Private Funds:** patients with no insurance but who have categorical or other grant funds applied to their accounts for services rendered. This also includes state or local indigent care or charity care programs that are earmarked to subsidize services rendered to uninsured patients, such as the Massachusetts Free Care Pool, New Jersey Uncompensated Care Program, New York Public Goods Pool Funding, New Mexico Tobacco Program, or Colorado Indigent Care Program.

**(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. Patients with health benefit plans purchased for government employees, retirees and dependents, such as TRICARE, the Federal Employees Insurance Program, state employee health insurance benefit programs, teacher health insurance, as well as workers' compensation, 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 Guidelines (FPG). 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; 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.

View the most current [HHS 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 fee discount program are to be classified as self-pay.

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

## Table 2: Patient Service Charges, Collections, and Adjustments

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 **six pay classes:** Medicare, Medicaid, Other Public/Private Funds, Private Insurance, Sliding Fee Schedule, 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. Sites with capitation contracts or who are reimbursed on a cost based flat fee, such as an 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 FQHC 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 including 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, including capitated managed care, administered either directly by the state agency or by its fiscal intermediaries.

**(Line 3) Other Public/Private Funds:** charges and receipts related to services provided to patients and payable by categorical or other grant funds. This also includes state or local indigent care or charity care programs that are earmarked to subsidize services rendered to uninsured patients, such as the Massachusetts Free Care Pool, New Jersey Uncompensated Care Program, New York Public Goods Pool Funding, New Mexico Tobacco Program, or Colorado Indigent Care Program.

**(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 Insurance Program, state employee health insurance benefit programs, teacher health insurance, as well as workers' compensation, and similar plans are to be classified as private insurance.

**(Line 5) Sliding Fee Schedule (SFS) and SFS Adjustments:** charges and receipts related to services provided to 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.

**SFS 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 6) Self-Pay and Self-Pay Adjustments:** 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. This also includes charges not payable by categorical or other grant funds.

**Self-Pay Adjustments:** the value of all self-pay adjustments only. This includes bad debt 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 7) Total:** the sum of lines 1-6.

### **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, including those physicians who obtained a Drug Addiction Treatment Act of 2000 (DATA 2000) waiver, 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 and physician assistant staff performing medical services. Nurse practitioners include psychiatric nurse practitioners. Nurse practitioners and physician assistants also include those who obtained a DATA 2000 waiver.

**(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, and 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 licensed 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, including those who obtained a DATA 2000 waiver, on line 6 under physicians. Report psychiatric nurse practitioners, including those who obtained a DATA 2000 waiver, on line 9 under nurse practitioners.**

**(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

### NHSC COMPREHENSIVE BEHAVIORAL HEALTH SERVICES CHECKLIST

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

Site Name \_\_\_\_\_

Address \_\_\_\_\_

#### **Section I. Core Comprehensive Behavioral Health Service Elements**

NHSC-approved Comprehensive Primary Behavioral/Mental Health Service sites must upload documentation demonstrating that Core Comprehensive Behavioral Health Services are provided on-site. Core service elements *must* be provided on-site; these services cannot be offered through referral, affiliation or contract.

Service	Check the box and upload supporting documentation for each Core service provided on-site
<p><b>1. Screening and Assessment:</b> <i>Screening</i> is the <a href="#">practice</a> 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"/>
<p><b>2. Treatment Plan:</b> 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"/>
<p><b>3. Care Coordination:</b> <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"/>



## Section II. Additional Comprehensive Behavioral Health Service Elements (Non-Core Elements)

NHSC-approved Comprehensive Primary Behavioral/Mental Health Service sites must upload documentation demonstrating patient access to non-core service elements, which may be provided on-site/in-network, through referral, affiliation or contract. Acceptable documentation includes: affiliation agreements; memorandums of understanding/agreement; contracts; letters of referral; letters of support/commitment; or referral and follow-up policy.

Service	Select On-site or Off-site and upload supporting documentation	
	Provided On-site	Provided Off-site
<p><b>1. Diagnosis:</b> 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><b>2. Therapeutic Services (including, but not limited to, psychiatric medication prescribing and management, chronic disease management, and Substance Use Disorder Treatment):</b> 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 (<i>e.g., individual, family, and group psychotherapy/ counseling; psychopharmacology; and short/long-term hospitalization</i>).</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"/>



Service	Select On-site or Off-site and upload supporting documentation	
	Provided On-site	Provided Off-site
<b>3. Crisis/Emergency Services (including, but not limited to, 24-hour crisis call access):</b> 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. <i>(Note: generic hotline, hospital emergency room referral, or 911 is not sufficient).</i>	<input type="checkbox"/>	<input type="checkbox"/>
<b>4. Consultative Services:</b> The practice of collaborating with health care and other social service providers <i>(e.g., education, child welfare, and housing)</i> to identify the biological, psychological, medical and social causes of behavioral health distress, to determine treatment approach(s), and to improve patient functioning.	<input type="checkbox"/>	<input type="checkbox"/>
<b>5. Case Management:</b> 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. Off-Site Behavioral Health Service Details

Under this section, the NHSC-approved site must provide basic information for each entity that supports access to non-core behavioral health services.

<p><b>Entity:</b> _____ _____</p> <p><b>Address:</b> _____ _____</p> <p><b>Services Covered:</b> _____ _____</p> <p><b>Date Documentation is Executed:</b> _____ _____</p> <p><b>Services available under this agreement are offered to all without regard for the ability to pay?</b> Yes <input type="checkbox"/> No <input type="checkbox"/></p>	<p><b>Entity:</b> _____</p> <p><b>Address:</b> _____</p> <p><b>Services Covered:</b> _____</p> <p><b>Date Documentation is Executed:</b> _____</p> <p><b>Services available under this agreement are offered to all without regard for the ability to pay?</b> Yes <input type="checkbox"/> No <input type="checkbox"/></p>
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<p><b>Affiliated:</b> _____ _____</p> <p><b>Address:</b> _____ _____</p> <p><b>Services Covered:</b> _____ _____</p> <p><b>Date Documentation is Executed:</b> _____ _____ _____</p> <p><b>Services available under this agreement are offered to all without regard for the ability to pay?</b> Yes <input type="checkbox"/> No <input type="checkbox"/></p>	<p><b>Affiliated:</b> _____</p> <p><b>Address:</b> _____</p> <p><b>Services Covered:</b> _____</p> <p><b>Date Documentation is Executed:</b> _____ _____ _____</p> <p><b>Services available under this agreement are offered to all without regard for the ability to pay?</b> Yes <input type="checkbox"/> No <input type="checkbox"/></p>
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**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><b>Full-time:</b> 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"/>



	Provided On-site	Not Provided On-site
<p><b>Half-time:</b> 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: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

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

**COMMENTS**



## APPENDIX F: 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]

