**Louisiana Conrad 30/J-1 Visa Waiver Program**

**FLEX (Non-HPSA) Support Request**

|  |  |
| --- | --- |
| Name and Address of Practice Site:Name of Practice Site.Address of Practice Site.City/state/zip of Practice Site. | Name and Address of Employer (if different):Name of Employer.Address of Employer.City/State/Zip of Employer. |
| Practice Contact Information:Practice Contact Name and TitleContact email addressContact Phone Number | Employer Contact Information:Employer Contact Name and TitleContact email addressContact Phone Number |
| **Patient Data for Services Rendered:** **From (MM/YY): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ To (MM/YY):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| **Patient Profile Statistics: Complete each item and indicate ACTUAL or ESTIMATED FOR THE TOTAL PRACTICE NUMBERS (write an E if estimated).** |
| # of total patients / # of visits: Click or tap here to enter text. **/** Click or tap here to enter text. | # Primary Care patients / # of visits: Click or tap here to enter text. **/** Click or tap here to enter text. |
| # Specialty Care patients / # of visits: Click or tap here to enter text. **/** Click or tap here to enter text. | # AIDS/HIV (if pertinent to approval) / visits: Click or tap here to enter text. **/** Click or tap here to enter text. |
| # Medicaid patients / # of encounters: Click or tap here to enter text. **/** Click or tap here to enter text. | # Medicare patients / # of encounters: Click or tap here to enter text. **/** Click or tap here to enter text. |
| # Uninsured/underinsured self pay (non-indigent) patients / # of visits: Click or tap here to enter text. **/** Click or tap here to enter text. | # Uninsured/underinsured indigent SFS patients / # of visits: Click or tap here to enter text. **/** Click or tap here to enter text. |
| # of total HPSA residents/patients treated / # of patient visits: Click or tap here to enter text. **/** Click or tap here to enter text. |
| **HPSA Name and ID served**  | **Zip Code within the HPSA** | **# of Patient / visits**  |
| Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. |
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| # of Medicaid patients from HPSAs / # of visits: Click or tap here to enter text. **/** Click or tap here to enter text. | # of Medicare patients from HPSAs / # of visits: Click or tap here to enter text. **/** Click or tap here to enter text. |
| # Uninsured / underinsured self pay (non-indigent) HPSA patients/# of visits: Click or tap here to enter text. **/** Click or tap here to enter text. | # Uninsured/underinsured indigent SFS patients / # of visits: Click or tap here to enter text. **/** Click or tap here to enter text. |
| ***By signing below, I verify that the information provided in this for this facility/medical practice is correct for the period noted on this form.*** |
| CEO/Administrator’s Signature/Title: | Office Manager/Form Compiler’s Signature/Title: |
| Date: | Date: |

Conrad 30 Form rev. 10/19