Well-Ahead Louisiana Primary Care Office

Louisiana Conrad 30/J-1 Visa Waiver Program

# FLEX (Non-HPSA) Support Request

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| 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 Title  Contact email address  Contact Phone Number | Employer Contact Information:  Employer Contact Name and Title  Contact email address  Contact 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: | |