Jeff Landry
GOVERNOR

Bruce D. Greenstein
SECRETARY

State of Louisiana

Louisiana Department of Health
Office of Public Health

Well-Ahead Louisiana Primary Care Office

Louisiana Conrad 30/J-1 Visa Waiver Program

FLEX (Non-HPSA) Support Request

Name and Address of Practice Site:	Name and Address of Employer (if different):
Practice Contact Information:	Employer Contact Information:

Patient Data for Services Rendered: From (MM/YY): _____ To (MM/YY):_____

Patient Profile Statistics: Complete each item and indicate ACTUAL or ESTIMATED	
# of total patients / # of visits: /	# Primary Care patients / # of visits: /
# Specialty Care patients / # of visits: /	# AIDS/HIV (if pertinent to approval) / visits: /
# Medicaid patients / # of encounters: /	# Medicare patients / # of encounters: /
# Uninsured/underinsured self pay (non-indigent) patients / # of visits: /	# Uninsured/underinsured indigent SFS patients / # of visits: /
# of total HPSA residents/patients treated / # of patient visits: /	

HPSA Name and ID served	**Zip Code within the HPSA**	**# of Patient / visits**
# of Medicaid patients from HPSAs / # of visits: /	# of Medicare patients from HPSAs / # of visits: /	
# Uninsured / underinsured self pay (non-indigent) HPSA patients/# of visits: /	# Uninsured/underinsured indigent SFS patients / # of visits: /	

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: