Florida Reimbursement Assistance for Medical Education | FRAME

Primary Care/Mental Health

Employment Verification Form

Please type or write legibly. Any illegible field will make this form incomplete.

SECTION 1: Applicant Information

1.1 Applicant Name: _____

1.2 Please select one:

☐ 1) I am an employee (I receive a W-2 Form at the end of the year).
[Sign acknowledgment in 1.3, then provide the form to your employer(s) to complete the remainder of the form.]

☐ 2) I am an independent contractor (I receive a 1099 Form at the end of the year).
[Sign acknowledgment in 1.3, then skip to Section 3]

☐ 3) I am in a practice with other MDs, DOs, or Autonomous practice APRNs, but not an employee (i.e., partner). The number of providers: _____
[Sign acknowledgment in 1.3, then skip to Section 3]]

☐ 4) I have my own practice (sole proprietor).
[Sign acknowledgment in 1.3, then skip to Section 3]

1.3 I acknowledge that the Florida Department of Health (FDOH) reserves the right to correct any field in the FRAMEworks portal that does not match the information attested to in this document. HPSA information may be updated to correct the information if it is incorrect on this form or as entered in the FRAMEworks portal. Furthermore, any changes made by FDOH in correcting data entry errors may change the award prioritization and scoring.

_____ _____
Applicant's Signature (Signature must be in ink) Date

SECTION 2: Current Employer Information

2.01 Employer Name:			
2.02 Address:			
2.03 City:	2.04 State:	2.05 ZIP:	2.06 County:
2.07 Employer Type: ☐ For Profit ☐ Non-Profit ☐ Government-Owned Entity (Local, State, Federal)			
2.08 Contact Name:		2.09 Telephone Number:	
2.10 Employer NPI Number (if applicable):			
2.11 Employer Medicaid Provider Number(s) (if applicable):			

SECTION 3: Current Primary Care Employment Locations

3.01 The applicant's first date of employment with this employer/practice: _____

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Applicant Name: _____

Primary Practice Site Location of Applicant

3.02 This site is:

- ☐ 1. An FQHC or FQHC Look-Alike
- ☐ 2. An Indian tribal health clinic
- ☐ 3. County health department
- ☐ 4. Free Clinic
- ☐ 5. Home Health Agency[2]
- ☐ 6. Intermediate care facility for the developmentally disabled[2]
- ☐ 7. Local correctional facility
- ☐ 8. Other state institution that employs eligible providers
- ☐ 9. Primary care practice office or clinic
- ☐ 10. Rural health clinic (RHC)
- ☐ 11. Rural Hospital [1]
- ☐ 12. Nursing Home Facility[2]
- ☐ 13. State mental hospital
- ☐ 14 State or Federal correctional institution
- ☐ 15. State university-run outpatient clinic
- ☐ 16. **Other/None of these** Specify: _____

3.03 Facility/Practice Name:	3.04 Telephone Number:
3.05 Address:	

3.06 City:	3.07 State:	3.08 ZIP:	3.09 County:

3.10 NHSC Approved Site: ☐ Yes ☐ No ☐ I don't know

3.11 Does this location accept Medicaid? ☐ Yes ☐ No	3.12 If yes, please list the Medicaid provider number(s) for this location:

3.13 HPSA Name[3]: _____

Primary care practitioners use primary care HPSA information and mental health practitioners use mental health HPSA information

3.14 HPSA Score:	3.15 HPSA ID Number:

3.16 Is the location a rural hospital as identified in section 395.602(2)(b) Florida Statutes ☐ Yes ☐ No

3.17 Direct Patient Care* Hours: Average number of hours providing direct patient care at this location on a weekly basis: In-person _____ Telehealth _____ TOTAL _____	* Direct patient care is defined as face-to-face care with patients. Hours spent on-call or travelling are not considered direct patient care and CANNOT be included. Telehealth may be provided to established patients for no more than 50% of weekly direct patient care hours. The provider must provide telehealth services from their practice site location identified in 3.02.

3.18 Supervisor's Printed Name:

By signing (in ink), I certify that all of the practice information is true and accurate, including that Weekly Direct Patient Care Hours do not include any hours conducting excluded activities. I also certify that the Weekly Direct Patient Care Hours are specific to providing primary care services in a primary care setting.

3.19 Supervisor's Signature: _____ 3.20 Signature Date: _____

If you only have one practice site location, you may skip to page 6 and only submit pages 1, 2, and 6.

[1] Rural hospitals are defined in section 395.602(2)(b) Florida Statutes.
[2] Physicians are not eligible for this location type
[3] If your site is #1, 2, 10, 13, or 14 you can check your HPSA name at https://data.hrsa.gov/tools/shortage-area/hpsa-find. All other sites should check their HPSAs at https://data.hrsa.gov/tools/shortage-area/by-address.

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Applicant Name: _____

Secondary Practice Site Location of Applicant

3.21 This site is:

- ☐ 1. An FQHC or FQHC Look-Alike
- ☐ 2. An Indian tribal health clinic
- ☐ 3. County health department
- ☐ 4. Free Clinic
- ☐ 5. Home Health Agency[5]
- ☐ 6. Intermediate care facility for the developmentally disabled[5]
- ☐ 7. Local correctional facility
- ☐ 8. Other state institution that employs eligible providers
- ☐ 9. Primary care practice office or clinic
- ☐ 10. Rural health clinic (RHC)
- ☐ 11. Rural Hospital[4]
- ☐ 12. Nursing Home Facility[5]
- ☐ 13. State mental hospital
- ☐ 14 State or Federal correctional institution
- ☐ 15. State university-run outpatient clinic
- ☐ 16. **Other/None of these** Specify: _____

3.22 Facility/Practice Name:		3.23 Telephone Number:	
3.24 Address:			
3.25 City:	3.26 State:	3.27 ZIP:	3.28 County:
3.29 NHSC Approved Site: ☐ Yes ☐ No ☐ I don't know			
3.30 Does this location accept Medicaid? ☐ Yes ☐ No		3.31 If yes, please list the Medicaid provider number(s) for this location:	
3.32 HPSA Name[6]: _____ Primary care practitioners use primary care HPSA information and mental health practitioners use mental health HPSA information			
3.33 HPSA Score:		3.34 HPSA ID Number:	
3.35 Is the location a rural hospital as identified in section 395.602(2)(b) Florida Statutes ☐ Yes ☐ No			
3.36 Direct Patient Care* Hours: Average number of hours providing direct patient care at this location on a weekly basis: In-person _____ Telehealth _____ TOTAL _____		* Direct patient care is defined as face-to-face care with patients. Hours spent on-call or travelling are not considered direct patient care and CANNOT be included. Telehealth may be provided to established patients for no more than 50% of weekly direct patient care hours. The provider must provide telehealth services from their practice site location identified in 3.21.	
3.37 Supervisor's Printed Name:			

By signing (in ink), I certify that all of the practice information is true and accurate, including that Weekly Direct Patient Care Hours do not include any hours conducting excluded activities. I also certify that the Weekly Direct Patient Care Hours are specific to providing primary care services in a primary care setting.

3.38 Supervisor's Signature: _____ 3.39 Signature Date: _____

If you have two practice site locations, you may skip to page 6 and only submit pages 1-3, and 6.

[4] Rural hospitals are defined in in section. 395.602(2)(b) Florida Statutes.
[5] Physicians are not eligible for this location type
[6] If your site is #1, 2, 10, 13, or 14 you can check your HPSA name at https://data.hrsa.gov/tools/shortage-area/hpsa-find. All other sites should check their HPSAs at https://data.hrsa.gov/tools/shortage-area/by-address.

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Applicant Name: _____

Tertiary Practice Site Location of Applicant

3.40 This site is:

- ☐ 1. An FQHC or FQHC Look-Alike
- ☐ 2. An Indian tribal health clinic
- ☐ 3. County health department
- ☐ 4. Free Clinic
- ☐ 5. Home Health Agency[8]
- ☐ 6. Intermediate care facility for the developmentally disabled[8]
- ☐ 7. Local correctional facility
- ☐ 8. Other state institution that employs eligible providers
- ☐ 9. Primary care practice office or clinic
- ☐ 10. Rural health clinic (RHC)
- ☐ 11. Rural Hospital[7]
- ☐ 12. Nursing Home Facility[8]
- ☐ 13. State mental hospital
- ☐ 14 State or Federal correctional institution
- ☐ 15. State university-run outpatient clinic
- ☐ 16. **Other/None of these** Specify: _____

3.41 Facility/Practice Name:		3.42 Telephone Number:	
3.43 Address:			
3.44 City:	3.45 State:	3.46 ZIP:	3.47 County:

3.48 NHSC Approved Site: ☐ Yes ☐ No ☐ I don't know

3.49 Does this location accept Medicaid? ☐ Yes ☐ No	3.50 If yes, please list the Medicaid provider number(s) for this location:

3.51 HPSA Name[9]: _____

Primary care practitioners use primary care HPSA information and mental health practitioners use mental health HPSA information

3.52 HPSA Score:	3.53 HPSA ID Number:

3.54 Is the location a rural hospital as identified in section 395.602(2)(b) Florida Statutes ☐ Yes ☐ No

3.55 Direct Patient Care* Hours: Average number of hours providing direct patient care at this location on a weekly basis: In-person _____ Telehealth _____ TOTAL _____	* Direct patient care is defined as face-to-face care with patients. Hours spent on-call or travelling are not considered direct patient care and CANNOT be included. Telehealth may be provided to established patients for no more than 50% of weekly direct patient care hours. The provider must provide telehealth services from their practice site location identified in 3.40.

3.56 Supervisor's Printed Name:

By signing (in ink), I certify that all of the practice information is true and accurate, including that Weekly Direct Patient Care Hours do not include any hours conducting excluded activities. I also certify that the Weekly Direct Patient Care Hours are specific to providing primary care services in a primary care setting.

3.57 Supervisor's Signature: _____ 3.58 Signature Date: _____

If you have three practice site locations, you may skip to page 6 and only submit pages 1-4, and 6.

[7] Rural hospitals are defined in in section. 395.602(2)(b) Florida Statutes.
[8] Physicians are not eligible for this location type
[9] If your site is #1, 2, 10, 13, or 14 you can check your HPSA name at https://data.hrsa.gov/tools/shortage-area/hpsa-find. All other sites should check their HPSAs at https://data.hrsa.gov/tools/shortage-area/by-address.

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Applicant Name: _____

Quaternary Practice Site Location of Applicant

3.59 This site is:

- ☐ 1. An FQHC or FQHC Look-Alike
- ☐ 2. An Indian tribal health clinic
- ☐ 3. County health department
- ☐ 4. Free Clinic
- ☐ 5. Home Health Agency[11]
- ☐ 6. Intermediate care facility for the developmentally disabled[11]
- ☐ 7. Local correctional facility
- ☐ 8. Other state institution that employs eligible providers
- ☐ 9. Primary care practice office or clinic
- ☐ 10. Rural health clinic (RHC)
- ☐ 11. Rural Hospital[10]
- ☐ 12. Nursing Home Facility[11]
- ☐ 13. State mental hospital
- ☐ 14 State or Federal correctional institution
- ☐ 15. State university-run outpatient clinic
- ☐ 16. **Other/None of these** Specify: _____

3.60 Facility/Practice Name:			3.61 Telephone Number:
3.62 Address:			
3.63 City:	3.64 State:	3.65 ZIP:	3.66 County:

3.67 NHSC Approved Site: ☐ Yes ☐ No ☐ I don't know

3.68 Does this location accept Medicaid? ☐ Yes ☐ No	3.69 If yes, please list the Medicaid provider number(s) for this location:

3.70 HPSA Name[12]: _____

Primary care practitioners use primary care HPSA information and mental health practitioners use mental health HPSA information.

3.71 HPSA Score:	3.72 HPSA ID Number:

3.73 Is the location a rural hospital as identified in section 395.602(2)(b) Florida Statutes ☐ Yes ☐ No

3.74 Direct Patient Care* Hours: Average number of hours providing direct patient care at this location on a weekly basis: In-person _____ Telehealth _____ TOTAL _____	* Direct patient care is defined as face-to-face care with patients. Hours spent on-call or travelling are not considered direct patient care and CANNOT be included. Telehealth may be provided to established patients for no more than 50% of weekly direct patient care hours. The provider must provide telehealth services from their practice site location identified in 3.59.

3.75 Supervisor's Printed Name:

By signing (in ink), I certify that all of the practice information is true and accurate, including that Weekly Direct Patient Care Hours do not include any hours conducting excluded activities. I also certify that the Weekly Direct Patient Care Hours are specific to providing primary care services in a primary care setting.

3.76 Supervisor's Signature: _____ 3.77 Signature Date: _____

Additional site locations must be submitted on a separate sheet. All location information must be included.

[10] Rural hospitals are defined in in section. 395.602(2)(b) Florida Statutes.
[11] Physicians are not eligible for this location type
[12] If your site is #1, 2, 10, 13, or 14 you can check your HPSA name at https://data.hrsa.gov/tools/shortage-area/hpsa-find. All other sites should check their HPSAs at https://data.hrsa.gov/tools/shortage-area/by-address.

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Applicant Name: _____

SECTION 4: Patient Mix by Payer Type

Please provide the number of all patients by each payer type for the entire practice for the previous calendar year.

	#	%		#	%
4.1 Cash Only/Concierge:		%	4.2 Sliding Fee/Charity Care/Free Clinic:		%
4.3 Medicare Only:		%	4.4 Medicaid (including dual eligibles)[13]:		%
4.5 Private Insurance:		%	4.6 Government Funding/Contracts:		%
			Total		100%

Please answer the following questions regarding Medicaid:

4.7 Is the applicant the rendering provider for Medicaid claims?

☐ Yes (NPI number: _____) OR (Medicaid number: _____)

☐ No (answer question 4.71)

4.71 Why is the applicant not the rendering provider on Medicaid claims? (choose all that apply)

☐ Applicant not eligible to bill based on license type (enter practice NPI or Medicaid provider number(s): _____

☐ Practice bills under group number only (enter practice NPI or Medicaid provider number(s): _____

☐ Other (Specify, and include any relevant billing numbers:_____)

SECTION 5: Attestation

I acknowledge that all information and statements contained herein are true and do not misrepresent fact and that I have not evaded or suppressed any information contained in this verification form.

I specifically attest that the first date of employment (question 3.01), all of the average weekly direct patient care hours for each practice location are accurate (questions 3.17, 3.36, 3.55, and 3.74), and the Medicaid percentage (question 4.4) is accurate.

5.1 Employer's Signature
(signature must be in ink)

5.2 Date

5.3 Employer's Printed Name

5.4 Signatory's role with employer[14]

5.5 Telephone Number

NOTICE: Any person who knowingly makes a false statement or misrepresentation on this form is subject to penalties under section 837.06, Florida Statutes, which may include fines, imprisonment, or both.

[13] Please include in your count all patients who might have other insurance and Medicaid is secondary (dual eligible).
[14] Please enter your role with the employer/practice. For example, immediate supervisor, HR staff, solo practitioner, partner, etc.