Florida Reimbursement Assistance for Medical Education | FRAME[dental]

Dental Program

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).
[Give the pdf document to your employer(s) to complete the remainder of the form, then sign acknowledgment.]

☐ 2) I am an independent contractor (I receive a 1099 Form at the end of the year).
[Complete Section 2 with your information as the current employer.]

☐ 3) I am a Dentist in a practice with other Dentists, but not an employee (i.e., partner). The number of providers: _____
[Complete Section 2 with practice/partnership information as the current employer.]

☐ 4) I have my own practice (sole proprietor). [Dentists only]
[Complete Section 2 with your information as the current employer.]

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. Dental 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 (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's Type: ☐ For Profit ☐ Non-Profit ☐ Government-Owned Entity (County, State, Federal)			
2.08 Employer NPI Number(s):		2.09 Employer Medicaid Number:	
2.10 Contact Name:		2.11 Telephone Number:	

SECTION 3: Current Employment Locations

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

Florida Reimbursement Assistance for Medical Education | FRAME[dental]

Dental Program

Employment Verification Form

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

Applicant Name: _____

Primary Practice Site Location of Applicant			
3.02 This site is:			
☐ 1. FQHC[1] or FQHC Look-Alike	☐ 4. Other non-profit agency	☐ 7. Children's Medical Services site	
☐ 2. Indian tribal health clinic	☐ 5. State University-run dental clinic	☐ 8. Other publicly funded agency/facility	
☐ 3. County health department	☐ 6. Federally funded rural health clinic (RHC)	☐ 9. Private Practice	
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 Dental HPSA Name[2]:			
3.14 HPSA Score:		3.15 HPSA ID Number:	
3.16 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. Any telehealth services must be provided from the practice site location identified in 3.02.	
3.17 Unduplicated total number of patients seen at this location by this dentist or dental hygienist for the last calendar year:			
3.18 Of the patients in 3.17, how many had Medicaid:			
3.19: Of the patients in 3.17, how many utilized your sliding fee scale/charity care program:			
3.20 Supervisor's Printed Name:			
By signing (in ink), I certify that all of the practice information is true and accurate, including that average weekly Direct Patient Care Hours do not include any hours conducting excluded activities. 3.21 Supervisor's Signature: _____ 3.22 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] Federally Qualified Health Center
[2] If your site is #1, 2, or 6 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.

Florida Reimbursement Assistance for Medical Education | FRAME[dental]

Dental Program

Employment Verification Form

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

Applicant Name: _____

Secondary Practice Site Location of Applicant		
3.23 This site is:		
☐ 1. FQHC[1] or FQHC Look-Alike	☐ 4. Other non-profit agency	☐ 7. Children's Medical Services site
☐ 2. Indian tribal health clinic	☐ 5. State University-run dental clinic	☐ 8. Other publicly funded agency/facility
☐ 3. County health department	☐ 6. Federally funded rural health clinic (RHC)	☐ 9. Private Practice
3.24 Facility/Practice Name:		3.25 Telephone Number:
3.26 Address:		
3.27 City:	3.28 State:	3.29 ZIP: 3.30 County:
3.31 NHSC Approved Site: ☐ Yes ☐ No ☐ I don't know		
3.32 Does this location accept Medicaid? ☐ Yes ☐ No		3.33 If yes, please list the Medicaid provider number(s) for this location:
3.34 Dental HPSA Name[2]:		
3.35 HPSA Score:		3.36 HPSA ID Number:
3.37 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. Any telehealth services must be provided from the practice site location identified 3.23.
3.38 Unduplicated total number of patients seen at this location by this dentist or dental hygienist for the last calendar year:		
3.39 Of the patients in 3.38, how many had Medicaid:		
3.40 Of the patients in 3.38, how many utilized your sliding fee scale/charity care program:		
3.41 Supervisor's Printed Name:		
By signing (in ink), I certify that all of the practice information is true and accurate, including that average weekly Direct Patient Care Hours do not include any hours conducting excluded activities. 3.42 Supervisor's Signature: _____ 3.43 Signature Date: _____		

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

[1] Federally Qualified Health Center
[2] If your site is #1, 2, or 6 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.

Florida Reimbursement Assistance for Medical Education | FRAME^{dental}

Dental Program

Employment Verification Form

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

Applicant Name: _____

Tertiary Practice Site Location of Applicant		
3.44 This site is:		
☐ 1. FQHC[1] or FQHC Look-Alike	☐ 4. Other non-profit agency	☐ 7. Children's Medical Services site
☐ 2. Indian tribal health clinic	☐ 5. State University-run dental clinic	☐ 8. Other publicly funded agency/facility
☐ 3. County health department	☐ 6. Federally funded rural health clinic (RHC)	☐ 9. Private Practice
3.45 Facility/Practice Name:		3.46 Telephone Number:
3.47 Address:		
3.48 City:	3.49 State:	3.50 ZIP: / 3.51 County:
3.52 NHSC Approved Site: ☐ Yes ☐ No ☐ I don't know		
3.53 Does this location accept Medicaid? ☐ Yes ☐ No	3.54 If yes, please list the Medicaid provider number(s) for this location:	
3.55 Dental HPSA Name[2]:		
3.56 HPSA Score:	3.57 HPSA ID Number:	
3.58 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. Any telehealth services must be provided from the practice site location identified in 3.44.	
3.59 Unduplicated total number of patients seen at this location by this dentist or dental hygienist for the last calendar year:		
3.60 Of the patients in 3.59, how many had Medicaid:		
3.61 Of the patients in 3.59, how many utilized your sliding fee scale/charity care program:		
3.62 Supervisor's Printed Name:		
By signing (in ink), I certify that all of the practice information is true and accurate, including that average weekly Direct Patient Care Hours do not include any hours conducting excluded activities. 3.63 Supervisor's Signature: _____ 3.64 Signature Date: _____		

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

[1] Federally Qualified Health Center
[2] If your site is #1, 2, or 6 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.

Florida Reimbursement Assistance for Medical Education | FRAME[dental]

Dental Program

Employment Verification Form

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

Applicant Name: _____

Quaternary Practice Site Location of Applicant		
3.65 This site is:		
☐ 1. FQHC[1] or FQHC Look-Alike	☐ 4. Other non-profit agency	☐ 7. Children's Medical Services site
☐ 2. Indian tribal health clinic	☐ 5. State University-run dental clinic	☐ 8. Other publicly funded agency/facility
☐ 3. County health department	☐ 6. Federally funded rural health clinic (RHC)	☐ 9. Private Practice
3.66 Facility/Practice Name:		3.67 Telephone Number:
3.68 Address:		
3.69 City:	3.70 State:	3.71 ZIP: / 3.72 County:
3.73 NHSC Approved Site: ☐ Yes ☐ No ☐ I don't know		
3.74 Does this location accept Medicaid? ☐ Yes ☐ No	3.75 If yes, please list the Medicaid provider number(s) for this location:	
3.76 Dental HPSA Name[2]:		
3.77 HPSA Score:	3.78 HPSA ID Number:	
3.79 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. Any telehealth services must be provided from the practice site location identified in 3.65.	
3.80 Unduplicated total number of patients seen at this location by this dentist or dental hygienist for the last calendar year:		
3.81 Of the patients in 3.80, how many had Medicaid:		
3.82 Of the patients in 3.80, how many utilized your sliding fee scale/charity care program:		
3.83 Supervisor's Printed Name:		
By signing (in ink), I certify that all of the practice information is true and accurate, including that average weekly Direct Patient Care Hours do not include any hours conducting excluded activities. 3.84 Supervisor's Signature: _____ 3.85 Signature Date: _____		

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

[1] Federally Qualified Health Center
[2] If your site is #1, 2, or 6 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.

Florida Reimbursement Assistance for Medical Education | FRAME^{dental}

Dental Program

Employment Verification Form

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

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)[3]:		%
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 direct patient care[4] hours for each practice location are accurate (questions 3.16, 3.37, 3.58, and 3.79), and the Medicaid percentage (question 4.4) are all accurate.

5.1 Employer's Signature (in ink) _____

5.2 Date _____

5.3 Employer's Printed Name _____

5.4 Signatory's role with employer[5] _____

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.

[3] Please include in your count all patients who might have other insurance and Medicaid is secondary (dual eligible).

[4] Direct patient care means face-to-face care with patients. Hours spent on-call or traveling are not considered direct patient care hours. 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 primary service location. Family members, friends, or translators present with a patient do not disqualify the time as direct patient care.

[5] Please enter your role with the employer/practice. For example, immediate supervisor, HR staff, solo practitioner, partner, etc.