INDIANA STATE LOAN REPAYMENT PROGRAM
HEALTH PROVIDER ACTIVITY REPORT

This report is to be completed by each provider approved under Indiana's State Loan Repayment.

Please complete this fillable form, print, sign and return by email to SLRP@isdh.in.gov

PART 1 - TO BE COMPLETED BY REPORTING PROVIDER:

Provider's Name: _____ _____ _____
(First Name) (Middle Initial) (Last Name)

Type Service or Discipline: _____

During this report period, I have practiced at a total of _____ practice sites, as named below.

Practice Site(s): _____
(Practice Site(s) Name)

Practice Address(es) During Report _____
(Street)

Period: (If additional practice sites, list on separate sheet of paper) _____ _____ _____ _____ - _____
(City) (County) (State) (Zip Code)

Practice Telephone #(s): ____ - _____ -_____ **Email Address:** _____

The start date of my grant agreement for this location(s) on: _____
(date)

Report Number _____

1. **First Report: due 30 days after grant start date and will reflect work from the 1st to the 30th day.**
2. **Second Report: due 6 months after the grant start date and will reflect work the second month through the sixth month.**
3. **Third Report: due 12 months after grant start date and will reflect work the seventh month through the 12th month.**
4. **Fourth Report: due 18 months after grant start date and will reflect work the 13th month through the 18th month.**
5. **Final Report: due 24 months after the grant start date and will reflect work the 19th month through the 24th month, plus complete the statement below.**

   I have completed 24 months service at above location(s), from _____ to _____, and:

   _____ I intend to remain at this location **_____ I do not intend to remain at this location**

My typical work schedule during this reporting period has been as follows: (Example of entry: From 8 AM to 5 PM, less 1 hour for meal break = 8 actual work hours.)

Monday: From _____ to _____ less _____ hour meal break = _____ actual in-clinic work hours

Tuesday: From _____ to _____ less _____ hour meal break = _____ actual in-clinic work hours

Wednesday: From _____ to _____ less _____ hour meal break = _____ actual in-clinic work hours

Thursday: From _____ to _____ less _____ hour meal break = _____ actual in-clinic work hours

Friday: From _____ to _____ less _____ hour meal break = _____ actual in-clinic work hours

Saturday: From _____ to _____ less _____ hour meal break = _____ actual in-clinic work hours

Sunday: From _____ to _____ less _____ hour meal break = _____ actual in-clinic work hours

TOTAL HOURS WORKED EACH WEEK: _____

The number of patient encounters I have treated during this reporting period were as follows:

		Number	Percentage
a.	**Total number of patient visits (encounters)**	_____	**100 %**
b.	**Number of patient visits for whom a *Medicare* claim was submitted**	_____	_____%
c.	**Number of patient visits for whom a *Medicaid* claim was submitted**	_____	_____%
d.	**Number of patient visits wherein services were rendered at a rate less than the usual and customary fee under a sliding fee scale**	_____	_____%
e.	**Number of patient visits for which no charge was made (based on inability to pay)**	_____	_____%
f.	**Number of patient visits covered by private insurance**	_____	_____%
g.	**Number of uninsured, self-pay visits who paid full charges**	_____	_____%

My *Medicare* Provider Number(s) is (are): _____

My *Medicaid* Provider Number(s) is (are):_____

I hereby certify, *under penalty of licensure action and possible revocation of State Loan Repayment Grant,* that I, the undersigned provider, personally delivered the type of health care services for which my ASLRP grant was approved at the above address at least 40 hours per week I further certify that my practice is using the sliding fee scale or 'no-pay' policy submitted with my ASLRP application for uninsured patients with household incomes at or below 200 percent of the Federal Poverty Level. All information reported on this form is true to the best of my knowledge and belief.

_____ _____ _____ _____

(Provider's Signature) (Date) (Telephone #) (Email Address)

PART 2 - TO BE COMPLETED BY SPONSOR/EMPLOYER:

I hereby certify *under penalty of licensure action and other liability for fraudulent claims* that the information provided on this report is true and correct to the best of my knowledge and belief. I further certify that this organization uses the sliding fee scale or 'no-pay' policy submitted with the sponsoring site's application to discount payment fees for uninsured patients with household incomes at or below 200 percent of the Federal Poverty Level. I further certify that the SLRP Provider, the subject of this report is being paid for services at the prevailing rate and that payment has not been reduced as a result of the SLRP award.

Organization: _____

_____ **_____**
Employer's Signature **Date**

_____ **Telephone: ____ - ____ - _____**
Printed/Typed Name

_____ **Email Address: _____**
Title

Please return this completed form to: **SLRP@isdh.in.gov**

If you have questions about completing this form, call: 317-234-5673 or email: SLRP@isdh.in.gov.