South Carolina Rural Incentive Grant Program

Practice Site Profile Form
Please complete and submit via the online application system.

Name of Applicant ________________________________

Section I:

1. Name of Practice: __________________________________________________

2. Practice Address: __________________________________________________
                                                                 ______________

3. Practice Site Contact Person: ___________________________________________

4. Contact Person Phone Number: _________________________________________

5. Contact Person Fax Number: ___________________________________________

6. Contact Person E-Mail Address: _________________________________________

Section II:

1. List Current FTE count for the following:

   Family Practitioners ______  General Surgeons_______
   Internists _______  Med/Peds _______
   Ob/Gyns ________  Pediatricians ______
   Psychiatrists_______  Nurse Midwives _________
   Nurse Practitioners ________  Physician Assistants ______

2. List Desired FTE count for the following:

   Family Practitioners ______  General Surgeons_______
   Internists _______  Med/Peds _______
   Ob/Gyns ________  Pediatricians ______
   Psychiatrists_______  Nurse Midwives _________
   Nurse Practitioners ________  Physician Assistants ______
3. List your practice’s referring hospital(s) and state the current medical staff status:

__________________________________________________________________

__________________________________________________________________

4. Report your approximate current patient mix using the following categories:

<table>
<thead>
<tr>
<th>Category</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Private Insurance</td>
<td>_________</td>
</tr>
<tr>
<td>Uninsured/Self Pay</td>
<td>___________</td>
</tr>
<tr>
<td>Medicare</td>
<td>__________</td>
</tr>
<tr>
<td>Medicaid</td>
<td>__________</td>
</tr>
<tr>
<td>Other</td>
<td>__________</td>
</tr>
</tbody>
</table>

**Section III:**

As conditions of participation in the South Carolina Rural Physician Incentive Grant Program, we, the Practice agree to:

A. Accept assignment for individuals who are beneficiaries under Medicare.
B. Enter into an appropriate agreement with the South Carolina Department of Health and Human Services for individuals who are beneficiaries under the Medicaid program.
C. Make every effort to provide health care services to individuals who are unable to pay for care by discounting fees taking into consideration the individual’s income and family size.
D. Report to the South Carolina Area Health Education Consortium (AHEC) on an annual basis, the numbers of patients seen by the Practice under categories A-C above.

Signatures below are assurance that this document contains true and correct information and that the Practice agrees to comply with all of the conditions of participation, A-D, listed above.

Name of Site Official: __________________________

Signature of Approving Official: __________________________

Title: __________________________  Date: ______________________