



Bureau of Primary Health Care (BPHC)



UNIFORM DATA SYSTEM
Calendar Year 2004

UDS Reporting Instructions for Section 330 Grantees

For help contact: 866-837-4357 (866-UDS-HELP) or udshelp330@bphcdata.net

BUREAU OF PRIMARY HEALTH CARE

BPHC UNIFORM DATA SYSTEM MANUAL

2004 REVISION

For use with Calendar Year 2004 UDS Data

BUREAU OF PRIMARY HEALTH CARE

4350 EAST WEST HIGHWAY ; BETHESDA, MARYLAND 20814

UNIFORM DATA SYSTEM - REVISED MANUAL 2004

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NOTE: TABLE 1, TABLE 9A AND TABLE 9B, WHICH WERE INCLUDED IN THE ORIGINAL UDS, HAVE BEEN DELETED.

PUBLIC BURDEN STATEMENT

Public reporting burden for this collection of information is estimated to average 24 hours per response for the Universal Report and 16 hours per response for the Grant Report, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to PHS Reports Clearance Officer; Paperwork Reduction Project (0915-0193); Room 737-F; Humphrey Building; 200 Independence Ave., SW; Washington, DC 20201. **OMB No. 0915-0193; Expiration 2/28/05**

INTRODUCTION

This ninth edition of the Bureau of Primary Health Care's User Manual: Uniform Data System (UDS) updates all instructions and modifications issued since the first UDS reporting year (1996). **This Manual supersedes all previous manuals, including instructions provided on the BPHC Web site prior to October 2004.**

The Manual includes a brief introduction to the Uniform Data System, a set of General Instructions for completing the UDS and detailed instructions for completing each table. The General Instructions include definitions which are used to insure consistent data are collected for many of the parameters. Where relevant, the table-specific instructions also include a set of "Questions and Answers", addressing frequently raised issues in completing the tables.

The UDS is an integrated reporting system used by all grantees of the following primary care programs administered by the Bureau of Primary Health Care (BPHC), Health Resources and Services Administration:

- **Community Health Center**, as defined in Section 330(e) of the Health Centers Consolidation Act;
- **Migrant Health Center**, as defined in Section 330(g) of the Health Centers Consolidation Act;
- **Health Care for the Homeless**, as defined in Section 330(h) of the Health Centers Consolidation Act;
- **Public Housing Primary Care**, as defined in Section 330(i) of the Health Centers Consolidation Act.

BPHC collects data on its programs to ensure compliance with legislative mandates and to report to Congress, OMB, and other policy makers on program accomplishments. To meet these objectives, BPHC requires a core set of information collected annually that is appropriate for monitoring and evaluating performance and for reporting on annual trends. The UDS is the vehicle used by BPHC to obtain this information.

The UDS includes two components:

- The **Universal Report** is completed by all grantees. This report provides data on services, staffing, and financing **across all four programs**. The Universal Report is the source of unduplicated data on BPHC programs.
- The **Grant Reports** are completed by a sub-set of grantees **who receive multiple BPHC grants**. These reports repeat four of the Universal Report tables to provide comparable data for that portion of their program that falls within the scope of a project **funded under a particular grant**. Separate grant reports are required for the Migrant Health Center, Homeless Health Care, Public Housing Primary Care and School Based Clinics grantees unless a grantee funded under one specific program receives no other BPHC funding.

Exhibit A outlines the contents of UDS reports, identifying tables included in the Universal Report and those included in Grant Reports. The Exhibit lists tables that have been deleted from the UDS since the system was initiated in 1996. No further reference to any of the deleted tables is made in this Manual.

The UDS report is always a calendar year report. Agencies whose funding begins, either in whole or in part, after the beginning of the year, or whose funding is terminated, again either in whole or in

part, before the end of the year, are nonetheless requested to report on the entire year to the best of their ability.

**EXHIBIT A: UDS
OVERVIEW OF UNIVERSAL AND GRANT REPORTS**

TABLE		UNIVERSAL REPORT	GRANT REPORTS
CENTER/GRANTEE PROFILE			
Cover Sheet	Grantee and Service Delivery Location Information	X	
Table 1:	NO LONGER REPORTED		
Table 2:	Services Offered	X	
USER PROFILE			
Table 3(A-B):	User Demographics	X	X
Table 4:	Socioeconomic Characteristics	X	X
STAFFING AND UTILIZATION			
Table 5:	Staffing and Utilization	X	< partial >
Table 6:	Selected Diagnoses and Services	X	X
Table 7:	Perinatal Profile	X	
FINANCIAL			
Table 8(A-B):	Costs	X	
Table 9(A-B):	NO LONGER REPORTED		
Table 9(C-E)	Managed Care and Revenue	X	

GENERAL INSTRUCTIONS

This section provides basic definitions and instructions for completing the UDS. These instructions should be used in conjunction with the instructions for completing specific tables, and are cross-referenced as appropriate.

SCOPE OF ACTIVITIES INCLUDED IN REPORTS

The **Universal Report** provides a comprehensive picture of all activities within the scope of BPHC-supported projects. In this report grantees should report on the total unduplicated number of users and activities **within the scope of projects supported by any of the four BPHC primary care programs covered by the UDS.**

For **Grant Reports**, grantees provide data on the users and activities within that part of their program which is **funded under a particular grant.** Because a user can receive services through more than one type of BPHC grant, and not all grants are reported separately, totals from the Grant Reports cannot be aggregated to generate totals in the Universal Report.

Grantees that receive only one BPHC grant are required to complete only the Universal Report. Agencies with multiple BPHC grants complete a Universal Report for the combined projects and a separate grant report for each Migrant, Homeless, School Based Clinics (formerly known as Healthy Schools Healthy Communities,) and/or Public Housing program grant. Examples include the following:

- A CHC grantee (Section 330e) that has a Health Care for the Homeless grant (Section 330h) completes a Universal Report and a Homeless Grant Report--but does not complete a Grant Report for the CHC grant.
- A CHC grantee (Section 330e) that also has Migrant Health (Section 330g) and Homeless (Section 330h) grants, completes a Universal Report, a Grant Report for the Homeless grant, and a grant report for the Migrant grant.
- A Homeless grantee (section 330h) that also has a School Based Clinic grant completes a Universal Report, a Grant Report for the Homeless grant and a Grant Report for the School Based Clinics grant.

NOTE: The reporting software will automatically identify the reports which must be filed and prompt the grantee if one is left out.

If the reporting grantee is a contractor to another organization that is the direct recipient of a BPHC grant, both entities report the users, utilization, costs and revenues associated with those users.

DEFINITION OF ENCOUNTERS

Encounter definitions are needed both to determine who is counted as a user (Tables 3A, 3B , 4 & 6) and to report total encounters by type of provider staff (Table 5). **Encounters are defined to include a documented, face-to-face contact between a user and a provider who exercises independent judgment in the provision of services to the individual. To be included as an encounter, services rendered must be documented.** Appendix A provides a list of health center personnel and the usual status of each as a provider or non-provider for purposes of UDS reporting. Encounters which are provided by contractors, **and paid for by the grantee**, such as Migrant Voucher encounters or out-patient or in-patient specialty care associated with an at-risk managed care contract, are considered to be encounters to the extent that they meet all other criteria.

Further explanation of the definitions and criteria for defining and reporting encounters are below.

1. To meet the criterion for "independent judgment", the provider must be acting on his/her own when serving the patient and not assisting another provider. For example, a nurse assisting a physician during a physical examination by taking vital signs, taking a history or drawing a blood sample **is not** credited with a separate encounter.
2. To meet the criterion for "documentation", the service (and associated patient information) must be recorded in written form. The patient record does not have to be a full and complete health record in order to meet this criterion. For example, if an individual receives services on an emergency basis and these services are documented, the documentation criterion is met even though a complete health record is not created. Mass screenings at health fairs or mass immunization drives for children or elderly do not result in encounters.
3. When a provider renders services to several patients simultaneously, the provider can be credited with an encounter for each person only if the provision of services is noted in **each** person's health record. Examples of "group encounters" include: family therapy or counseling sessions and group mental health counseling during which several people receive services and the services are noted in each person's health record. In such situations, **each** patient is normally billed for the service. Medical visits must be provided on an individual basis. Patient education or health education classes (e.g., smoking cessation) are not credited as encounters.
4. An encounter may take place in the health center or at any other location in which project-supported activities are carried out. Examples of other locations include mobile vans, hospitals, patients' homes, schools, homeless shelters, and extended care facilities. Encounters also include contacts with patients who are hospitalized, where health center medical staff member(s) follow the patient during the hospital stay, as physician of record or where they provide consultation to the physician of record. A provider may not generate more than one inpatient encounter per patient per day.
5. Such services as drawing blood, collecting urine specimens, performing laboratory tests, taking X-rays, and filling/dispensing prescriptions, **in and of themselves**, do not constitute encounters.
6. A patient may have more than one encounter with the health center per day. The number of encounters per service delivery location per day is limited as follows:

- One medical encounter (physician, nurse practitioner, physicians assistant, certified nurse midwife, or nurse);
 - One dental encounter (dentist or hygienist);
 - One "other health" encounter for each type of "other health" provider (nutritionist, podiatrist, speech therapist, acupuncturist, optometrist, etc.).
 - One enabling service (case management or health education) encounter;
 - One mental health encounter; and
 - One substance abuse encounter
7. A provider may be credited with no more than one encounter with a given patient during that patient's visit to the center in a single day, regardless of the type or number of services provided.
8. The encounter criteria **are not** met in the following circumstances:
- When a provider participates in a community meeting or group session that is **not** designed to provide clinical services. Examples of such activities include information sessions for prospective users, health presentations to community groups (high school classes, PTA, etc.), and information presentations about available health services at the center.
 - When the only health service provided is part of a large-scale effort, such as a mass immunization program, screening program, or community-wide service program (e.g., a health fair).
 - When a provider is primarily conducting outreach and/or group education sessions, not providing direct services.
 - When the **only** services provided are lab tests, x-rays, immunizations, Tb tests and/or prescription refills.

Further definitions of encounters for different provider types follow:

PHYSICIAN ENCOUNTER – An encounter between a physician and a user.

NURSE PRACTITIONER/PHYSICIANS ASSISTANT ENCOUNTER – An encounter between a Nurse Practitioner or Physicians Assistant and a user in which the practitioner acts as an independent provider.

CERTIFIED NURSE MIDWIFE ENCOUNTER – An encounter between a Certified Nurse Midwife and a user in which the practitioner acts as an independent provider.

NURSE ENCOUNTER (Medical) – An encounter between an R.N., L.V.N. or L.P.N. and a user in which the nurse acts as an independent provider of medical services exercising independent judgment, such as in a triage encounter. The service may be provided under standing orders of a physician, under specific instructions from a previous visit, or under the general supervision of a physician or Nurse Practitioner/Physicians Assistant/Certified Nurse Midwife (NP/PA/CNM) who has no direct contact with the patient during the visit. (Note that some states prohibit an LVN or an LPN to exercise independent judgment, in which case no encounters would be counted for them. Note also that, under no circumstances are services provided by Medical Assistants or other non-nursing personnel counted as nursing visits.)

DENTAL SERVICES ENCOUNTER – An encounter between a dentist or dental hygienist and a user for the purpose of prevention, assessment, or treatment of a dental problem, including restoration. NOTE: A dental hygienist is credited with an encounter only when (s)he provides a service independently, not jointly with a dentist. Two encounters may **not** be generated during a patient's visit to the dental clinic in one day, regardless of the number of clinicians who provide

services or the volume of service provided.

MENTAL HEALTH ENCOUNTER – An encounter between a licensed mental health provider (psychiatrist, psychologist, LCSW, and certain other Masters Prepared mental health providers licensed by specific states) and a user, during which mental health services (i.e., services of a psychological, psychosocial, or crisis intervention nature) are provided.

SUBSTANCE ABUSE ENCOUNTER – An encounter between a substance abuse provider (e.g., credentialed substance abuse counselor, rehabilitation therapist, psychologist) and a user during which alcohol or drug abuse services (i.e., assessment and diagnosis, treatment, aftercare) are provided.

OTHER PROFESSIONAL ENCOUNTER – An encounter between a provider, other than those listed above and a user during which health services are provided. Examples are provided in Appendix A.

CASE MANAGEMENT ENCOUNTER – An encounter between a case management provider and a user during which services are provided that assist patients in the management of their health and social needs, including patient needs assessments, the establishment of service plans, and the maintenance of referral, tracking, and follow-up systems.

EDUCATION ENCOUNTER – An encounter between an education provider and a user in which the services rendered are of an educational nature relating to health matters and appropriate use of health services (e.g., family planning, HIV, nutrition, parenting, and specific diseases). Classes are not counted as encounters.

DEFINITION OF A PROVIDER

A provider is the individual who assumes primary responsibility for assessing the patient and documenting services in the patient's record. Providers include only individuals who exercise independent judgment as to the services rendered to the patient during an encounter. The provider who exercises independent judgment is credited with the encounter, even when two or more providers are present and participate. If two or more providers of the same type divide up the services for a patient (e.g., a family practitioner and a pediatrician both seeing a child) only one may be credited with an encounter. Where health center staff are following a patient in the hospital, the primary responsible center staff person is the provider (and is credited with an encounter), even if other staff from the health center and/or hospital are present. (Appendix A provides a listing of personnel, indicating whether or not they are considered a provider who can generate encounters for purposes of UDS reporting.)

If contract providers who are part of the scope of the approved grant-funded program and are paid with grant funds or program income, serve center users and document their services in the center's records, they are considered providers. Also, contract providers paid with grant funds or program income who report encounters of users to the direct recipient of a BPHC grant (e.g., under a migrant voucher program or contractors with homeless grantees) are considered providers and their activities are to be reported by the direct recipient of the BPHC grant.

DEFINITION OF A USER

Users are individuals who have at least one encounter during the year, as defined above.

As described under "Scope of Activities Included in Reports," tables in the **Universal Report** include as users all individuals who have at least one encounter during the year within the scope of activities supported by **any** BPHC grant covered by the UDS. In the Universal Report, each user is counted once and only once, even if s/he received more than one type of service or services supported by more than one BPHC grant. For each **Grant Report**, users include individuals who have at least one encounter during the year within the scope of project activities supported by the specific BPHC grant.

Users never include individuals who only have encounters such as outreach, community education services, and other types of community-based services not documented on an individual basis. Also, persons who only receive services from large-scale efforts such as mass immunization programs, screening programs, and health fairs are not users. Persons whose only contact with the grantee is to receive WIC counseling and vouchers are not users and the contact does not generate an encounter. See "Definition of Encounters" for further discussion of contacts included as encounters.

WHO SUBMITS REPORTS AND REPORTING PERIODS

Reports should be submitted by the BPHC grantee. The **grantee** is the direct recipient of one or more BPHC grants. All grantees are expected to report for the entire calendar year, even if they were funded, in whole or in part, for less than the full year. The one exception to this rule is for grantees who are funded for the first time after October 1st of the year and who have had no other BPHC funds during the year. The following information is reported on all UDS Tables (and is completed automatically in electronic UDS software):

DATE OF SUBMISSION – The date the report is submitted.

REPORTING PERIOD – The time period covered by the report. All reports cover an entire calendar year. The reporting period is January 1st through December 31 of each reporting year.

UDS NUMBER – The identifying number assigned to the grantee by the BPHC.

DUE DATES AND REVISIONS TO REPORTS

Initial submissions of all UDS reports are due by **February 15th** of each calendar year. Submission is electronic, by disk or email, as instructed in the reporting software.

If revisions to your tables are needed after your data have been exported from the software, you will need to contact the toll free **UDS support line** at **(866) UDS-HELP (866-837-4357)**. If you have already been contacted by a UDS data editor, coordinate all data changes with that individual.

For revision of Prior Year UDS Reports, you will need to contact the toll free **UDS support line** at **(866) UDS-HELP (866-837-4357)** for instructions.

WHERE TO SUBMIT THE DATA

- Grantees will submit their data electronically. If a grantee has difficulty in submitting the data electronically, the grantee will need to contact the UDS support line: **(866) UDS-HELP**.
- Grantee will submit the data, electronically to: submit330uds@bphcdata.net

**BPHC UDS Data
P.O. Box 333
Concord, NH 03302-0333**

INSTRUCTIONS FOR CENTER/GRANTEE PROFILE COVER SHEET

The content of this table has not changed since the 2003 Reporting period.

The cover sheet provides basic identifying information about the grantee, its leadership and the address of its service delivery locations.

GRANTEE LEGAL NAME AND ADDRESS OF GRANTEE ADMINISTRATIVE OFFICES:

- Provide the legal name and address of the recipient of the BPHC grant. If administrative offices are located separately from the clinical service delivery locations, use the address of the administrative offices.
- Provide the 9-digit zip code. The zip code is separated into two cells. The first cell contains the first five digits and the second cell contains the last four digits.

CEO/EXECUTIVE DIRECTOR OR PROJECT DIRECTOR:

- Provide the name of the CEO, Executive Director, or Project Director of the grantee organization. Public health departments or other public entities should list the individual responsible for directing the BPHC-funded project.
- Provide the phone number and e-mail address of the CEO, Executive or Project Director.

CMO/CLINICAL DIRECTOR:

- Provide the name of the Clinical Director for the grantee organization. Organizations with both Medical and Dental Clinical Directors should list the Medical Director.
- Provide the phone number and e-mail address of the Clinical Director.

CHAIRPERSON OF THE GOVERNING BOARD, HEALTH OFFICER, OR OTHER ACCOUNTABLE INDIVIDUAL (E.G. CHAIR OF THE BOARD OF SUPERVISORS, PRESIDENT OF THE BOARD OF TRUSTEES, ETC.)

- Provide the name of the Chair of the grantee organization's Governing Board. State and local health departments receiving grants that do not include requirements for a Governing Board (e.g., Health Care for the Homeless grantees) should provide the name of the State Health Officer or Local Health Officer or other accountable individual, as appropriate.

GRANTEE CONTACT PERSON:

- Provide the name of the grantee staff person with primary responsibility for preparing the UDS report (do not list consultants, contractors or contracted employees). Two names may be listed if they prepare separate tables, but the first name listed should be the one for whom the phone number is provided.
- Provide the address with 9-digit zip code, phone/fax numbers, including area code, and e-mail address for the Grantee Contact Person.

SCHOOL HEALTH COORDINATOR:

- Provide the name of the grantee staff person with primary responsibility for any school-based health center activities managed by the grantee, regardless of whether or not BPHC funding supports the activities.

HOMELESS PROGRAM COORDINATOR:

- Provide the name of the grantee staff person with primary responsibility for any homeless program managed by the grantee, regardless of whether or not BPHC funding supports the activities.

PUBLIC HOUSING PROGRAM COORDINATOR:

- Provide the name of the grantee staff person with primary responsibility for any public housing program managed by the grantee, regardless of whether or not BPHC funding supports the activities.

MEDICAID PROVIDER BILLING NUMBER:

- If your agency has a single billing number, which you use for all Medicaid billing, enter it here. If you have multiple service delivery locations, which use separate Medicaid billing numbers, record these numbers on the following pages with the data for each individual service delivery location. If each provider uses their own number, report one number **only**, usually the Clinic Director's, or lead clinician's, for each service delivery location.

MEDICAID PHARMACY NUMBER:

- If your agency has a single billing number that you use for all Medicaid pharmacy billing, enter it here. If you do not have a separate identifier for pharmacy services, enter your Medicaid medical provider number. If there are individual service delivery location numbers, record them on the following pages with each individual service delivery location listing.

NUMBER OF SERVICE DELIVERY LOCATIONS.

- Report the total number of service delivery locations supported by BPHC grant(s). This should match the number of boxes used on the following pages.. Do not include administration-only locations.

NUMBER OF NHSC ASSIGNEES.

- Report the total number of National Health Service Corps Assignees working at your service delivery location(s) as of December 31st of the reporting period.

GRANTEE PARTICIPATION IN AN INTEGRATED SERVICES NETWORK:

- Report if the grantee participates in an integrated services network. Grantees will check one box only for participation in a horizontal network, a vertical network, or both. Grantees that do not participate in a network will check 'No ISN Participation'. An integrated services network is defined as a group of safety net providers collaborating through the redesign of practices to integrate services, optimize patient outcomes, and/or negotiate managed care contracts on behalf of the participating collaborators. Vertical integration is the collaboration of different providers, such as health centers, hospitals, and physician offices. Horizontal integration is collaboration occurring across the same type of provider, i.e. several health centers.
- Report if the network received Integrated Services Development Initiative (ISDI) funds from BPHC by checking the ISDI box whether or not the grantee is the direct recipient of the funds and regardless of whether the original grant may have expired.

FEDERAL TORT CLAIMS ACT (FTCA)

- Check the box indicating whether or not you were 'deemed' under the FTCA for any

portion of the reporting period.

DRUG PRICING PARTICIPATION

- Check the box indicating whether or not you participated in the 340(b) drug pricing program during the reporting period.
- Check the box if you participate in an alternate drug pricing program. (Alternative drug pricing programs are programs, often sponsored by health care consortiums, designed to lower the cost of pharmaceuticals to members by facilitating group purchasing activities.)

SERVICE DELIVERY LOCATIONS.

- A service delivery location is defined as a permanent unit providing services to a defined geographic service area or population.
 - Locations where individual patients may be visited by providers but where the grantee has not established a permanent unit (e.g., private homes, hospitals and nursing homes) are NOT service delivery locations.
 - Locations where the grantee has established a permanent unit are service delivery locations (e.g., a hospital OPD, homeless shelter or nursing home where the grantee has established and staffed a clinic).
 - Mobile vans providing health care services are service delivery locations; the service area is the area the van(s) cover.
 - Vans, homeless shelter, migrant camps, and other similar locations can be grouped if the area they cover is the same. Generally multiple shelters, camps and other locations visited by a mobile service delivery team should be grouped together unless services are delivered at the site *more than* 50 days a year.
 - A special population's service area may be a larger geographic area but focus on a specific population within that area.

Report the name and address of each service delivery location, **including the 9-digit zip code.** For each service delivery location, also:

1. Include your service delivery location alpha identifier, as assigned by BPHC. (If you do not have the alpha identifiers for your service delivery locations, *leave the fields blank. Do not make up your own alpha identifiers!*)
2. Indicate whether the service delivery location operates year-round or on a seasonal basis.
3. Indicate the location or type(s) of facility, using codes in the drop-down menu. These codes provide information on the type of facility in which the service delivery location is located, NOT the specific services offered at the service delivery location. Examples of coding are shown below.
 - A community-based primary care service delivery location not located in a health department or substance abuse treatment clinic/facility should be coded as "1".
 - A primary care service delivery location located in a health department should be coded "5" -- Health Department clinic.
 - A primary care service delivery location located in a substance abuse clinic should be coded "6".
 - A community-based homeless grantee service delivery location located in a mental health clinic operated by a local health

department should be coded "5" and "8".

4. Define the service area by listing the census tracts, whole or partial counties, or Minor Civil Divisions included in it.
5. Provide, if relevant, individual service delivery location Medicaid provider and pharmacy billing numbers.

QUESTIONS AND ANSWERS FOR CENTER/GRANTEE PROFILE COVERSHEET

1) Are there any changes to this table?

NO

UDS No. _____

Date Submitted: _____

Reporting Period: January 1, 2004 through December 31, 2004

Initial Submission

Revision

CENTER/GRANTEE PROFILE COVER SHEET (Part I)

GRANTEE LEGAL NAME			
Address of Grantee Administrative Offices	Street		
	City		
	State		
	9-Digit zip code (required)	-	
CEO/Executive Director or Project Director	Name		
	Phone	Extension	
	E-Mail		
Clinical Director	Name		
	Phone	Extension	
	E-Mail		
Chairperson, Governing Board, Health Officer, or other Accountable Individual (e.g. Chair of Board of Supervisors, President of the Board of Trustees, etc.)	Name		
Grantee Contact Person (Person completing report):	Name		
	Street		
	City		
	State	Zip -	
	Phone	Extension	
	Fax		
	E-mail		
School Health Coordinator	Name		
Homeless Program Coordinator	Name		
Public Housing Program Coordinator	Name		
Medicaid Provider Billing Number: (Organization Wide Only)			
Medicaid Pharmacy Number: (Organization Wide Only)			

UDS No. _____

Date Submitted: _____

Reporting Period: January 1, 2004 through December 31, 2004

Initial Submission

Revision

CENTER/GRANTEE PROFILE COVER SHEET (Part II)

# service delivery locations supported by BPHC Grant(s)	
Number of NHSC Assignees as of 12/31	
Grantee Participation in an Integrated Services Network	<p>CHECK ONE BOX:</p> <p><input type="checkbox"/> Horizontal Network <input type="checkbox"/> Vertical Network</p> <p><input type="checkbox"/> Both (Horizontal & Vertical Integration) <input type="checkbox"/> No ISN Participation</p> <hr/> <p>If participation in a network was indicated above, did the <u>network</u> receive ISDI funding from BPHC at any time in the past?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
Federal Tort Claims Act (FTCA) Deemed?	<input type="checkbox"/> Yes <input type="checkbox"/> No
340(b) Drug Pricing Participation?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Alternative drug discounting program?	<input type="checkbox"/> Yes <input type="checkbox"/> No

UDS No. _____

Date Submitted: _____

Reporting Period: January 1, 2004 through December 31, 2004

Initial Submission

Revision

CENTER/GRANTEE PROFILE COVER SHEET (Part III)

NOTE: Use Location Codes listed below to describe the type of facility in which the service delivery location is located. More than one location code may apply for a given service delivery location. Use Medicaid numbers for service delivery locations only if applicable. For location code 11, School-based health center, include name of school in service delivery location name.

service delivery location # 1:	service delivery location #2:
<p>Year Round Seasonal</p> <p>UDS # + alpha Name: Address:</p> <p style="text-align: center;">Zip(9) (required)</p> <p>Location Code(s): Service Area</p> <p>Medicaid Number: Medicaid Pharmacy Number:</p>	<p>Year Round Seasonal</p> <p>UDS # + alpha Name: Address:</p> <p style="text-align: center;">Zip(9) (required)</p> <p>Location Code(s): Service Area</p> <p>Medicaid Number: Medicaid Pharmacy Number:</p>
service delivery location #3	service delivery location #4
<p>Year Round Seasonal</p> <p>UDS # + alpha Name: Address:</p> <p style="text-align: center;">Zip(9) (required)</p> <p>Location Code(s): Service Area</p> <p>Medicaid Number: Medicaid Pharmacy Number:</p>	<p>Year Round Seasonal</p> <p>UDS # + alpha Name: Address:</p> <p style="text-align: center;">Zip(9) (required)</p> <p>Location Code(s): Service Area</p> <p>Medicaid Number: Medicaid Pharmacy Number:</p>

Location Codes for service delivery location Locations:

1. Community-based Primary Care Clinic
2. Hospital or worksite clinic
3. Fully equipped mobile health van
4. Community-based social service center
5. Health Department Clinic
6. Substance Abuse treatment clinic/facility

7. HIV/AIDS medical care clinic/facility
8. Mental Health Clinic
9. Public Housing
10. Migrant camp
11. School-Based Health Center
12. Homeless shelter
13. Soup Kitchen
14. Other-Specify

UDS No. _____

Date Submitted: _____

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CENTER/GRANTEE PROFILE COVER SHEET (Part IV)

service delivery location #		service delivery location #	
<p>Year Round Seasonal</p> <p>UDS # + alpha Name: Address:</p> <p style="text-align: center;">Zip(9) (required)</p> <p>Location Code(s): Service Area</p> <p>Medicaid Number: Medicaid Pharmacy Number:</p>	<p>Year Round Seasonal</p> <p>UDS # + alpha Name: Address:</p> <p style="text-align: center;">Zip(9) (required)</p> <p>Location Code(s): Service Area</p> <p>Medicaid Number: Medicaid Pharmacy Number:</p>		
service delivery location #		service delivery location #	
<p>Year Round Seasonal</p> <p>UDS # + alpha Name: Address:</p> <p style="text-align: center;">Zip(9) (required)</p> <p>Location Code(s): Service Area</p> <p>Medicaid Number: Medicaid Pharmacy Number:</p>	<p>Year Round Seasonal</p> <p>UDS # + alpha Name: Address:</p> <p style="text-align: center;">Zip(9) (required)</p> <p>Location Code(s): Service Area</p> <p>Medicaid Number: Medicaid Pharmacy Number:</p>		

Location Codes for service delivery

location Locations:

1. Community-based Primary Care Clinic
2. Hospital or worksite clinic
3. Fully equipped mobile health van
4. Community-based social service center
5. Health Department Clinic
6. Substance Abuse treatment clinic/facility

7. HIV/AIDS medical care clinic/facility
8. Mental Health Clinic
9. Public Housing
10. Migrant camp
11. School-Based Health Center
12. Homeless
13. Soup Kitchen
14. Other-Specify

INSTRUCTIONS FOR TABLE 2 – SERVICES OFFERED AND DELIVERY METHOD

The content of this table has changed slightly since the 2003 reporting period to include 1 new line. This table indicates the types of services provided by the grantee and reports whether these services are provided directly or through **formal** referral arrangements. Table 2 is only included in the Universal Report. Only services included within the scope of the federally-approved project(s) should be reported. This table is a compilation of the wide array of services provided through different BPHC grants. Individual grantees will rarely provide or refer for all of the services listed in this table. Also, since more than one delivery method may apply for a given service there may be notations in more than one of the columns.

1. **SERVICE TYPE.** This table lists medical, dental, behavioral, and enabling services that may be provided by BPHC grantees. Service definitions appear in Appendix B.
2. **DELIVERY METHOD.** Mark the delivery method(s) applicable to the particular service type. If the service is not offered, leave the row blank.
 - **PROVIDED BY GRANTEE** – Includes services rendered by salaried employees, contracted providers, National Health Service Corps Staff, volunteers and others such as out-stationed eligibility workers who render services in the grantee's name.
 - **BY REFERRAL – GRANTEE PAYS** - Includes services provided by another organization under a **formal** arrangement, only when the grantee pays for provision of the service, though the grantee may also bill the patient or a third party payor for the service. The arrangement may involve discounted payment (i.e., payment less than cost). These services are generally provided off site.
 - **BY REFERRAL – GRANTEE DOES NOT PAY** – Includes services that are provided by another organization or individual under a **formal** referral arrangement where the grantee DOES NOT pay for or bill for the service.

A formal referral arrangement means either a written agreement or the ability to document the service in the patient record.

QUESTIONS AND ANSWERS FOR TABLE 2

1. Are there any changes to this table?

Yes – a new line, 33a Comprehensive mental health / Substance abuse screening, has been added.

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**TABLE 2 –
SERVICES OFFERED AND DELIVERY METHOD (Part I of V)**

SERVICE TYPE NOTE: NOT ALL CENTERS WILL PROVIDE ALL SERVICES (See Appendix B for definitions)		DELIVERY METHOD Mark (X) if Applicable [More than one method may apply for a given service]		
		PROVIDED BY GRANTEE (a)	BY REFERRAL/ GRANTEE PAYS (b)	BY REFERRAL/ GRANTEE DOESN'T PAY (c)
PRIMARY MEDICAL CARE SERVICES				
1.	General Primary Medical Care (other than listed below)			
2.	Diagnostic Laboratory (technical component)			
3.	Diagnostic X-Ray Procedures (technical component)			
4.	Diagnostic Tests/Screenings (professional component)			
5.	Emergency medical services			
6.	Urgent medical care			
7.	24-hour coverage			
8.	Family Planning			
9.	HIV testing and counseling			
10.	Testing for Blood Lead Levels			
11.	Immunizations			
12.	Following hospitalized patients			
OBSTETRICAL AND GYNECOLOGICAL CARE				
13.	Gynecological Care			
14.	Prenatal care			
15.	Antepartum fetal assessment			
16.	Ultrasound			
17.	Genetic counseling and testing			
18.	Amniocentesis			
19.	Labor and delivery professional care			
20.	Postpartum care			

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**TABLE 2 –
SERVICES OFFERED AND DELIVERY METHOD (Part II of V)**

SERVICE TYPE NOTE: NOT ALL CENTERS WILL PROVIDE ALL SERVICES (See Appendix B for definitions)		DELIVERY METHOD Mark (X) if Applicable [More than one method may apply for a given service]		
		PROVIDED BY GRANTEE (a)	BY REFERRAL/ GRANTEE PAYS (b)	BY REFERRAL/ GRANTEE DOESN'T PAY (c)
SPECIALTY MEDICAL CARE				
21.	Directly observed TB therapy			
22.	Respite Care			
23.	Other Specialty Care			
DENTAL CARE SERVICES				
24.	Dental Care – Preventive			
25.	Dental Care – Restorative			
26.	Dental Care – Emergency			
27.	Dental Care – Rehabilitative			
MENTAL HEALTH/SUBSTANCE ABUSE SERVICES				
28.	Mental Health Treatment/Counseling			
29.	Developmental Screening			
30.	24-hour Crisis Intervention/Counseling			
31.	Other Mental Health Services			
32.	Substance Abuse Treatment/Counseling			
33.	Other Substance Abuse Services			
33a.	Comprehensive mental health / Substance abuse screening			
OTHER PROFESSIONAL SERVICES				
34.	Hearing Screening			
35.	Nutrition Services Other Than WIC			
36.	Occupational or Vocational Therapy			
37.	Physical Therapy			
38.	Pharmacy – Licensed Pharmacy staffed by Registered Pharmacist			
39.	Pharmacy – Provider Dispensing			

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**TABLE 2 –
SERVICES OFFERED AND DELIVERY METHOD (Part III of V)**

SERVICE TYPE NOTE: NOT ALL CENTERS WILL PROVIDE ALL SERVICES (See Appendix B for definitions)		DELIVERY METHOD Mark (X) if Applicable [More than one method may apply for a given service]		
		PROVIDED BY GRANTEE (a)	BY REFERRAL/ GRANTEE PAYS (b)	BY REFERRAL/ GRANTEE DOESN'T PAY (c)
40.	Vision Screening			
41.	Podiatry			
42.	Optometry			
ENABLING SERVICES				
43.	Case management			
44.	Child Care (during visit to center)			
45.	Discharge planning			
46.	Eligibility Assistance			
47.	Environmental Health Risk Reduction (via detection and/or alleviation)			
48.	Health Education			
49.	Interpretation/Translation services			
50.	Nursing home and assisted-living placement			
51.	Outreach			
52.	Transportation			
53.	Out Stationed Eligibility Workers			
54.	Home Visiting			
55.	Parenting Education			

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**TABLE 2 -
SERVICES OFFERED AND DELIVERY METHOD (Part IV of V)**

SERVICE TYPE NOTE: NOT ALL CENTERS WILL PROVIDE ALL SERVICES (See Appendix B for definitions)		DELIVERY METHOD Mark (X) if Applicable [More than one method may apply for a given service]		
		PROVIDED BY GRANTEE (a)	BY REFERRAL/ GRANTEE PAYS (b)	BY REFERRAL/ GRANTEE DOESN'T PAY (c)
56.	Special Education Program			
57.	Other (specify: _____)			
PREVENTIVE SERVICES RELATED TO TARGET CLINICAL AREAS				
I. Cancer				
58.	Pap smear			
59.	Fecal occult blood test			
60.	Sigmoidoscopy			
61.	Colonoscopy			
62.	Mammograms			
63.	Smoking cessation program			
II. Diabetes				
64.	Glycosylated hemoglobin measurement for people with diabetes			
65.	Urinary microalbumin measurement for people with diabetes			
66.	Foot exam for people with diabetes			
67.	Dilated eye exam for people with diabetes			
II. Cardiovascular Disease				
68.	Blood pressure monitoring			
69.	Weight reduction program			

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**TABLE 2 -
SERVICES OFFERED AND DELIVERY METHOD (Part V of V)**

SERVICE TYPE NOTE: NOT ALL CENTERS WILL PROVIDE ALL SERVICES (See Appendix B for definitions)		DELIVERY METHOD Mark (X) if Applicable [More than one method may apply for a given service]		
		PROVIDED BY GRANTEE (a)	BY REFERRAL/ GRANTEE PAYS (b)	BY REFERRAL/ GRANTEE DOESN'T PAY (c)
70.	Blood cholesterol screening			
IV. HIV/AIDS				
See line 9. HIV testing and counseling				
V. Infant Mortality				
71.	Follow-up testing and related health care services for abnormal newborn bloodspot screening			
See line 14. Prenatal Care				
VI. Immunizations				
See line 11. Immunizations				
OTHER SERVICES				
72.	WIC services			
73.	Head Start services			
74.	Food banks / Delivered meals			
75.	Employment / Educational Counseling			
76.	Assistance in obtaining housing			

INSTRUCTIONS FOR TABLES 3A and 3B – USERS BY AGE, GENDER, RACE/ETHNICITY and LINGUISTIC PREFERENCE

The content of Table 3B has had a minor change since the 2002 Reporting period. Table 3A is unchanged. Please see a guide to changes in the Questions and Answers Section below.

Tables 3A and 3B provide demographic data on users of the program and are included in **both** the Universal Report and the Grant Reports.

For the **Universal Report**, include as users all individuals receiving at least one face-to-face encounter for services within the scope of the four programs covered by UDS. Each user is to be counted only once, regardless of the number or types of services received.

The **Grant Reports** include only individuals who received at least one face-to-face encounter within the scope of the program in question. Users are to be reported only once in each report filed, however the if the same user is served in more than one program, they will be reported on the grant report for each program that served them.

An encounter is a face-to-face contact between a client and a provider who exercises independent judgment in the provision of services to the individual, and the services rendered must be documented to be counted as an encounter. See the General Instructions for additional detail on the definition of encounters.

TABLE 3A: USERS BY AGE AND GENDER

Report the number of total users by appropriate categories for age and gender. For reporting purposes, use the individual's age on June 30 of the reporting period.

TABLE 3B: USERS BY RACE/ETHNICITY AND LINGUISTIC PREFERENCE

RACE/ETHNICITY:

- This table requests the number of users in each racial/ethnic category. The total on Table 3B line 7 must equal the total on Table 3A, line 39 Columns A + B.

LINGUISTIC PREFERENCE:

- Table 3B requests the number of users who are best served in a language other than English or with sign language.
- Include those users who were served by a bilingual provider and those who may have brought their own interpreter.

NOTE: Data reported on line 8, Linguistic preference, **only** may be estimated if the health center does not maintain actual data in its MIS. Wherever possible, the estimate should be based on a sample.

QUESTIONS AND ANSWERS FOR TABLE 3A and 3B

1. **How do we report individuals who receive different types of services or use more than one of the grantee's service delivery locations? For example, a person who receives both medical and dental services or a woman who receives primary care from one clinic, but gets prenatal care at another.**

UDS Table 3A provides an unduplicated count of users. Grantees are required to report each user once and only once on this table, regardless of the type or number of services they receive or where they receive them. Each person who has received one or more encounter that is reported on Table 5 is to be counted once and only once on Table 3A. Encounters are defined in detail in the General Instructions. Note the following:

- Persons who only receive WIC services and no other services at the agency are not to be counted as users or reported on Table 3A.
- Persons who only receive lab services or whose only service was an immunization or screening test as part of a community wide health promotion/disease prevention effort are not to be counted as users or reported on Table 3A.

NOTE: The sum of Table 3A, Line 39, Column A + B must equal Table 4, Line 6 and Line 12, Column A + B. The sum of Table 3A, Lines 1-20, Column A + B must equal Table 4, Line 12, Column A.

2. **Are there changes to these tables for 2004?**

Yes. On Table 3B, grantees now report actual numbers of users by linguistic preference rather than percentages.

3. **Do we need to collect information on and report on the race and ethnicity of all of our patients?**

Yes. According to the Office of Management and Budget (OMB) this information must be collected for all users. Users may refuse to provide the information and there is a line for this now on table 3B.

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TABLE 3A – USERS BY AGE AND GENDER

AGE GROUPS		MALE USERS (a)	FEMALE USERS (b)
NUMBER OF USERS			
1	Under age 1		
2	Age 1		
3	Age 2		
4	Age 3		
5	Age 4		
6	Age 5		
7	Age 6		
8	Age 7		
9	Age 8		
10	Age 9		
11	Age 10		
12	Age 11		
13	Age 12		
14	Age 13		
15	Age 14		
16	Age 15		
17	Age 16		
18	Age 17		
19	Age 18		
20	Age 19		
21	Age 20		
22	Age 21		
23	Age 22		
24	Age 23		
25	Age 24		
26	Ages 25 – 29		
27	Ages 30 – 34		
28	Ages 35 – 39		
29	Ages 40 – 44		
30	Ages 45 – 49		
31	Ages 50 – 54		
32	Ages 55 – 59		
33	Ages 60 – 64		
34	Ages 65 – 69		
35	Ages 70 – 74		
36	Ages 75 – 79		
37	Ages 80 – 84		
38	Age 85 and over		
39	TOTAL USERS (SUM LINES 1-38)		

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**TABLE 3B –
USERS BY RACE/ETHNICITY/LANGUAGE**

RACE/ETHNICITY/LANGUAGE		NUMBER (a)
PROPORTION OF USERS		
1a.	Asian	
1b.	Native Hawaiian	
1c.	Other Pacific Islander	
1.	TOTAL ASIAN/PACIFIC ISLANDER (SUM LINES 1A + 1B + 1C)	
2.	Black/African American (not Hispanic or Latino)	
3.	American Indian/Alaska Native	
4.	White (not Hispanic or Latino)	
5.	Hispanic or Latino (all races)	
6.	Unreported / Refused to report	
7.	TOTAL USERS (SUM LINES 1 - 6)	
8.	Users best served in a language other than English	

- Asian, Native Hawaiian and Pacific Islander users should be reported separately in lines 1a, 1b and 1c. The total of Asian, Native Hawaiian and Pacific Islander users should equal the sum of lines 1a, 1b and 1c. This should be reported on line 1.

INSTRUCTIONS FOR TABLE 4 – SOCIOECONOMIC CHARACTERISTICS

INSTRUCTIONS FOR TABLE 4 SOCIOECONOMIC CHARACTERISTICS

Table 4 provides descriptive data on socioeconomic status of users. The table is included in **both** the Universal Report and the Grant Reports.

For the **Universal Report**, include as users all individuals receiving at least one face-to-face encounter for services within the scope of any of the programs covered by UDS. The **Grant Reports** include only individuals who received at least one face-to-face encounter that was within the scope of the program in question. **Users are to be reported only once in each report filed.**

INCOME AS PERCENT OF POVERTY LEVEL, LINES 1 - 6

Grantees are expected to collect income data on all users, but are not required to collect this information more frequently than once during the year. If income information is updated during the year, report the most current information available. Users for whom the information was not captured **must** be reported on line 5 as unknown.

Income is defined in ranges relative to the federal poverty guidelines (e.g., < 100% of the federal poverty level). In determining a user's income relative to the poverty level, grantees should use official poverty line guidelines defined and revised annually. The official Poverty Guidelines are published in the Federal Register in February/March of each year.

PRINCIPAL THIRD PARTY INSURANCE SOURCE, LINES 7 - 12

This portion of the table provides data on users by principal source of insurance for primary medical care services. Users are divided into two age groups (a) 0 - 19 and (b) age 20+.

DEFINITIONS OF INSURANCE LINES

MEDICAID – State-run programs operating under the guidelines of Title XIX of the Social Security Act. Medicaid includes programs called by state-specific names (e.g., California's Medi-Cal program). While Medicaid coverage is generally funded by Federal and State funds, some states also have "state-only" programs covering individuals ineligible for Federal matching funds (e.g., general assistance recipients).

NOTE: Individuals who are enrolled in Medicaid but who receive services through a private managed care plan that contracts with the state Medicaid agency should be reported as Medicaid, not privately insured.

MEDICARE – Federal insurance program for the aged, blind and disabled (Title XVIII of the Social Security Act).

PRIVATE INSURANCE – Health insurance provided by commercial and non-profit companies. Individuals may obtain insurance through employers or on their own.

OTHER PUBLIC INSURANCE – Federal, State and/or local government programs providing a broad set of benefits for eligible individuals. ***Do not include uninsured individuals whose visit may be covered by a public source with limited benefits such as the Early Prevention, Screening, Detection and Treatment (EPSDT) program or the Breast and Cervical Cancer Control Program, (BCCCP), etc.*** An example of an “other public insurance” program would be a State Based Children’s Health Insurance Program (S-CHIP) run outside of the Medicaid program.

CHIP – The Child Health Insurance Program (also known as S-CHIP) provides primary health care coverage for children and, on a state by state basis, others – especially parents of these children. CHIP coverage can be provided through the state’s Medicaid program and/or through contracts with private insurance plans. In some states it is difficult to distinguish between regular Medicaid and CHIP-Medicaid. In other states the distinction is readily apparent (e.g., they may have different cards). Where it is not obvious, CHIP may be identifiable from a “plan” code or some other embedded code in the membership number. This may also vary from county to county within a state. Obtain information from the state and/or county on their coding practice. If there is no way to distinguish between them, classify all covered users as “regular” Medicaid. In those states where CHIP is contracted through a private third party payor, participants are to be classified as “other public-CHIP” rather than as private on Table 4.

SPECIFIC INSTRUCTIONS FOR REPORTING USERS BY SOURCE OF INSURANCE

Grantees should report the user's **principal health insurance covering primary medical care**, if any, as of the last visit during the reporting period. **Principal** insurance is defined as the insurance plan/program that the grantee would **bill first** for services rendered.

NOTE: Users who have both Medicare and Medicaid, would be reported as Medicare users because Medicare is billed before Medicaid. The exception to the Medicare first rule is the Medicare-eligible person who is still working and insured by both an employer-based plan and Medicare. In this case, the principal health insurance is the employer-based plan, which is billed first.

Patients whose services are subsidized through State/local government “indigent care programs” are uninsured. Examples of state government “indigent care programs” include Massachusetts Free Care Pool, New Jersey Uncompensated Care Program, NY Public Goods Pool Funding, and Colorado Indigent Care Program.

For both Medicaid and Other Public Insurance, the table distinguishes between “regular” enrollees and enrollees in CHIP.

MEDICAID = Line 8b includes Medicaid-CHIP enrollees only; Line 8a includes all other enrollees; and Line 8 is the sum of 8a + 8b.

OTHER PUBLIC = Line 10b includes CHIP enrollees who are covered by a plan other than Medicaid only; Line 10a includes all other persons with other public insurance; and Line 10 is the sum of 10a + 10b.

SELECTED USER CHARACTERISTICS, PAGE 2 - LINES 13 - 23

MIGRANT OR SEASONAL AGRICULTURAL WORKERS AND THEIR DEPENDENTS, LINES 13 - 15

All grantees are required to report on Line 15 the combined total number of users during the reporting period who were either migrant or seasonal agricultural workers or their dependents. Only section 330(g) grantees are asked to provide separate totals for migrant and for seasonal agricultural workers on Lines 13 and 14. For Section 330(g) grantees, Lines 13 + 14 = 15

DEFINITIONS OF MIGRANT AND SEASONAL AGRICULTURAL WORKERS

MIGRANT AGRICULTURAL WORKERS – Defined by Section 330(g) of the Public Health Service Act, a migrant agricultural worker is an individual whose principal employment is in agriculture on a seasonal basis (as opposed to year-round employment) and who establishes a temporary home for the purposes of such employment. Migrant agricultural workers are usually hired laborers who are paid piecework, hourly or daily wages. The definition includes those individuals who have been so employed within the past 24 months and their dependent family members who have also used the center. The dependent family members may or may not move with the worker or establish a temporary home. Note that agricultural workers who *leave* a community to work elsewhere are equally eligible to be classified as migrant as are those who migrate *to* a community to work there.

SEASONAL AGRICULTURE WORKERS – Seasonal agricultural workers are individuals whose principal employment is in agriculture on a seasonal basis (as opposed to year-round employment) and who do not establish a temporary home for purposes of employment. Seasonal agricultural workers are usually hired laborers who are paid piecework, hourly, or daily wages. The definition includes those individuals who have been so employed within the past 24 months and their dependent family members who have also used the center.

For both categories of workers, agriculture is defined as farming of the land in all its branches, including cultivation, tillage, growing, harvesting, preparation, and on-site processing for market or storage. Aquaculture, lumbering, poultry processing, cattle ranching etc. are **not** included.

HOMELESS USERS, LINES 16 - 22

All grantees are to report the total number of users known to be homeless at some time during the reporting period on Line 22. Only section 330(h) Homeless Program grantees will provide separate totals for homeless program users by type of shelter arrangement. The shelter arrangement reported is their arrangement as of the first visit during the reporting period. "Street" includes living outdoors, in a car, in an encampment, in makeshift housing/shelter or in other places generally not deemed safe or fit for human occupancy. Persons who spent the prior night incarcerated or in a hospital should be reported based on where they intend to spend the night after their encounter. If they do not know,

code as "street". Section 330(h) Homeless Program grantees should report previously homeless persons now housed but still eligible for the program on Line 20.

DEFINITION OF A HOMELESS INDIVIDUAL

HOMELESS INDIVIDUALS – Defined as individuals who lack housing (without regard to whether the individual is a member of a family), including individuals whose primary residence during the night is a supervised public or private facility that provides temporary living accommodations, and individuals who reside in transitional housing.

SCHOOL-BASED HEALTH CENTER USERS, LINE 23

All grantees that identified a school-based health center as a service delivery location on the UDS Cover Sheet are to report the total number of users of primary health care services delivered at the school service delivery location(s).

A school-based health center is a health center located on or near school grounds, including pre-school, kindergarten, and primary through secondary schools that provides on-site comprehensive preventive and primary health services.

NOTE: The sum of Table 3A, Line 39, Column A + B (total users by age and gender) must equal Table 4, Line 6 (users by income) and Line 12, Column A + B (users by insurance status.) The sum of Table 3A, Lines 1-20, Column A + B must equal Table 4, Line 12, Column A.

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**TABLE 4 –
SOCIOECONOMIC CHARACTERISTICS**

CHARACTERISTIC		NUMBER OF USERS (a)	
INCOME AS PERCENT OF POVERTY LEVEL			
1.	100% and below		
2.	101 - 150%		
3.	151 - 200%		
4.	Over 200%		
5.	Unknown		
6.	TOTAL (SUM LINES 1 - 5)		
PRINCIPAL THIRD PARTY INSURANCE SOURCE		0-19 (a)	20 AND OLDER (b)
7.	NONE/ UNINSURED		
8a.	Regular Medicaid (Title XIX)		
8b.	CHIP Medicaid		
8.	TOTAL MEDICAID (LINE 8A + 8B)		
9.	MEDICARE (TITLE XVIII)		
10a.	Other Public Insurance Non-CHIP		
10b.	Other Public Insurance CHIP		
10.	TOTAL PUBLIC INSURANCE (LINE 10A + LINE 10B)		
11.	PRIVATE INSURANCE		
12.	TOTAL (SUM LINES 7 + 8 + 9 + 10 + 11)		

NOTE: Lines 8a and 8b distinguish between CHIP enrollees and all other Medicaid enrollees; Line 8 equals the sum of 8a and 8b. Lines 10a and 10b distinguish between CHIP enrollees covered through a non-Medicaid state plan and other enrollees in public insurance programs; Line 10 equals the sum of lines 10a and 10b.

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TABLE 4 – SOCIOECONOMIC CHARACTERISTICS

SELECTED USER CHARACTERISTICS		
CHARACTERISTIC		NUMBER OF USERS (a)
13.	Migrant (330g grantees only)	
14.	Seasonal (330g grantees only)	
15.	TOTAL MIGRANT/SEASONAL AGRICULTURAL WORKER OR DEPENDENT (ALL GRANTEES REPORT THIS LINE)	
16.	Homeless Shelter (330h grantees only)	
17.	Transitional (330h grantees only)	
18.	Doubling Up (330h grantees only)	
19.	Street (330h grantees only)	
20.	Other (330h grantees only)	
21.	Unknown (330h grantees only)	
22.	TOTAL HOMELESS (ALL GRANTEES REPORT THIS LINE)	
23.	TOTAL SCHOOL BASED HEALTH CENTER USERS (ALL GRANTEES REPORT THIS LINE)	

INSTRUCTIONS FOR TABLE 5 – STAFFING AND UTILIZATION

The content of this table has changed significantly since the 2002 Reporting period, please see a guide to changes in the Questions and Answers Section below. As of 2004, Grant Reports are required on Table 5 as well as the Universal Report

For the **Universal Report**, all staff, all encounters and all users are reported in Columns A, B and C. For the **Grant Reports, only Columns B and C are to be completed**. Every eligible encounter must be counted on the Universal Report. Grant Reports report on encounters and users supported by funds which are within the scope of one of the non-CHC grants. This could include both BPHC and non-BPHC funds.

As a rule, all encounters for persons reported on Homeless Table 4 will be reported on Homeless Table 5; encounters for persons reported on Migrant Table 4 will be reported on Migrant Table 5, encounters for persons reported on School Based Clinics Table 4 will be reported on School Based Clinics Table 5, and encounters for persons reported on Public Housing Table 4 will be reported on Public Housing Table 5.

This table provides a profile of grantee staff, the number of encounters they render and the number of users served. Unlike Tables 3 and 4, where an unduplicated count of users is reported, Table 5 is designed to produce an unduplicated user figure within each of six major personnel categories: medical, dental, mental health, substance abuse, other professional services, and enabling. The staffing information in Table 5 is designed to be compatible with approaches used to describe staff for financial/cost reporting, while ensuring adequate detail on staff categories for program planning and evaluation purposes.

INSTRUCTIONS FOR COMPLETING TABLE 5- COLUMN A - FTES

This table includes information on all individuals who work in programs and activities that are within the scope of the project for the four types of projects included in the UDS. **All staff are to be reported in terms of Full-Time Equivalents (FTEs)**. A person who works 20 hours per week (i.e., 50% time) is reported as "0.5 FTE." This example is based on a 40 hour work week. Positions with less than a 40 hour base, especially clinicians, should be calculated on whatever they have as a base for that position. Similarly, an employee who works four months out of the year would be reported as "0.33 FTE".

Staff may provide services on behalf of the grantee on a regularly scheduled basis under many different arrangements including, but not limited to: salaried full-time, salaried part-time, hourly wages, National Health Service Corps assignment, under contract, under capitation, block time, or donated time. Individuals who are paid by the grantee on a fee-for-service basis only are not counted as FTEs since there is no basis for determining their hours. The FTE column is only completed on the Universal Report. Staff are not separated according to the different BPHC funding streams.

All staff time is to be allocated by function among the major service categories listed. For example, a full-time nurse who works solely in provision of direct medical services would be counted as 1.0 FTE on Line 11 (Nurses). If that nurse provided case management services for 10 hours per week, and provided medical care services for the other 30 hours per week, time would be allocated 0.25 FTE case manager (Line 24) and 0.75 FTE nurse (Line 11).

Time for clinicians should be allocated to the appropriate clinical personnel category **except** when such personnel perform corporate administrative duties not directly connected with provision of clinical services. The time spent by clinicians for charting, reviewing lab test results, writing prescriptions, returning phone calls, arranging for referrals, etc. is **not** considered administrative and should be reported as "medical care services." However, time for a physician/medical director **should** be allocated between medical care services and administration.

An individual who is hired as a full-time clinician must be counted as 1.0 FTE regardless of the number of "direct patient care" or "face-to-face hours" they provide. Providers who have released time to compensate for on-call hours or who receive leave for continuing education or other reasons are still considered full-time if this is how they were hired. The time spent by providers doing administrative work such as charting, reviewing labs, filling prescriptions, returning phone calls, arranging for referrals, etc. is not to be adjusted. The one exception to this rule is when a Medical Director is engaged in corporate administrative activities, in which case time can be allocated to administration. This does not, however, include clinical administrative activities including chairing or attending clinical meetings, supervising staff, etc.

PERSONNEL BY MAJOR SERVICE CATEGORY – Staff are distributed into categories that reflect the types of services they provide. Major service categories include: medical care services, dental services, mental health services, substance abuse services, other professional health services, pharmacy services, enabling services, other program related services staff, and administration and facility. Whenever possible, the contents of major service categories have been defined to be consistent with definitions used by Medicare. The following summarizes the personnel categories; a detailed list appears in Appendix A.

- **MEDICAL CARE SERVICES**

- **Physicians** - M.D.s and D.O.s, except psychiatrists, pathologists and radiologists
- **Nurse Practitioners**
- **Physician Assistants**
- **Certified Nurse Midwives**
- **Nurses** - registered nurses, licensed practical and vocational nurses, home health and visiting nurses, clinical nurse specialists, and public health nurses
- **Laboratory Personnel** - pathologists, medical technologists, laboratory technicians and assistants, phlebotomists
- **X-ray Personnel** - radiologists, X-ray technologists, and X-ray technicians
- **Other Medical Personnel** - medical assistants, nurses aides, and all other personnel providing services in conjunction with services provided by a physician, nurse practitioner, physician assistant, certified nurse midwife, or nurse

- **DENTAL SERVICES**
 - **Dentists** - general practitioners, oral surgeons, periodontists, and pedodontists
 - **Dental Hygienists**
 - **Other Dental Personnel** - dental assistants, aides, and technicians

- **MENTAL HEALTH SERVICES**
 - Psychiatrists,
 - Other licensed clinicians, including psychiatric nurses, psychiatric social workers, clinical psychologists, clinical social workers, and family therapists
 - Other individuals providing counseling, treatment or support services related to mental health professionals.

- **SUBSTANCE ABUSE SERVICES** - Psychiatric nurses, psychiatric social workers, mental health nurses, clinical psychologists, clinical social workers, and family therapists and other individuals providing counseling and/or treatment services related to substance abuse.

- **ALL OTHER PROFESSIONAL HEALTH SERVICES** - Occupational and physical therapists, podiatrists, optometrists and other staff professionals providing health services. Note: WIC nutritionists and others working in WIC programs are now reported on Line 29a, Other Program Related Staff. (A more complete list is included in Appendix A.)

- **PHARMACY SERVICES** - Pharmacists , pharmacist assistants and others supporting pharmaceutical services including individuals assisting in applying for free drugs from pharmaceutical companies.

- **ENABLING SERVICES**
 - **Case Managers** - staff who provide services to aid patients in the management of their health and social needs, including assessment of patient medical and/or social services needs, and maintenance of referral, tracking and follow-up systems. Case managers may provide eligibility assistance, if performed in the context of other case management functions. Staff may include nurses, social workers and other professional staff.
 - **Education Specialists** - health educators, family planning, HIV specialists, and others who provide information about health conditions and guidance about appropriate use of health services that are not otherwise classified under outreach.
 - **Outreach Workers** - individuals conducting case finding, education or other services to identify potential clients and/or facilitate access/referral of clients to available services.
 - **Personnel Performing Other Enabling Service Activities** - all other staff performing services listed in Appendix B as enabling services, such as child care, eligibility assistance, referral for housing assistance, interpretation and translation.

- **OTHER PROGRAM RELATED SERVICES STAFF**

Some grantees, especially “umbrella agencies,” operate programs which, while within their scope of service, are not directly a part of their medical or social health services. These include WIC programs, job training programs, head start or early head start programs, shelters, housing programs, etc. The staff for these programs are reported under Other Related Services. The cost of these programs are reported on Table 8A on line 12.

- **ADMINISTRATION AND FACILITY**

- **Administration** - executive director, medical director, physicians or nurses with corporate (not clinical) administrative responsibilities, secretaries, fiscal and billing personnel, all other support staff and staff with administrative responsibilities.
- **Facility** - staff with facility support and maintenance responsibilities, including custodians, housekeeping staff, and other maintenance staff.
- **Patient Services Support Staff** - intake staff and medical/patient records.

NOTE: The Administration and Facility category for this report is more comprehensive than that used in some other program definitions and includes **all** personnel working in a BPHC-supported program, whether or not that individual's salary was supported by the BPHC grant.

Note also: Tables 8A and 8B have data relating to cost centers. Staff classifications should be consistent with classifications on other tables. The staffing on Table 5 is routinely compared to the costs on Table 8A and 8B during the editing process. If there is a reason why such a comparison would look strange (e.g., volunteers on Table 5 resulting in no cost on Table 8A) be sure to include an explanatory note on Table 8A .

INSTRUCTIONS FOR COMPLETING TABLE 5 COLUMN B (ENCOUNTERS) AND COLUMN C (USERS)

ENCOUNTERS – An encounter is a documented, face-to-face contact between a user and a provider who exercises independent professional judgment in the provision of services to the individual. (See General Instructions for further detail on the definition of encounters). Grantees are to report encounters rendered by identified staff during the reporting period. **No** encounters are reported for personnel who are not “providers who exercise independent professional judgment” within the meaning of the definition above; in Column B, the cells applicable to these staff are blocked out.

Encounters that are purchased from non-staff providers on a fee-for-service basis are also counted in this column, even though no corresponding FTE are included in Column A. To be counted, the service must meet the following criteria:

- 1) the service was provided to a patient of the Grantee by a provider that is not part of the grantee's staff (neither salaried nor contracted on the basis of time worked),
- 2) the service was paid for by the grantee, and
- 3) the service otherwise meets the above definition of an encounter.

This category **does not include unpaid referrals** or referrals for services that would otherwise not be counted as encounters.

USERS – A user is an individual who has at least one encounter during the year. Report the number of users for **each** of the six separate services listed below. **Within each category, an individual can only be counted once as a user. A person who receives multiple types of services should be counted once for each service.** For example, a person receiving only medical services is reported once (as a medical user) regardless of the number of encounters made.

A person receiving medical, dental and enabling services is reported once as a medical user (Line 15), once as a dental user (Line 19) and once as an enabling user (Line 29), but is counted only once each time in column C, regardless of the number of visits reported in column B. An individual patient may be counted once (and **only** once) in each of the following categories:

- Medical care services users (Line 15)
- Dental services users (Line 19)
- Mental health services users (Line 20)
- Substance abuse services users (Line 21)
- Users of other professional services (Line 22)
- Enabling services users (Line 29)

Though it would be relatively uncommon, an individual whose only contact with the clinic was through a paid referral (e.g., a patient who was referred in December and seen in January of the next year) would also be counted as a user here as well as on Tables 3A, 3B, and 4.

If you show encounters in Column B for any of these six categories, you are required to show the unduplicated number of persons who received these encounters. Since users must have at least one documented encounter, it is not possible for the number of users to exceed the number of encounters.

QUESTIONS AND ANSWERS FOR TABLE 5

1. **Are there changes to this table?**

Several changes to the table have been made:

- 1) Line 9, which previously reported "Nurse Practitioners / Physician Assistants" has been replaced by line 9a "Nurse Practitioners" and line 9b "Physician Assistants."
- 2) Line 6, Psychiatrists, has been eliminated. Psychiatrists will now be reported as Mental Health providers as they were in past years.
- 3) Line 20, "Mental Health Services", is now a total line, and we have added three new lines: Line 20a Psychiatrists, Line 20b Other Licensed Mental Health Providers, and Line 20c: Other Mental Health staff, including all non-licensed and support staff. Line 20 is the sum of Lines 20a + 20b + 20c.
- 4) Table 5 is now reported for grants as well as for the universal report, though staff FTE are not reported separately for the grant reports.

2. **How do I count participants in a group session?**

If you have group treatment sessions (e.g., for substance abuse or mental health) you must record the encounter in each participant's chart and then record an encounter for each participant. If an encounter is not recorded in a participant's chart, that participant may not be counted as a user. No group medical encounters are counted on the UDS. Though in some instances they may be billable as counseling services, the UDS specifically does not count as encounters activities in such sessions.

3. **How do I report the FTEs for a clinician who regularly sees patients 75 percent of the time and covers after-hours call the remaining 25 percent of his/her time?**

An individual who is hired as a full-time clinician must be counted as 1.0 FTE regardless of the number of "direct patient care" or "face-to-face hours" they provide. Providers who have released time to compensate for on-call hours or hours spent on clinical committees, or who receive leave for continuing education or other reasons are still considered full-time if this is how they were hired. The time spent by providers doing administrative work such as charting, reviewing labs, filling prescriptions, returning phone calls, arranging for referrals, etc. is not to be adjusted for. The one exception to this rule is when a Medical Director is engaged in corporate administrative activities, in which case time can be allocated to administration. This does not, however, include clinical administrative activities including chairing or attending meetings, supervising staff, supervising. Note that UGS, the FOHC Medicare intermediary, has different definitions for full time providers. These UGS definitions are **not** to be used in reporting on the UDS,

4. **Is it appropriate for the total number of users reported on Table 3A to be equal to the sum of the several types of users on Table 5?**

Not usually. On Table 5, the grantee reports **users of each type of service, with the user counted once for each type of service received**. Thus a person who receives both medical and dental services would be counted once as a medical user on Line 15 and once as a dental user on Line 19. Because there are six different types of users identified on Table 5, a patient who is counted only once on Table 3A may be counted up to six different places on Table 5.

On the other hand, grantees which provide only medical services will report the same number of total users on Table 3A as they do medical users on Table 5 (Line 15). But where

an agency has more than one type of user (e.g., medical and dental or medical and enabling) these numbers are not the same.

5. **If I report case management services on Table 2 or costs for them on Tables 8A and 8B, do I have to report case managers on Table 5?**

Yes. There should be a logical consistency between Table 5 and Tables 2 and 8A and 8B. If a grantee reports that case management services are provided by the grantee (i.e., Table 2, Column A is marked), one would expect to see case managers reported on Table 5. For example, if nurses also have case management duties, their time (FTEs) should be split.

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TABLE 5 – STAFFING AND UTILIZATION

Personnel by Major Service Category		FTEs (a)	Clinic Encounters (b)	Users (c)
1	Family Practitioners			
2	General Practitioners			
3	Internists			
4	Obstetrician/Gynecologists			
5	Pediatricians			
7	Other Specialty Physicians			
8	Total Physicians (Total lines 1 through 7)			
9a	Nurse Practitioners			
9b	Physician Assistants			
10	Certified Nurse Midwives			
11	Nurses			
12	Other Medical personnel			
13	Laboratory personnel			
14	X-ray personnel			
15	Total Medical Care Services (Total Lines 8 through 14)			
16	Dentists			
17	Dental Hygienists			
18	Dental Assistants, Aides, Techs			
19	Total Dental Services (Lines 16 through 18)			

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TABLE 5 – STAFFING AND UTILIZATION

Personnel by Major Service Category		FTEs (a)	Clinic Encounters (b)	Users (c)
20a	Psychiatrists			
20b	Other Licensed Mental Health Providers			
20c	Other Mental Health Staff			
20	Mental Health Services (Lines 20a + 20b + 20c)			
21	Substance Abuse Services			
22	Other Professional Services			
23	Pharmacy Personnel			
24	Case Managers			
25	Education Specialists			
26	Outreach Workers			
27	Transportation Staff			
28	Other Enabling Services			
29	Total Enabling Services (Lines 24 through 28)			
29a	Other Programs and Services (see instructions)			
30	Administrative Staff			
31	Facility Staff			
32	Patient Support Staff			
33	Total Administration and Facility (Lines 30 through 32)			
34	Total (Lines 15 + 19 + 20 + 21 + 22 + 23 + 29 + 29a + 33)			

INSTRUCTIONS FOR TABLE 6 – SELECTED DIAGNOSES AND SERVICES RENDERED

The content of this table has changed significantly since the 2002 Reporting period, please see a guide to changes in the Questions and Answers Section below.

This table reports data on selected diagnoses and services rendered. It is designed to provide information on diagnoses and services of greatest interest using data maintained for billing purposes. As a subset of diagnoses, Table 6 is not expected to reflect the full range of diagnoses and services rendered by a grantee. The selected conditions and services represent those that are prevalent among BPHC users or a sub-group of users or are generally regarded as sentinel indicators of access to primary care.

The table is included in **both** the Universal Report and Grant Reports.

- The **Universal Report** reports on encounters in the indicated diagnostic or service categories and a count of all individuals who had at least one encounter in the indicated diagnostic or service category within the scope of any and all BPHC - supported projects included in the UDS.
- The **Grant Report** reports only those encounters and those individuals which were provided or served within the scope of the program in question.

SELECTED DIAGNOSES – Lines 1 through 20 present the name and applicable ICD-9CM codes for the diagnosis or diagnostic range/group. Wherever possible, diagnoses have been grouped into code ranges. Where a range of ICD-9CM codes is shown, grantees should report on all of the diagnoses included in the range/group.

SELECTED TESTS/SCREENINGS/PREVENTIVE SERVICES – Lines 21 through 26 present the name and applicable ICD-9CM and/or CPT procedure codes for selected tests, screenings, and preventive services which are particularly important to the populations served. On several lines both CPT codes and IC9 codes are provided. Grantees should use either the CPT codes or the ICD9 codes for any given line, not both!

INSTRUCTIONS FOR REPORTING ENCOUNTERS - COLUMN (A).

LINES 1 – 20: Diagnostic Data.

ENCOUNTERS BY SELECTED DIAGNOSES (Lines 1-20): Report the total number of encounters during the reporting period where the indicated diagnosis is listed on the encounter/billing records as the **primary** diagnosis **only**. If an encounter is attributed to one of the many diagnoses not listed on Table 6, it is not reported. Note that, while most encounters are not reported on this table, those which *are* counted, are reported for only the primary diagnosis on lines 1 through 20. All visits are entered into the computer in order, with one diagnosis listed as primary and successive diagnoses listed as secondary, tertiary, etc.

LINES 21 – 34: Service Data.

ENCOUNTERS BY SELECTED TESTS/SCREENINGS/PREVENTIVE AND DENTAL SERVICES (Lines 21-34) – Report the total number of encounters for the listed diagnostic tests/screenings/preventive services. Note that codes for these services may either be diagnostic (ICD-9) codes or procedure (ADA or CPT-4) codes. During one encounter there may be more than one test/screening or preventive service.

- One encounter may involve more than one of the indicated services and all should be reported. For example, if during an encounter both a PAP smear and an HIV test were conducted then an encounter would be reported on both lines 21 and 23.
- If a client receives multiple immunizations at one visit, only one encounter should be reported.
- Services may be reported *in addition to* diagnoses. A hypertensive patient who also receives an HIV test would be counted once on the hypertension line 11 and once on line 21, HIV test.
- If a patient had more than one tooth filled, only one encounter for restorative services should be reported.

INSTRUCTIONS FOR REPORTING USERS - COLUMN (B)

LINES 1 – 20: Diagnostic Data.

USERS BY DIAGNOSIS – For Column B report each individual who had one or more encounter during the year where the primary diagnosis was the indicated diagnosis (e.g., a user with one or more encounters for hypertension (Line 11, Column A). A user is counted once and only once regardless of the number of encounters made for that specific diagnosis. Any one user may have encounters with different primary diagnoses, for example, one for hypertension and one for diabetes on different days. In this case, the user would be reported once for each diagnosis used during the year.

LINES 21 – 26: Services Data.

USERS BY SELECTED DIAGNOSTIC TESTS/SCREENINGS/PREVENTIVE SERVICES -- Report users who have had at least one encounter during the reporting period for the selected diagnostic tests, screenings, and/or preventive services listed on Lines 21-26. If a user had a PAP smear and contraceptive management during the same encounter, this user would be counted on both Lines 23 and 25 in Column B.

LINES 27 – 34: Dental Services Data.

USERS BY SELECTED DENTAL SERVICES -- Report users who have had at least one encounter during the reporting period for the selected dental services listed on Lines 27-34. If a user had two teeth repaired and sealants applied during one encounter, this user would be counted once (only) on both Lines 30 and 32 in Column B.

QUESTIONS AND ANSWERS FOR TABLE 6

1. Are there any changes to the table this year?

Several critical changes have been made to the table:

- Some of the CPT codes and ICD9 codes have been updated. Be sure to check with your software vendor to ensure that the appropriate codes are included.
- There are several new categories for mental health codes,
- Service categories have been added for dental services.
- Some of the immunizations on the list have been changed adding, for example, the inactivated polio vaccine and the DTaP (diphtheria, tetanus and acellular pertusis) vaccine.

2. Some diagnostic and/or procedure codes in my system are different from the codes listed. What do I do?

It is possible that several items on Table 6 are not available in the requested form because of idiosyncrasies in state or clinic billing systems. Generally, these involve situations where (a) the state uses unique billing codes, other than the normal CPT code, for state billing purposes (e.g., EPSDT) or (b) internal or state confidentiality rules mask certain diagnostic data. The following provides examples of problems and solutions.

LINE #	PROBLEM	POTENTIAL SOLUTION
1 and 2	HIV diagnoses are kept confidential and alternative diagnostic codes are used.	Include the alternative codes used at your center on these lines as well.
26	Well child visits are charged to the state EPSDT program using a special code (often starting with W, X, Y or Z).	Add these special codes to the other codes listed and count all such visits as well. Do not count EPSDT follow-up visits in this category.

3. The instructions specifically say that the source of information for Table 6 is “billing systems.” There are some services for which I do not pay and there are no encounters in my system. What do I do?

While grantees are only required to report data derived from billing systems, the reported data will understate services in the circumstances described. In order to more accurately reflect your level of service, grantees are encouraged to use other sources of information (e.g., referral or tracking logs), although there is no requirement to do so. The following provides examples of these sources.

LINE	PROBLEM	POTENTIAL SOLUTION
21	HIV Tests are processed and paid for by the State and do not show on the encounter form or in the billing system.	Use other data sources such as logs of HIV tests conducted or reports to Ryan White programs and use this number of tests.
22	Mammograms are paid for, but are conducted by a contractor and do not show in the billing system for individual patients.	Use the bills from the independent contractor to identify the total number of mammograms conducted during the course of the year and report this number.
23	Pap smears are processed and paid for by the State and do not show on the encounter form or in the billing system.	Use other data sources such as logs of PAP tests conducted and use this number of tests.
24	Flu shots are not counted because they are obtained at no cost by the center.	Use the Medicare cost report data on influenza vaccination reimbursements as an estimate for the number of actual encounters where flu shots were administered.
25	Contraceptive management is funded under Title X or a state family planning	Use records developed for the Title X or state family planning program to count the number of family planning visits. Take

	program and does not have a V-25 diagnosis attached to it.	care not to count the same visit twice.
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**TABLE 6 –
SELECTED DIAGNOSES AND SERVICES RENDERED**

DIAGNOSTIC CATEGORY		APPLICABLE ICD-9-CM CODE	NUMBER OF ENCOUNTERS BY PRIMARY DIAGNOSIS (A)	NUMBER OF USERS WITH PRIMARY DIAGNOSIS (B)
SELECTED INFECTIOUS AND PARASITIC DISEASES				
1.	Symptomatic HIV	042.xx		
2.	Asymptomatic HIV	V08		
3.	Tuberculosis	010.xx – 018.xx		
4.	Syphilis and other venereal diseases	090.xx – 099.xx		
SELECTED DISEASES OF THE RESPIRATORY SYSTEM				
5.	Asthma	493.xx		
6.	Chronic bronchitis and emphysema	490.xx – 492.xx 496.xx		
SELECTED OTHER MEDICAL CONDITIONS				
7.	Abnormal breast findings, female	174.xx; 198.81; 233.0x; 793.8x		
8.	Abnormal cervical findings	180.xx; 198.82; 233.1x; 795.0x		
9.	Diabetes mellitus	250.xx; 775.1x; 790.2		
10.	Heart disease (selected)	391.xx – 392.0x 410.xx – 429.xx		
11.	Hypertension	401.xx – 405.xx;		
12.	Contact dermatitis and other eczema	692.xx		
13.	Dehydration	276.5x		
14.	Exposure to heat or cold	991.xx – 992.xx		

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TABLE 6 – SELECTED DIAGNOSES AND SERVICES RENDERED

DIAGNOSTIC CATEGORY		APPLICABLE ICD-9-CM CODE	NUMBER OF ENCOUNTERS BY PRIMARY DIAGNOSIS (A)	NUMBER OF USERS WITH ANY DIAGNOSIS (B)
SELECTED CHILDHOOD CONDITIONS				
15.	Otitis media and eustachian tube disorders	381.xx – 382.xx		
16.	Selected perinatal medical conditions	770.xx; 771.xx; 773.xx; 774.xx – 779.xx (excluding 779.3x)		
17.	Lack of expected normal physiological development (such as delayed milestone; failure to gain weight; failure to thrive)--does not include sexual or mental development; Nutritional deficiencies	260.xx – 269.xx; 779.3x; 783.3x – 783.4x;		
SELECTED MENTAL HEALTH AND SUBSTANCE ABUSE CONDITIONS				
18.	Alcohol related disorders	291.xx, 303.xx; 305.0x 357.5x		
19.	Other substance related disorders (excluding tobacco use disorders)	292.1x – 292.8x 304.xx, 305.2x – 305.9x 357.6x, 648.3x		
20a.	Depression and other mood disorders	296.xx, 300.4 301.13, 311.xx		
20b.	Anxiety disorders including PTSD	300.0x, 300.21, 300.22, 300.23, 300.29, 300.3, 308.3, 309.81		
20c.	Attention deficit and disruptive behavior disorders	312.8x, 312.9x, 313.81, 314.xx		
20d.	Other mental disorders, excluding drug or alcohol dependence (includes mental retardation)	290.xx 293.xx – 302.xx (excluding 296.xx, 300.0x, 300.21, 300.22, 300.23, 300.29, 300.3, 300.4, 301.13); 306.xx - 319.xx (excluding 308.3, 309.81, 311.xx, 312.8x, 312.9x,313.81,314.xx)		

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TABLE 6 – SELECTED DIAGNOSES AND SERVICES RENDERED

SERVICE CATEGORY		APPLICABLE ICD-9-CM OR CPT-4 CODE(S)	NUMBER OF ENCOUNTERS (A)	NUMBER OF USERS (B)
SELECTED DIAGNOSTIC TESTS/SCREENING/PREVENTIVE SERVICES				
21.	HIV test	CPT-4: 86689; 86701-86703; 87390-87391		
22.	Mammogram	CPT-4: 76090-76092 ICD-9: V76.1x		
23.	Pap Smear	CPT-4: 88141-88155; 88164-88167 ICD-9: V72.3; V76.2		
24.	Selected Immunizations:	CPT-4: 90633-90634, 90645 – 90648; 90657 – 90660; 90669; 90700 – 90702; 90704 – 90716; 90718; 90720 – 90723, 90743 – 90744; 90748		
25.	Contraceptive management	ICD-9: V25.xx		
26.	Health supervision of infant or child (ages 0 through 11)	CPT-4: 99391-99393; 99381-99383; 99431-99433 ICD-9: V20.xx; V29.xx		
SELECTED DENTAL SERVICES				
27.	I. Emergency Services	ADA: 09110		
28.	II. Oral Exams	ADA: 00120		
29.	Prophylaxis – adult or child	ADA: 01110, 01120		
30.	Sealants	ADA: 01351		
31.	Fluoride treatment	ADA: 01203		
32.	III. Restorative Services	ADA: 021xx, 023xx, 027xx		
33.	IV Oral Surgery (extractions only)	ADA: 07111, 07140, 07210, 07220, 07230, 07240, 07241, 07250, 07260, 07261, 07270, 07272, 07280, 07281		
34.	V. Rehabilitative services (Endo, Perio, Prostho, Ortho)	ADA: 03xxx, 04xxx, 05xxx, 06xxx, 08xxx		

Note: x denotes any number including the absence of a number in that place.

I International Classification of Diseases, 9th Revision, 6th Edition, Clinical Modification, Volumes 1 and 2, 2004. Reston, VA: St. Anthony Publishing. Codes for HIV Infection reflect revisions published in MMWR Volume 43, No. RR-12, September 30, 1994.

II Physicians' Current Procedural Terminology, 4th edition, CPT 2004. American Medical Association.

III Current Dental Terminology, CDT 4, 2002. American Dental Association.

INSTRUCTIONS FOR TABLE 7 – PERINATAL PROFILE

The content of this table has changed since the 2002 Reporting period, please see a guide to changes in the Questions and Answers Section below.

This table provides detail on pregnant and postpartum women users and their newborn infants, as well as services rendered by grantees that provide prenatal care. Table 7 is included in the Universal Report only.

DATA REPORTED BY ALL GRANTEES

TOTAL USERS KNOWN TO BE PREGNANT – NO LONGER REPORTED

TOTAL USERS KNOWN TO BE HIV-POSITIVE AND PREGNANT (Line 2) – Report the total number of users known to have been both pregnant and infected with HIV at some time during the reporting period, regardless of whether the woman received services from the grantee directly related to the pregnancy or to HIV infection.

NOTE: All grantees, whether or not they provide or assume primary responsibility for a client's perinatal care services, complete Line 2. Requesting this information does not mean that the grantee must provide pregnancy or HIV testing if those services are not in the scope of their services.

DATA REPORTED ONLY BY GRANTEES WHO PROVIDE PRENATAL CARE

Only grantees that provide or assume primary responsibility for a client's prenatal care services, whether or not the grantee does the delivery, complete the remaining sections of Table 7. **All data reported apply only to users who received prenatal care services during the reporting period.**

DEMOGRAPHIC CHARACTERISTICS OF PRENATAL CARE USERS

AGE OF PRENATAL CARE USERS (Lines 3-8) – Report the total number of users who received prenatal care services at any time during the reporting period by age group. Be sure to include women who began prenatal care during the previous reporting period and continued into this reporting period as well as women who began their care in this reporting period but will not /did not deliver until the next year. To determine the appropriate age group, use the woman's age on June 30 of the reporting period.

RACE / ETHNICITY OF PRENATAL CARE USERS (Lines 9-15) – Report the number of prenatal care users during the reporting period in each race / ethnicity category. The total women reported on line 15 must equal the total by age reported on line 8 above. Data on race / ethnicity may be estimated where not fully known. Asian, Native Hawaiian and Other Pacific Islander users should be reported separately on Lines 9a, 9b and 9c; the total percentage of Asian, Native Hawaiian and Other Pacific Islander users should be reported on Line 9.

TRIMESTER OF ENTRY INTO PRENATAL CARE

TRIMESTER OF FIRST VISIT (Lines 16-18) – Report the total number of pregnant women users who received prenatal care during the reporting period, by trimester of pregnancy when they began prenatal care either at one of the grantee's service delivery locations or with another provider. A woman is counted only once regardless of the number of trimesters during which she receives care. A woman who begins her prenatal care at another provider and then comes to the center, is counted once and only once Column B. Prenatal care is considered to have begun at the time the patient has her first visit with the obstetrical care giver, not when she registers for care at the center or has lab tests done.

- **FIRST TRIMESTER** – Includes women who received prenatal care during the reporting period and whose pregnancy at the time of enrollment was estimated to be anytime less than 13 weeks after conception.
- **SECOND TRIMESTER** – Includes women who received prenatal care during the reporting period and whose pregnancy at the time of enrollment was estimated to be between the 13th and through the 26th week after conception.
- **THIRD TRIMESTER** – Includes women who received prenatal care during the reporting period and whose pregnancy at the time of enrollment was estimated to be 27 weeks or more after conception.

NOTE: Line 8 (total prenatal care users by age) and the sum of Lines 16-18 (total prenatal care users by trimester) must be the same.

DELIVERY, POSTPARTUM AND WELL CHILD CARE

This section reports on deliveries, infant birthweight, and infant and postpartum visits. All data except line 19a, center deliveries, are to be reported by race / ethnicity subcategories to enable BPHC to account for impact on racial disparities.

PRENATAL CARE USERS WHO DELIVERED DURING THE YEAR (Line 19) – Report the total number of women who both received prenatal care from the grantee during the reporting period and delivered during the year, even if the delivery was done by another provider. Include all deliveries, regardless of the outcome.

NOTE: Line 8 (total prenatal care users by age) and Line 19, Column H (total prenatal care users who deliver during the year) should **not** be identical.

DELIVERIES BY CENTER CLINICIANS (Line 19a) – Report the total number of deliveries performed by center clinicians during the reporting period in column H. (This line is not reported by the race / ethnicity of the women delivered.) On this line **ONLY**, include deliveries of women who were *not* part of the grantee's prenatal care program during the calendar year. This would include such circumstances as the delivery of another doctor's patients when the clinic provider participates in a call group and is on call at the time of delivery; emergency deliveries when the clinic provider is on-call for the emergency room; and deliveries of "un-

doctored" patients who are assigned to the provider as a requirement for privileging at a hospital.

BIRTHWEIGHT OF INFANTS BORN TO PRENATAL CARE USERS DURING THE YEAR (Lines 20-22) – Report the total number of live births during the reporting period for women who received prenatal care from the grantee or referral provider during the reporting period, according to the appropriate birthweight group. **NOTE:** Grantees must report deliveries and the birth-weight of children delivered for **all** women who were in their prenatal care program and who delivered during the reporting period, *regardless of whether the grantee did the delivery themselves or referred the delivery to another provider.*

PRENATAL CARE USERS WHO RETURNED FOR POSTPARTUM CARE DURING THE YEAR (Line 23) – Report the total number of women who:

- received prenatal care from the grantee during the reporting period,
- delivered during the reporting period,
- and returned to the grantee within 8 weeks of delivery for postpartum care during the reporting period
-

INFANTS WHO RECEIVED A NEWBORN VISIT (Line 24). Report the total number of infants who

- were born during the reporting period
- to women who received prenatal care from the grantee during the reporting period
- who also received a newborn care visit from the grantee during the reporting period.
- And who did so during the first 4 weeks after birth)

WIC ENROLLEES

This section of Table 7 tracks enrollment of prenatal care users in the Special Supplemental Food Program for Women, Infants and Children (WIC). Report the total number of users in the following three categories:

- **PRENATAL CARE USERS** – Line 25 reports only women who are enrolled in the prenatal care program, not a grantee's total WIC program. It asks how many of the women reported on Line 8 (total prenatal care users by age) were also enrolled in WIC, either at your center or elsewhere. The number is never more than the number reported on Line 8.
- **INFANTS** – Line 26 reports only children born in a grantee's prenatal care program, not a grantee's total WIC program. It asks how many of the children reported on Lines 20-22 (infants by birthweight) were also enrolled in WIC, either at your center or elsewhere. It is never more than the sum of these lines.
- **POSTPARTUM CARE USERS.** – Line 27 reports only women in the prenatal care program who delivered during the year, not a grantee's total WIC program. It asks how many of the women reported on Line 19 Column H as having delivered this year were also enrolled in WIC, either at your center or elsewhere. It is never more than the number reported on Line 19.

NOTE: Grantees are expected to provide case management for their perinatal care patients and to track whether or not they received WIC services. Report on all successful referrals regardless of whether or not the grantee actually operates the WIC program the woman was referred. NOTE ALSO that a woman may be reported in more than one category (i.e., a woman may be reported as having been both a prenatal and a postpartum WIC program enrollee).

QUESTIONS AND ANSWERS FOR TABLE 7

1. **Are there changes to the table this year?**

Yes. Two changes have been implemented. The number of women served by race and ethnicity is now being reported as a number, not as a percentage. And the total number of deliveries by center providers are now reported on line 19a.

2. **If a prenatal user in one year (e.g., 2004) gives birth in the next year (i.e., 2005) without having prenatal care in that year (i.e., 2005), is the delivery reported for that year (i.e., 2005)?**

The delivery is NOT reported in 2005, nor was it to be reported in 2004. The table only includes data on women who received prenatal care during the year.

3. **Are deliveries by women who are not in the grantee's prenatal care program excluded from Table 7?**

Except for line 19a, the answer is "Yes". For example, women who are delivered by a center provider as a result of being in a call group or staffing the emergency room, are not reported on this form as a user, as a delivery, or as a postpartum visit.

4. **Are birth outcomes of prenatal care users delivered by a non-grantee provider to be reported?**

Yes. Comprehensive prenatal care includes case management and thus case tracking is a responsibility of all grantees.

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**TABLE 7 –
PERINATAL PROFILE
SECTION 1: ALL GRANTEES**

CHARACTERISTICS		NUMBER OF USERS (a)
1.	Total Users Known to be Pregnant	THIS LINE NO LONGER REPORTED
2.	Total Users Known to be HIV+ Pregnant Women	
*** ONLY CONTINUE IF YOU PROVIDE PRENATAL SERVICES ***		
SECTION II: GRANTEES WHO PROVIDE PRENATAL CARE		
A. DEMOGRAPHIC CHARACTERISTICS OF PRENATAL CARE USERS		
AGE		Number of Users (a)
3.	Less than 15 years	
4.	Ages 15-19	
5.	Ages 20-24	
6.	Ages 25-44	
7.	Ages 45 and Over	
8.	TOTAL USERS (SUM LINES 3 – 7)	
RACE/ETHNICITY		Number of Users (a)
9a.	Asian	
9b.	Native Hawaiian	
9c.	Other Pacific Islander	
9.	TOTAL ASIAN/NATIVE HAWAIIAN/PACIFIC ISLANDER (Sum Lines 9a through 9c)	
10.	Black/African American (not Hispanic or Latino)	
11.	American Indian/Alaska Native	
12.	White (not Hispanic or Latino)	
13.	Hispanic or Latino (all races)	
14.	Unreported / Refused to Report	
15.	TOTAL NUMBER OF USERS (Sum Lines 9 through 14)	

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TABLE 7 – PERINATAL PROFILE

B. TRIMESTER OF ENTRY INTO PRENATAL CARE										
Trimester of First Known Visit for Women Receiving Prenatal Care During Reporting Year		Women Having First Visit with Grantee (a)			Women Having First Visit with Another Provider (b)					
16.	First Trimester									
17.	Second Trimester									
18.	Third Trimester									
C. DELIVERY, POSTPARTUM AND INFANT UTILIZATION DURING THE CALENDAR YEAR										
		Asian (a)	Native Hawaiian (b1)	Pacific Islander (b2)	Black/African American (c)	American Indian/Alaska Native (d)	White (not Hispanic or Latino) (e)	Hispanic or Latino (all races) (f)	Unreported/Refused to Refused (g)	Total (h)
19	Prenatal Care users who delivered during the year									
19a	Deliveries performed by grantee provider									
20	Births less than 1,500 grams (very low)									
21	Births 1,501 to 2,500 grams (low)									
22	Births more than 2,500 grams (normal)									
23	Prenatal care users who received postpartum care within 8 weeks of delivery									
24	Infant delivered who received newborn visit within 4 weeks of birth									
D. ENROLLMENT OF PRENATAL CARE USERS AND THEIR INFANTS IN WIC (Only Patients Who Receive Prenatal Services From The Grantee)										
		Number of Users (a)								
25.	Prenatal Care Users									
26.	Infants									
27.	Postpartum Care Users									

INSTRUCTIONS FOR TABLE 8A – COSTS

The content of this table has changed since the 2002 Reporting period, please see a guide to changes in the Questions and Answers Section below.

Table 8A must be completed by all BPHC grantees. It is included only in the Universal Report. The table covers the **total cost** of all activities, which are within the scope of the project(s) supported, in whole or in part, by any of the four BPHC grants covered by the UDS. All costs are to be reported on an accrual basis. These are the costs attributable to the period, including depreciation, regardless of when actual payments were made.

DIRECT AND LOADED COSTS (COLUMN DEFINITIONS)

Column A : This column reports the accrued direct costs associated with each of the services listed. See Line Definitions for costs to be included in each category. Column A also reports the total cost of administration and facility (Overhead) separately on Lines 14 -16.

Column B : This column shows the allocation of overhead costs (from lines 14-15, Column A) to each of the direct cost centers. The total of facility and administration costs, reported in Column A, lines 14-15, are to be distributed in Column B. The total amounts entered in Column B will thus equal the amount reported on Line 16, Column A. NOTE: for Lines 1-3, it is acceptable to report all medical overhead on Line 1 only if a more appropriate allocation is not available. It is also reasonable to allocate all pharmacy overhead to the non-supply line, and no overhead costs to pharmaceutical supplies (line 9a)

The allocation of administration and facility costs should be done as follows, unless your center has a more accurate system:

FACILITY COSTS should be allocated based on the amount of square footage utilized for Medical, Dental, Mental Health, Substance Abuse, Pharmacy, Other Professional, Enabling, or Other Program Related Services. Square Footage refers to the portion of the grantee's facility space used in the operation of the organization, not including common spaces such as hallways, rest rooms, and utility closets. For reporting purposes, the square footage associated with space owned by the grantee and leased or rented to other parties should not be included if it is considered to be outside of the scope of the project. If it has been included inside the scope of project, it should be allocated to Other Program Related Services (Row 12) and the rent received should be included on Table 9E under Other Revenues (Line 10).

ADMINISTRATIVE COSTS should be allocated after facility cost has been allocated, and should include the facility costs allocated to it. Administrative cost is allocated based on a straight line allocation method. The proportion of total cost (excluding administrative cost) that is attributable to each service category should be used to allocate administrative cost. For example, if medical staff account for 50 percent of total cost (excluding administration) then 50 percent of administrative cost is allocated to medical staff. If you have an alternative method that provides more accurate allocations, it may be used, but save your paper work for review and explain the methods used in the table note.

Column C : This column shows the loaded cost of each of the cost centers listed on Lines 1 - 13. The

loaded cost is the sum of the direct cost, reported in Column A, plus the allocation of overhead, reported in Column B. The Total Accrued Cost reported on Line 17 should be the same in Column A and Column C. Column C also shows the value of any donated services and supplies on Line 18. Donations should be reflected as a positive number, and are not included in any of the lines above. Line 19, Column C is the total cost including the value of donations.

BPHC MAJOR SERVICE CATEGORIES (LINE DEFINITIONS)

- A. **MEDICAL CARE SERVICES** (Lines 1- 4) – This category includes costs for medical care staff personnel; services provided under agreement; X-ray and laboratory; and other direct costs wholly attributable to medical care (e.g., equipment depreciation, supplies, or professional dues and subscriptions). It does not include costs associated with pharmacy, dental care, substance abuse specialists, or clinical psychologist and clinical social worker services.

STAFF COSTS (Line 1) – Include all staff costs, including salaries and fringe benefits for personnel supported directly or under contract, for medical care staff except lab and x-ray staff. The costs of medical records and billing and collections are considered administrative and should be included on Line 15 and allocated in Column B. Include the cost for vouchered or contracted medical services on line 1.

LAB AND X-RAY COSTS (Line 2) – Include all costs for lab and x-ray, including salaries and fringe benefits for personnel supported directly or under contract, for lab and x-ray staff; and all other direct costs including, but not limited to, supplies, equipment depreciation, related travel, contracted or vouchered lab and xray services, etc. The costs of medical records, billing and collections are considered administrative and should be included on Line 15 and allocated in Column B.

OTHER DIRECT COSTS (Line 3) – Include all other direct costs for medical care including, but not limited to, supplies, equipment depreciation, related travel, etc.

TOTAL MEDICAL (Line 4) – The sum of lines 1 + 2 + 3.

- B. **OTHER CLINICAL SERVICES** (Lines 5 - 10) – This category includes staff and related costs for dental, mental health, substance abuse services, pharmacy, and other services rendered by professional personnel (e.g., optometrists, occupational and physical therapists, and podiatrists).

DENTAL (Line 5) – Report all costs for the provision of dental services including but not limited to staff, fringe benefits, supplies, equipment depreciation, related travel, contracted dental lab services and dental xray. Corporate administrative and facility costs should be included on Line 15 Column A and allocated in Column B.

MENTAL HEALTH (Line 6) – Report all direct costs for the provision of mental health services, *other than substance abuse services*, including but not limited to staff, fringe benefits, supplies, equipment depreciation, and related travel. Corporate administrative and facility costs should be included on Line 15 Column A and allocated in Column B.

SUBSTANCE ABUSE (Line 7) – Report all direct costs for the provision of substance abuse services including but not limited to staff, fringe benefits, supplies, equipment depreciation, and related travel. Corporate administrative and facility costs should be included on Line 15 Column A and allocated in Column B.

PHARMACY (NOT INCLUDING PHARMACEUTICALS) (Line 8a) – Report all direct costs for the provision of pharmacy services including but not limited to staff, fringe benefits, non-pharmaceutical supplies, equipment depreciation, related travel, contracted purchasing services, etc. Corporate administrative and facility costs should be included on Line 15 Column A and allocated in Column B.

PHARMACEUTICALS (Line 8b) – Report all direct costs for the purchase of pharmaceuticals. Do not include other supplies. Do **not** include the value of donated pharmaceutical supplies (these **are** recorded on Line 18, Column C.) Overhead costs are not allocated to pharmaceuticals.

OTHER PROFESSIONAL (Line 9) – Report all direct costs for the provision of other professional and ancillary health care services including but not limited to: optometry, podiatry, chiropractic, occupational and physical therapy, etc. (A more complete list appears at Appendix A.) Included in direct costs are staff, fringe benefits, supplies, equipment depreciation, related travel, and contracted services. Corporate administrative and facility costs should be included on Line 15 Column A and allocated in Column B.

TOTAL OTHER CLINICAL (Line 10) – The sum of lines 5 + 6 + 7 + 8a + 8b + 9.

- C. **ENABLING AND OTHER PROGRAM RELATED SERVICES** (Lines 11 - 13) – This category includes enabling staff and related costs for case management, outreach, transportation, translation and interpretation, education, environmental risk reduction and other services that support and assist in the delivery of primary medical services and facilitate patient access to care. The cost of these services are also reported on Table 8B. For definitions of specific enabling services, see Appendix B.

It also includes the staff of other program related services such as WIC, day care, job training, delinquency prevention and other activities not included in other BPHC categories.

ENABLING (Line 11) – Enabling services include a wide range of services which support and assist primary medical care and facilitate patient access to care. A non-exclusive list of 15 such services is included in Appendix B. Report all direct costs for the provision of enabling services including but not limited to costs such as staff, fringe benefits, supplies, equipment depreciation, related travel, and contracted services. Corporate administrative and facility costs should be included on Line 15 Column A and allocated in Column B.

OTHER PROGRAM RELATED (Line 12) – Report all direct costs for the provision of services not included in any other category here. This includes services such as WIC, childcare centers, and training programs. Report all direct costs for staff, fringe benefits, supplies, equipment depreciation, related travel and contracted

services. (Staff for these programs are now reported on line 29a of Table 5.) Corporate administrative and facility costs should be included on Line 15 Column A and allocated in Column B.

TOTAL ENABLING AND OTHER PROGRAM RELATED SERVICES (Line 13) – The sum of lines 11 + 12.

D. **FACILITY AND ADMINISTRATIVE COSTS** (Lines 14 - 16) – This includes all traditional overhead costs that are later allocated to other cost centers. Specifically:

FACILITY COSTS (Line 14) – Facility costs include rent or depreciation, interest payments, utilities, security, grounds keeping, maintenance, janitorial services, and all other related costs.

ADMINISTRATIVE COSTS (Line 15) – Administrative costs include the cost of all corporate administrative staff, billing and collections staff, medical records and intake staff, and the costs associated with them including, but not limited to, supplies, equipment depreciation, travel, etc. In addition, include other corporate costs (e.g., purchase of insurance, audits, Board of Directors' costs, etc.) The cost of all patient support services (e.g., medical records and intake) should be included in Administrative Costs. Most notably, the "cost" of bad debts is **NOT to be included in administrative costs or shown on this table in any way.** Instead, the UDS reduces income by the amount of patient bad debt on table 9D.

NOTE: Some grant programs have limitations on the proportion of **funds** that may be used for administration. **Limits on administrative costs for those programs is not to be considered in completing lines 14 and 15.** The Administration and Facility categories for this report includes **all** administrative costs and personnel working in a BPHC-supported program, whether or not that cost was identified as administrative in any specific grant application.

TOTAL OVERHEAD (Line 16) – The sum of lines 14 + 15.

TOTAL ACCRUED COST (Line 17) – It is the sum of lines 4 + 10 + 13 + 16

VALUE OF DONATED FACILITIES, SERVICES AND SUPPLIES (Line 18) - Include here the total imputed value of all in-kind and donated services, facilities and supplies applicable to the reporting period that are within your scope of project, using the methodology discussed below. In-kind services and donations include all services (generally volunteers, but sometimes paid staff donated to the grantee by another organization), supplies, equipment, space, etc that are necessary and prudent to the operation of your program that you do not pay for directly and which you included in your budget as donated. Line 18 reports the estimated reasonable acquisition cost of donated personnel, supplies, services, space rental, and depreciation for the use of donated facilities and equipment. The value of these services should not be included in the lines above.

The estimated reasonable acquisition cost should be calculated according to the cost that would be required to obtain similar services, supplies, equipment or facilities within the immediate area at the time of the donation. Donated pharmaceuticals, for example, would be shown at the price that would be paid under the federal drug pricing program, not the manufacturer's suggested retail price. Donated value should only be recognized when the

intent of the donating parties is explicit and when the services, supplies, etc., are both prudent and necessary to the grantee's operation.

The full market value of National Health Service Corps (NHSC) Federal assignee(s) should also be included in this category. NHSC-furnished equipment, including dental operatories, should be capitalized at the amount shown on the NHSC Equipment Inventory Document, and the appropriate depreciation expense should be shown in this category for the reporting period.

TOTAL WITH DONATIONS (Line 19) – It is the sum of lines 17 and 18, column C.

CONVERSION FROM FISCAL TO CALENDAR YEAR

Grantees whose cost allocation system permits them to provide accurate accrued cost data should use that system. Grantees whose fiscal year does not correspond to the calendar year and whose accounting system is unable to provide accurate accrued cost data may calculate calendar year costs, using the following straight-line allocation methodology:

Step 1: Calculate the proportion of the calendar reporting period covered by the cost report and use that ratio to calculate the proportion of cost in each category attributable to the calendar year. Example: A grantee whose fiscal year ends March 31, 2003, allocates 25% of costs in each cost category to the 2003 calendar year.

Step 2: Using the trial balance for the end of December, determine the total cost for the remainder of the calendar year for each column. For example, a grantee whose fiscal year ends March 31, 2003 would use the nine-month trial balance for December 31. (**Note**: Grantees who do not accrue depreciation monthly should adjust depreciation to an annual total.)

Step 3: Sum results of Steps 1 and 2 and enter the total in Column A.

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**TABLE 8A –
FINANCIAL COSTS**

		ACCRUED COST	ALLOCATION OF FACILITY AND ADMINISTRATION	TOTAL COST AFTER ALLOCATION OF FACILITY AND ADMINISTRATION
		(a)	(b)	(c)
FINANCIAL COSTS FOR MEDICAL CARE				
1.	Medical Staff			
2.	Lab and X-ray			
3.	Medical/Other Direct			
4.	TOTAL MEDICAL CARE SERVICES (SUM LINES 1 THROUGH 3)			
FINANCIAL COSTS FOR OTHER CLINICAL SERVICES				
5.	Dental			
6.	Mental Health			
7.	Substance Abuse			
8a.	Pharmacy not including pharmaceuticals			
8b.	Pharmaceuticals			
9.	Other Professional			
10.	TOTAL OTHER CLINICAL SERVICES (SUM LINES 5 THROUGH 9)			
FINANCIAL COSTS OF ENABLING AND OTHER PROGRAM RELATED SERVICES				
11.	Enabling			
12.	Other Related Services			
13.	TOTAL ENABLING AND OTHER SERVICES (SUM LINES 11 AND 12)			
OVERHEAD AND TOTALS				
14.	Facility			
15.	Administration			
16.	TOTAL OVERHEAD (SUM LINES 14 AND 15)			
17.	TOTAL ACCRUED COSTS (SUM LINES 4 + 10 + 13 + 16)			
18.	Value of Donated Facilities, Services and Supplies			
19.	TOTAL WITH DONATIONS (SUM LINES 17 AND 18)			

INSTRUCTIONS FOR TABLE 8B – ENABLING SERVICES

The content of this table has not changed since the 2002 Reporting period.

Table 8B should be completed by all of the four types of BPHC grantees covered by the UDS. The table provides information on the costs of specific services that are important components of BPHC-supported programs, but which are not broken out on Table 8A. This table includes only direct costs of service, and not allocation of overhead expenses. Costs are to be reported on an accrual basis in the same manner as costs are reported on Table 8A.

MENTAL HEALTH/SUBSTANCE ABUSE SERVICES. (Lines 1 – 3 are no longer reported as of the 2002 reporting period.)

- A. **ENABLING SERVICES.** Most of the enabling services included in this section are defined in Appendix A. To the extent possible, distribute direct staff and other direct costs associated with enabling services into the listed service categories. Enabling services staff includes those for whom FTE data were provided on Table 5. **For Lines 4 through 12,** include total direct costs for each of the listed service types. Include all staff costs including fringe benefits and other associated direct costs (e.g., equipment depreciation, supplies, related travel, professional liability insurance, etc.). Grantees should provide estimates where costs cannot be broken out by type of service. If a particular enabling service is not provided, leave the cost line blank for that service.

TOTAL ENABLING SERVICES COSTS (Line 13) – Sum Lines 4 through 12.

NOTE: This must match Table 8A, Line 11, Column A.

QUESTIONS AND ANSWERS FOR TABLE 8B

1. **Can the cost of enabling services reported on Table 8B be higher than the cost for enabling services reported on Table 8A, line 11?**

No. The total enabling services in 8B should equal the enabling costs reported on table 8A, line 11, column A (prior to the allocation of facility and administrative costs) and should be less than table 8A, Line 11 column C.

2. **Is it permissible for donated costs to be included in Table 8B?**

No.

3. **Are there changes to the table this year?**

No.

4. **Is WIC included as an enabling service?**

No. WIC is not included in the list of enabling services in Appendix B. NOTE: Services such as WIC, Headstart, and other non-medical services are reported on line 12 of Table 8A as Other Related Services).

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TABLE 8B – ENABLING SERVICES

SERVICE		COST (a)
MENTAL HEALTH/SUBSTANCE ABUSE SERVICES		
1-3	(These lines are no longer required.)	
ENABLING SERVICES		
4.	Case Management	
5.	Transportation	
6.	Outreach	
7.	Patient Education	
8.	Translation/Interpretation	
9.	Community Education	
10.	Environmental Health Risk Reduction	
11.	Other Enabling Services (specify: _____)	
12.	Other Enabling Services (specify: _____)	
13.	TOTAL ENABLING SERVICES COST (SUM LINES 4 - 12)	

INSTRUCTIONS FOR TABLE 9C: MANAGED CARE

The content of this table has not changed since the 2002 Reporting period.

Table 9C should be completed by all grantees participating in Medicare, Medicaid, commercial, or other managed care plans; it is included only in the Universal Report. Grantees should also report the number of enrollees in Primary Care Case Management (PCCM) programs. If the grantee has more than one managed care contract of a particular type with Medicare, Medicaid, commercial, or other insurers, the information for each category should be added together and reported as a total.

NOTE: There is one exception to this rule. Managed care plans covering only dental or mental health or pharmacy should **not** be reported on this table.

This report includes revenue, expense, enrollment, and utilization information for capitated and fee-for-service managed care plans. It also includes information on the number of enrollees in PCCM programs, though number of enrollees is the only information collected on these programs.

CAPITATED (PRE-PAID) PLANS – Are defined as plans under which the grantee receives a fixed payment per enrollee. Payment is made in advance, generally on a monthly basis, and covers all services included in the plan's contract with the center. Under capitated arrangements, the grantee may also contract to be at full or partial risk for services beyond traditional primary care services.

FEE-FOR-SERVICE PLANS (FFS) – Are defined as plans under which the grantee receives payment on a fee-for-service basis for enrollees, when the enrollees receive contractually specified services. As a rule, the provider receives a list of eligible enrollees just as it would for a capitated program and these enrollees must receive all their primary care and other stipulated services from their "Primary Care Provider" or PCP.

PRIMARY CARE CASE MANAGEMENT PROGRAMS - Are defined as arrangements whereby the grantee receives a case management fee, and is expected to serve as gatekeeper for the enrollee, providing referrals to more specialized services. While PCCM providers generally also provide the primary care services for the patient, this may not be required by the program. Table 9C only requests information on PCCM enrollees, reported on Line 11. Do not include any revenue or expenditures for PCCM enrollees on this Table.

SOURCE OF PAYMENT – Medicaid and Medicare payments should be reported according to the original source of payment. For example, if a center has a contract with a private HMO to provide services to enrolled Medicaid patients, this would be reported under Medicaid. Similarly, S-CHIP programs which are operated by private HMOs are classified under the "Other Public" payment source.

SCOPE OF PROJECT – This table requires the grantee to report on all activities included in their managed care contracts, within the "Scope of Project" in the grantee's application for BPHC funding. The contract the project has with the managed care plan determines the types of services reported on this table. Ordinarily, the Scope of Project includes all (or virtually all) services included in a grantee's managed care contract. A small number of grantee's have

contracts that include services, which are not included in the grantee's application for BPHC funding (e.g., inpatient hospital services). These services are considered "outside the scope of the project" and are not reported on this table.

SERVICES WITHIN THE SCOPE OF PROJECT – Services within the scope of BPHC supported projects are often restricted to primary care but in some Centers may include lab, x-ray, pharmacy and/or specialty services. They may be covered by capitation or by fee-for-service payments. The defining element is whether or not they are included in the funded BPHC project (and its budget) and reported on in the FSR. Services within the scope of project are included in all of these documents. Services outside of scope have not been reported since CY-2000.

REVENUE

CAPITATION REVENUE FOR SERVICES (Line 1a) – Enter the accrued revenue from capitation for services. This figure is equal to the capitation *earned* during the calendar year, regardless of when it was received, though capitation is almost always received in the same year that it is earned. This amount generally equals the collection in Table 9D minus retroactive and wraparound payments, unless there were late or early capitation payments received. Report only the capitation earned from the HMO on this line. Other payments are reported below.

FEE-FOR-SERVICE REVENUE FOR SERVICES (Line 1b) – Enter the "net accrued revenue" from fee-for-service for services. This figure is equal to the income *earned* during the calendar year, regardless of when it was or will be received. It is equal to full charges less all actual or anticipated disallowances or allowances *except* that allowances for anticipated FQHC settlements on these charges are *not* included here.

Note that a contract may pay a capitation to cover the cost of the basic visit, and pay fee-for-services for other costs such as lab, x-ray and pharmacy. In this instance the grantee will report income on both line 1a and 1b.

TOTAL REVENUE FOR SERVICES (Line 1) – Enter the sum of Lines 1a and 1b.

COLLECTIONS FROM STATE MEDICAID OR FEDERAL MEDICARE RECONCILIATIONS OR WRAP AROUND PAYMENTS FOR THE CURRENT YEAR. (Line 3a) – Enter the (cash) amount received from Medicaid and Medicare reconciliation payments (payments based on the settlement of a cost report) and/or wrap around payments (amounts paid to bring reimbursement to cost or a negotiated fee-per-visit amount) for services rendered in the current (reporting) calendar year.

NOTE: In most circumstances, these cells should equal Table 9D Column C1 totals for managed care.

COLLECTIONS FROM STATE MEDICAID OR FEDERAL MEDICARE RECONCILIATIONS AND WRAP AROUND PAYMENTS FOR A PRIOR BILLING PERIOD. (Line 3b) – Enter the (cash) amount received from Medicaid and Medicare reconciliation payments (payments based on the settlement of a cost report) and/or wrap around payments (amounts paid to bring reimbursement to cost or a negotiated fee-per-visit amount) for services which were rendered in prior years.

NOTE: In most circumstances, these cells should equal Table 9D Column C2 totals for managed care.

NOTE: If reconciliations and/or wrap around payments are made for a grantee's fiscal

year, and the fiscal year does not correspond to the calendar year, payments must be allocated between the current and prior calendar years. Grantees may use a straight line allocation methodology; for example, a grantee receiving reconciliations and/or wrap around payments covering the fiscal year April 1, 2003 - March 31, 2004 would allocate 25% of the payment to the current year (i.e., 2004) and 75% to the prior year (i.e., 2003). Grantees with more sophisticated cost allocation systems may use their own systems but be sure to keep documentation.

COLLECTIONS FROM PATIENT CO-PAYMENTS AND FROM MANAGED CARE PLANS FOR OTHER RETROACTIVE PAYMENTS (Line 3c) – Enter the (cash) amount received from patient co-payments and from other retroactive payments such as risk pools, incentives, and withholds. The income may have been earned in this or any preceding year.

NOTE: In many instances these cells *will not* equal Table 9D Column C3 totals for managed care because co-payments are recognized on this line, but are not reported in column C3 of Table 9D.

PENALTIES OR PAYBACKS TO MANAGED CARE PLANS (Line 3d) – Enter the (cash) amount paid during the reporting period as a result of penalties imposed by managed care plans, and FQHC paybacks. The penalties may have been “earned” in this or any preceding year.

TOTAL MANAGED CARE REVENUE (Line 4) – Enter the sum of Lines 1, 3a, 3b, 3c minus Line 3d.

EXPENSES

Expenses as used in this section means “accrued costs”. To the extent it is maintained, grantees should include “Incurred but not reported costs” (IBNR) for the reporting period for which they are liable. All amounts are reported on a modified accrual basis.

CAPITATION EXPENSES FOR SERVICES (Line 5a) – Enter the cost of providing the capitated services reported, i.e., the visits reported on line 9a and other associated costs (e.g. lab, xray, pharmacy, etc.) covered by the capitation.

FEE-FOR-SERVICE EXPENSES FOR SERVICES (Line 5b) – Enter the cost of providing the fee for services reported, i.e., the visits reported on line 9b and other associated costs (e.g. lab, xray, pharmacy, etc) covered by the fee-for-service payments. Note that a contract may pay a capitation for basic visits and pay fee-for-services for other costs such as lab, xray and pharmacy. In this instance the grantee will report associated costs for the “carved out services” separately on line 5b.

TOTAL EXPENSES FOR MANAGED CARE SERVICES (Line 5) – Enter the sum of Lines 5a and 5b.

NOTE: Not all centers formally maintain a cost-accounting system that reports these data in this format. If this is the case, two methods for calculating these required numbers may be used retrospectively:

1. **AVERAGE COST PER ENCOUNTER:** Virtually all health centers have a process to develop a Medicaid and/or Medicare approved cost per encounter. *Presuming that the services offered under the*

managed care program is the same as those in the FQHC program it is simple to take the total number of encounters reported on lines 9a, 9b and 9 and multiply this number times the average cost per encounter. The results would be placed on lines 5a, 5b and 5.

2. **RATIO OF CHARGES:** *If the center has a cost based fee schedule* (and this is necessary to use this method) a more accurate method of calculating costs is possible. This system would permit the center's cost analysis to be sensitive to questions of different levels of services, which are provided to prepaid patients as compared to others. (For example, because there is no incentive to multiple visits, a center may try to do more at a single visit than to call back the patient.)

In this methodology, the center looks at the total *charges* for services to managed care patients and compares it to the total charges for this same set of services for all patients in the system. This ratio (charges for managed care divided by charges for all patients) is then multiplied times the total cost of providing those services. The result is a more complex but, theoretically, more accurate statement of expenses. Note that this has to be done for each type of third party payor on Table 9C.

UTILIZATION DATA

MEMBER MONTHS: A member month is defined as one member being enrolled for one month. An individual who is a member of a plan for a full year generates 12 member months; a family of five enrolled for six months generates (5 X 6) 30 member months. Member month information can often be obtained from monthly enrollment lists generally supplied by managed care companies to their providers.

MEMBER MONTHS FOR MANAGED CARE (CAPITATED) (Line 8a) – Enter the total capitated member months by source of payment. This is derived by adding the total enrollment reported by the plan for each month.

MEMBER MONTHS FOR MANAGED CARE (FEE-FOR-SERVICE) (Line 8b) – Enter the total fee-for-service member months by source of payment. A fee-for-service member month is defined as one patient being assigned to a service delivery location for one month during which time the patient may use only that center's services, but for whom the services are paid on a fee-for-service basis. NOTE: Do not include individuals who receive "carved-out" services under a fee-for-service arrangement if those individuals have already been counted for the same month as a capitated member month.

TOTAL MEMBER MONTHS FOR MANAGED CARE (Line 8) – Enter the sum of Lines 8a and 8b.

MANAGED CARE ENCOUNTERS (CAPITATED) (Line 9a) – Enter the total encounters for **capitated** enrollees by source of payment.

MANAGED CARE ENCOUNTERS (FEE-FOR-SERVICE) (Line 9b) – Enter the total encounters **for fee-for-service** enrollees by source of payment.

TOTAL MANAGED CARE ENCOUNTERS (Line 9) – Enter the sum of Lines 9a and 9b.

ENROLLEES IN MANAGED CARE PLANS (CAPITATED) (Line 10a) – Enter the number of capitated enrollees by source of payment as of (i.e., for the month of) December 31 of the reporting period.

ENROLLEES IN MANAGED CARE PLANS (FEE-FOR-SERVICE) (Line 10b) – Enter the number of fee-for-service enrollees by source of payment as of (i.e., individuals assigned to the grantee for the month of) December 31 of the reporting period.

TOTAL MANAGED CARE ENROLLEES (Line 10) – Enter the sum of Lines 10a and 10b.

ENROLLEES IN PRIMARY CARE CASE MANAGEMENT PROGRAMS (Line 11) – Enter the **number of enrollees in PCCM programs** as of December 31 of the reporting period.

NUMBER OF MANAGED CARE CONTRACTS (Line 12) – Enter the **number of managed care contracts** as of December 31 of the reporting period. If a contract with an HMO covers two different types of patients, e.g., Medicaid and Commercial, count it once in each column. If a single HMO has different “options” in its contract (e.g., a high benefit vs. a moderate benefit commercial plan) count it only once in the appropriate column.

QUESTIONS AND ANSWERS FOR TABLE 9C

1. What is the difference between a PCCM program and a FFS plan that also pays case management fees?

Under a FFS managed care plan, an entity (e.g., HMO, HIO, provider network, etc.) is capitated and at risk. This capitated entity is usually (but not always) someone other than the primary care provider (PCP), and contracts with the PCP. PCCM is almost always a contract between the primary care provider and the state, involves neither risk nor incentives, and generally has no penalties if utilization is excessive. PCCM rarely involves payment of capitation for primary care services.

2. We have a capitated managed care contract, but some services are “carved-out” and paid on a fee-for-service basis. How do we report?

Report revenue and expenses for the carve-out services on the appropriate fee-for-service lines. Report managed care fee-for-service encounters on Line 9b, but do NOT report managed care member months for fee-for-service plans on Line 8b nor enrollees on 10b. Since these persons have already been reported under capitation, counting them under fee-for-service would result in double counting individuals in the plan.

3. Do we report PCCM contracts on Line 9?

No.

4. Are there any changes to this table?

No.

UDS No. _____

Date Submitted: _____

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Initial Submission

Revision

**TABLE 9C (Part I of III) –
MANAGED CARE REVENUE AND EXPENSES**

PAYOR CATEGORY		MEDICAID (a)	MEDICARE (b)	OTHER PUBLIC INCLUDING NON- MEDICAID CHIP (c)	PRIVATE (d)	TOTAL (e)
REVENUE						
1a.	Capitation revenue for Services					
1b.	Fee-for-Service revenue for Services					
1.	TOTAL REVENUE FOR SERVICES (LINES 1A + 1B)					
2a.	Capitation revenue for Services Outside Scope of Project	NO LONGER REPORTED				
2b.	Fee-for-Service revenue for Services Outside Scope of Project					
2.	TOTAL REVENUE FOR SERVICES OUTSIDE SCOPE OF PROJECT (LINES 2A + 2B)					
3a.	Collections from State Medicaid or Federal Medicare reconciliation/ wrap around (For current year)					
3b.	Collections from State Medicaid or Federal Medicare reconciliation/ wrap around (For previous years)					
3c.	Collections from patient co-payments and from managed care plans for other retroactive payments / risk pool/ incentive/ withhold					
3d.	Penalties or paybacks to managed care plans					
4.	TOTAL MANAGED CARE REVENUE (SUM LINE 1 + 3A + 3B + 3C) - (LINE 3D)					

NOTE: Do not include information on this table for plans that only cover dental or mental health or pharmacy services.

UDS No: _____

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Revision

**TABLE 9C (Part II of III) –
MANAGED CARE REVENUE AND EXPENSES**

PAYOR CATEGORY		MEDICAID (a)	MEDICARE (b)	OTHER PUBLIC INCLUDING NON- MEDICAID CHIP (c)	PRIVATE (d)	TOTAL (e)
EXPENSES						
5a.	Capitation expenses for Services					
5b.	Fee-for-Service expenses for Services					
5.	TOTAL EXPENSES FOR SERVICES (LINES 5A + 5B)					
6a.	Capitation expenses for Services Outside Scope of Project	NO LONGER REPORTED				
6b.	Fee-for-Service expenses for Services Outside Scope of Project					
6.	TOTAL EXPENSES FOR SERVICES OUTSIDE SCOPE OF PROJECT (LINES 6A + 6B)					
7.	TOTAL MANAGED CARE EXPENSES (LINES 5)					

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**TABLE 9C (Part III of III)–
MANAGED CARE REVENUE AND EXPENSES**

PAYOR CATEGORY		Medicaid (a)	Medicare (b)	Other Public including Non- Medicaid CHIP (c)	Private (d)	Total (e)
UTILIZATION DATA						
8a.	Member months for managed care (capitated)					
8b.	Member months for managed care (fee-for-service)					
8.	TOTAL MEMBER MONTHS FOR MANAGED CARE (LINES 8A + 8B)					
9a.	Managed Care Encounters (capitated)					
9b.	Managed Care Encounters (fee-for-service)					
9.	TOTAL MANAGED CARE ENCOUNTERS (LINES 9A + 9B)					
10a.	Enrollees in Managed Care Plans (capitated) (as of 12/31)					
10b.	Enrollees in Managed Care Plans (fee-for-service) (as of 12/31)					
10.	TOTAL MANAGED CARE ENROLLEES (LINES 10A + 10B) (AS OF 12/31)					
11.	Enrollees in Primary Care Case Management Programs (PCCM)					
12.	Number of Managed Care Contracts					

NOTE: *Enrollees* in a capitated plan who also receive services under a fee-for-service arrangement (e.g. for a carved out service such as pregnancy or dental care) should have their enrollment reported only on the capitated line. Do not count the same person twice.

INSTRUCTIONS FOR TABLE 9D: PATIENT-RELATED REVENUE (SCOPE OF PROJECT ONLY)

The content of this table has not changed since the 2002 Reporting period.

Table 9D must be completed by all of the four types of BPHC grantees covered by the UDS. It is included only in the Universal Report. This table collects information on charges, collections, retroactive settlements, allowances, self-pay sliding fee discounts, and self-pay bad debt write-off.

ROWS: PAYOR CATEGORIES AND FORM OF PAYMENT

Five payor categories are listed: Medicaid, Medicare, Other Public, Private, and Self Pay. Except for Self Pay, all categories have three sub-groupings. They consist of non-managed care, capitated managed care, and fee-for-service managed care. Note that while similar data elements on Table 9C *exclude* dental-only or mental health-only managed care plans, information reported on table 9D *includes* these charges, collections and allowances in the managed care lines.

Grantees should report as **"Medicaid"** all services paid for by Medicaid (Title XIX) regardless of whether they are paid directly or through a fiscal intermediary or an HMO. For example, in states with a capitated Medicaid program, where the grantee has a contract with a private plan like Blue Cross, the payor is Medicaid, even though the actual payment may have come from Blue Cross. Note that EPSDT (the childhood Early Prevention, Screening, Diagnosis and Treatment program which has various names in different states,) is a part of Title XIX and is included in the numbers reported here. Note also that SCHIP, the State based Children's Health Insurance Program, which also has many different names in different states, is sometimes paid through Medicaid. If this is the case, it should be included in the numbers reported here.

Grantees should report as **"Medicare"** all services paid for by Medicare (Title XVIII) regardless of whether they are paid directly or through a fiscal intermediary or an HMO. Specifically, for patients enrolled in a capitated Medicare program, where the grantee has a contract with a private plan like Blue Cross, the payor is Medicare, even though the actual payment may have come from Blue Cross.

Grantees should report as **"Other Public"** all services paid for by State or local governments through specific programs *other than indigent care programs*. The most common of these would be S-CHIP, the State based Children's Health Insurance Program, which also has many different names in different states, *when it is paid for through commercial carriers*. Other Public also includes family planning programs, BCCP (Breast and Cervical Cancer Control Programs with various state names,) and other dedicated state or local programs as well as state insurance plans, such as Washington's Basic Health Plan.

NOTE. Reporting on state or local indigent care programs that subsidize services rendered to the uninsured is as follows:

- Report all charges for these services and collections from patients as "self-pay" (line 13 of this table);

- Report all amounts not collected from the patients as sliding discounts or bad debt write-off, as appropriate, on line 13 of this table; and
- Report collections from the associated state and local indigent care programs on table 9E. State/local indigent care programs are now reported on a separate line (line 6a – “state/local indigent care programs”) on that table.

Grantees should report as **“Private”** all services paid for by commercial or private insurance companies. Specifically, *do not* include any services that fall into one of the other categories. As noted above, charges etc. for Medicaid, Medicare and S-CHIP programs which use commercial programs as intermediaries are classified elsewhere.

Grantees should report as **“Self Pay”** all services and charges where the responsible party is the patient, including charges for indigent care programs as discussed above. **NOTE: This includes the reclassified co-payments, deductibles, and charges for uncovered services for otherwise insured individuals which become the patient’s personal responsibility.**

COLUMNS: CHARGES, PAYMENTS, AND ADJUSTMENTS RELATED TO SERVICES DELIVERED (Reported on a cash basis.)

FULL CHARGES THIS PERIOD (Column A) – Record in Column A the total charges for each payor source. This should always reflect the full charge (per the fee schedule) for services rendered to patients in that payor category. Charges should only be recorded for services that are billed **AND** covered in whole or in part by a payor, the patient, or written off to sliding fee discounts.

Example: Optometry services and pharmacy charges should not be included in Medicare charges, since Medicare provides no coverage for these services. If a patient has both Medicare and Medicaid coverage, charges for optometry and pharmacy services would be included in “Medicaid charges.” If a patient has only Medicare coverage, charges for optometry and pharmacy services would be entered under “self-pay”.

Charges that are generally not billable or covered by traditional third-party payors should not be included on this table. For example, a charge for parking or for job training would not normally be included. WIC services are not billable charges. Charges for transportation and similar enabling services would not generally be included in Column A, except where the payor (e.g., Medicaid) accepts billing and **pays** for these services.

Charges for pharmaceuticals donated to the clinic or directly to a patient through the clinic should not be included since the clinic may not legally charge for these drugs. Charges for standard dispensed pharmaceuticals, however, are to be included.

Charges which are not accepted by a payor and which need to be reclassified (including deductibles and co-insurance) should be reversed as negative charges if your MIS system does not reclassify them automatically. Reclassifying these charges by utilizing an adjustment and rebilling to the proper category is an incorrect procedure since it will result in overstatement of both charges and adjustments.

NOTE: Under no circumstances should the amount paid by Medicaid or any other payor be used as the actual charges. Charges *must* come from the grantee's CPT based fee schedule.

AMOUNT COLLECTED THIS PERIOD (Column B) – Record in Column B the amount of net receipts for the year on a cash basis, regardless of the period in which the paid for services were rendered. *This includes the FQHC reconciliations, managed care pool distributions and other payments recorded in the columns C1, C2, C3, C4.* Note: Charges and collections for deductibles and co-payments which are charged to and due from patients are recorded on Line 13.

RETROACTIVE SETTLEMENTS, RECEIPTS, OR PAYBACKS (Column C) – **IN ADDITION TO INCLUDING THEM IN COLUMN B**, details on cash receipts or payments for FQHC reconciliation, managed care pool distributions, payments from managed care withholds, and paybacks to FQHC or HMOs are reported in Column C.

COLLECTION OF RECONCILIATION/WRAP AROUND, CURRENT YEAR (Column C1) – Enter FQHC cash receipts from Medicare and Medicaid that cover services provided during the current reporting period.

COLLECTION OF RECONCILIATION/WRAP AROUND, PREVIOUS YEARS (Column C2) – Enter FQHC cash receipts from Medicare and Medicaid that cover services provided during previous reporting periods.

COLLECTION OF OTHER RETROACTIVE PAYMENTS INCLUDING RISK POOL/INCENTIVE/WITHHOLD (Column C3) – Enter other cash payments including managed care risk pool redistribution, incentives, and withholds, from any payor. These payments are only applicable to managed care plans. (Note: While table 9C includes co-payments in a similar data element, this column does *not* include co-payments. They are recorded on line 13 as self pay collections.)

PENALTY/PAYBACK (Column C4) – Enter payments made to FQHC payors because of overpayments collected earlier. Also enter payments made to managed care plans (e.g., for over-utilization of the inpatient or specialty pool funds).

NOTE: If a center arranges to have their “repayment” deducted from their monthly payment checks, the amount deducted should be shown in Column (C4) *as if it had actually been paid.*

ALLOWANCES (Column D) – Allowances are granted as part of an agreement with a third-party payor. Medicare and Medicaid, for example, may have a maximum amount they pay, and the center agrees to write off the difference between what they charge and what they receive. *Allowances must be reduced by the net amount of retroactive settlements and receipts reported in the columns C1, C2, C3, C4, including current and prior year FQHC reconciliations, managed care pool distributions and other payments.*

If Medicaid, Medicare, other third-party, and other public payors reimburse less than the grantee's full charge, and the grantee cannot bill the patient for the remainder, enter the remainder or reduction on the appropriate payor line in Column D at the time the Explanation of Benefits (EOB) is received and the amount is written off.

Example: The State Title XIX Agency has paid \$40 for an office visit that was billed at a full charge of \$75. The \$75 should be reported on Line 1 Column A as a full charge to Medicaid. After payment was made, the \$40 payment is recorded on Line 1 Column B. The \$35 reduction is reported as an adjustment on Line 1 Column D.

Under FOHC programs, where the grantee is paid based on cost, it is possible that the cash payment will be greater than the charge. In this case, the adjustment recorded in Column D would be a negative adjustment. (Financial adjustments received under FOHC are reported in Columns C1 and C2)

NOTE: Amounts for which another third party or a private individual can be billed (e.g., amounts due from patients or "Medigap" payors for copayments) are not considered adjustments and should be recorded or reclassified as full charges due from the secondary source of payment. These amounts will only be classified as adjustments when all sources of payment have been exhausted and further collection is not anticipated and/or possible.

Because capitated plans typically pay on a per-member per-month basis only, and make this payment in the current month of enrollment, these plans typically don't carry any receivables. For Capitated Plans (lines 2a, 5a, 8a, and 11a, **ONLY!**) the allowance column should be the arithmetic difference between the charge recorded in column A and the collection in column B unless there were early or late capitation payments (received in a month other than when they were earned) and which span the beginning or end of the calendar year.

Also note that Line 13 Column D is blanked out because up-front allowances given to self-pay patients are recorded as sliding fee discounts and valid self-pay receivables that are not paid should be recorded as self pay bad debt.

SLIDING DISCOUNTS (Column E) – In this column, enter reductions to patient charges based on the patient's ability to pay, as determined by the grantee's sliding discount schedule. This would include discounts to required co-payments, as applicable.

NOTE: Only self-pay patients may be granted a sliding discount based on their ability to pay. All other cells are blanked out. For this reason, "column E" is a "virtual column" on the electronic version of the UDS, appearing below line 14 on the screen. When a charge originally made to a third party such as Medicare or a private insurance company has a co-payment or deductible written off, **THE CHARGE MUST FIRST BE RECLASSIFIED TO SELF-PAY. TO RECLASSIFY,** first reduce the third-party charge by the amount due from the patient and increase the self-pay charges by this same amount.

BAD DEBT WRITE OFF (Column F) – Any payor responsible for a bill may default on a payment due from it. **In the UDS, only self pay bad debts are recorded.** In order to keep responsible financial records, centers are required to write off bad debts on a routine basis. (It is recommended that this be done no less than annually). In some systems this is accomplished by posting an allowance for bad debts rather than actually writing off specific named accounts. Amounts removed from the center's self-pay receivables through either mechanism are recorded here.

Reductions of the net collectable amount for the Self-Pay category should be made on Line 13 column F. Bad debt write off may occur due to the grantee's inability to locate persons, a

patient's refusal to pay, or a patient's inability to pay even after the sliding fee discount is granted.

Under no circumstances are bad debts to be reclassified as sliding discounts, even if the write off to bad debt is occasioned by a patient's inability to pay the remaining amount due. For example, a patient eligible for a sliding discount is supposed to pay 50% of full charges for a visit. If the patient does not pay, even if he or she later qualifies for a 100% discount, the amount written off must still be reported as bad debt, not sliding discount. At the time of the visit, it was a valid collectable from the patient.

Only bad-debts from patients are recorded on this table. While some insurance companies do, in fact, default on legitimate debts as they go bankrupt, centers are not asked to report these data. For this reason, "column F" is a "virtual column" on the electronic version of the UDS, appearing below line 14 on the screen.

TOTAL PATIENT RELATED INCOME (Line 14) – Enter the sum of Lines 3, 6, 9, 12, and 13. Be sure to include only these "subtotal" lines and not the detail for each of the subtotals.

QUESTIONS AND ANSWERS FOR TABLE 9D

1. Are there any important issues to keep in mind for this table?

Payments received from state or local indigent care programs subsidizing services rendered to the uninsured are not reported on this table. All such payments, whether made on a per encounter basis or as a lump sum for services rendered, shall be recorded on Table 9E. See Table 9E for specific instructions. Grantees receiving payments from state/local indigent care programs that subsidize services rendered to the uninsured should:

- Report all charges for these services and collections from patients as “self-pay” (Line 13);
- Report all amounts not collected from the patient as sliding discounts or bad debt, as appropriate, on Line 13 of this table;
- Report collections from the state/local indigent care programs on Table 9E. State/local indigent care programs are now to be reported as a separate category (Line 6a - state/local indigent care programs).

2. Are the data on this table cash or accrual based?

Table 9D is a ‘cash’ table in as much as all entries represent charges, collections, and adjustments recognized in the current year. All entries represent actual charges and adjustments for the calendar year and actual cash receipts for the year.

3. Should the lines of the table “balance”?

No. Because the table is on a ‘cash’ basis, the columns for amount collected and for allowances will include payments and adjustments for services rendered in the prior year. Conversely, some of the charges for the current year will be remaining in accounts receivable at the end of the year. The one exception is on the capitated lines (lines 2a, 5a, 8a, and 11a) where allowances are the difference between charges and collections by definition, provided there are no early or late capitation payments that cross the calendar year change.

4. If we have not received any reconciliation payments for the reporting period what do we show in Column C1 (current year reconciliations)?

If you have not received a check during this reporting period for current year services, enter zero (0) in Column C1.

5. We regularly apply our sliding discount program to write off the deductible portion of the Medicare charge for our certified low-income patients. The sliding discount column (Column E) is blanked out for Medicare. How do we record this write off?

The charge needs to be removed from the Medicare line (Lines 4 - 6 as appropriate) and added into the self-pay line (Line 13). It can then be written off on Line 13. The same process would be used for any other co-payment or deductible write-off.

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UDS No. _____

Date Submitted: _____

Reporting Period: January 1, 2004 through December 31, 2004

Initial Submission

Revision

**TABLE 9D (Part I of II) –
PATIENT RELATED REVENUE (Scope of Project Only)**

PAYOR CATEGORY	FULL CHARGES THIS PERIOD (a)	AMOUNT COLLECTED THIS PERIOD (b)	RETROACTIVE SETTLEMENTS, RECEIPTS, AND PAYBACKS (c)				ALLOWANCES (d)	SLIDING DISCOUNTS (e)	BAD DEBT WRITE OFF (f)
			COLLECTION OF RECONCILIATION/ WRAP AROUND CURRENT YEAR (c1)	COLLECTION OF RECONCILIATION/ WRAP AROUND PREVIOUS YEARS (c2)	COLLECTION OF OTHER RETROACTIVE PAYMENTS INCLUDING RISK POOL/ INCENTIVE/ WITHHOLD (c3)	PENALTY/ PAYBACK (c4)			
1. Medicaid Non-Managed Care									
2a. Medicaid Managed Care (capitated)									
2b. Medicaid Managed Care (fee-for-service)									
3. TOTAL MEDICAID (LINES 1 + 2A + 2B)									
4. Medicare Non-Managed Care									
5a. Medicare Managed Care (capitated)									
5b. Medicare Managed Care (fee-for-service)									
6. TOTAL MEDICARE (LINES 4 + 5A+ 5B)									
7. Other Public including Non-Medicaid CHIP (Non Managed Care)									
8a. Other Public including Non-Medicaid CHIP (Managed Care Capitated)									

UDS No.: _____

Date Submitted: _____

**TABLE 9D (Part II of II) –
PATIENT RELATED REVENUE (Scope of Project Only)**

PAYOR CATEGORY	Full Charges This Period (a)	AMOUNT COLLECTED THIS PERIOD (b)	RETROACTIVE SETTLEMENTS, RECEIPTS, AND PAYBACKS (c)				ALLOWANCES (d)	SLIDING DISCOUNTS (e)	BAD DEBT WRITE OFF (f)
			COLLECTION OF RECONCILIATION/ WRAP AROUND CURRENT YEAR (c1)	COLLECTION OF RECONCILIATION/WRAP AROUND PREVIOUS YEARS (c2)	COLLECTION OF OTHER RETROACTIVE PAYMENTS INCLUDING RISK POOL/ INCENTIVE/ WITHHOLD (c3)	PENALTY/ PAYBACK (c4)			
8b. Other Public including Non-Medicaid CHIP (Managed Care fee-for-service)									
9. TOTAL OTHER PUBLIC (LINES 7 + 8A + 8B)									
10. Private Non-Managed Care									
11a. Private Managed Care (capitated)									
11b. Private Managed Care (fee-for-service)									
12. TOTAL PRIVATE (LINES 10 + 11A + 11B)									
13. Self Pay									
14. TOTAL (LINES 3 + 6 + 9 + 12 + 13)									

INSTRUCTIONS FOR TABLE 9E – OTHER REVENUE

The content of this table is essentially unchanged since the 2002 Reporting period.

Table 9E should be completed by all BPHC grantees covered by the UDS. It is included only in the Universal Report. This table collects information on cash receipts for the reporting period that supported activities described in the scope of project(s) covered by any of the four BPHC grant programs. Income received during the reporting period means cash receipts received during the calendar year for a Federally-approved project even if the revenue was accrued during the previous year.

BPHC GRANTS

LINES 1A THROUGH LINE 1F – Enter draw-downs during the reporting period for all BPHC grants in the primary care cluster. These include all four primary care programs included in the UDS. Amounts should be consistent with the PMS-272 report.

TOTAL HEALTH CENTER CLUSTER (Line 1g) – Enter the total of Lines 1a through 1f.

INTEGRATED SERVICES DEVELOPMENT INITIATIVE GRANTS (line 1h) – Enter the amount of the Integrated Services Development Initiative grant dollars drawn down.

SHARED INTEGRATED MANAGEMENT INFORMATION SYSTEMS GRANTS (line 1i) – Enter the amount of the Shared Integrated Management Information Systems grant dollars drawn down.

CAPITAL IMPROVEMENT PROGRAM GRANTS (line 1j) – Enter the amount of Capital Improvement Program grant dollars drawn down.

TOTAL BPHC GRANTS (Line 1) – Enter the total of Lines 1g (Total Health Center Cluster), 1h (Integrated Services Development Initiative Grants), 1i (Shared Integrated Management Information Systems Grants), and 1j (Capital Improvement Program Grants). Be sure that all BPHC Section 330 grant funds drawn down during the year are included on line 1. NOTE: The amounts shown on the BPHC Grant Lines should reflect **direct funding only** and should not include passthrough or be reduced by money that benefited other centers.

OTHER FEDERAL GRANTS

RYAN WHITE TITLE III HIV EARLY INTERVENTION (Line 2) – Enter the amount of the Ryan White Title III funds drawn down in the reporting period.

OTHER FEDERAL GRANTS (Lines 3-4) – Enter the amount and source of any other Federal grant revenue received during the reporting period which falls within the scope of the project(s). These grants include only those received directly by the center from the Federal Government. Do not include federal funds which are first received by a State or Local government or other agency and then passed on to the grantee. These are included below on Lines 6 through 8.

Grantees are asked to describe the programs so the UDS editor can make sure that the classification of the program as a federal grant is appropriate.

TOTAL OTHER FEDERAL GRANTS (Line 5) – Enter the total of Lines 2 - 4.

NON-FEDERAL GRANTS OR CONTRACTS

STATE GOVERNMENT GRANTS AND CONTRACTS (Line 6) – Enter the amount of funds received under State government grants or contracts. "Contracts and Grants" are defined as amounts received on a line item or other basis which are not tied to the delivery of services. They do NOT include funds from state/local indigent care programs. When a state or local grant or contract *other than an indigent care program* pays a grantee based on the amount of health care services provided or on a negotiated fee for service or fee per visit, the charges, collections and allowances are reported on Table 9D as "Other Public" services, not here on Table 9E

STATE/LOCAL INDIGENT CARE PROGRAMS (Line 6a) – Enter the amount of funds received from state/local indigent care programs that subsidize services rendered to the uninsured (examples include Massachusetts Free Care Pool, New Jersey Uncompensated Care Program, NY Public Goods Pool Funding, California Expanded Access to Primary Care Program, and Colorado Indigent Care Program).

NOTE: Payments received from state or local indigent care programs subsidizing services rendered to the uninsured should be reported on Line 6a of this table whether or not the actual payment to the grantee is made on a per encounter or visit basis or as a lump sum for services rendered. **Patients covered by these programs are reported as uninsured on table 4** and all of their charges, sliding discounts, and bad debt write-offs are reported on the self-pay line (line 13) on Table 9D. Monies collected from the patients covered by indigent programs should be reported on 9D. However, none of the funds reported on Line 6a of Table 9E are to be reported on Table 9D.

LOCAL GOVERNMENT GRANTS AND CONTRACTS (Line 7) Report the amount received from local governments during the reporting period that covers costs included in the scope of the grantee's project(s).

FOUNDATION / PRIVATE GRANTS AND CONTRACTS (Line 8) Report the amount received during the reporting period that covers costs included within the scope of the project(s). Funds which are transferred from another grantee or another community service provider are considered "private grants and contracts" and included on this line.

TOTAL NON-FEDERAL GRANTS AND CONTRACTS (Line 9) – Enter the total of Lines 6, 6a, 7, and 8.

OTHER REVENUE (Line 10) – Other Revenue refers to other receipts included in the Federally approved scope of project that are not related to charge-based services. This may include fund-raising, interest income, rent from tenants, etc.

TOTAL REVENUE (Line 11) – Enter the total of Lines 1, 5, 9, and 10 for total other revenues / income.

NOTE: GRANT FUNDS SHOULD ALWAYS BE REPORTED BASED ON THE ENTITY THAT AWARDS THEM, REGARDLESS OF THEIR ORIGIN. FOR EXAMPLE, FUNDS AWARDED BY THE STATE FOR MATERNAL AND CHILD HEALTH SERVICES USUALLY INCLUDE A MIXTURE OF FEDERAL FUNDS SUCH AS TITLE V AND STATE FUNDS. THESE SHOULD BE REPORTED AS STATE GRANTS BECAUSE THEY ARE AWARDED BY THE STATE.

UDS No. _____

Date Submitted: _____

Reporting Period: January 1, 2004 through December 31, 2004

Initial Submission

Revision

TABLE 9E – OTHER REVENUES

	SOURCE	AMOUNT (a)
BPHC GRANTS (ENTER AMOUNT DRAWN DOWN - CONSISTENT WITH PMS-272)		
1a.	Migrant Health Center	
1b.	Community Health Center	
1c.	Health Care for the Homeless	
1e.	Public Housing Primary Care	
1f.	School Based Clinics	
1g.	TOTAL HEALTH CENTER CLUSTER (SUM LINES 1A THROUGH 1F)	
1h.	Integrated Services Development Initiative	
1i.	Shared Integrated Management Information Systems	
1j.	Capital Improvement Program Grants	
1.	TOTAL BPHC GRANTS (SUM LINES 1G + 1H + 1I + 1J)	
OTHER FEDERAL GRANTS		
2.	Ryan White Title III HIV Early Intervention	
3.	Other Federal Grants (specify: _____)	
4.	Other Federal Grants (specify: _____)	
5.	TOTAL OTHER FEDERAL GRANTS (SUM LINES 2 - 4)	
NON-FEDERAL GRANTS OR CONTRACTS		
6.	State Government Grants and Contracts	
6a.	State/Local Indigent Care Programs	
7.	Local Government Grants and Contracts	
8.	Foundation/Private Grants and Contracts	
9.	TOTAL NON-FEDERAL GRANTS AND CONTRACTS (SUM LINES 6 + 6A + 7 + 8)	
10.	Other Revenue (Non-patient related revenue not reported elsewhere)	
11.	TOTAL REVENUE (LINES 1 + 5 + 9 + 10)	

APPENDIX A LISTING OF PERSONNEL

(All Line numbers in the following table refer to Table 5)

PERSONNEL BY MAJOR SERVICE CATEGORY	PROVIDER	NON-PROVIDER
PHYSICIANS		
• Family Practitioners (Line 1)	X	
• General Practitioners (Line 2)	X	
• Internists (Line 3)	X	
• Obstetrician/Gynecologists (Line 4)	X	
• Pediatrician (Line 5)	X	
•		
OTHER SPECIALIST PHYSICIANS (Line 7)		
• Allergists	X	
• Cardiologists	X	
• Dermatologists	X	
• Orthopedists	X	
• Surgeons	X	
• Urologists	X	
• Ophthalmologists	X	
• Other Specialists And Sub-Specialists	X	
NURSE PRACTITIONERS (Line 9a)	X	
PHYSICIANS ASSISTANTS (Line 9b)	X	
CERTIFIED NURSE MIDWIVES (Line 10)	X	
NURSES (Line 11)		
• Clinical Nurse Specialists	X	
• Public Health Nurses	X	
• Home Health Nurses	X	
• Visiting Nurses	X	
• Registered Nurse	X	
• Licensed Practical Or Vocational Nurse	X	
OTHER MEDICAL PERSONNEL (Line 12)		
• Nurse Aide/Assistant (Certified And Uncertified)		X
• Clinic Aide/Medical Assistant (Certified And Uncertified Medical Technologists)		X
LABORATORY PERSONNEL (Line 13)		
• Pathologists		X
• Medical Technologists		X

PERSONNEL BY MAJOR SERVICE CATEGORY	PROVIDER	NON-PROVIDER
• Laboratory Technicians		X
• Laboratory Assistants		X
• Phlebotomists		X
X-RAY PERSONNEL (Line 14)		
• Radiologists		X
• X-Ray Technologists		X
• X-Ray Technician		X
DENTISTS (Line 16)		
• General Practitioners	X	
• Oral Surgeons	X	
• Periodontists	X	
• Endodontists	X	
OTHER DENTAL		
• Dental Hygienists (Line 17)	X	
• Dental Assistant (Line 18)		X
• Dental Technician (Line 18)		X
• Dental Aide (Line 18)		X
MENTAL HEALTH (Line 20) & SUBSTANCE ABUSE (Line 21)		
• Psychiatrists (Line 20a)	X	
• Psychologists	X	
• Social Workers - Clinical And Psychiatric	X	
• Nurses - Psychiatric And Mental Health	X	
• Alcohol And Drug Abuse Counselors	X	
• Nurse Counselor	X	
ALL OTHER PROFESSIONAL PERSONNEL (Line 22)		
• Audiologists	X	
• Acupuncturists	X	
• Chiropractors	X	
• Herbalists	X	
• Occupational Therapists	X	
• Optometrists	X	
• Podiatrists	X	
• Physical Therapists	X	
• Respiratory Therapists	X	
• Speech Pathologists	X	
• Traditional healers	X	
• Nutritionists/Dietitians	X	
PHARMACY PERSONNEL (Line 23)		

PERSONNEL BY MAJOR SERVICE CATEGORY	PROVIDER	NON-PROVIDER
• Pharmacist		X
• Pharmacist Assistant		X
• Pharmacy clerk		X
ENABLING SERVICES		
CASE MANAGERS (Line 24)		
• Case Managers	X	
• Social Workers	X	
• Public Health Nurses	X	
• Home Health Nurses	X	
• Visiting Nurses	X	
• Registered Nurses	X	
• Licensed Practical Nurses	X	
HEALTH EDUCATORS (Line 25)		
• Family Planning Counselors	X	
• Health Educators	X	
• Social Workers	X	
• Public Health Nurses	X	
• Home Health Nurses	X	
• Visiting Nurses	X	
• Registered Nurses	X	
• Licensed Practical Nurses	X	
OUTREACH WORKERS (Line 26)		
		X
PATIENT TRANSPORTATION WORKERS (Line 27)		
• Patient Transportation Coordinator		X
• Driver		X
OTHER ENABLING SERVICES PERSONNEL (Line 28)		
• Child Care Workers		X
• Eligibility Assistance Workers		X
• Interpreters/Translators		X
OTHER RELATED SERVICES STAFF (Line 29a)		
• WIC Workers		X
• Head Start Workers		X
• Housing assistance workers		X
• Food bank / meal delivery workers		X
• Employment / Educational Counselors		X
ADMINISTRATION (Line 30)		
• Project Director		X

PERSONNEL BY MAJOR SERVICE CATEGORY	PROVIDER	NON-PROVIDER
• Administrator		X
• Finance Director		X
• Accountant		X
• Bookkeeper		X
• Secretary		X
• Director Of Planning And Evaluation		X
• Clerk Typist		X
• Billing Clerk		X
• Cashier		X
• Director Of Data Processing		X
• Key Punch Operator		X
• Personnel Director		X
• Registration Clerk		X
• Receptionist		X
• Director Of Marketing		X
• Marketing Representative		X
• Enrollment/Service Representative		X
FACILITY (Line 31)		
• Janitor/Custodian		X
• Security Guard		X
• Groundskeeper		X
• Equipment Maintenance Personnel		X
• Housekeeping Personnel		X
PATIENT SERVICES SUPPORT STAFF (Line 32)		
• Medical And Dental Team Clerks		X
• Medical And Dental Team Secretaries		X
• Medical And Dental Appointment Clerks		X
• Medical And Dental Patient Records Clerks		X
• Patient Records Supervisor		X
• Patient Records Technician		X
• Patient Records Clerk		X
• Patient Transcriptionist		X
• Appointments Clerk		X

APPENDIX B SERVICE DEFINITIONS

(All line numbers in the following table refer to Table 2)

SERVICE CATEGORY	DEFINITIONS
PRIMARY MEDICAL CARE SERVICES	
General Primary Medical Care (Line 1)	Provision of basic preventive and curative medical services.
Diagnostic Laboratory (Technical Component) (Line 2)	Technical component of laboratory procedures. Does not include services of a physician to order or to analyze/interpret results from these procedures.
X-Ray Procedures (Technical Component) (Line 3)	Technical component of diagnostic X-ray procedures. Does not include services of a physician to order or to analyze/interpret results from these procedures.
Diagnostic Tests/Screenings (Professional Component) (Line 4)	Professional services to order and analyze/interpret results from diagnostic tests and screenings. Includes services of a physician to order or to analyze/interpret results from these procedures.
Emergency Medical Services (Line 5)	Provision of emergency services on a regular basis to meet life, limb or function-threatening conditions. Nearly all centers will provide EMS via referral arrangements.
Urgent Medical Care (Line 6)	Provision of medical care of an urgent or immediate nature on a routine or regular basis.
24-Hour Coverage (Line 7)	The availability of services on a 24-hour basis.
Family Planning Services (Contraceptive Management) (Line 8)	Provision of contraceptive/birth control or infertility treatment. Counseling and education by providers are included here; when provided by other staff, include under enabling services.
HIV Testing and counseling (Line 9)	Testing and counseling for HIV. Counseling and education by providers included here; when provided by other staff, include under enabling services.
Testing Blood Lead Levels (Line 10)	Testing to ensure that levels of lead in blood are below critical levels. Tests are generally conducted for at risk children.
Immunizations (Line 11)	Provision of the following preventive vaccines: Diphtheria, Pertussis, Tetanus, Measles, Mumps, Rubella, Poliovirus, Influenza virus, Hepatitis B, Hemophilus influenza B.
Following Hospitalized Patients (Line 12)	Visits to health center patients during hospitalizations.
OBSTETRICAL AND GYNECOLOGICAL CARE	
Gynecological Care (Line 13)	Gynecological services provided by a nurse, nurse practitioner, nurse midwife or physician, including annual pelvic exams and pap smears, follow-up of abnormal findings, and diagnosis and treatment of sexually transmitted diseases/infections. This category does not include family planning services.
Obstetrical Care (Lines 14 through 20)	Provision of listed services (i.e., prenatal care, antepartum fetal assessment, ultrasound, genetic counseling and testing, amniocentesis, labor and delivery professional care, postpartum care) related to pregnancy, delivery and postpartum care.

SERVICE CATEGORY	DEFINITIONS
SPECIALTY MEDICAL CARE	
Directly observed TB therapy (Line 21)	Delivery of therapeutic TB medication under direct observation of center staff.
Respite Care (Line 22)	Recuperative or convalescent services used by homeless people with medical problems who are too ill to recover on the streets or in a shelter. It includes the provision of shelter and medical care with linkages to other health care services such as mental health, oral health, substance abuse treatment and social services.
Other specialty care (Line 23)	Services provided by medical professionals trained in any of the following specialty areas: Allergy; Dermatology; Gastroenterology; General Surgery; Neurology; Optometry/Ophthalmology; Otolaryngology; Pediatric Specialties; Anesthesiology.
DENTAL CARE	
Dental Care (Lines 24 through 27)	Provision by a dentist or dental hygienist of the listed services: preventive, restorative, emergency, and restorative.
MENTAL HEALTH/SUBSTANCE ABUSE SERVICES	
Mental Health Treatment/ Counseling (Lines 28 & 31) Developmental Screening (Line 29) 24-Hour Crisis Intervention/ Counseling (Line 30)	Mental health therapy, counseling, or other treatment provided by a mental health professional.
Substance Abuse Treatment/ Counseling (Lines 32 & 33)	Counseling and other medical and/or psychosocial treatment services provided to individuals with substance abuse (i.e., alcohol and/or other drug) problems. May include screening and diagnosis, detoxification, individual and group counseling, self-help support groups, alcohol and drug education, rehabilitation, remedial education and vocational training services, and aftercare.
Comprehensive mental health / substance abuse screening. (Line 33a)	Comprehensive mental health / substance abuse screening is a tool used to identify individuals / clients / users / patients with emotional problems, mental illness, and /or addictive disorders who may desire or benefit from behavioral health and recovery services designed to promote mental health and wellness. The screening is conducted by or under the direction of the following licensed behavioral health providers: clinical or counseling psychologist, psychiatrist, clinical social worker, marriage/family therapist, psychiatric nurse specialist or professional counselor.
OTHER PROFESSIONAL SERVICES	
Hearing Screening (Line 34)	Diagnostic services to identify potential hearing problems.
Nutrition Services Other Than WIC (Line 35)	Advice and consultation appropriate to individual nutrition needs.
Occupational Or Vocational Therapy (Line 36)	Therapy designed to improve or maintain an individual's employment/career skills and involvement.
Physical Therapy (Line 37)	Assistance designed to improve or maintain an individual's physical capabilities.
Pharmacy	Dispensing of prescription drugs and other pharmaceutical

SERVICE CATEGORY	DEFINITIONS
(Line 38)	products.
Pharmacy – Physician Dispensing (Line 39)	Operation of a dispensary at a clinic service delivery location where the clinicians are responsible for doing the actual dispensing of the drugs.
Vision Screening (Line 40)	Diagnostic services to identify potential vision problems.
Podiatry (Line 41)	Services provided by a medical professional licensed to diagnose and treat conditions affecting the human foot, ankle, and their governing and related structures, including the local manifestations of systemic conditions.
Optometry (Line 42)	Services provided by a medical professional licensed or certified to diagnose, treat and manage diseases and disorders of the visual system, the eye and associated structures as well as diagnosis of related systemic conditions.
ENABLING SERVICES	
Case Management (Line 43)	Client-centered service that links clients with health care and psychosocial services to insure timely, coordinated access to medically appropriate levels of health and support services and continuity of care. Key activities include: 1)assessment of the client's needs and personal support systems; 2) development of a comprehensive, individualized service plan; 3)coordination of services required to implement the plan; client monitoring to assess the efficacy of the plan; and 4) periodic re-evaluation and adaptation of the plan as necessary.
Child Care (Line 44)	Assistance in caring for a user's young children during medical and other health care visits.
Discharge Planning (Line 45)	Services related to arranging an individual's discharge from the hospital (e.g., home health care).
Eligibility Assistance (Line 46)	Assistance in securing access to available health, social service and other assistance programs, including Medicaid, WIC, SSI, food stamps, TANF, and related assistance programs. Does not include eligibility assistance provided by grantee or government staff under arrangements for Out-stationed Eligibility Workers, as mandated by law; report the latter on line 51.
Environmental Health Risk Reduction (Line 47)	Includes the detection and alleviation of unhealthful conditions associated with water supplies, sewage treatment, solid waste disposal, rodent and parasitic infestation, field sanitation, housing, and other environmental factors related to health (e.g., lead paint abatement and pesticide management).
Health Education (Line 48)	Personal assistance provided to promote knowledge regarding health and healthy behaviors, including knowledge concerning sexually transmitted diseases, family planning, prevention of fetal alcohol syndrome, smoking cessation, reduction in misuse of alcohol and drugs, improvement in physical fitness, control of stress, nutrition, and other topics. Included are services provided to the client's family and/or friends by non-licensed mental health staff which may include psychosocial, caregiver support, bereavement counseling, drop-in counseling, and other support groups activities.
Interpretation/Translation Services (Line 49)	Services to assist individuals with language/communication barriers in obtaining and understanding needed services.
Nursing Home And Assisted-Living Placement (Line 50)	Assistance in locating and obtaining nursing home and assisted-living placements.

SERVICE CATEGORY	DEFINITIONS
Outreach (Line 51)	Case finding, education or other services to identify potential clients and/or facilitate access/referral of clients to available services.
Transportation (Line 52)	Transportation, including tokens and vouchers, provided by the grantee for users.
Out-Stationed Eligibility Workers (Line 53)	Provision of assistance to individuals to enable them to qualify for Medicaid, under provisions of Federal law requiring Out-Stationed Eligibility Workers.
Home Visiting (Line 54)	Provision of services in the client's home. Not inclusive of services such as medical, home nursing, case management etc. which have their own categories.
Parenting Education (Line 55)	Individual or group sessions designed to enhance the child-rearing skills of parents/caregivers.
Special Education Program (Line 56)	Educational programs designed for children with a disability.
Other (Line 57)	This line provides the opportunity to identify an enabling service you are providing that is otherwise not listed. Please specify the service provided.
PREVENTIVE SERVICES RELATED TO TARGET CLINICAL AREAS	
Pap Smear (Line 58)	Microscopic examination of cells collected from the cervix to detect cancer, changes in cervix, or non-cancerous conditions such as infection or inflammation.
Fecal occult blood test (Line 59)	Test to check for small amounts of hidden blood in stool.
Sigmoidoscopy (Line 60)	An examination of the rectum and lower part of the colon through a tube which contains a light source and a camera lens.
Colonoscopy (Line 61)	An examination of the rectum and entire colon using a colonoscope. Procedure can be used to remove polyps or other abnormal tissue.
Mammograms (Line 62)	An x-ray of the breast.
Smoking cessation program (Line 63)	A clinical and public-health intervention program for smoking cessation which may involve identification of smokers, diagnosis of nicotine dependence, and self-help products and counseling.
Glycosylated hemoglobin measurement for people with diabetes (Line 64)	A test that assesses the average blood glucose level during several months.
Urinary microalbumin measurement for people with diabetes (Line 65)	A laboratory procedure to detect very small quantities of protein in the urine indicating kidney damage.
Foot exam for people with diabetes (Line 66)	A foot examination using monofilaments to test for sensation from pressure that identifies those patients who have lost protective sensation in their feet.
Dilated eye exam for people with diabetes (Line 67)	An examination in which the pupils are dilated in order to check for diabetic eye disease.
Blood pressure monitoring (Line 68)	Tracking blood pressure through regular measurement of blood pressure.
Weight reduction program (Line 69)	A program in which patients are taught to eat healthy foods, engage in exercise, and monitor caloric intake in order to lose weight and improve their health.
Blood cholesterol screening (Line 70)	A blood test that will detect the levels of cholesterol and triglycerides in the body in order to discover if there are abnormal or unhealthy levels of cholesterol in the blood.

SERVICE CATEGORY	DEFINITIONS
Follow-up testing and related health care services for abnormal newborn bloodspot screening (Line 71)	Conducting additional newborn screening (using the bloodspot screening or other methods) to assess for common and/or serious health conditions of newborn infants.
OTHER SERVICES	
WIC Services (Line 72)	Nutrition and health counseling services provided through the Special Supplemental Food Program for Women, Infants and Children
Head Start (Line 73)	Comprehensive developmental services for low-income, preschool children less than 5 years of age
Food Banks / Delivered Meals (Line 74)	Provision of food or meals, not the finances to purchase food or meals.
Employment/ Educational Counseling (Line 75)	Counseling services to assist an individual in defining career/employment/educational interests, and in identifying employment opportunities and/or education options
Assistance in Obtaining Housing (Line 76)	Assistance in locating and obtaining suitable shelter, either temporary or permanent. May include locating costs, moving costs, and/or rent subsidies.