

Send to: Tracey Martin
Fax #: 301-443-4370

RHC Provider #:

Office of Shortage Designation
CERTIFICATE OF ELIGIBILITY
DOCUMENT REQUIRED FOR AUTOMATIC HPSA DESIGNATION FOR RURAL HEALTH CLINICS

We, _____
Rural Health Clinic Name and Address (separate forms required for each separate site)

agree to:

- A. Not deny requested health care services, and shall not discriminate in the provision of services to an individual because:
 - The individual is unable to pay for the services, or
 - Because payment for services would be made under: the Medicare program (Title XVIII for the Social Security Act), the Medicaid program (Title XIX of such Act), or the State's children's health insurance program (Title XXI of such Act).
- B. Prepare a schedule of fees or payments for services, consistent with locally prevailing rates or charges for health care services and designed to cover the reasonable cost of operation
- C. Prepare a corresponding schedule of discounts (including, in appropriate cases, waivers) to be applied to such fees and payments. Discounts shall be adjusted on the basis of the patient's ability to pay. Please enclose a copy of the discount schedule.
- D. Make every reasonable effort to secure from patients fees and payments for services in accordance with such schedules, and fee or payments shall be sufficiently discounted in accordance with C above.
- E. Accept assignment for individuals who are beneficiaries under Medicare.
- F. Enter into an appropriate agreement with the state agencies administering Medicaid and SCHIP for individuals who are beneficiaries under those programs.
- G. Take reasonable and appropriate steps to collect all payments due for health care services provided by the entity, including payments from any third party.
- H. Display prominently a notice of the availability of discounted fees and acceptance of Medicare, Medicaid, and SCHIP to assure public awareness of these options.

These requirements will be reflected in our Policies and Procedures Manual, and subject to review as part of the regular Rural Health Clinic certification process.

Signatures below are assurance that this document contains true and correct information and that the site agrees to comply with all of the above requirements.

Name of RHC Site Official: _____ Phone: _____

Signature of RHC Approving Official: _____ Phone: _____

Title: _____ Date: _____

Do you have a pending NHSC R & R application with the NHSC? Y_____ N_____

[Information on the NHSC R & R application can be found at <http://nhsc.hrsa.gov/communities/apply.htm>]