



OMB No.: 0915-0285. Expiration Date: 01/31/2020

<b>DEPARTMENT OF HEALTH AND HUMAN SERVICES</b> <b>Health Resources and Services Administration</b>  <b>FORM 5B: SERVICE SITES</b>	<b>FOR HRSA USE ONLY</b>	
	Grant Number	Application Tracking Number

**Note:** Form 5B is only required if you are proposing to add a new service site.

**Site Qualification Criteria**

<p>1. Is the site an Admin-only site?</p> <p>If Yes, the site is an Admin-only site, select 'Not Applicable' for questions a through d below. If No, the site is a Service Delivery site, answer questions a through d Yes or No.</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p>a. Are/will health center visits be generated by documenting in the patients' records face-to-face contacts between patients and providers?</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable
<p>b. Do/will providers exercise independent judgment in the provision of services to the patient?</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable
<p>c. Are/will services be provided directly by or on behalf of the grantee, whose governing board retains control and authority over the provision of the services at the location?</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable
<p>d. Are/will services be provided on a regularly scheduled basis (e.g., daily, weekly, first Thursday of every month)?</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable
<p>2. Is the site a Domestic Violence (Confidential) shelter?</p> <p>Select Yes for this question only if the site being added is a confidential site serving victims of domestic violence and the site address cannot be published due to the necessity to protect the location of the domestic violence shelter.</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable

**Site Information**

Site Name		Site Physical Address (Please ensure your address contains the appropriate unique suite, building, or other notation, if appropriate. If the address displayed does not contain this information, please select Change Physical Location and update as appropriate)	
Site Type	<input type="checkbox"/> Administrative/Service Delivery Site <input type="checkbox"/> Service Delivery Site	Site Phone Number	
Web URL			

**The following fields are required for "Service Delivery" and "Administrative/Service Delivery" site types:**

Location Type	<input type="checkbox"/> Permanent <input type="checkbox"/> Seasonal <input type="checkbox"/> Mobile <input type="checkbox"/> Migrant Voucher <input type="checkbox"/> Intermittent	Site Setting	<input type="checkbox"/> All Other Clinic Types <input type="checkbox"/> Hospital <input type="checkbox"/> School
Date Site was Added to Scope	N/A	Site Operational Date	



Site Information			
FQHC Site Medicare Billing Number Status	<input type="checkbox"/> This site is neither permanent nor seasonal per CMS (i.e., does not require unique FQHC Medicare Billing Number) <input type="checkbox"/> Health center does not/will not bill under the FQHC Medicare system at this site <input type="checkbox"/> Number is pending; application for this site has been submitted to CMS <input type="checkbox"/> Application for this site has not yet been submitted to CMS <input type="checkbox"/> This site has a Medicare billing number	FQHC Site Medicare Billing Number (Required if 'This site has a Medicare billing number' is selected in 'FQHC Site Medicare Billing Number Status' field)	
FQHC Site National Provider Identification (NPI) Number (Optional field)		Total Hours of Operation (when patients will be served per week)	
Months of Operation			
Service Area Zip Codes			
Number of Contract Service Delivery Locations (Required only for 'Migrant Voucher Screening' Site Type)		Number of Intermittent Sites (Required only for 'Intermittent Site' Type)	
Site Operated by	<input type="checkbox"/> Health Center/Applicant <input type="checkbox"/> Subrecipient <input type="checkbox"/> Contractor		
Subrecipient or Contractor Information			
(Required only if 'Subrecipient' or 'Contractor' is selected in 'Site Operated By' field)			
Subrecipient/Contractor Organization Name			
Subrecipient/Contractor Organization Physical Site Address			
Subrecipient/Contractor EIN			

Public Burden Statement: An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. The OMB control number for this project is 0915-0285. Public reporting burden for this collection of information is estimated to average 1 hour per response, including the time for reviewing instructions, searching existing data sources, 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 HRSA Reports Clearance Officer, 5600 Fishers Lane, Room 14N-39, Rockville, Maryland, 20857.