FORM C: FQHC SECONDARY SITE

***Instructions: Complete a separate form for each clinic site, numbered consecutively (see FQHC Secondary Site Form Instructions).***

|  |
| --- |
| **Legal Name of Applicant/FQHC:       Site #    of**  |

|  |
| --- |
| **FQHC Site Name to Appear on OSDH Website:** |
| **Service Area (counties to be served by this site):** |
| **FQHC Site Contact Person:**  |
| **Number of Patients Served at this Site in SFY 2016:**  |
| **Location of Site:       Street Address:**  |
| **City:       County:       Zip Code:**  |
| **Phone: (   )   -     Fax: (   )   -** |
| **Is this Site a Subcontractor Site? [ ]  Yes [ ]  No** |
| **Email:**      **Website:**         |

FORM D: FQHC SECONDARY SITE

***Instructions: Complete a separate form for each clinic site, numbered consecutively (see FQHC Secondary Site Form Instructions).***

|  |  |  |  |
| --- | --- | --- | --- |
| **DAY** | **HOURS OF OPERATION** | **SERVICES PROVIDED / CLINIC TYPE** | **# MONTHLY CLINICS** |
|  | **From** | **To** |  |  |
| **MONDAY** | **Morning** |   :   |   :   |       |      |
| **Afternoon** |   :   |   :   |       |  |
| **Evening (After 5 PM)** |   :   |   :   |       |  |
| **TUESDAY** | **Morning** |   :   |   :   |       |      |
| **Afternoon** |   :   |   :   |       |  |
| **Evening (After 5 PM)** |   :   |   :   |       |  |
| **WEDNESDAY** | **Morning** |   :   |   :   |       |      |
| **Afternoon** |   :   |   :   |       |  |
| **Evening (After 5 PM)** |   :   |   :   |       |  |
| **THURSDAY** | **Morning** |   :   |   :   |       |      |
| **Afternoon** |   :   |   :   |       |  |
| **Evening (After 5 PM)** |   :   |   :   |       |  |
| **FRIDAY** | **Morning** |   :   |   :   |       |      |
| **Afternoon** |   :   |   :   |       |  |
| **Evening (After 5 PM)** |   :   |   :   |       |  |
| **SATURDAY** | **Morning** |   :   |   :   |       |      |
| **Afternoon** |   :   |   :   |       |  |
| **Evening (After 5 PM)** |   :   |   :   |       |  |
| **SUNDAY** | **Morning** |   :   |   :   |       |      |
| **Afternoon** |   :   |   :   |       |  |
| **Evening (After 5 PM)** |   :   |   :   |       |  |
| **TOTAL HOURS/MONTH** |      | **TOTAL # CLINICS PER MONTH** |      |