

SCOPE OF SERVICES SURVEY BASELINE DOCUMENTATION

Facility: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____

License Number: _____

Name of Chief Executive: _____

Name of Person Completing Survey: _____

Date of Survey: _____

Instructions

With the implementation of a Prospective Payment System for Primary Care Centers and Rural Health Clinics, Centers and Clinics will complete this form for each separately licensed Center or Clinic to document services in the base year. If an organization operates multiple licensed primary care centers or RHC's, a form will have to be completed for each facility. Thereafter, this form will be completed during the annual licensure survey.

Cover	Information requested is self explanatory
Page 2-3	Instructions
Page 4, No. 1	Documents services by primary care medical specialty (Page 4, No. 1.a provides ample room to list other services) If for example, the Center has a Family Practitioner who provides prenatal, deliveries, pediatrics, mental health, family care and inpatient services, then all cells should be checked.
Page 4, No. 1.a	Provides space for other scope of service categories the Facility provides.
Page 5, No. 2	Listing of health education and outreach services the Facility provides to Medicaid and other patients. Services of these types are required to have a Facility license. These services generally do not generate a billable encounter. Examples would include nursing education, diabetic counseling, prenatal education, screening at a housing project, school nurse programs, etc.

- Page 5, No 3. Requires documentation of the level of laboratory services provided. Refer to your **CLIA** certifications for the proper response.
- Page 5, No. 4 Document radiology services provided.
- Page 5, No. 5 Facility's supplemental services are listed. At least two of these services must be provided directly to obtain a primary care license. Other services, such as pharmacy and home health can be provided, but are generally not billed as a primary care service. Report only those services reimbursed under the Facility's PPS rate.
- Page 6, No. 6 List Extension (satellite) locations.
- Page 6, No. 7 Document holding beds.
- Page 7, No. 8 Other services not documented elsewhere in this survey, should be listed. Example: could include transportation services or other services included in the Facility's base PPS rate.
- Page 7, No. 9 - 11 Documents changes in scope and provides an affirmation and attestation of the validity of the information provided.
- Page 7 Signature and Date line for the Chief Executive of the Facility.

Specialty	Scope of Services Category							
	OB Prenatal	OB Deliveries	Peds	Family or General Medicine	Mental Health	Geriatrics	Inpatient	
Family Practice								
Internal Medicine								
Obstetrics								
GYN								
Peds								

Ia. Checklist of Basic Medical and Diagnostic Treatment Services (Continued)

Specialty	Scope of Services Category							

2. List health education and outreach services that do not generate a Medicaid billable encounter. (Such as diabetic counseling, smoking cessation, etc.)

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

3. Does the Facility provide Laboratory Services?

_____ Yes _____ NO (all **labs** are send outs)

If yes: What level of Laboratory Service does the Facility Provide? _____

4. Does the Facility provide X-Ray Services?

_____ Yes _____ NO

If yes: List various modalities provided, i.e.: routine diagnostics, mammography, ultrasound, etc.

_____	_____	_____
_____	_____	_____
_____	_____	_____

5. Identify Supplemental Services provided by the Facility under its Primary Care License and reimbursed under the Facility's PPS rate.

Pharmacy	_____ YES	_____ NO
Dentistry	_____ YES	_____ NO
Optometry	_____ YES	_____ NO
Midwifery Services	_____ YES	_____ NO
Family Planning	_____ YES	_____ NO
Nutrition services provided By a qualified Dietitian or Nutritionist	_____ YES	_____ NO

Social Services Counseling
Provided by a licensed
Social Worker _____YES _____NO

Home Health
(licensed agency) _____YES _____NO

6. Does the Facility have Extension Services (i.e. satellites) under its Primary Care License and included under the Facility's PPS rate?

_____Yes _____No

If yes: List each Extension Service and their respective license numbers.

Extension Service Name	License # and/or Location
_____	_____
_____	_____
_____	_____
_____	_____

7. Does the Facility currently operate holding beds as a service?

_____Yes _____No

8. Are there other services currently provided which have not been reported in other sections of this document?

If yes: please list.

_____	_____	_____
_____	_____	_____
_____	_____	_____

9. Does this report reflect any changes in scope of services?

[] Yes - Increase in services

[] Yes - Decrease in services

[] No Change

10. **If a decrease in scope of services has occurred, does it affect encounter cost?**

Yes - Estimated increased

Yes - Estimated decreased

No Change in rate cost

11. **Is a rate change being requested based on the increase in scope of service?**

Yes

No

I attest and affirm that to the best of my knowledge all information is correct.

Facility's Chief Executive

Date