



Health Professional Shortage Area Designation Request Application

PLEASE TYPE OR PRINT CLEARLY

I. Contact Information:

Name: Last:	First:	Middle:
Email Address:		Telephone Number:

II. Site Information:

Facility/Practice Name:			
Address:			
City:	State:	Zip:	County:
E-Mail Address (if applicable):			
Telephone Number:			
Populations Served:			
Medicaid: %	Sliding Fee Scale: %	Medicare: %	Private: %
Majority of Practice Patients Are: <input type="checkbox"/> Outpatient <input type="checkbox"/> Inpatient <input type="checkbox"/> Other (specify):			

III. Reason for Request:

Type of HPSA Requested: <input type="checkbox"/> Primary Care <input type="checkbox"/> Mental Health <input type="checkbox"/> Dental
This HPSA is being requested to meet the criteria for this site to apply as a:
<input type="checkbox"/> Area of Critical Need Facility Designation <input type="checkbox"/> National Health Service Corps Site Application <input type="checkbox"/> Other
Additional Information:

Please submit application electronically to: FL.PCO@flhealth.gov

For Department Use Only:			
Date Request Received:	Current HPSA at this location: <input type="checkbox"/> Yes <input type="checkbox"/> No		
Did RSA Meet criteria: PC: <input type="checkbox"/> Yes <input type="checkbox"/> No	MH: <input type="checkbox"/> Yes <input type="checkbox"/> No	Dental: <input type="checkbox"/> Yes <input type="checkbox"/> No	
HPSA Score:	PC:	MH:	Dental:
Date submitted to HRSA:			
HPSA Approved:	<input type="checkbox"/> Yes (Date Notified: _____)		<input type="checkbox"/> No (Date Notified: _____)