Health Professional Shortage Area Designation Request Application

PLEASE TYPE OR PRINT CLEARLY

I. Contact Information:

Name, Last: First: Middle:

Email Address: Telephone Number:

II. Clinic Site Information:

Name of Practice:

Email Address: Telephone Number:

Address:

City: Zip: County:

Populations Served:

Medicaid % Sliding Fee:% Medicare:% Private: %

Reason for Request:

☐ Area of Critical Need Facility Designation ☐ National Health Service Corps Site Application ☐ Other (describe):

For Department Use Only:

Date Request Received:

HPSA Type Application Status: Created in SDMS ☐ RSA: ☐ CA: ☐

Supplemental Information ☐ Submitted: Date In HRSA Review: ☐ HRSA Denied ☐ Approved ☐

Date of HRSA Approval or Denial: Comments:

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