Florida Reimbursement Assistance for Medical Education – Dental Program | FRAME[dental]

Employment Verification Form

Please type or write legibly. Any illegible field will make this form incomplete.

SECTION 1: Applicant Information

1.1 Applicant Name: _____

1.2 Please select one:

☐ 1) I am an employee (I receive a W-2 Form at the end of the year).
[Sign acknowledgment, then give the form to your employer(s) to complete the remainder of the form.]

☐ 2) I am an independent contractor (I receive a 1099 Form at the end of the year).
[Sign acknowledgment, then skip to Section 3]

1.3 I acknowledge that the Florida Department of Health (FDOH) reserves the right to correct any field in the FRAMEworks portal that does not match the information attested to in this document. Dental HPSA information may be updated to correct the information if it is incorrect on this form or as entered in the FRAMEworks portal. Furthermore, any changes made by FDOH in correcting data entry errors may change the award prioritization and scoring.

_____ _____
Applicant's Signature Date

SECTION 2: Current Employer Information

2.1 Employer Name:			
2.2 Address:			
2.3 City:	2.4 State:	2.5 ZIP:	2.6 County:
2.7 Employer's Type: ☐ For Profit ☐ Non-Profit ☐ Government-Owned Entity (County, State, Federal)			
2.8 Contact Name:		2.9 Telephone Number:	

SECTION 3: Current Primary Care Employment Locations

3.1 The applicant's first date of employment with this employer/practice: _____

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Applicant Name: _____

Primary Practice Site Location of Applicant			
3.2 This site is: ☐ 1. An FQHC[1] or FQHC Look-Alike ☐ 2. An Indian tribal health clinic ☐ 3. County health department ☐ 4. Other non-profit agency ☐ 5. State University-run dental clinic ☐ 6. Federally funded Rural health clinic (RHC) ☐ 7. Children's Medical Services site ☐ 8. Other publicly funded agency			
3.3 Facility/Practice Name:		3.4 Telephone Number:	
3.5 Address:			
3.6 City:	3.7 State:	3.8 ZIP:	3.9 County:
3.10 NHSC Approved Site: ☐ Yes ☐ No ☐ I don't know		3.11 Does this location accept Medicaid? ☐ Yes ☐ No	
3.12 Dental HPSA Name[2]:		3.13 HPSA Score:	3.14 HPSA ID Number:
3.15 Direct Patient Care Hours for the month immediately preceding application: Week 1: Week 2: Week 3: Week 4+: Direct patient care hours are defined as in-person, face-to-face care with live patients. Time spent providing telemedicine services, research, administrative duties, or traveling CANNOT be included.			
3.16 Number of Patients[3] seen at this location by this dentist:		3.17 With Medicaid:	3.18:
3.19 Supervisor's Printed Name:			
By signing, I certify that all of the practice information is true and accurate, including that Weekly Direct Patient Care Hours do not include any hours conducting excluded activities. I also certify that the Weekly Direct Patient Care Hours are specific to providing primary care services.			
3.20 Supervisor's Signature:			3.21 Signature Date:

[1] Federally Qualified Health Center
[2] If your site is #1, 2, or 6 you can check your HPSA name at https://data.hrsa.gov/tools/shortage-area/hpsa-find. All other sites should check their HPSAs at https://data.hrsa.gov/tools/shortage-area/by-address.
[3] This has to be an unduplicated count and Medicaid counts will be verified using data from the Agency for Health Care Administration.

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Applicant Name: _____

Secondary Practice Site Location of Applicant			
3.22 This site is: ☐ 1. An FQHC[4] or FQHC Look-Alike ☐ 5. State University-run dental clinic ☐ 2. An Indian tribal health clinic ☐ 6. Federally funded Rural health clinic (RHC) ☐ 3. County health department ☐ 7. Children's Medical Services site ☐ 4. Other non-profit agency ☐ 8. Other publicly funded agency			
3.23 Facility/Practice Name:			3.24 Telephone Number:
3.25 Address:			
3.26 City:	3.27 State:	3.28 ZIP:	3.29 County:
3.30 NHSC Approved Site: ☐ Yes ☐ No ☐ I don't know		3.312 Does this location accept Medicaid? ☐ Yes ☐ No	
3.32 Dental HPSA Name[5]:		3.33 HPSA Score:	3.34 HPSA ID Number:
3.35 Direct Patient Care Hours for the month immediately preceding application: Week 1: Week 2: Week 3: Week 4+: Direct patient care hours are defined as in-person, face-to-face care with live patients. Time spent providing telemedicine services, research, administrative duties, or traveling CANNOT be included.			
3.36 Number of Patients[6] seen at this location by this dentist:		3.37 With Medicaid:	3.38 Utilizing a Sliding Fee Scale:
3.39 Supervisor's Printed Name:			
By signing, I certify that all of the practice information is true and accurate, including that Weekly Direct Patient Care Hours do not include any hours conducting excluded activities. I also certify that the Weekly Direct Patient Care Hours are specific to providing primary care services.			
3.40 Supervisor's Signature:			3.41 Signature Date:

[4] Federally Qualified Health Center
[5] If your site is #1, 2, or 6 you can check your HPSA name at https://data.hrsa.gov/tools/shortage-area/hpsa-find. All other sites should check their HPSAs at https://data.hrsa.gov/tools/shortage-area/by-address.
[6] This has to be an unduplicated count and Medicaid counts will be verified using data from the Agency for Health Care Administration.

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Applicant Name: _____

Tertiary Practice Site Location of Applicant			
3.42 This site is: ☐ 1. An FQHC[7] or FQHC Look-Alike ☐ 5. State University-run dental clinic ☐ 2. An Indian tribal health clinic ☐ 6. Federally funded Rural health clinic (RHC) ☐ 3. County health department ☐ 7. Children's Medical Services site ☐ 4. Other non-profit agency ☐ 8. Other publicly funded agency			
3.43 Facility/Practice Name:		3.44 Telephone Number:	
3.45 Address:			
3.46 City:	3.47 State:	3.48 ZIP:	3.49 County:
3.50 NHSC Approved Site: ☐ Yes ☐ No ☐ I don't know		3.51 Does this location accept Medicaid? ☐ Yes ☐ No	
3.52 Dental HPSA Name[8]:	3.53 HPSA Score:	3.54 HPSA ID Number:	
3.55 Direct Patient Care Hours for the month immediately preceding application: Week 1: Week 2: Week 3: Week 4+: Direct patient care hours are defined as in-person, face-to-face care with live patients. Time spent providing telemedicine services, research, administrative duties, or traveling CANNOT be included.			
3.56 Number of Patients[9] seen at this location by this dentist:	3.57 With Medicaid:	3.58 Utilizing a Sliding Fee Scale:	
3.59 Supervisor's Printed Name:			
By signing, I certify that all of the practice information is true and accurate, including that Weekly Direct Patient Care Hours do not include any hours conducting excluded activities. I also certify that the Weekly Direct Patient Care Hours are specific to providing primary care services.			
3.60 Supervisor's Signature:		3.61 Signature Date:	

[7] Federally Qualified Health Center
[8] If your site is #1, 2, or 6 you can check your HPSA name at https://data.hrsa.gov/tools/shortage-area/hpsa-find. All other sites should check their HPSAs at https://data.hrsa.gov/tools/shortage-area/by-address.
[9] This has to be an unduplicated count and Medicaid counts will be verified using data from the Agency for Health Care Administration.

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Applicant Name: _____

Quaternary Practice Site Location of Applicant			
3.62 This site is: ☐ 1. An FQHC[10] or FQHC Look-Alike ☐ 5. State University-run dental clinic ☐ 2. An Indian tribal health clinic ☐ 6. Federally funded Rural health clinic (RHC) ☐ 3. County health department ☐ 7. Children's Medical Services site ☐ 4. Other non-profit agency ☐ 8. Other publicly funded agency			
3.63 Facility/Practice Name:		3.64 Telephone Number:	
3.65 Address:			
3.66 City:	3.67 State:	3.68 ZIP:	3.69 County:
3.70 NHSC Approved Site: ☐ Yes ☐ No ☐ I don't know		3.71 Does this location accept Medicaid? ☐ Yes ☐ No	
3.72 Dental HPSA Name[11]:	3.73 HPSA Score:	3.74 HPSA ID Number:	
3.75 Direct Patient Care Hours for the month immediately preceding application: Week 1: Week 2: Week 3: Week 4+: Direct patient care hours are defined as in-person, face-to-face care with live patients. Time spent providing telemedicine services, research, administrative duties, or traveling CANNOT be included.			
3.76 Number of Patients[12] seen at this location by this dentist:	3.77 With Medicaid:	3.78 Utilizing a Sliding Fee Scale:	
3.79 Supervisor's Printed Name:			
By signing, I certify that all of the practice information is true and accurate, including that Weekly Direct Patient Care Hours do not include any hours conducting excluded activities. I also certify that the Weekly Direct Patient Care Hours are specific to providing primary care services.			
3.80 Supervisor's Signature:		3.81 Signature Date:	

Additional site locations must be submitted on a separate sheet. All location information must be included.

[10] Federally Qualified Health Center
[11] If your site is #1, 2, or 6 you can check your HPSA name at https://data.hrsa.gov/tools/shortage-area/hpsa-find. All other sites should check their HPSAs at https://data.hrsa.gov/tools/shortage-area/by-address.
[12] This has to be an unduplicated count and Medicaid counts will be verified using data from the Agency for Health Care Administration.

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Applicant Name: _____

SECTION 4: Payer Type

Please provide a breakdown of each payer type for the employer/practice for the previous calendar year.

4.1 Cash Only/Concierge:	%	4.2 Sliding Fee/Charity Care/Free Clinic:	%
4.3 Medicare Only:	%	4.4 Medicaid[13]:	%
4.5 Private Insurance:	%	4.6 Government Funding/Contracts:	%

Total Must Equal 100%

If the employer/practice serves patients with Medicaid, please answer the following:

4.7 Is the applicant the rendering provider for Medicaid claims?

☐ Yes (Medicaid provider or NPI number: _____)
☐ No (answer question 4.71)

4.71 Why is the applicant not the rendering provider on Medicaid claims? (choose all that apply)

☐ Applicant not eligible to bill based on license type (practice Medicaid number: _____)
☐ Practice bills under group number only (practice Medicaid number: _____)
☐ Other (Specify: _____)

SECTION 5: Attestation

I acknowledge that all information and statements contained herein are true and do not misrepresent fact and that I have not evaded or suppressed any information contained in this verification form.

I specifically attest that the first date of employment (question 3.1), all of the direct patient care hours[14] for each practice location during the month immediately preceding the application are accurate (questions 3.15, 3.35, 3.55, and 3.75), and the Medicaid percentage (question 4.4) are all accurate.

4.72 Employer's Signature _____ 4.73 Date _____ 4.74 Employer's Printed Name _____

4.75 Signatory's role with employer[15] _____ 4.76 Telephone Number _____

NOTICE: Any person who knowingly makes a false statement or misrepresentation on this form is subject to penalties under section 837.06, Florida Statutes, which may include fines, imprisonment, or both.

[13] Please include all patients who might have other insurance and Medicaid is secondary (dual eligible).
[14] Direct patient care hours are defined as in-person, face-to-face care with live patients. Time spent providing telemedicine services, research, administrative duties, or traveling CANNOT be included.
[15] Please enter your role with the employer/practice. For example, immediate supervisor, HR staff, solo practitioner, partner, etc.