A. General Information

ATTACHMENT 1

1. Applicant Legal Entity Name

If legal name varies from the name registered with the Tennessee Department of State, please attach an explanation of the relationship between the parties. Address organizational structure, responsibilities of governing body (clinical, fiscal, regulatory compliance, performance improvement, etc.)

2. DBA/Nickname

3. Type of Center

4. Corporate Status

5. Place of Incorporation (if different from Tennessee)

6. FEIN

7. State ID Number (As assigned by the Secretary of State, Tennessee Department of State-ONLY IF A CORPORATION)

8. Name of Contact

9.Title of Contact

10. Authorized Signatory

11.Title, Signatory

12. Clinic Address

13. Location County

14. Service County (or Counties)

15. Contact Address

16. Contact Telephone

17. Contact Fax

18. Contact E-Mail

19. Clinic Phone

20. Clinic Fax

21. Web Site

22. Applicant or Recipient in Past

Yes ☐ No ☐

23. If yes, Grant Year

B. Application Content

1.Please provide days per week that care is provided at the facility. Please include your hours of operation in your answer.

2. Please list the full time equivalent (FTE) for your clinical staffing. One (1) FTE = 2,080 hours per year based on a 40 hour work week.)

Position: Position:

Position: Position:

3. Describe the emergency dental services that your center will provide to uninsured adults ages 19-64.

4. State the length of time your center has provided emergency dental services to uninsured adults.

5. Please describe the process that the facility uses to evaluate and monitor the provision of dental care services.

6. State the **ACTUAL NUMBER** of dental extractions provided in your center to uninsured adults ages 19 to 64 during the period July 1, 2014, through June 30, 2015.

7. State the **ACTUAL NUMBER** of unduplicated uninsured adults ages 19 to 64 who received emergency dental extractions at your center during the period July 1, 2014, through June 30, 2015.

8. State the **ESTIMATED NUMBER** of emergency dental extractions/preventive hygienic services to be provided by your center to uninsured adults ages 19 to 64 during the period April 1, 2016, through June 30, 2017.

9. Please describe how your clinic delineates uninsured dental patients by age. If applicable, please state the name of the software program used.

☐ 10. Is your center in a HPSA? 10.a. If so, where?

☐ 11. MUA? ☐ 11.a. MUP? 11.b. If so, where?

12. Please provide a copy of your center's sliding fee scale, if applicable. If your center does not provide services to uninsured adults on a sliding fee scale basis, describe the methodology of how the center charges emergency dental services at a reduced cost to uninsured adults. Please explain how the percentage discount offered to uninsured adults compares to the usual and customary fees charged by the clinic. If your center does not charge uninsured adults (e.g. you are a "free clinic"), please confirm.

13. Please verify that services are not denied based on non-payment.

C. Please provide a letter of support from healthcare providers or facilities detailing the services they provide for your center and their willingness to continue to provide services for your center.

D. Signature of Provider Representative:

The representative named in Section IV.A.10. must sign and date the complete Application (**in BLUE ink**). The application must be delivered to Melissa Painter at the address in Section III by **deadline shown in "Schedule of Events".**

Signature Date

Printed Name & Title