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Supplemental Application — Community Clinic

IMPORTANT NOTICE
This is a SUPPPLMENT to an MIEC application. This document alone is insufficient to apply for and be approved for coverage with MIEC. Be sure to submit this along with your complete signed and dated MIEC application.

APPLICANT

Entity or Last name, first name

COMMUNITY CLINIC — ANSWERS A-D

A. Please list all locations where you provide services, and the corresponding estimated and actual visit information. Please attach visit information for at least the last five (5) years.

Name of Location	Years in operation	Lease/own space	Estimated visits for next 12 months	Actual visits for last 12 months

B. Is the clinic licensed? ☐Yes ☐No If yes, please provide type of licensure and license number.

Type of Licensure _____ License Number _____

C. Is the clinic accredited? ☐Yes ☐No If yes, by whom? _____

D. Please indicate each type of service rendered and/or procedure performed at the clinic.

Counseling
- ☐ Family planning
- ☐ Drug/Alcohol
- ☐ Domestic (family, marital, abuse/violence)
- ☐ Crisis Intervention
- ☐ AIDS counseling

- ☐ Primary Care including Pediatrics
- ☐ Cardiac Services (EKG, ECG, stress tests)

Gynecology
- ☐ Prenatal and/or postnatal care
- ☐ Abortions
- ☐ Fertility treatments
- ☐ Deliveries

- ☐ Dentistry

Therapy
- ☐ Speech
- ☐ Occupational
- ☐ Physical
- ☐ Other: _____

- ☐ Acupuncture
- ☐ Chiropractic
- ☐ Podiatry
- ☐ Optometry/vision services
- ☐ AIDS treatment
- ☐ Audiology/hearing services

Orthopedics
- ☐ Open/closed fracture reductions
- ☐ Sports medicine/injuries
- ☐ Hip/Knee/Hand surgery

Addiction Medicine
- ☐ Alcohol detoxification
- ☐ Drug detoxification
- ☐ Methadone dispensary

- ☐ Travel Medicine
- ☐ Home Health
- ☐ Hospice

- ☐ Other (please describe): _____

E. Are patients charged for services? ☐ Yes ☐ No

F. Does the clinic have bed and board accommodations? ☐ Yes ☐ No

G. Are you classified as a FQHC (Federally Qualified Health Center)? ☐ Yes ☐ No

H. Are you eligible for coverage by the FTCA (Federal tort Claims Act) ☐ Yes ☐ No

If yes, please indicate what percentage of services provided are covered by the FTCA? _____ %

Note: this policy will ONLY provide coverage for those claims not covered by the FTCA. It is not considered excess limits of liability.

I. Do you provide any of the following services at any location?

Pharmacy ☐ Yes ☐ No If yes, what is the annual revenue? _____

X- ray ☐ Yes ☐ No If yes, how many images per year: _____

Laboratory ☐ Yes ☐ No

Independent medical evaluations (IME) ☐ Yes ☐ No

Work/sport physicals ☐ Yes ☐ No

COVID vaccines/testing ☐ Yes ☐ No

J. Do you provide anesthesia services? ☐ Yes ☐ No

If yes, what kind?

☐ Conscious _____ %

☐ Local _____ %

☐ General _____ %

☐ Other _____ %

If Yes, who is providing the anesthesia services? _____

K. Please indicate the number of the following types of professionals providing services at the clinic

_____ Physician (please indicate what specialty) _____

_____ Dentist

_____ Podiatrist

_____ Nurse Practitioner

_____ Physician Assistants

_____ Therapist

_____ Psychologist

_____ Optometrist

_____ Audiologist

_____ Counselor/Social worker

_____ Nurse (RN, LPN)

_____ Technician (EKG, X-ray, Lab)

_____ Pharmacist

_____ Phlebotomist

_____ Medical Assistant

_____ Dental Assistant/Hygienist

_____ Other (please describe) _____

SIGNATURE

_____ _____

Signature Date