COLORADO
Department of Health Care Policy & Financing

Federally Qualified Health Center

Application for Scope-of-Service Rate Adjustment

Application Form and Attestation Statement

FQHC Information:

FQHC Name: _____

FQHC Fiscal Year End: _____

FQHC Number(s) Affected:

_____

_____

_____

_____

_____

Date(s) of Change(s) in Scope of Service:

_____

_____

_____

_____

_____

Information on the Change(s) in Scope of Service:

Please select the change(s) in scope of service below that corresponds most directly with the change(s) in scope of service at your FQHC:

- ☐ The addition of a new service not incorporated in the baseline PPS rate, or deletion of a service incorporated in the baseline PPS rate;
- ☐ The addition or deletion of a covered Medicaid service under the State Plan;
- ☐ Changes necessary to maintain compliance with amended state or federal regulations or regulatory requirements;
- ☐ Changes in service due to a change in applicable technology and/or medical practices utilized by the FQHC;
- ☐ Changes resulting from the changes in types of patients served, including, but not limited to, populations with HIV/AIDS, populations with other chronic diseases, or homeless, elderly, migrant, or other special populations that require more intensive and frequent care;
- ☐ Changes resulting from a change in the provider mix, including, but not limited to;

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- ☐ A transition from mid-level providers (e.g. nurse practitioners) to physicians with a corresponding change in the services provided by the FQHC;
- ☐ The addition or removal of specialty providers (e.g. pediatric, geriatric, or obstetric specialists) with a corresponding change in the services provided by the FQHC (e.g. delivery services);
- ☐ Indirect medical education adjustments and a direct graduate medical education payment that reflects the costs of providing teaching services to interns and/or residents; or
- ☐ Changes in operating costs attributable to capital expenditures (including new, expanded, or renovated service facilities), regulatory compliance measures, or changes in technology or medical practices at the FQHC, provided that those expenditures result in a change in the services provided by the FQHC.

For a list of items that do not prompt a scope-of-service rate adjustment, please see the Scope-of-Service Rate Adjustment Application instructions. Please provide a brief narrative description of the change(s) in scope of service checked above, including how services were provided both before and after the change(s):

Attach the following required items to your Application Form and Attestation Statement:

- Cost reports and/or other detailed documentation that substantiate the change in the scope of services

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Describe any other documentation attached:

Other notes/comments:

Attestation by Officer or Administrator of the FQHC:

I, the undersigned, hereby certify under penalty of perjury that as an official of the subject facility I am duly authorized to sign this attestation, and that to the best of my informed knowledge and belief the statements made herein, and the documents attached hereto are accurate, true, and complete in all material aspects.

I understand that the Colorado Department of Health Care Policy and Financing is relying upon this application as part of its process to adjust the FQHC Prospective Payment System per-visit encounter rate in a manner that adheres to Section 702(b) of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act (BIPA) included in the Consolidated Appropriations Act of 2000, Public Law 106 – 554; and that should it be determined that this attestation is materially false, incomplete, or incorrect, or that it includes incorrect, false, or misleading information, appropriate enforcement action will be taken.

Signature: _____

Name: _____

Position/Title: _____

Email Address: _____

Phone Number: _____

Date: _____

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