

**COUNTY INDIGENT HEALTH CARE PROGRAM
END OF YEAR REPORT**

Entity Name: _____ **State Fiscal Year:** _____
(September 1-August 31)

Check below which type of entity you represent:

County Public Hospital Hospital District

I. TOTAL NUMBER OF UNDUPLICATED CLIENTS SERVED: _____

To get the number of unduplicated clients, do not count the same individual more than once.

◆ How many of these clients are SSI appellants? _____

II. TOTAL EXPENDITURES: _____

Break the total expenditures down into the following categories:

1. Physician Services	\$
2. Prescription Drugs	\$
3. Hospital, Inpatient Services	\$
4. Hospital, Outpatient Services	\$
5. Laboratory/X-Ray Services	\$
6. Skilled Nursing Facility Services	\$
7. Family Planning Services	\$
8. Rural Health Clinic Services	\$
9. State Hospital Contracts	\$
10. Optional Health Care Services	\$
11. Reimbursements/Errors	\$

III. TOTAL

DSRIP Projects: _____
Uncompensated Care: _____
Expenditures for 1115 _____
Waiver: _____

IV. DIAGNOSES – List the five top diagnoses of your clients.

1. _____
2. _____
3. _____
4. _____
5. _____

V. FEDERAL POVERTY GUIDELINE % Used to Determine Eligibility: _____

Signature of Person Submitting Form 300: _____

Telephone Number of Person Submitting Form 300: _____

Date: _____