

PRIMARY CARE DESIGNATION FORM

Hospital Name: _____ (the "Hospital")

As a Medicaid-designated disproportionate share hospital provider, the Hospital acknowledges that it is required to spend no less than fifteen percent (15%) of its gross Indigent Care Trust Fund payments for support of primary care services.

A. The Hospital agrees that fifteen percent (15%) of the Hospital's Indigent Care Trust Fund payment amount will be used for one or several of the following purposes:

<u>Purpose</u>	<u>Primary Care Dollars</u>	<u>Effective Date</u>
a. PeachCare Outreach	_____	_____
b. Rural Health Center Development	_____	_____
c. Support for Public Health	_____	_____
d. Prescription Drug Assistance	_____	_____
e. Uninsured Proposal*	_____	_____
f. Cancer Screening Programs*	_____	_____

The Hospital acknowledges that the use of the Hospital's primary care service funds for the purposes above are within the intent of the Indigent Care Trust Fund statute. O.C.G.A. § 31-5-154.

*Hospitals opting for the *Uninsured Proposal* or *Cancer Screening Programs* check-off must attach a one page description of the specific initiative, target population, financial commitment and anticipated impact.

OR

B. The Hospital elects to file an individual primary care service plan, in compliance with Rule 350-6-.03(3)(e)(11), subject to the approval by the Division of Medical Assistance. The Hospital understands that the hospital's Indigent Care Trust Fund payment will be made upon approval of the primary care service plan by the Division of Medical Assistance.

Submitted by: _____ Date: _____
Signature

Print Signer's Name and Title: _____

Signer's Telephone Number: _____

Signer's Fax Number: _____