Quarterly Work Report

SHARP Program- Alaska Department of Health & Social Services

This report form is to be completed by each SHARP practitioner and his/her respective practice site (agency). The SHARP program must verify that each participant has been delivering healthcare services at the specified practice site during the past quarter. Please confirm this by completing this form electronically in Adobe Reader, saving, and sending it to SHARP program office via email to robert.sewell@alaska.gov.

Check one:	Reporting Period	Report Due
◯	January 1 – March 31	April 30
◯	April 1 – June 30	July 31
◯	July 1 – September 30	October 31
◯	October 1 – December 31	January 31

Practitioner Information	
Last Name	First Name
Email	Phone number
AK License number	Discipline & Specialty

Practice Information		
Authorized FTE (in accordance with signed MOA):	◯ Full-Time	◯ Half-Time
Start date (effective date)		
Check one: ◯ Full Quarter	◯ Partial Quarter – Start date	End date
SHARP Program Component:	◯ SHARP-I	◯ SHARP-II
Number of practice sites		
Do you currently have, or anticipate having, a service obligation in addition to SHARP?	◯ Yes	◯ No
If yes, describe:		

Practice Site 1 Name	
Site Street Address	
Site Phone	Site E-mail
Date SHARP practice began	
AK Medicaid No.	AK Medicare No.

Practice Site 2 Name	
Site Street Address	
Site Phone	Site E-mail
Date SHARP practice began	
AK Medicaid No.	AK Medicare No.

Practice Site 3 Name	
Site Street Address	
Site Phone	Site E-mail
Date SHARP practice began	
AK Medicaid No.	AK Medicare No.

Please attach extra sheets if additional site information is necessary.

Does your positon include administrative duties (i.e. mgmt, supervision)? ◯ No ◯ Yes: %
Does your position include direct patient care? ◯ No ◯ Yes: % of time
What portion of your position involves delivery of primary care? %

Clinician's Patient Payer Mix - *Note: refers to direct patient care delivered by SHARP Clinician*			
	Number of Patients	Number of Visits	*Pharmacists Only:* Number of prescriptions
Medicaid			
Medicare			
Patient Pay - Sliding Fee Scale			
Patient Pay - Full Fee			
No Charge or No Payment			
Private Insurance			
Indian Health Service			
VA or other Federal Program			
Other (explain)			
Total	0	0	0
Note: number of patients cannot exceed number of visits; unduplicated (each patient in one category)			

Site's Patient Payer Mix		
	Number of Patients	Number of Visits
Medicaid		
Medicare		
Patient Pay - Sliding Fee Scale		
Patient Pay - Full Fee		
No Charge or No Payment		
Private Insurance		
Indian Health Service		
VA or other Federal Program		
Other (explain)		
Total	0	0
Note: number of patients cannot exceed number of visits; unduplicated (each patient in one category)		
Comments:		

SHARP Clinician:
I certify that all data contained in this report are accurate and can be substantiated by a record review. I hereby certify, under penalty of revocation of my Alaska SHARP agreement, that I personally delivered the type of health care services for which my SHARP award was approved.

◯ Yes ◯ No	Date

Authorized Site Representative (Administrator or Clinical Supervisor):
As an authorized site (agency) representative, I certify via my signature that all data contained in this report are accurate and can be substantiated by a record review.

- The practitioner named above worked as a clinician during the stated period, provided the direct patient care listed above at the clinic site(s) listed above, in accordance with his/her SHARP MOA;
- This site (agency) used the sliding fee scale or "no pay" policy for uninsured patients submitted with the sponsoring site's application;
- During reporting period, this practitioner was off work, including vacation, sick days, and holidays, for a total of days (not including weekends)

◯ Yes ◯ No	Date
Printed name	
Title	Phone number