My Health LA - CLINIC SITE PROFILE

Date Completed:

Agency Name:

(Enter Legal Name Only)

Instructions: Complete For Each Clinic Site ***(Click and type in the GRAY HIGHLIGHTED placeholders below)***

Clinic Site Location:

Electronic Health Records: Yes No

Site Name: Phone Number: Fax Number: After Hours Phone Number:

Address: City/State: Zip Code: Email Address - Organization-Specific:

Language(s) Spoken in the Clinic: English; Other: ___________________

Type of Site: Intermittent/Part-Time Site Full-Time Site Satellite Site Community School Administrative Enrollment

Mobile: License Plate # ___________ : Services provided: [ ] Single Location - Address [ ] Multiple Locations - Address:

Primary Care Services:

Number of Days of Clinical Operation Per Week: Number of Hours of Clinical Operation Per Week:

	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Hours of Operation (e.g. 8:00am to 5:00pm) *(If Mobile – indicate address location)*							

Dental Care Services:

Does this Clinic Site provide MHLA Dental Services No Yes

Number of Days of Clinical Operation Per Week: Number of Hours of Clinical Operation Per Week:

	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Hours of Operation (e.g. 8:00am to 5:00pm) *(If Mobile – indicate address location)*							

Ancillary Services:

Radiology Services: (*Clinic site must provide basic radiology services that are within the scope of Ancillary Services and operate a radiological unit or establish a formal subcontract agreement with a certified radiological entity. – Provide Copy of Agreement)*

On-Site - Name: Days/Hours of Operation:
Address: City/State: Zip Code: Phone Number:

Off-Site - Name: Days/Hours of Operation:
Address: City/State: Zip Code: Phone Number:

Laboratory Services: (*Clinic must provide all Medically Necessary laboratory services related to Primary Health Care Services and must operate a full-service laboratory or establish a formal subcontract agreement with a certified laboratory. - Provide Copy of Agreement)*

***On-Site - Name:** Days/Hours of Operation:
Address: City/State: Zip Code: Phone Number:

Off-Site - Name: Days/Hours of Operation:
Address: City/State: Zip Code: Phone Number:

* Provide CLIA for on-site laboratory services

Pharmacy Services: (*Clinic Site must provide all medically necessary pharmaceuticals related to the conditions for which the Participants are receiving Included Services, and for paying for such pharmaceuticals. Clinic Site must also be registered with HRSA Office of Pharmacy Affairs to access the 340B Drug Pricing Program and register at least one contracted 340B pharmacy to dispense 340B pharmaceuticals to Participants in order to qualify for a MHLA approved site.)*

HRSA 340B Drug Pricing ID #: Participating Start Date: Approved Date:

Do you have at least one HRSA 340B Contract Pharmacy No Yes Did you select DHS Central and Rx-E-Fill Pharmacy **No Yes**

On-Site Licensed Pharmacy Services (owned and operated by Contractor) - Retail Pharmacy License #: Expiration Date:
Days/Hours of Operation: Phone Number:

On-Site Pharmacy Dispensary - Clinic Permit #: Expiration Date:
Days/Hours of Operation: Phone Number:

Form Completed By: Telephone Number: Email: