# Limited Review Application

**State of New York Department of Health/Office of Health Systems Management**

**Schedule LRA 8**

**Staffing**

|  |  |
| --- | --- |
| **Staffing Categories** | **Number of FTEs to the Nearest Tenth** |
| **Current Year\*** | **First Year of implementation** | **Third Year of implementation** |
| **Health Providers\*\*:** |  |
|  |       |       |       |
|  |       |       |       |
|  |       |       |       |
|  |       |       |       |
|  |       |       |       |
|  |       |       |       |
| **Support Staff\*\*\*:** |  |
|  |       |       |       |
|  |       |       |       |
|  |       |       |       |
|  |       |       |       |
|  |       |       |       |
|  |       |       |       |
| ***Total Number of Employees*** |       |       |       |

\* Last complete year prior to submitting application

\*\* “Health Providers” includes all providers serving patients at the site. A Health Provider is any staff who can

provide a billable service – physician, dentist, dental hygienist, podiatrist, physician assistant, physical therapist, etc.

 \*\*\* All other staff.

**Describe how the number and mix of staff were determined:**

|  |
| --- |
|  |

**PLEASE COMPLETE THE FOLLOWING:**

|  |  |
| --- | --- |
| 1. Are staff paid and on Payroll?
 | [ ]  Yes [ ]  No  |
|  |  |
|  2. Provide copies of contracts for any independent contractor. |  |
|  |  |
| 3. Please attach the Medical Doctors C.V.  |  |
|  |  |
| 4. Is this facility affiliated with any other facilities? (If yes, please describe affiliation and/or agreement.) | [ ]  Yes [ ]  No  |
|  |  |

*(Rev. 7/7/2010)*