Maryland Loan Repayment Programs

Impact Data Collection

To be completed by participant or participant's employer.

Participant Name: ______________________________________

Practice Site Name: ____

Section I: Patients Served

Document for the time period July 1, 2024 - June 30, 2025 (estimate time period from today's date to June 30), the patients served by the above noted participant at the practice site noted on the Employment Verification Form:

1. Number of **patients served by this participant** by payer type:

	# of patients	% of patients	Comments:
Medicaid			
Medicare			
Commercial Insurance			
Sliding Fee Scale/ Financial Aid Policy			
No payment (Patient not charged)			
Self Pay			
Other			
Total			

2. Patient service area (zip codes served):

Section 2: Quality Improvement/ Health Outcomes Goals

The practice site, including the participant, focused on the following practice quality improvement/ health outcomes goals, measures, or outcomes during the time period noted above:

Quality Improvement Focus/Source	2024 Outcome	2025 Progress
1.		
2.		
3.		
Example: Colorectal Cancer Screening (HEDIS)	35% screened	38% screened
Patient satisfaction review scores (HCAPS)	80% satisfaction	90% satisfaction

Section 3: Attestation and Signature

I certify that the information provided above is true and complete to the best of my knowledge.

Signature of Completing Individual ______________________________________ Date_________________

Printed/Typed Name ______________________________ Title _________________________________

Email Address ______________________________________