Maryland
DEPARTMENT OF HEALTH

# 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**

During the time period July 1, 2023 - June 30, 2024, the participant noted above provided services to the following patients at the practice site noted on the Employment Verification Form:

1. List the number of patients served by this participant by payer type:

| | # of patients | % of patients | |
|---|---|---|---|
| Medicaid | | | Comments: |
| Medicare | | | |
| Commercial Insurance | | | |
| Sliding Fee Scale | | | |
| No Payment (un/under-insured) | | | |
| Self Pay | | | |
| Other | | | |
| Total | 0 | 0.00% | |

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 | 2022 Outcome | 2023 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**

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 _____