Maryland Loan Repayment Programs

Impact Data Collection

To be completed by participant or participant's employer.

Participant Name: _____

Practice Site Name: _____

Section 1: Patients Served

During the time period July 1, 2025 - June 30, 2026, 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	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	**2025 Outcome**	**2026 Progress**
1.		
2.		
3.		
Ex. *Colorectal Cancer Screening (HEDIS*	*38% screened*	*35% screened*
Ex.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 Certifying Official:_____ Date: _____

Printed/Typed Name: _____ Title:_____

Email Address: _____