ACCREDITATION INITIATIVE
Notice of Interest

Grant Number	
Applicant Organization Name	
Applicant Organization Address	
Indicate BPHC program funding for this organization (select all that apply)	☐ CHC ☐ MHC ☐ HCH ☐ PHPC
Requesting Accrediting Organization (select one)	☐ Accreditation Association for Ambulatory Health Care ☐ The Joint Commission
If the health center has been previously accredited, please provide the dates of past accreditation survey(s) and the name(s) of the accrediting organization(s):	

	Date of Last Survey	Accrediting Organization
Primary Care		
Laboratory		
Behavioral Health		

Type of survey requested (select all that apply)	☐ Initial Survey PCMH ☐ Lab Survey ☐ Behavioral Health
Number of health delivery and administrative sites	
Number of patient visits per year (from the most recent UDS)	
The applicant organization has (select all that apply)	☐ Planned a 6 month preparation for the survey ☐ Designated a lead person for the survey ☐ Performed a self-assessment versus standards
Preferred month for the onsite survey	
Comments	
Name of Accrediting Contact	
Title	
Phone	
Email	
HRSA Project Officer Name	

FOR OQD Staff Use

Date Sent:

Approved: Y N Reviewing Analyst Signature | Date: