Commonwealth of Virginia
Department of Social Services

# Neighborhood Assistance Program
# Services Contribution Data Sheet
**(To be completed and submitted with the CNF-H)**
**(Print)**

**To Be Used For Donated Physician Specialist Services** to patients who are referred from a NAP organization whose sole purpose is providing specialty medical referral services to patients of participating clinics or federally qualified health centers regardless of where the services are delivered.

**(Please use a separate form for each clinic)**

| | |
|---|---|
| NAME OF DONOR: | |
| ADDRESS: | |
| NAME OF NAP ORGANIZATION: | |

| **Contact Info Of Clinic Where Services Were Provided** | | **DATE** (List each date separately) | **HOURLY RATE** (excludes fringes) | **TOTAL HOURS WORKED** | **TOTAL VALUE** (Rate x Hours) |
|---|---|---|---|---|---|
| Federal ID#: | | | | | |
| Name of Clinic or Federally Qualified Health Center: | | | | | |
| Street Address of Clinic: | | | | | |
| City, State, Zip: | | | | | |
| Phone Number: | | | | | |

**NOTE: Other formats providing the same information will be accepted. Sign and attach this form to the CNF or other format and return to the NAP Organization.**

**CERTIFICATION BY PHYSICIAN SPECIALIST:** I certify that the value of the donated service(s) was determined by the standards stated in the instructions and does not exceed the statutory maximum. I also certify I will not receive any type of compensation or reimbursement from medical insurance filing or from my company for the donated service(s) nor will my company receive any compensation. I understand that if I falsify information, I may be subject to penalties prescribed by the Virginia Departments of Taxation and Social Services.

Date

Signature of Donor