Print Form

APPLICATION PART 3 of 3
INDIVIDUAL PRIMARY CARE PRACTICE PROFILE

STATE OF CONNECTICUT
OFFICE OF THE HEALTHCARE ADVOCATE
STATE INNOVATION MODEL PROGRAM MANAGEMENT OFFICE
REQUEST FOR APPLICATIONS (RFA) FOR THE ADVANCED MEDICAL HOME VANGUARD PROGRAM

Note to the Advanced Network Representative: Please have each participating primary care office for which you are seeking to be included in the program fill out this form.

GENERAL INFORMATION

Date: _____ Name of Primary Care Practice: _____

How many offices/sites does this practice have? _____

Street Address of primary office: _____

City and Zip: _____

Phone: _____ Fax: _____

Lead physician or APRN for the AMH pilot: _____

Lead physician email address: _____

What best describes your practice?

☐ Family practice ☐ Pediatrics

☐ General internal medicine ☐ Other: _____

Number of physicians that are primarily primary care: _____

Number of APRNs: _____

Number of physicians that are primarily specialty care: _____

Staff member names that will be part of the program's transformation team:

PILOT ELIGIBILITY REQUIREMENTS

Does your practice have an ONC Certified electronic health record (EHR)?	☐ YES ☐ NO
Has your practice utilized this EHR for at least 6 months?	☐ YES ☐ NO
Are you currently recognized under an existing national medical home standard?	☐ YES ☐ NO If yes, which one? ☐ NCQA 2008

	☐NCQA 2011 ☐NCQA 2014 ☐0ther: _____
Have you recently submitted an application for an existing medical home standard?	☐ YES ☐ NO If yes, which one? ☐NCQA 2011 ☐NCQA 2014 ☐0ther: _____
Are you committed to apply for NCQA 2014 medical home recognition and obtaining NCQA recognition as a condition for participating in and completing the program?	☐ YES ☐ NO
Are you committed to submit an application for Planetree Bronze Recognition for Achievement in Patient Centered Care?	☐ YES ☐ NO
Are you committed to achieving AMH specific must pass elements and critical factors?	☐ YES ☐ NO
Are you committed to participate in the AMH Learning Collaborative?	☐ YES ☐ NO
Is your practice currently participating in the DSS Medicaid PCMH Glide Path program?	☐ YES ☐ NO

Please describe why you are interested in pursuing medical home recognition through the Advanced Medical Home Vanguard Program:

By signing this form you certify that all statements contained in the responses are accurate to the best of your knowledge. By signing you also commit to the program guidelines and program components as laid out in the State Innovation Model Advanced Medical Home Vanguard Program Request for Applications (RFA).

Signature of Lead Physician: _____

Print Name: _____

Date: _____