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 complete this form.

Name of Advanced Network: ________________________ (enter N/A if independent practice)

GENERAL INFORMATION

Date: ____________ Name of Primary Care Practice: _______________________________ Tax ID Number: ________________ Street Address of practice: ________________________________ City and Zip: ________________________________ Phone: __________________________ Fax: _____________________________
Lead physician or APRN for the AMH pilot: _______________ Lead physician email address: ____________________Phone number: ____________________ Office Manager name: ____________________________________ Office Manager email: _______________________ phone number: _______________________
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

Question	Response
1. Is your practice currently receiving direct transformation services as part of the CT Medicaid Glide Path to PCMH?	YES NO
2. Are you currently recognized under an existing national medical home standard?	YES NO If yes, which one? NCQA 2008 NCQA 2011 NCQA 2014 0ther: ___________
3. Have you recently submitted an application for an existing medical home standard?	YES NO If yes, which one? NCQA 2011 NCQA 2014 0ther: ___________
4. Does your practice have an ONC Certified electronic health record (EHR)?	YES NO
5. Has your practice utilized this EHR for at least 6 months?	YES NO
6. 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
7. Are you committed to submit an application for Planetree Bronze Recognition for Achievement in Patient Centered Care?	YES NO
8. Are you committed to achieving Advanced Medical Home specific must pass elements and critical factors?	YES NO
9. Are you committed to participate in the AMH Learning Collaborative?	YES NO
10. Are you committed to working with the AMH transformation vendor to advance the capabilities of your practice?	YES NO

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

Signature Page

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 Advanced Medical Home Vanguard Program guidelines and program components as laid out in the State Innovation Model Advanced Medical Home Vanguard Program Request for Applications (RFA).

Practice Name: ____

Signature of Lead Physician: ____

Print Name: ____

Date: ________________