INDEPENDENT PRIMARY CARE PRACTICE APPLICATION

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

Note: This single application form is for primary care practices with no affiliation to an Advanced Network. Advanced Network applicants (and their practices) should not complete this form.

GENERAL INFORMATION

Name of Primary Care Practice: ____________________________Tax ID Number: ________________
Street Address of practice: _________________________________
City and Zip: _________________________________
Name & Title of Single Point of Contact for Practice: __________________________________
Phone: ___________________________ Email: ________________________________

Lead physician or APRN for the AMH program: _______________
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:___________________

Which of the following does your practice provide care for?

- Medicaid
- Medicare
- Self-pay/ uninsured

Total Number of Clinicians in the Practice: ______

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:

Please indicate if the practice expects to make in any of the following changes over the next year:

- Ownership / closure
- Electronic health record system
- Office location
- Significant personnel changes

If any of the boxes are checked, please explain:

ELIGIBILITY REQUIREMENTS

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
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 2017 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 if you request this technical assistance?	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 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 Program guidelines and program components as laid out in the State Innovation Model Advanced Medical Home Program Request for Applications (RFA).

Practice Name: ____

Signature of Lead Physician/APRN: ____

Print Name: ____

Date: ________________