Name of Advanced Network: _________________________________



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

## PART 1 of 3
## ADVANCED NETWORK PROFILE

***This form should be completed by the Advanced Network.***

*Advanced Networks are defined as independent practice associations, large medical groups, clinically integrated networks, and integrated delivery system organizations that have entered into shared savings plan (SSP) arrangements with at least one payer. This definition includes entities designated as Accountable Care Organizations for the purpose of participating in the Medicare SSP.*

## GENERAL INFORMATION

| |
|---|
| 1. Date: _______________ 2. Name of Advanced Network: ___________________________________ |
| 3. *Administrative Office Location*<br>Street Address: _______________________________ City and Zip: ___________________________<br>Phone: ____________________________ Fax: _______________________________<br>Tax ID: ________________________________ |
| 4. *Contact Person*<br>Name & Title of Single Point of Contact for Advance Network: ______________________________<br>E-mail address of Contact Person: ________________________________<br>Telephone Number of Contact Person: __________________________________<br>Name & Title of Secondary Contact: ____________________________ Phone: __________________ |
| 5. What best describes the relationship among the healthcare providers in your Advanced Network?<br>Group practice<br>Network of individual practices (IPA)<br>Hospital / healthcare provider partnership or joint venture<br>Hospital contracted healthcare providers<br>Employer contracted healthcare providers<br>Healthcare provider-health plan partnership |
| 6. Which Connecticut hospital(s) is part of your Advanced Network?<br>_______________________________________________________________ |
| 7. Which of the following types of patients does your organization provide care to?<br>Medicare Medicaid |

Name of Advanced Network: ________________________________

| Commercial | Self-pay/Uninsured |
|---|---|

## OTHER INFORMATION

| | |
|---|---|
| 8. Estimated number of the following employed by or affiliated with your Advanced Network:<br>Primary Care MD: ______ Primary Care RN: ______<br>Primary Care APRN: ______ Specialty MD: ______ | |
| 9. Please indicate if the Advanced Network expects to make changes in any of the following areas over the next year:<br>Yes No<br>**If yes, please explain:**<br>Organization ownership / closure Electronic health record system<br>Administrative office location Practice management software | |
| 10. Does your Advanced Network currently participate in a Shared Savings Program (SSP)? | Medicare SSP<br>Commercial SSP<br>Medicaid SSP |
| 11. Does your Advanced Network provide change management support to practices that are trying to advance their capabilities? **If YES, please describe:** | YES NO |

Name of Advanced Network: ________________________________

## CERTIFICATION OF APPLICATION

***Statement of Acceptance:*** *The terms and conditions contained in the SIM AMH Request for Applications for the Advanced Medical Home Program constitute a basis for this procurement. These terms and conditions, as well as others so labeled elsewhere in this document are mandatory for the resultant contract. The Office of the Healthcare Advocate is solely responsible for rendering decisions in matters of interpretation on all terms and conditions.*

My signature below, for and on behalf of ______________________________________*(Name of Advanced Network)*, certifies and indicates acceptance of the following:

1. I have the authority to submit this application (Part 1, Part 2, and Part 3) on behalf of the Advanced Network.
2. I hereby certify that the statements contained in the responses to this application are true to the best of my knowledge and belief.
3. I am committed to following all program guidelines and completing all components of the Advanced Medical Home Program as laid out in the State Innovation Model Advanced Medical Home Program Request for Applications (RFA).
4. I agree to accept the Mandatory Terms and Conditions as set forth in the Office of the Healthcare Advocate State Innovation Model Program Management Office's Request for Applications for the Advanced Medical Home Program.

____________________________________________

Signature of Authorized Official

____________________________________________

Name of Authorized Official

___________________________

Date