

Attachment D: Applicant Background Information

Organization Name:	
Organizational Tax Identification Number:	
Website, if applicable:	
Name and Title of Person Authorized to Conduct Busin Behalf of Agency:	ess on
Is this the same person submitting the application? If no, under which capacity are they allowed to submit this application?	Yes □ No □
Name and Title of the Contact Person Regarding Questions about the Application:	
Address:	
City:	State: Zip Code:
Phone Number:	
Fax:	
Email Address:	
Date Application Submitted:	



Domain 1: Breadth and Characteristics of Participating Providers

Template: Domain 1.1-1.2 Provider Base

Organization Name:

<u>Directions:</u> Please complete the following template with a list of participating AE members. Please make sure to complete accurately and with the most up to date information. Note that this template includes two parts.

*Note: For the purposes of these certification standards provider is differentiated from individual clinicians and is defined as a corporate entity with an identification number for services to patients based on the work of individual clinicians working with or for the corporate entity.

Part A of this template should include an entry for each participating Provider (please add rows as needed).

Part B of this template should include an entry for each participating Clinician (please add rows as needed).

Part A: Participating Providers

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Provider Name*	Tax Identification Number (FEIN)	Primary Provider Type (Please select from dropdown)	Secondary Provider Type - if applicable (Please select from dropdown)	Tirtiary Provider Type - if applicable (Please select from dropdown)	Primary Population Served (Please select from dropdown)	Relationship Type (Please select from dropdown)	Certification of Agreement to Participate in AE? (Please select from dropdown)	voting Rights:	Participation in Shared Savings? (Please select from dropdown)	Sample Protocol Provided (Please select from dropdown)	
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art B: Participating Clinicians					Total Estin	nated Attributable Members:	0	
							Children	Adults
							0	0
	Provider Name*	Tax Identification Number (FEIN)	Clinician Name	Clinician NPI	RI Licensure Type	Estimated Number of Attributable Members: Children (Under Age 21)	Estimated Number of Attributable Members: Adults (Age 21 and Over)	Comments
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Domain 2: Corporate Structure and Governance Template: Domain 2.1-2.3 Governance

Organization Name:

Audited statements for the most recent fiscal year

<u>Directions:</u> Please complete the following template. Note that this template includes separate sections for Multiple Entity Applicants and Single Entity Applicants. Please indicate the type of application and complete the relevant section.

Type of Application:

Multiple Entity ■ See Row 12

Single Entity ■ See Row 48

.1.1	Separate RI Corporation	Input:
	Tax Identification Number	
	Attachments	Attached (Select: Yes/No)
	Articles of Incorporation	•
	Organizational Bylaws	
2	Regular Meetings	Attached (Select: Yes/No)
	Dates and Times of Three Most Recent Board Meetings	
	Board Meeting Minutes (optional)	
2	Statement of Purpose/Mission Statement	Attached (Select: Yes/No)
	Statement of Purpose/Mission Statement	
2.1.1	Governance Board Bylaws	Attached (Select: Yes/No)
	Bylaws setting forth BOD membership and voting rights	
2.1.2	Sub-committees	Attached (Select: Yes/No)
	Identification of sub-committees (integrated care, quality oversight, finance)	
2.1.3	Quarterly Dashboards	Attached (Select: Yes/No)
	Operational Reports/Dashboards	
1.4/2.3	Compliance Officer	Input:
	Is the Compliance Officer position filled?	
	If yes, Name of Compliance Officer:	
	If no, date the position will be filled:	
	Attachments	Attached (Select: Yes/No)
	Compliance Officer Job Description	
2.1.5	Community Advisory Committee	Input:
	Are the positions on the CAC filled?	
	How frequently has the CAC met in the last 6 months?	
	Attachments	Attached (Select: Yes/No)
	Charter for the CAC Inclusive of Membership Requirements	
	Minutes from the Most Recent Two Meetings	
2.1.6	Fiduciary and Administrative Responsibility Resides with BOD	Attest (Select: Yes/No)
	Attest that the AE's administration must report exclusively to the governing Board through the AE's	
	CEO	
2.1.7	Conflict of Interest Provisions	Attached (Select: Yes/No)
	Documentation of Conflict of Interest Provisions Completed Audit (if available)	Attached (Select: Yes/No)

Boa	Board of Directors: Detail: 2.2												
Pleas	Please enter member names and complete columns to the right as applicable; add lines as needed to list all BOD members												
	Members of Board of Directors	Representative of Primary Care Provider? (Yes/No)	Representative of Behavioral Health Provider? (Yes/No)	Representing services to children? (Yes/No)	Representing services to adults? (Yes/No)	Member of Consumer Advisory Committee? (Yes/No)	Representing Provider of Social Supports? (Yes/No)						
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	To Be Completed by Single	ngle Entity Applicants			
2.1.1	Established RI Corporation	Input:			
	Tax Identification Number				
	Attachments	Attached (Select: Yes/No)			
	Articles of Incorporation				
	Organizational Bylaws				
2	Governing Committee is Distinct and Separate from Governing Board	Attest (Select: Yes/No)			
	Attest that the Governing Committee is distinct and separate from the governing board of any AE				
	participant				
2	Regular Meetings of the Governing Committee	Attached (Select: Yes/No)			
	Dates and Times of Three Most Recent Governing Committee Meetings				
	Governing Committee Meeting Minutes (optional)				
2	Statement of Purpose/Mission Statement	Attached (Select: Yes/No)			
	Statement of Purpose/Mission Statement				
2	Governing Committee Charter	Attached (Select: Yes/No)			
	Governing Committee Charter setting forth membership and voting rights				
	Documentation of sole authority to make binding decisions re: distribution of savings/loss (details in				
	2.2.2)				
2.1.2	Sub-committees Sub-committees	Attached (Select: Yes/No)			
	Identification of sub-committees (integrated care, quality oversight, finance)				
2.1.3	Quarterly Dashboards	Attached (Select: Yes/No)			
	Operational Reports/Dashboards				
2.1.4/2.3	Compliance Officer	Input:			
	Is the Compliance Officer position filled?				
	If yes, Name of Compliance Officer:				
	If no, date the position will be filled:				
	Attachments	Attached (Select: Yes/No)			
	Compliance Officer Job Description				
2.1.5	Community Advisory Committee	Input:			
	Are the positions on the CAC filled?				
	How frequently has the CAC met in the last 6 months?				
	Attachments	Attached (Select: Yes/No)			
	Charter for the CAC Inclusive of Membership Requirements				
	Minutes from the Most Recent Two Meetings				
2.1.7	Conflict of Interest Provisions	Attached (Select: Yes/No)			
	Documentation of Conflict of Interest Provisions				
	Completed Audit (if available)	Attached (Select: Yes/No)			
	Audited statements for the most recent fiscal year				

	Committee Committee Dataile 2.2											
	Governing Committee: Detail: 2.2 Please enter member names and complete columns to the right as applicable; add lines as needed to list all Governing Committee members											
Please												
	Members of Governing Committee	Representative of Primary Care Provider? (Yes/No)	Representative of Behavioral Health Provider? (Yes/No)	Representing services to children? (Yes/No)	Representing services to adults? (Yes/No)	Member of Consumer Advisory Committee? (Yes/No)	Representing Provider of Social Supports? (Yes/No)					
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lease enter member names and complete columns to the right as applicable; add lines as needed to list all CAC members										
	Members of Community Advisory Committee	Representing?	Organizational Affiliation, if applicable							
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Domain 5: Commitment to Population Health and System Transformation

Template: Domain 5.2 Social Determinants of Health (SDOH)

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Directions: Please complete the following template to reflect the AE's approach to adressing high stress areas of social determinants of health. If an external party provides support in multiple areas, repeat that party for each SDOH area to which it applies. Please make sure to complete accurately and with the most up to date information. Add rows as needed.

	Social Determinants of Health: Area Addressed (Please select from dropdown)	OTHER Area Addressed (If OTHER, please describe here)	Name of Service Provided	Capacity Type: In-house vs. Relationship with External Party (Please select from dropdown)	External Party: On-site vs. Referral (IF EXTERNAL PARTY, Please select from dropdown)	External Party: Name (IF EXTERNAL PARTY, Enter Name)	External Party: TIN (IF EXTERNAL PARTY, Enter TIN)
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This sheet contains dropdown menu options; do not modify this sheet.

Provider Type	Social Determinants of Health	Lisensure	Certification of Agreement to Participate in AE?	Membership Type	Voting Rights	Participate in Shared Savings	Participate in written mutual protocols f collaborative practice?	for Internal Medicine or Specialty Care?*	PCP Practice PCMH Based?*	If PCMH, NCQA Level Attained*	Speciality*	Primary Population Serve	d Sample Protocol Provide
Primary Care	Criminal Justice Involvement	Active	Fully Executed Agreement	Partner	Yes	Yes	Protocols in Place	Internal Medicine	Yes	Level 1	Family Medicine	Children	Yes
ІНН/СМНС	Education and Literacy	Inactive	Memorandum of Agreement	Affiliate	No	No	Protocols in Development	Specialty Care	No	Level 2	Pediatrics	Adults	No
Other Behavioral Health	Employment	Other	Letter of Agreement	Associate			Protocols Planned			Level 3	Internal Medicine	Children and Adults	
Substance Use Disorder Treatment	Family, Caregiver, Social Supports		Letter of Intent	Other			No Protocols				Ob/Gyn		
Social Supports - Social Determinants of Health Services	Food Security		Other								Mental Health		
Other (Please explain in comments section)	Housing Search and Placement										Substance Abuse		
	Housing Stabilization and Support Services										Both Mental Health and Substan	ce Abuse	
	Legal Assistance										Other		
	Physical Activity and Nutrition												
	Safety and Violence												
	Transportation												
	Utility Assistance												
	Other (Please Describe)												

Troviaci Type	Membership Type	certification of 76 recificite to	raracipate in All. (res) in voting rights. (res) res)	r articipate in shared sa r articipate in w			
Non-profit	Partner	Yes	Yes	Yes	Yes		
Community Mental Health Cetner	Affiliate	No	No	No	No		
Other	Associate						
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Attachments							

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All	MCO	
Most	AE	
Some	Other (Please specify in notes)	
None		
	Most Some	Most AE Some Other (Please specify in notes)

ns	Capacity Type	External Party: Location	
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l 6	Arrangement with External Party	Referral relationship	
Sel	Both	Both	
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Team Supervisor	Discipline	Primary Population Served
Yes	PCP	Children
No	Pharmacist	Adults
	Social Worker	Children and Adults
	BH Clinician	Special Needs
	Community Health Worker	
	Oher	

Ū	Pass Fail	Self-Score
<u> </u>	Yes	1
Se	No	2
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<u> </u>		4
S		5