



# DELAWARE HEALTH AND SOCIAL SERVICES

## Division of Long Term Care Residents Protection

### CMP REQUEST FORM LONG TERM CARE RESIDENTS' TRUST FUND

Date of Request: \_\_\_\_\_  
MM/DD/YYYY

#### **PART I: Background Information**

Name of the Organization Submitting Request:

\_\_\_\_\_

Address Line 1: \_\_\_\_\_

Address Line 2: \_\_\_\_\_

City, County, State, Zip Code: \_\_\_\_\_

Tax Identification Number: \_\_\_\_\_

CMS Certification Number, if applicable: \_\_\_\_\_

Medicaid Provider Number, if applicable: \_\_\_\_\_

Contact Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

Name of the Project Leader: \_\_\_\_\_

Address: \_\_\_\_\_

City, County, State, Zip Code: \_\_\_\_\_

Internet E-mail Address: \_\_\_\_\_

Phone #: \_\_\_\_\_ Cell Phone #: \_\_\_\_\_

Organization Name: \_\_\_\_\_

Date: \_\_\_\_\_

Please list the names of Delaware certified nursing homes that will benefit from this request:

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Have other funding sources been applied for and/or granted for this proposal?

Yes  No

If yes, please explain/identify sources and amount.

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**PART II:  
Applicable to Certified Nursing Home Applicants**

Name of the Facility: \_\_\_\_\_

Address Line 1: \_\_\_\_\_

Address Line 2: \_\_\_\_\_

City, County, State, Zip Code: \_\_\_\_\_

Telephone Number: \_\_\_\_\_

CMS Certification Number: \_\_\_\_\_

Medicaid Provider Number: \_\_\_\_\_

Date of Last Recertification Survey: \_\_\_\_\_  
MM/DD/YYYY

Highest Scope and Severity Determination: (A – L) \_\_\_\_\_

Date of Last Complaint Survey: \_\_\_\_\_  
MM/DD/YYYY

Highest Scope and Severity Determination: (A – L) \_\_\_\_\_

Organization Name: \_\_\_\_\_  
Date: \_\_\_\_\_

Currently Enrolled in the Special Focus Facility (SFF) Initiative?  Yes  No

Previously Designated as a Special Focus Facility?  Yes  No

Participating in a Systems Improvement Agreement?  Yes  No

Administrator's Name: \_\_\_\_\_

Owner of the Nursing Home: \_\_\_\_\_

CEO Telephone Number: \_\_\_\_\_

CEO Email Address: \_\_\_\_\_

Name of the Management Company: \_\_\_\_\_

Chain Affiliation (please specify): \_\_\_\_\_

Name and Address of Parent Organization: \_\_\_\_\_

Outstanding Civil Money Penalty?  Yes  No

Nursing Home Compare Star Rating: (can be 1, 2, 3, 4 or 5 stars) \_\_\_\_\_

Date of Nursing Home Compare Rating: \_\_\_\_\_  
MM/DD/YYYY

Is the Nursing Home in Bankruptcy or Receivership?  Yes  No

If an organization is represented by various partners and stakeholders, please attach a list of the stakeholders in the appendix.

NOTE: The entity or nursing home which requests CMP funding is accountable and responsible for all CMP funds entrusted to it. If a change in ownership occurs after CMP funds are granted or during the course of the project completion, the project leader shall notify CMS and the DLTCRP within five calendar days. The new ownership shall be disclosed as well as information regarding how the project shall be completed. A written letter regarding the change in ownership and its impact on the CMP Grant application award shall be sent to CMS and the DLTCRP.

Organization Name: \_\_\_\_\_  
Date: \_\_\_\_\_

**Part III:  
Project Category**

Please place an "X" by the project category for which you are seeking CMP funding.

_____	Direct Improvement to Quality of Care		
_____	Resident or Family Councils	_____	Training/Education
_____	Culture Change/Quality of Life	_____	Consumer Information
_____	Resident Transition Preparation		
_____	Resident Transition due to Facility Closure or Downsizing		
_____	Other: Please specify: _____		

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**Part IV:  
Funding**

Amount Requested: \$ \_\_\_\_\_

**Part V:  
Proposed Period of Support**

From: \_\_\_\_\_ To: \_\_\_\_\_  
MM/DD/YYYY MM/DD/YYYY

Organization Name: \_\_\_\_\_  
Date: \_\_\_\_\_

For Parts VI through XII, below, type/put all the required information starting on page 6 and ending on page 20 (the maximum length of the submission).

**Part VI:**

**Expected Outcomes**

**Project Abstract**

**Statement of Need**

**Program Description**

**Part VII:**

**Results Measurement**

**Part VIII:**

**Benefits to Nursing Home Residents**

**Part IX:**

**Consumer/Stakeholder Involvement**

**Part X:**

**Involved organization(s)**

**Part XI:**

**Budget and Narrative**

**Part XII:**

**Appendices**

Organization Name: \_\_\_\_\_  
Date: \_\_\_\_\_