|  |  |  |
| --- | --- | --- |
| 1. | Facility Name: | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  | Contact Name: | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  | Address: | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  |  | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  | Telephone: | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Fax: | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  | Email Address: | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  | County: | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | [ ]  | Non-Profit |
|  |  |  |[ ]  Public |
|  |  |  |
|  | Practice Site Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  | Contact Name: | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  | Address: | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  |  | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  | Telephone: | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Fax: | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  | Email Address: | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  | County: | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| 2.3. | Is this practice site prepared to provide the Delaware Health Care Commission with 50% (up to $50,000) of the applicant’s awarded funds for the first two (2) years of contractual agreement? [ ]  Yes [ ]  NoName of Applicant being recruited by this site: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  | Present Home Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  |  |  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  | Home Telephone: |  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Cell Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |
|  | Email Address: |  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  |  |  |
| 4.  | Date of Application: |  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Start Date at Site: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  |  |
| 5. | Total Number of Patients receiving the following services during the previous calendar year: |
|  |  |
|  | Primary Care: |       |  | Specialty Care: |       |  |
|  | General Dental Care: |       |  | Mental Health Care: |       |  |
|  | Pediatric Dental Care:  |       |  | Other: |       |  |
|  |  |  |  **Total:** | **0** |  |
|  |  |  |
|  | Total Patients in previous calendar year below 200% of Federal Poverty Level:       |
|  |  |
|  | Please provide the percentage of patients at this practice site that fall under the following payment categories:  |
|  |  |
|  | **Medicaid or****S-Chip** | **Medicare** | **Self-Pay** **Negotiated/Reduced Fee or Free Service** | **Commercial Insurance** | **Total** |
|  |      % |      % |      % |       % | = 100% |
|  |  |
| 6. | Practice Site Hours of Operation: |
|  |  |
|  | **Day** | **Time** | **Total Hours** |
|  | Monday | \_\_\_\_\_\_\_ AM | \_\_\_\_\_\_\_ PM | \_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  | Tuesday | \_\_\_\_\_\_\_ AM | \_\_\_\_\_\_\_ PM | \_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  | Wednesday | \_\_\_\_\_\_\_ AM | \_\_\_\_\_\_\_ PM | \_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  | Thursday | \_\_\_\_\_\_\_ AM | \_\_\_\_\_\_\_ PM | \_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  | Friday | \_\_\_\_\_\_\_ AM | \_\_\_\_\_\_\_ PM | \_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  | Saturday | \_\_\_\_\_\_\_ AM | \_\_\_\_\_\_\_ PM | \_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  | Sunday | \_\_\_\_\_\_\_ AM | \_\_\_\_\_\_\_ PM | \_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  |  |
| 7. | Proposed Loan Repayment Clinician Weekly Work Schedule:\* |
|  |  |
|  | **Day** | **Time** | **Total Work Hours\*\*** |
|  | Monday | \_\_\_\_\_\_\_ AM | \_\_\_\_\_\_\_ PM | \_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  | Tuesday | \_\_\_\_\_\_\_ AM | \_\_\_\_\_\_\_ PM | \_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  | Wednesday | \_\_\_\_\_\_\_ AM | \_\_\_\_\_\_\_ PM | \_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  | Thursday | \_\_\_\_\_\_\_ AM | \_\_\_\_\_\_\_ PM | \_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  | Friday | \_\_\_\_\_\_\_ AM | \_\_\_\_\_\_\_ PM | \_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  | Saturday | \_\_\_\_\_\_\_ AM | \_\_\_\_\_\_\_ PM | \_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  | Sunday | \_\_\_\_\_\_\_ AM | \_\_\_\_\_\_\_ PM | \_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  | *\*Please provide a separate work schedule for each Loan Repayment Clinician requested and specify the specialty of each.**\*\*Do not include travel, or on-call time.* |
|  |  |
|  | **RETENTION***Describe your short and long-term plan for the retention of a Loan Repayment Clinician during and beyond the required two-year obligation. Please be specific. In the event the Loan Repayment Clinician is not employed by the practice site applicant but is employed by another entity and has been approved by the Delaware Health Care Commission and said Clinician is merely utilizing the practice site applicant’s facilities and staff while such Clinician is providing medical care services as required under the terms and conditions of the State Loan Repayment Program, the practice site applicant need not describe either short or long-term retention of such Clinician until and unless such Clinician becomes employed by and under direct control of the practice site applicant. Applications submitted without a retention plan are deemed incomplete and will not be considered unless the clinician is NOT employed by the Practice Site.* |
|  | *Type Retention Plan here or provided on separate sheet of paper.*  |
|  | **Practice Site Agreement**The Delaware Health Care Commission (DHCC) is committed to ensuring that all Delaware residents have access to quality, affordable health care. Accordingly, DHCC is prepared to consider loan repayment applications on behalf of clinicians under certain conditions. The director or applicant official for the facility or practice site applying to the Loan Repayment Program must initial each of the following requirements. |
|  |  |
|  | **Access** |
|[ ]  The practice site agrees to comply with all of the Program requirements set forth in this agreement and guidelines.The Loan Repayment Clinician will provide health care services for at least 40 hours per week (not including time spent in travel and/or on-call) at the practice site named in the application for a minimum of two years, as agreed upon in the contract. No more than eight of those hours may be devoted to practice-related administrative activities. The practice will include hospital treatment coverage appropriate to meet the needs of patients of the approved service site and to ensure continuity of care. With the exception of obstetrics/gynecology and geriatric services, at least 32 hours of the minimum 40 hours per week will be spent providing clinical services at the approved practice site during normally scheduled office hours. The remaining eight hours will be spent providing clinical services at the approved site or in alternative settings (e.g., hospitals, nursing homes, shelters), as directed by the approved site, or performing practice-related administrative activities.Providers of obstetrics/gynecology or geriatric services will spend at least 21 hours of the minimum 40 hours per week providing clinical services at the approved practice site during normally scheduled office hours. The remaining 19 hours will be spent providing clinical services or teaching at the approved site, providing clinical services in alternative settings (e.g., hospitals, nursing homes, shelters), as directed by the approved site, or performing practice-related administrative activities (administrative activities are limited to eight hours per week). |
|[ ]  The practice site agrees to provide health services to Medicare, Medicaid, S-CHIP, and uninsured patients on a reduced or pro bono basis for those patients demonstrating a hardship. |
|[ ]  The practice site has a nondiscrimination policy that prohibits discrimination based on race, creed, disability or religion. |
|[ ]  The practice site must allow loan repayment ***dentists*** to agree that a minimum of 20% of their scheduled appointments will be comprised of Medicaid patients and/or low income (less than 200% FPL) dentally uninsured patients who will be provided care at reduced rates or free-of-charge. |
|[ ]  Practice sites must agree to allow non-dental clinicians to participate in Delaware Community Healthcare Access Program (CHAP) and the Voluntary Initiative Program Phase II (VIP II) sponsored by the Medical Society of Delaware. To enroll in VIP II, contact Cynthia Bristor, VIP Coordinator at the Medical Society of Delaware by phone (302) 224-5190 or email Cynthia.Bristor@MedSocDel.org |
|[ ]  I understand and acknowledge that the review of this practice site application is discretionary and that in the event a decision is made not to approve the site application, I hold harmless the State of Delaware, DHCC and all State Employees and/or any and all individuals or organizations involved in the review process from any action or lack of action made in connection with this request. |
|  | **Comprehensive System of Care** |
|[ ]  The providers shall practice in ambulatory settings that assure the availability of services, including after-hours coverage, and arrangements for inpatient coverage and referrals, as needed. |
|[ ]  Hospital privileges for inpatient practice shall be maintained.  |
|  | **Quality of Care** |
|[ ]  The physician practice site has a credentialing program in place, including National Practitioner Data Bank Query to review references and verify licensure and certification status of all providers, whether employed by the practice site or third party entity.  |
|[ ]  The practice site has a quality monitoring and improvement system in place, which may include patient satisfaction surveys, peer review systems, clinical outcome measures, or other such tools. |
|[ ]  Services will be delivered in culturally appropriate fashion so as to be sensitive and responsive to the needs of the target population. |
|[ ]  The practice site will address retention of providers through monitoring turnover rates, clinical team management efforts, pay comparability, surveys, exit interviews, and other means. However, it will NOT be necessary to address retention of providers in those instances where providers are employed by third party entities and are not employed by and under the direct control of the practice site. |
|  | **Provider Employment Contract** |
|[ ]  Loan Repayment Clinicians shall practice only in the Health Professional Shortage Area (HPSA) and at the practice site for which originally approved by the DHCC, unless a change is approved in writing by DHCC. |
|[ ]  The practice site shall inform DHCC about Loan Repayment Clinician vacancies, including resignations, termination and extended leave for providers. Notification shall be provided within 30 days prior to such occurrence, or soon as it is known. The practice site shall document in writing all circumstances surrounding resignations and terminations of both Loan Repayment Clinicians employed by the practice site and those employed by a third party entity utilizing the practice site’s facilities and staff. |
|[ ]  The practice Site agrees to cooperate with email, mail, telephone, and/or site visits conducted by DHCC for the purpose of monitoring compliance with Delaware Loan Repayment Program.  |
| [ ]  | The practice site agrees to provide matching funds as specified in the SLRP Program Guidelines and as referenced above. |
|  |
|  | I certify that the information provided in this application is true and correct. I also understand that any intentional or negligent misrepresentation(s) of the information contained in this application may result in the forfeiture of eligibility to participate in the State Loan Repayment Program.Signature of Facility Director or Applicant Official:  |
|  | Title: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |