DELAWARE HEALTH AND SOCIAL SERVICES

Division of Health Care Quality

CMP REQUEST FORM

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 #:_____

Please list the names of Delaware State Licensed LTC Facilities that will benefit from this request:

_____

_____

Have other funding sources been applied for and/or granted for this proposal?
___ Yes ___ No

If yes, please explain/identify sources and amount.

_____

_____

_____

PART II:
As Applicable to State Licensed LTC Facilities

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) _____

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 State Licensed LTC Facility:_____

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

Is the State Licensed LTC Facility 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 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 DHCQ 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 DHCQ.

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: _____

_____

Part IV:
Funding

Amount Requested: $_____

Part V:
Proposed Period of Support

From: _____ To: _____
MM/DD/YYYY MM/DD/YYYY

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