Attachment D: Applicant Background Information

Organization Name:

Organizational Tax Identification Number:

Website, if applicable:

Name and Title of Person Authorized to Conduct Business on Behalf of Agency:

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:

Directions: Please complete the folllowing 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 identifiable tax 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

	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? (Please select from dropdown)	Participation in Shared Savings? (Please select from dropdown)	Participation in written mutual protocols for collaborative practice? (Please select from dropdown)	Sample Protocol Provided (Please select from dropdown)	Comments
1													
2													
3													
4													
5													
6													
7													
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9													
10													
11													
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30													
31													
32													

Part B: Participating Clinicians

Total Estimated 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
1								
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5								
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11								
12								
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16								
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37								
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39								

Domain 2: Corporate Structure and Governance
Template: Domain 2.1-2.3 Governance

Organization Name:

Directions: 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

Multi Entity Applicants Only.

To Be Completed by Multiple Entity Applicants

2.1.1	**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	
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	
2.1.6	**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)**
	Audited statements for the most recent fiscal year	

Board of Directors: Detail: 2.2

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)
1							
2							
3							
4							
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11							

Community Advisory Committee: Detail: 2.1.5

Please 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
1			
2			
3			
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10			
11			

Single Entity Applicants Only

To Be Completed by Single 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**	**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	

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

	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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11							

Community Advisory Committee: Detail: 2.1.5

Please 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
1			
2			
3			
4			
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Domain 5: Commitment to Population Health and System Transformation

Template: Domain 5.2 Social Determinants of Health (SDOH)

Organization Name:

Directions: Please complete the folllowing 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.

Domain 1 Selections

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 for collaborative practice?	Internal Medicine or Specialty Care?*	PCP Practice PCMH Based?*	If PCMH, NCQA Level Attained*	Speciality*	Primary Population Served	Sample Protocol Provided
Primary Care	Criminal Justice Involvement	Active	Fully Executed Agreement	Partner	Yes	Yes	Protocols in Place	Internal Medicine	Yes	Level 1	Family Medicine	Children	Yes
IHH/CMHC	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 Servic	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 Substance Abuse		
	Legal Assistance										Other		
	Physical Activity and Nutrition												
	Safety and Violence												
	Transportation												
	Utility Assistance												
	Other (Please Describe)												

Provider Type	Membership Type	Certification of Agreement to Participate in AE? (Yes/No)	Voting rights? (*Yes/No*)	Participate in shared sav	Participate in writt
Non-profit	Partner	Yes	Yes	Yes	Yes
Community Mental Health Cetner	Affiliate	No	No	No	No
Other	Associate				

Domain 2 Selections

Attachments
Yes
No

Domain 4 Selections

Yes/No	All/Most/Some/None	High/Rising Risk Member Roster: Creation	
Yes	All	MCO	
No	Most	AE	
	Some	Other (Please specify in notes)	
	None		

Domain 5 Selections

Capacity Type	External Party: Location
In-house	On-site
Arrangement with External Party	Referral relationship
Both	Both

Domain 6 Selections

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	

Self Selec

Pass Fail	Self-Score
Yes	1
No	2
	3
	4
	5