



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 5: Commitment to Population Health and System Transformation

Template: Domain 5.2 Social Determinants of Health (SDOH)

Organization Name:

Directions: Please complete the following template to reflect the AE's approach to addressing 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)
1							
2							
3							
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19							
20							

This sheet contains dropdown menu options; do not modify this sheet.

Domain 1 Selections	Provider Type	Social Determinants of Health	Licensure	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*	Specialty*	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 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 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 sa	Participate in writ
Non-profit	Partner	Yes	Yes	Yes
Community Mental Health Cetner	Affiliate	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	
		Other	

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