Medicaid Pediatric Healthcare Recovery Program Application

This application is due by 5pm EST on October 11, 2022.

Prior to beginning the application, please read the program guidance available at http://www.eohhs.ri.gov/Initiatives/PediRelief.aspx. To complete this application, you will need:

- The applicant's Tax Identification Number (TIN)
- The applicant's National Provider Identifier (NPI) (also referred to as a Type 2 NPI or Group NPI).
- The names and National Provider Identifier (NPI) numbers for each clinician with credentials MD, DO, NP, or PA who manages a patient panel at any of the applicant's practice sites.
- The applicant's number of active Rhode Island Medicaid-covered patients who are children under the age of 18. Active patients are defined as those patients who have been served by the applicant over the last two years: August 1, 2020 through July 31, 2022.
- Signed Financial Agreement, available at http://www.eohhs.ri.gov/Initiatives/PediRelief.aspx.
- Completed Performance Improvement Plan, template available at http://www.eohhs.ri.gov/Initiatives/PediRelief.aspx.

Payments will be processed by the Medicaid Management Information System (MMIS). You will be asked to report a Medicaid Legacy Provider ID.

If applicant has multiple practice sites that operate under a single TIN, please submit one (1) application for all practice sites.

Incomplete applications will not be accepted. If you have questions about this application, please contact OHHS.PediRelief@ohhs.ri.gov.

Contact Information

1. Please fill out your contact information.
    a. First Name
    b. Last Name
    c. Title
    d. Email Address
    e. Phone Number

Applicant Information

2. Please fill out the following information for the organization seeking participation in the program.
    a. Legal Name of Organization/Practice
    b. DBA, if applicable
    c. Street Address
    d. City
    e. State
    f. Zip + 4
    g. Applicant Contact Person's Name
    h. Applicant Contact Person's Email Address
    i. Phone Number
    j. Fax Number
    k. Address for principal place of performance of grant funded activities in Rhode Island, if different from prior address
    l. Street Address
    m. City
    n. State
    o. Zip + 4
    p. If applicable, list the names and DBAs of any distinct practices or practice sites that are seeking to participate in the program under the applicant's TIN.
3. What is the applicant's Tax Identification Number (TIN)?
4. What is the applicant's National Provider Identifier (NPI)?
5. How many full-time equivalent clinicians with the credential MD, DO, NP, or PA manage a patient panel at any of the applicant's practice sites?
6. For each clinician with the credential MD, DO, NP, or PA managing a patient panel at any of the applicant's practice sites, please list the clinician's first name, last name, and National Provider Identifier (NPI) number.
7. Which of the below specialties best indicates the primary care specialty of the applicant?
    a. Family Practice
    b. Pediatric Practice
    c. Other (please specify)
8. Please report the number of active Rhode Island Medicaid covered patients (Fee-for-Service and Managed Care) as of July 31, 2022 who are children under the age of 18. Active patients are defined as those patients who have been served by the practice over the last 24 months (between August 1, 2020 and July 31, 2022).
9. Is the applicant registered on SAM.gov?
    a. If yes, please provide the applicant's Unique Entity ID (UEI):
    b. If no, the following questions are required.
        i. In its preceding fiscal year, did applicant receive 80% or more of its annual gross revenue from federal funds? Yes or No.
        ii. In the preceding fiscal year, did applicant receive $25 million or more of its annual gross revenue from federal funds? Yes or No.

iii. Is the "total compensation" for the applicant's five highest paid officers publicly listed or otherwise listed in SAM.gov? Yes or No.

iv. If the applicant is not registered in sam.gov and answered yes to the first two questions above and no to the third (the applicant did receive 80% or more from federal funds, did receive $25 million or more in federal funds, and the applicant's officers are not publicly listed), answer the following:

1. List Executive Name and Compensation for five highest paid officers.

10. Attachments

Attach Signed Financial Agreement

Attach Performance Improvement Plan

Attestation

By submitting this application for the Rhode Island Medicaid Pediatric Healthcare Recovery Program, I acknowledge that I am authorized to submit this request on behalf of the provider/practice and that all of the information provided is accurate to the best of my knowledge and ability. I acknowledge the State of Rhode Island is relying upon the information as submitted in order to determine whether to issue a Rhode Island Pediatric Healthcare Recovery Program payment. Therefore, if I become aware of any inaccuracies in the information provided, I will immediately notify the State of Rhode Island through email at OHHS.PediRelief@ohhs.ri.gov. I also agree that the Care Transformation Collaborative of Rhode Island is authorized to obtain data on my provider/practice's performance on lead screening and childhood immunization rates from KIDSNET Rhode Island. I agree to unblinded public reporting on immunization/lead screening performance amongst the participating Medicaid Pediatric Recovery practices.