COMMUNITY BENEFITS PROGRAMS
Fiscal Year 2018-19
Elevating the Safety Net Provider Recruitment Program Application
Cycle Two

Please read the accompanying Request for Application (RFA) before filling out this application.

I. APPLICANT INFORMATION

Name of Contracted Provider and of Fiscal Agent if not the same: _____

_____

Must be contracted with L.A. Care Health Plan either through IPA/MSO or Direct Network.

Check one: ☐ Name of IPA/MSO: _____; or **☐ L.A. Care Health Plan's Direct Network.**

Tax ID Number or Employer Identification Number (EIN): _____

Contracted provider founded in: _____

Corporate Street Address: _____ **City:** _____

State: _____ **Zip Code:** _____

Street Address where new physician will be placed: _____

City: _____ **State:** _____ **Zip Code:** _____

Name and title (*e.g. ED, CEO, President, Owner*): _____

Telephone(s): _____ **Email:** _____

Project contact name and title (must provide a 2nd contact person): _____

2nd contact telephone: _____ **2nd contact email:** _____

Amount request: _____ **Contracted Provider's annual operating budget:** _____

Total patient population: _____ **Total Medi-Cal/uninsured population**: _____

Percentage of Medi-Cal/uninsured to total patient population: _____%.

Total number of L.A. Care members (including L.A. Care Health Plan "Plan Partners": *Anthem, Care 1st, Kaiser Permanente*)**:** _____

II. ORGANIZATION TYPE

Please only check one:
☐ Federally Qualified Health Center (FQHC) **or** FQHC Look-alike
☐ 501(c)(3) Licensed Community Clinic (NOT an FQHC or FQHC Look-alike)
☐ Independent Private Provider

III. PROJECT AND ORGANIZATIONAL BACKGROUND

1. **State the contracted provider's current total number of FTE primary care physicians: _____. How many of these physicians have a total patient panel of over 1,500 unique unduplicated medical users? _____. Total number of FTE mid-level clinicians: _____.**

2. **What is your total number of unique unduplicated medical users? _____. If you receive an award, how many more <u>new</u> unique unduplicated medical users do you expect to serve in the next 12 months? _____. What would be the cumulative unique unduplicated medical user population in 12 months? _____.**

3. **Are you replacing a physician? Check one:** ☐Yes or ☐ No.

4. **Is this a new physician position? Check one:** ☐ Yes or ☐ No

5. **New physician to be hired is (please check only one):**
   Pediatrician ☐; OB/GYN ☐; Family Medicine ☐; or Internal Medicine ☐ How many hours of direct patient care will this physician be providing per week? _____ Board Eligible or Board Certified? Check one: ☐ Yes or ☐No

6. **Have you hired, or will you hire, a qualified physician between September 6, 2018 and March 6, 2019? Check one:** ☐ Yes or ☐ No
   If "No," go to question #7. If "Yes," complete the following:
   Physician's full name: _____ Physician's title: _____
   Physician License Number: _____ Current/Projected hire date: _____
   Confirmation the physician is new to L.A. Care Health Plan's Medi-Cal network:

7. **Why do you need to hire a new physician provider?**

8. **In no more than one paragraph, please summarize the applicant's mission and commitment to serve the Medi-Cal, low-income, and/or uninsured populations**.

9. **Will the new physician provide services in a Medically Underserved Area (MUA) and/or a medical Health Professional Shortage Area (HPSA)? Check one:** ☐Yes or ☐ No. **If so, please provide the MUA and/or HPSA identification number(s):** _____ **and area name(s)**:

IV. GRANT AGREEMENT SIGNATOR INFORMATION

Print Name **and** Title of Grant Agreement Signator: _____

Grant Agreement Signator's Phone number: _____ and Email: _____

Grant Agreement Signator's Signature **(Only needed on the hard copy)**

Hard Copy Signature: _____ Date Submitted: _____

The application form ends here. Completed application cannot be over three (3) pages. Please refer to RFA for submittal instructions.