**COMMUNITY BENEFITS PROGRAMS**

**Fiscal Year 2018-19**

**Elevating the Safety Net Provider Recruitment Program Application**

**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**:Click or tap here to enter text.

**Must be contracted with L.A. Care Health Plan either through IPA/MSO or Direct Network. Check one:** [ ]  **Name of IPA/MSO:** Click or tap here to enter text.; or [ ]  **L.A. Care Health Plan’s Direct Network.**

**Tax ID Number or Employer Identification Number (EIN):** Click or tap here to enter text. **Contracted provider founded in:** Click or tap here to enter text.

**Corporate Address:** Click or tap here to enter text. **City:** Click or tap here to enter text. **State:** Click or tap here to enter text. **Zip Code:** Click or tap here to enter text.

**Address where new physician will be placed:** Click or tap here to enter text.

**Name and title, *e.g. ED, CEO, President, Owner***: Click or tap here to enter text.

**Telephone(s):** Click or tap here to enter text. **Email:** Click or tap here to enter text.

**Project contact name and title (must provide a second contact person):** Click or tap here to enter text. **2nd contact telephone:** Click or tap here to enter text. **2nd contact email:** Click or tap here to enter text.

**Amount request:** Click or tap here to enter text. **Contracted Provider’s annual operating budget:** Click or tap here to enter text.

**Total patient population:** Click or tap here to enter text. **Total Medi-Cal/uninsured population**: Click or tap here to enter text.

**Percentage of Medi-Cal/uninsured to total patient population:** Click or tap here to enter text.%.

**Total number of L.A. Care members** (including L.A. Care Health Plan “Plan Partners”: *Anthem, Care 1st, Kaiser Permanente*)**:** Click or tap here to enter text.

**II. ORGANIZATION TYPE**

**Please only check the one that applies to you:**

[ ]  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

**Limit this entire application to no more than three pages. The requested budget is not part of this page limit. Font size must at least 11 point**

**III. PROJECT AND ORGANIZATIONAL BACKGROUND**

1. **State the contracted provider’s current total number of FTE primary care physicians:** Click or tap here to enter text., **total number of FTE mid-level clinicians:** Click or tap here to enter text., **and total number of unique unduplicated medical users:** Click or tap here to enter text.. **How many of these physicians have a total patient panel of over 1,500 unique unduplicated medical users?** Click or tap here to enter text.
2. **What is your total current patient population (baseline)?**Click or tap here to enter text. **If you receive an award, how many more new patients do you expect to serve in the next 12 months?** Click or tap here to enter text. **What would be the cumulative total patient population in 12 months?** Click or tap here to enter text.
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?**Click or tap here to enter text. **Board Eligible or Board Certified? Check one:** [ ]  Yes or [ ] No.
6. **Why do you need to hire a new physician provider?** Click or tap here to enter text.
7. **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**. Click or tap here to enter text.
8. **Will the new physician provide services in a Medically Underserved Area (MUA) or a medical Health Professional Shortage Area (HPSA)? Check one:** [ ] Yes or [ ]  No. **If so, please provide the identification number**: Click or tap here to enter text. **and area name**:Click or tap here to enter text..

**IV. GRANT AGREEMENT SIGNATOR INFORMATION**

Print Name **and** Title of Grant Agreement Signator: Click or tap here to enter text.

Grant Agreement Signator’s: Phone number Click or tap here to enter text.. Email: Click or tap here to enter text.

Grant Agreement Signator’s Signature **(not necessary on the electronic version, only needed on the hard copy)**

Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_

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