



# PRIMARY CARE FUND

## APPLICATION FORM FOR FISCAL YEAR 2009-10

**Issued:  
May 8, 2009**

**Response Date:  
June 15, 2009**

**Department of Health Care Policy and Financing  
Budget and Finance Office  
State Programs and Federal Financing Division  
Safety Net Programs Section  
1570 Grant Street  
Denver, CO 80203-1818**

**Application Form Available at:  
[Colorado.gov/hcpf](http://Colorado.gov/hcpf)**

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## PRIMARY CARE FUND

### Section A: APPLICATION INFORMATION (Please read before completing the application.)

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#### Item 1. INTRODUCTION

In accordance with Section 21 of Article X (Tobacco Taxes for Health Related Purposes) of the State Constitution, an increase in Colorado's tax on cigarettes and tobacco products became effective January 1, 2005, and created a cash fund that was designated for health related purposes. House Bill 05-1262 divided the tobacco tax cash fund into separate funds, assigning 19% of the moneys to establish the Primary Care Fund, set forth how the funds will be allocated and designated the Department of Health Care Policy and Financing (the Department) as the administrator of the Primary Care Fund.

The Primary Care Fund provides an allocation of moneys to health care providers that make basic health care services available in an outpatient setting to residents of Colorado who are considered medically indigent. Moneys shall be allocated based on the number of medically indigent patients served by one health care provider in an amount proportionate to the total number of medically indigent patients served by all health care providers who qualify for moneys from this fund.

#### Item 2. DEFINITIONS

The following listing of terminology and definitions is included to assist the applicant agency in understanding language used throughout this application form.

Arranges For - Demonstrating Established Referral Relationships with health care providers in the community for any of the Comprehensive Primary Care services not directly provided by the applicant agency.

Children's Basic Health Plan also known as Child Health Plan Plus (CHP+) - As specified in 25.5-8-101 et seq., C.R.S. (2007).

Colorado Indigent Care Program (CICP) - As specified in 25.5-3-101 et seq., C.R.S. (2008).

Comprehensive Primary Care - Basic, entry-level health care provided by health care practitioners or non-physician health care practitioners that is generally provided in an outpatient setting. At a minimum, this includes providing or arranging for the provision of the following services on a Year-Round Basis: primary health care; Maternity Care, Including Prenatal Care; preventive, developmental, and diagnostic services for infants and children; adult preventive services; diagnostic laboratory and radiology services; emergency care for minor trauma; Pharmaceutical Services; and coordination and follow-up for hospital care. It may also include optional services based on a patient's needs such as dental, behavioral health and eyeglasses.

Cost-Effective Care - Provides or Arranges For Comprehensive Primary Care that is appropriate and at a reasonable average cost per patient Visit/Encounter.

Eligible Qualified Provider – A Qualified Provider who is identified by the Department to receive funding from the Primary Care Fund.

Established Referral Relationship - A formal, written agreement in the form of a letter, a memorandum of agreement or a contract between two entities which includes:

1. The Comprehensive Primary Care and/or products (e.g., pharmaceuticals, radiology) to be provided by one entity on behalf of the other entity;
2. Any applicable policies, processes or procedures;
3. The guarantee that referred Medically Indigent Patients shall receive services on a Sliding Fee Schedule or at no charge;
4. The date range that the agreement has been or is in effect; and
5. Signatures by representatives of both entities.

Maternity Care, Including Prenatal Care - Medical care, physical examinations and routine testing related to pregnancy and postpartum care. The focus of this component of primary care is on the provision of prenatal care. Maternity Care as defined for the Primary Care Fund does not include labor and delivery services.

Medical Assistance Program (Medicaid) - As specified in 25.5-4-101 et seq., C.R.S. (2008).

Medically Indigent Patient - A patient receiving medical services from a Qualified Provider and:

1. Whose yearly family income is below two hundred percent (200%) of the Federal Poverty Level (FPL);
2. Who is not eligible for Medicaid, CHP+, Medicare or any other governmental reimbursement for health care costs such as through Social Security, the Veterans Administration, Military Dependency (TRICARE or CHAMPUS), or the United States Public Health Service. (Payments received from the Colorado Indigent Care Program are not considered a governmental reimbursement for health care costs related to a specific patient); and
3. There is no Third Party Payer.

Medically Underserved Area - A federal government designation given to a geographical area based on the ratio of medical personnel (physicians, dentists, behavioral health workers, etc.) to the population. These areas have fewer than a generally accepted minimum number of medical personnel per thousand population resulting in insufficient health resources (personnel and/or facilities) to meet the medical needs of the resident population. Such areas are also defined by measuring the health status of the resident population; an area with an unhealthy population being considered underserved. (For the most current information go to <<http://bphc.hrsa.gov/databases/newmua/>>).

Medically Underserved Population - A federal government designation given to a human population that does not receive adequate medical attention or have access to health care facilities. (For the most current information go to <<http://bphc.hrsa.gov/databases/newmua/>>).

Outside Entity - A business or professional that is not classified as an employee of the applicant agency or the Department and does not have a direct or indirect financial interest with the applicant agency. The business or professional shall have auditing experience or experience working directly with Medicaid or similar services or grants for Medically Indigent Patients.

Pharmaceutical Services - Provides prescription drugs, or coordinates access to or Arranges For client to receive prescription drugs prescribed by the Qualified Provider on a Sliding Fee Schedule or at no charge. Coordinating access to pharmacy services may include getting patients on reduced drug-pricing programs and/or referring patients to patient assistance programs that assist them in obtaining prescriptions. However, it is not sufficient for a clinic to provide sample medications.

Primary Care Fund Application Response - The applicant agency's written reply to the Primary Care Fund Application Form that is officially submitted to the Department.

Qualified Provider - an entity that provides Comprehensive Primary Care in Colorado and that:

1. Accepts all patients regardless of their ability to pay and uses a Sliding Fee Schedule for payments or does not charge Medically Indigent Patients for services;
2. Serves a designated Medically Underserved Area or Medically Underserved Population as provided in section 330(b) of the federal "Public Health Service Act", 42 U.S.C. sec. 254b, or demonstrates to the Department that the entity serves a population or area that lacks adequate health care services for low-income, uninsured persons;
3. Has a demonstrated Track Record of providing Cost-Effective Care;
4. Provides or Arranges For the provision of Comprehensive Primary Care to persons of all ages. An entity in a rural area may be exempt from this requirement if they can demonstrate that there are no providers in the community to provide one or more of the Comprehensive Primary Care services;
5. Completes a screening that evaluates eligibility for Medicaid, CHP+, and the Colorado Indigent Care Program and refers patients potentially eligible for one of the programs to the appropriate agency (e.g., county departments of human/social services) for eligibility determination if they are not qualified to make eligibility determinations; and
6. Is a community health center, as defined in Section 330 of the federal "Public Health Services Act", 42 U.S.C. Section 254b; or at least 50% of the patients served by the applicant agency are Medically Indigent Patients or patients who are enrolled in Medicaid, CHP+, or any combination thereof.

Quality Assurance Program - Formalized plan and processes designed to ensure the delivery of quality and appropriate Comprehensive Primary Care in a defined medical setting. This can be demonstrated by obtaining a certification or accreditation through the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or by the Accreditation Association for Ambulatory Health Care, Inc. (AAAHC). If such certification or accreditation is not available, then at a minimum, the Quality Assurance Program shall be comprised of elements that meet or exceed the following components:

1. Establishment of credentialing/re-credentialing requirements for medical personnel;

2. Surveying and monitoring of patient satisfaction;
3. Establishment of a grievance process for patients, including documentation of grievances and resolutions;
4. Development of clinic operating policies and scheduled performance monitoring;
5. Review of medical records to check for compliance with established policies and to monitor quality of care;
6. Assessment of state and federal regulations to ensure compliance;
7. Establishment of patient safety procedures; and
8. Establishment of infection control practices.

Sliding Fee Schedule - A tiered co-payment system that determines the level of patient financial participation and guarantees that the patient financial participation is below usual and customary charges. Factors considered in establishing the tiered co-payment system shall only be financial status and the number of members in the patient's family unit. In the case of Pharmaceutical Services, formal arrangements with pharmaceutical companies to provide prescriptions at a minimal charge or at no fee can replace a Sliding Fee Schedule as long as all classes of prescription medications are covered.

Third Party Payments or Third Party Payer - Any individual, entity or program with a legal obligation to pay for some or all health-related services rendered to a patient. Examples include Medicaid; CHP+; Medicare; commercial, individual or employment-related health insurance; court-ordered health insurance (such as that required by non-custodial parents); workers' compensation; automobile insurance; and long-term care insurance. The Colorado Indigent Care Program is not considered a Third Party Payer and payments received from the Colorado Indigent Care Program are not considered Third Party Payments.

Track Record - Evidence of providing Comprehensive Primary Care covering at least a consecutive 52-week period prior to the submission of the application.

Unduplicated User/Patient Count (or Unduplicated Users/Patients) - The sum of patients who have had at least one Visit/Encounter and received at least one of the services under the definition of Comprehensive Primary Care during the applicable calendar year, but does not include the same patient more than once. The sum shall be calculated on a specific point-in-time occurring between the end of the applicable calendar year and prior to the submission of the application. Each patient shall be counted once under only one payment source designation (Third Party Payer or Medically Indigent Patient). The patient's payment source designation shall be the payment source designation listed for the patient at the specific point-in-time in which the calculation is made. The sum shall not include:

1. Counting a patient more than once if the same patient returns for additional services (e.g., medical or dental) and/or products (e.g., pharmaceuticals) during the applicable calendar year;
2. Counting a patient more than once if the payment source designation changed during the applicable calendar year;

3. Persons who have only received services through an outreach event, community education program, nurse hotline, or other types of community-based events or programs and were not documented on an individual basis;
4. Persons who have only received services from large-scale efforts such as mass immunization programs, screening programs, and health fairs;
5. Persons whose only contact with the applicant agency is to receive Special Supplemental Nutrition Program for Women, Infants, and Children (WIC Program) counseling and vouchers are not users and the contact does not generate an encounter;
6. Persons whose only contact with the applicant agency is at an inpatient or residential treatment facility (e.g., hospital, hospice, long term care facility, assisted living residence, community residential home/group home, intermediate care facility for the mentally retarded, or psychiatric residential treatment facility); or
7. Different applicant agencies counting the same patient in instances where the patient was seen at the same location.

Visit/Encounter - A face-to-face appointment with medical personnel (physicians, physician assistants, dentists, behavioral health workers, etc.) in which the patient received health related services and/or products (e.g., pharmaceuticals or radiology) and the appointment is customarily billable to a Third Party Payer.

Year-Round Basis - Comprehensive Primary Care provided in a consecutive 52-week period directly by the applicant agency and/or through an established referral relationship with other providers. If an organization is closed for four consecutive weeks or longer in a calendar year on a regularly scheduled basis, it is not considered to directly provide services on a year-round basis.

**Item 3. APPLICATION TIMELINE**

The following timeline may be revised at the discretion of the Department:

<b>DATE</b>	<b>ACTIVITY</b>
Friday, May 8, 2009	Application Form Released
Friday, May 22, 2009	Questions Due from Applicant Agencies and Intent to Apply Notification Due from Applicant Agencies
Monday, June 1, 2009	Pre-Bid Conference for Applicant Agencies
<b>Monday, June 15, 2009 2:00 PM</b>	<b>Application Responses Due</b>
Wednesday, July 15, 2009	Award Notification

**Questions Due from Applicant Agencies** – Agencies should submit questions regarding the application or the Primary Care Fund by e-mail to Nancy Dolson at nancy.dolson@state.co.us by Friday, May 22, 2009. Answers to received questions will be compiled and posted on the Department’s Web site.

**Pre-Bid Conference** – A Pre-Bid Conference is held to discuss questions regarding the application or the Primary Care Fund. Questions discussed will be compiled and posted on the Department’s Web site after the conference has taken place. Any interested party is welcome to attend the pre-bid conference in person or by conference call. If you would like to attend by conference call, notify Nancy Dolson by Friday, May 29, 2009.

The pre-bid conference is scheduled as follows:

Pre-Bid Conference  
Monday, June 1, 2009  
2:00 P.M. – 4:00 P.M.  
1st floor conference room  
225 East 16<sup>th</sup> Ave  
Denver, CO 80203

**Intent to Apply Notification** – Agencies should notify the Department of their intent to submit an application response for the Primary Care Fund in writing, by FAX or by email to Nancy Dolson (see Section A, item 7, page 9 for Application Contact Information). Notification should be sent to the Department contact person in writing, by FAX or by email no later than Thursday, May 22, 2009. The notification should include:

1. Applicant agency’s business name
2. Contact person
3. E-mail and telephone number for contact person

**Award Notification** – Announcement of the applicant agencies qualifying to receive funding will be posted on the Department’s Web site and notifications will be sent to each applicant agency.

#### **Item 4. APPLICATION RESPONSE INSTRUCTIONS**

The applicant agency shall respond to all requests for information contained in Section B, Primary Care Fund Application Response. Please note that capitalized words or phrases in Section B are defined in Section A, Item 2, Definitions.

The Primary Care Fund Application Response shall consist of a complete copy of Section B from this application form with responses provided where required and supporting documentation included only if specifically requested. Unnecessarily elaborate applications are not desired.

Applicant agencies are permitted to submit only one Primary Care Fund Application Response which shall only include data that encompasses facilities or clinics that are operated solely by the applicant agency and are operated under the same Federal Employer Identification Number associated with the legal name of the applicant agency.

The Primary Care Fund Application Response shall reflect current, relevant information on the applicant agency, unless otherwise specified. The response shall be presented in ring binders, on letter-size paper, with one-inch margins on all sides, printed in 12-point font (including responses in the tables) **double-sided**, with consecutive page numbers in a consistent numbering format printed on each page. Sequential numbers assigned to each question in this application form must be retained in the response. All tables in Section B may be expanded to the size necessary in order to provide an adequate detailed response.

The complete response package shall include the following tabs:

- **Table of Contents**
- **Application Response** (followed by the completed response to Section B)
- **Appendix A** (followed by Sliding Fee Schedule)
- **Appendix B** (followed by formal written agreements [if necessary])
- **Appendix C** (followed by JCAHO or AAAHC Accreditation [if applicable])
- **Appendix D** (followed by letter from Outside Entity)
- **Appendix E** (followed by required documentation [if necessary])
- **Appendix F** (followed by completed Certification to Waive Documentation of Qualified Provider Criteria [if applicable])

**SUBMIT ONE (1) ORIGINAL AND ONE (1) COMPLETE COPY OF THE COMPLETED PRIMARY CARE FUND APPLICATION RESPONSE. THE ORIGINAL SHOULD INCLUDE ORIGINAL SIGNATURES ON ALL PAGES REQUIRING SIGNATURES. LABEL THE BINDERS “ORIGINAL” and “COPY 1 OF 1.”**

The Primary Care Fund Application Response shall present a complete response to all of the questions listed in the application form. It is important that the response package include all of the responses and materials requested since any deviation from this may result in the determination that an applicant agency does not meet the criteria for this program. The

Department may, but is not required to, make additional inquiries to clarify any detail in the response. Primary Care Fund Application Responses received from applicant agencies not meeting the complete criteria of Qualified Provider, as it is defined for the Primary Care Fund, will be considered not qualified. There will be no opportunity to provide new information or documentation once the application response has been submitted.

Submit the Primary Care Fund Application Response to Nancy Dolson (see Section A, Item 7, page 11, for contact information). All Primary Care Fund Application Responses received any time after the due date and time will be rejected.

#### **Item 5. APPLICATION RESPONSE SUBMISSION**

The Primary Care Fund Application Response deadline is **Monday, June 15, 2009, 2:00 P.M. MDT**. The Primary Care Fund Application Response shall be received by the Department no later than this date and time. Postmarks will not be accepted.

All material submitted regarding the Primary Care Fund Application Response becomes the property of the State of Colorado and is subject to the terms of 24-72-201 through 24-72-206 C.R.S. (2008), Public (Open) Records. The State of Colorado has the right to use any or all information/material presented in the Primary Care Fund Application Response, subject to limitations for proprietary or confidential information. Disqualifications or denial of the Primary Care Fund Application Response does not eliminate this right. Any additional restrictions on the use or inspection of material contained within the Primary Care Fund Application Response shall be clearly stated in the Primary Care Fund Application Response itself.

#### **Item 6. APPEALS PROCESS**

Any applicant agency who is aggrieved in connection with the Primary Care Fund, the Primary Care Fund Application Form for Fiscal Year 2009-10, the Primary Care Fund Application Response or the final determination of Eligible Qualified Providers by the Department may file a grievance in writing within five (5) business days of award notification.

The grievance shall be sent to Joan Henneberry, Executive Director, Department of Health Care Policy and Financing, 1570 Grant Street, Denver, CO 80203-1818. A copy of the grievance shall be sent to Chris Underwood, Director, State Programs and Federal Financing Division, Department of Health Care Policy and Financing, 1570 Grant Street, Denver, CO 80203-1818. Copies of the grievance shall be sent by fax to both parties listed above at 303-866-4411.

Following receipt of the grievance, the Director of the State Programs and Federal Financing Division will perform a review. This review will focus on procedural issues and utilize documents from the application evaluation process. In addition, a review of the original determination and the results of the first review will be conducted by the Director of the Budget and Finance Office.

No new information or documentation may be submitted by an applicant agency during the appeals process. A final determination will be made by the Executive Director within 10 business days of receipt of the grievance. The decision of the Executive Director is final.

**Item 7. APPLICATION CONTACT INFORMATION**

Name: Nancy Dolson  
Title: Supervisor, Safety Net Programs Policy Unit

Mailing Address: Primary Care Fund  
Safety Net Programs Section  
Department of Health Care Policy and Financing  
1570 Grant Street  
Denver, CO 80203-1818

Phone: 303-866-3698  
Fax: 303-866-4411

E-mail: nancy.dolson@state.co.us

Web Address: [Colorado.gov/hcpf](http://Colorado.gov/hcpf). Click “Providers”, then click “Primary Care Fund.”

**SECTION B: PRIMARY CARE FUND APPLICATION RESPONSE**

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**Item 1. APPLICANT AGENCY INFORMATION**

(Expand the table as necessary in order to provide an adequate detailed response.)

<b>LEGAL NAME OF APPLICANT AGENCY:</b>	
<b>BUSINESS NAME OF APPLICANT AGENCY (IF DIFFERENT THAN LEGAL NAME):</b>	
<b>CHECK THE APPROPRIATE BOX:</b>	<input type="checkbox"/> Individual/Sole Proprietor (If this applies, contact Nancy Dolson prior to the application response due date. Citizen and identification documentation required by 24-76.5.101 et seq., C.R.S. (2008) should be provided behind a tab labeled Appendix E.) <input type="checkbox"/> Corporation <input type="checkbox"/> Partnership <input type="checkbox"/> Other _____
<b>FEDERAL EMPLOYER IDENTIFICATION NUMBER:</b>	
<b>LEGAL ADDRESS OF APPLICANT AGENCY:</b>	
<b>MAILING ADDRESS (IF DIFFERENT THAN LEGAL ADDRESS):</b>	
<b>NAME OF APPLICANT AGENCY CONTACT PERSON AND POSITION/TITLE:</b>	
<b>CONTACT TELEPHONE NUMBER:</b>	
<b>CONTACT E-MAIL ADDRESS:</b>	
<b>STATE YOUR AGENCY'S MISSION AND THE HISTORY OF YOUR AGENCY:</b>	

## **Item 2. QUALIFIED PROVIDER CRITERIA DOCUMENTATION\***

The applicant agency shall meet all of the requirements established for the Primary Care Fund at the time the Primary Care Fund Application Response is submitted. Applicant agencies shall provide documentation, reference and/or responses indicating that the agency is an entity that meets all of the eligibility criteria of a Qualified Provider (see definition in Section A, 2, Qualified Provider, page 5). Responses to Question 1 through Question 7 demonstrate how the applicant agency meets all of the criteria and qualifications as defined for the Primary Care Fund.

**\*IF AN APPLICANT AGENCY MEETS THE FOLLOWING CRITERIA, AND COMPLETES THE ATTACHED CERTIFICATE TO WAIVE DOCUMENTATION OF QUALIFIED PROVIDER CRITERIA, THAT AGENCY IS NOT REQUIRED TO RESPOND TO QUESTIONS 1 THROUGH 6. HOWEVER, ALL APPLICANT AGENCIES MUST RESPOND IN FULL TO QUESTION 7 TO BE CONSIDERED FOR FUNDING.**

- The applicant agency is an entity that has been awarded funding from the Primary Care Fund or the Comprehensive Primary and Preventive Care (CPPC) Grant Program within the last three (3) years (July 1, 2006 – June 30, 2009).
- The applicant agency documents that it meets all of the eligibility criteria of a Qualified Provider, as defined above, by completing the attached Certificate to Waive Documentation of Qualified Provider Criteria, thereby affirming that the applicant agency:
  - Has been awarded funding from the Primary Care Fund or the CPPC Grant Program within the last three (3) years (July 1, 2006 – June 30, 2009).
  - Currently meets and can demonstrate that the agency is an entity that meets all of the eligibility criteria of a Qualified Provider defined above.
  - Certifies that there has been no change in the agency's capacity to meet all of the eligibility requirements including providing, Arranging For or is Exempt From the provision of Comprehensive Primary Care Services to uninsured and Medically Indigent Patients since the original Primary Care Fund or CPPC Grant Program application was submitted.
  - Certifies that if there have been any changes in the agency's capacity to meet all of the eligibility requirements, that these changes are documented below and that the changes continue to meet the Primary Care Fund or CPPC Grant Program eligibility requirements for a Qualified Provider.
  - Signs the Certificate to Waive Documentation of Qualified Provider Criteria by a person authorized to enter into a contract for this agency.
  - Includes the Certificate to Waive Documentation of Qualified Provider Criteria with the applicant agency's response to the Primary Care Fund application.

**CERTIFICATE TO WAIVE DOCUMENTATION OF QUALIFIED PROVIDER  
CRITERIA**

The Colorado Department of Health Care Policy and Financing (the Department) is the State agency charged with the administration of the Primary Care Fund. To be eligible for funding from the Primary Care Fund, an applicant must meet all of the criteria of a Qualified Provider, as defined in the FY 2009-10 Primary Care Fund Application Form, Section A, 2. Definitions:

Qualified Provider - An entity that provides Comprehensive Primary Care in Colorado and that:

1. Accepts all patients regardless of their ability to pay and uses a Sliding Fee Scale for payments or does not charge Medically Indigent Patients for services;
2. Serves a designated Medically Underserved Area or Medically Underserved Population as provided in Section 330(b) of the federal "Public Health Service Act", 42 U.S.C. Section 254b, or demonstrates to the Department that the entity serves a population or area that lacks adequate health care services for low-income, uninsured persons;
3. Has a demonstrated Track Record of providing Cost-Effective Care;
4. Provides or Arranges For the provision of Comprehensive Primary Care to persons of all ages. An entity in a rural area may be exempt from this requirement if they can demonstrate that there are no providers in the community to provide one or more of the Comprehensive Primary Care services;
5. Completes a screening that evaluates eligibility for Medicaid, CHP+, and the Colorado Indigent Care Program and refers patients potentially eligible for one of the programs to the appropriate agency (e.g., county departments of human/social services) for eligibility determination if they are not qualified to make eligibility determinations; and
6. Is a community health center, as defined in Section 330 of the federal "Public Health Services Act", 42 U.S.C. Section 254b; or at least 50% of the patients served by the applicant agency are Medically Indigent Patients or patients who are enrolled in Medicaid, CHP+, or any combination thereof.

The Department has determined that if an applicant agency is an entity which has been awarded funding from the Primary Care Fund or the CPPC Grant Program within the last three (3) years (July 1, 2006 – June 30, 2009), then the Primary Care Fund application requirement to respond to Questions 1 through 6 is waived. To document that this agency meets all of the eligibility criteria of a Qualified Provider, as defined above, please complete the following Certification and include it with your response to the Primary Care Fund application form under the tab marked Appendix F.

**CERTIFICATE TO WAIVE DOCUMENTATION OF QUALIFIED PROVIDER  
CRITERIA, QUESTIONS 1 THROUGH QUESTION 7**

I, \_\_\_\_\_, \_\_\_\_\_, authorized to execute  
Name Title

contracts for \_\_\_\_\_, attest that \_\_\_\_\_:  
Name of Applicant Agency Name of Applicant Agency

1. Has been awarded funding from the Primary Care Fund or CPPC Grant Program within the last three (3) years, (July 1, 2006 – June 30, 2009). This award was for the amount of \$ \_\_\_\_\_ and the date the award was received was \_\_\_\_\_.
2. Currently meets and can demonstrate that the agency is an entity that meets all of the eligibility criteria of a Qualified Provider defined above.
3. Certifies that there has been no change in the agency's capacity to meet these eligibility requirements including providing, Arranging For or is Exempt From the provision of Comprehensive Primary Care Services to uninsured and Medically Indigent Patients since the Primary Care Fund or CPPC Grant Program application response, cited above, was submitted on \_\_\_\_\_.
4. Certifies that if there have been any changes in the agency's capacity to meet all of the eligibility requirements, that these changes are documented below and that the changes continue to meet the Primary Care Fund or CPPC Grant Program eligibility requirements for a Qualified Provider.

Changes include:

- 
- 

\_\_\_\_\_  
Applicant Agency

\_\_\_\_\_  
Signature of Authorized Representative

\_\_\_\_\_  
Printed Name and Title of Authorized Representative

\_\_\_\_\_  
Date

**If the applicant agency is not waiving Documentation of Qualified Provider Criteria, QUESTIONS 1 THROUGH QUESTION 6, please RESPOND TO THE FOLLOWING:**

(Expand all tables as necessary in order to provide an adequate detailed response.)

**Q1. Sliding Fee Schedule.** Summarize the applicant agency's policies and procedures regarding accepting all patients regardless of their ability to pay and the applicant agency's policies and procedures to use a Sliding Fee Schedule for payment or to offer Comprehensive Primary Care free of charge.

State how the details of this policy are made available to patients.

Provide a copy of the applicant agency's Sliding Fee Schedule behind a tab labeled as Appendix A.

Q1. RESPONSE:

**Q2. Medically Underserved Area or Population.** Cite evidence or reference that demonstrates that the applicant agency serves an area or population that lacks adequate health care services for low-income, uninsured persons.

If your agency provides service in an area that has a MUA or MUP designation, provide the County Name, Designation Type, Service Area Name, and Federal ID Number.

If your agency provides service in an area that does not have a MUA or MUP designation, provide evidence and cite the source(s) that demonstrate that the applicant agency serves an area or population that lacks adequate health care services for low-income, uninsured persons.

Q2. RESPONSE:

**Q3. Track Record of Cost-Effective Care.** Complete the following table to demonstrate that the applicant agency:

- Has a Track Record (covering a consecutive 52-week period prior to the submission of the application response) of providing Cost-Effective Care;
- Will continue to provide or Arrange For or Comprehensive Primary Care Services to Persons of All Ages on a Year-Round Basis.

Include the average cost per patient Visit/Encounter for your agency for the previous year and list the services that are included in the average cost.

Provide a response for each service listed that covers at least the consecutive 52-week period prior to the submission of this application response and is provided to Persons of All Ages on a Year-Round Basis including:

1. A description of specifically what was provided to Persons of All Ages on a Year-Round Basis during the 52-week period prior to the submission of this application response;
2. How the service or component of the service (e.g., laboratory or radiology) was provided to Persons of All Ages on a Year-Round Basis and/or Arranged For during the 52-week period prior to the submission of this application response;
3. If applicable, description of what was Arranged For and with whom the agency had an Established Referral Relationship. Where an Established Referral Relationship was in place, provide a formal, written agreement behind a tab labeled Appendix B. As specified under the definitions, the agreement shall be in the form of a memorandum of agreement or a contract. The agreement shall specifically address or cover the 52-week period prior to the submission of this application response, and include:
  - a. The Comprehensive Primary Care and/or products (e.g., pharmaceuticals, radiology) to be provided to Persons of All Ages on a Year-Round Basis by one entity on behalf of the other entity;
  - b. Any applicable policies, processes or procedures;
  - c. The guarantee that referred Medically Indigent Patients shall receive services on a Sliding Fee Schedule or at no charge;
  - d. The date range that the agreement has been or is in effect; and
  - e. Signatures by representatives of both entities; and/or
4. If applicable, a notation that the applicant agency should be considered exempt from providing or Arranging For the service or a component of the service to Persons of All Ages on a Year-Round Basis due to its location in a rural area pursuant to the Code of Colorado Regulations (CCR) at 10 CCR 2505-10, Section 8.950.2.N. In addition, include:
  - a. Specify the component of the service that could not be provided or Arranged For;

- b. An explanation that includes a description of the efforts to obtain an Established Referral Relationship for the service;
- c. Details to demonstrate that there were no health care providers in the community to provide that service; and
- d. Description of what the applicant agency would do for a patient requiring that service.

NOTE: If an exemption is being claimed, the applicant agency must understand that if the exemption is not approved by the Department, and the agency does not otherwise meet the criterion, it will not qualify for funding from this program.

**The applicant agency shall provide adequate details and materials to demonstrate that it meets these criteria. It is important that the response include all details and materials requested since any deviation from this may result in the determination that an applicant agency does not meet the criteria for this program.**

Q3. RESPONSE:

(Expand the table as necessary in order to provide an adequate detailed response.)

COMPREHENSIVE  
PRIMARY CARE  
SERVICES:

EXPLAIN HOW YOUR AGENCY DIRECTLY PROVIDED, ARRANGED FOR OR WAS EXEMPT FROM PROVIDING THE LISTED COMPREHENSIVE PRIMARY CARE SERVICES:

- **DURING THE CONSECUTIVE 52-WEEK PERIOD PRIOR TO THE DATE THIS APPLICATION RESPONSE WAS SUBMITTED, AND**
- **WILL CONTINUE TO PROVIDE THESE SERVICES TO PERSONS OF ALL AGES ON A YEAR-ROUND BASIS.**

Please pick the appropriate category (Directly, Arrange For or Exempt From) for each response. In a few instances it may be appropriate to choose more than one category for a response. You may delete categories that are not relevant to your agency. For example, if your agency directly provides a service, you may delete the Arrange For and Exempt From categories from the application form.

1. Primary Health  
Care

**DIRECTLY PROVIDED AND WILL CONTINUE TO PROVIDE TO PERSONS OF ALL AGES ON A YEAR-ROUND BASIS DURING THIS GRANT PERIOD.**

a. SPECIFIC SERVICE/CARE PROVIDED:

b. HOW PROVIDED:

c. DATE RANGE FOR DIRECTLY PROVIDING SERVICE:

d. HOW WILL YOU CONTINUE TO PROVIDE THESE SERVICES TO PERSONS OF ALL AGES ON A YEAR-ROUND BASIS:

	<p><b>ARRANGED FOR AND WILL CONTINUE TO ARRANGE FOR PERSONS OF ALL AGES ON A YEAR-ROUND BASIS DURING THIS GRANT PERIOD.</b>  (Include signed agreement(s) in Appendix B. If more than one agreement is required for this Comprehensive Primary Care service, repeat the following entries, a through c, and provide responses to a through c for each agreement.)</p> <p>a. SPECIFIC SERVICE/CARE ARRANGED FOR:</p> <p>b. ENTITY WITH WHOM HAVE AN AGREEMENT:</p> <p>c. DATE RANGE OF AGREEMENT:</p> <p>d. HOW WILL YOU CONTINUE TO PROVIDE THESE SERVICES TO PERSONS OF ALL AGES ON A YEAR-ROUND BASIS:</p>
	<p><b>EXEMPT FROM AND WILL CONTINUE TO BE EXEMPT FROM PROVIDING TO PERSONS OF ALL AGES ON A YEAR-ROUND BASIS DURING THIS GRANT PERIOD.</b></p> <p>a. SPECIFIC SERVICE/CARE UNABLE TO PROVIDE OR ARRANGE FOR:</p> <p>b. EFFORTS TO OBTAIN ESTABLISHED REFERRAL RELATIONSHIP:</p> <p>c. DEMONSTRATION THAT THERE ARE NO HEALTH CARE PROVIDERS IN THE COMMUNITY TO PROVIDE THE CARE:</p> <p>d. WHAT WAS DONE BY APPLICANT AGENCY FOR PATIENT NEEDING THIS SPECIFIC CARE DURING 52-WEEK PERIOD PRIOR TO SUBMISSION OF APPLICATION RESPONSE:</p>
<p>2. Maternity Care, Including Prenatal Care (The provision of labor &amp; delivery services is not required.)</p>	<p><b>DIRECTLY PROVIDED AND WILL CONTINUE TO PROVIDE TO PERSONS OF ALL AGES ON A YEAR-ROUND BASIS DURING THIS GRANT PERIOD.</b></p> <p>a. SPECIFIC SERVICE/CARE PROVIDED:</p> <p>b. HOW PROVIDED:</p> <p>c. DATE RANGE FOR DIRECTLY PROVIDING SERVICE:</p> <p>d. HOW WILL YOU CONTINUE TO PROVIDE THESE SERVICES TO PERSONS OF ALL AGES ON A YEAR-ROUND BASIS:</p> <p><b>ARRANGED FOR AND WILL CONTINUE TO ARRANGE FOR PERSONS OF ALL AGES ON A YEAR-ROUND BASIS DURING THIS GRANT PERIOD.</b>  (Include signed agreement(s) in Appendix B. If more than one agreement is required for this Comprehensive Primary Care service, repeat the following entries, a through c, and provide responses to a through c for each agreement.)</p> <p>a. SPECIFIC SERVICE/CARE ARRANGED FOR:</p> <p>b. ENTITY WITH WHOM HAVE AN AGREEMENT:</p> <p>c. DATE RANGE OF AGREEMENT:</p> <p>d. HOW WILL YOU CONTINUE TO PROVIDE THESE SERVICES TO PERSONS OF ALL AGES ON A YEAR-ROUND BASIS:</p>

	<p><b>EXEMPT FROM PROVIDING PERSONS OF ALL AGES ON A YEAR-ROUND BASIS DURING THIS GRANT PERIOD.</b></p> <p>a. SPECIFIC SERVICE/CARE UNABLE TO PROVIDE OR ARRANGE FOR:</p> <p>b. EFFORTS TO OBTAIN ESTABLISHED REFERRAL RELATIONSHIP:</p> <p>c. DEMONSTRATION THAT THERE ARE NO HEALTH CARE PROVIDERS IN THE COMMUNITY TO PROVIDE THE CARE:</p> <p>d. WHAT WAS DONE BY APPLICANT AGENCY FOR PATIENT NEEDING THIS SPECIFIC CARE DURING 52-WEEK PERIOD PRIOR TO SUBMISSION OF APPLICATION RESPONSE:</p>
<p>3. Preventive, Developmental and Diagnostic Services for Infants and Children</p>	<p><b>DIRECTLY PROVIDED AND WILL CONTINUE TO PROVIDE TO PERSONS OF ALL AGES ON A YEAR-ROUND BASIS DURING THIS GRANT PERIOD.</b></p> <p>a. SPECIFIC SERVICE/CARE PROVIDED:</p> <p>b. HOW PROVIDED:</p> <p>c. DATE RANGE FOR DIRECTLY PROVIDING SERVICE:</p> <p>d. HOW WILL YOU CONTINUE TO PROVIDE THESE SERVICES TO PERSONS OF ALL AGES ON A YEAR-ROUND BASIS:</p> <hr/> <p><b>ARRANGED FOR AND WILL CONTINUE TO ARRANGE FOR PERSONS OF ALL AGES ON A YEAR-ROUND BASIS DURING THIS GRANT PERIOD.</b> (Include signed agreement(s) in Appendix B. If more than one agreement is required for this Comprehensive Primary Care service, repeat the following entries, a through c, and provide responses to a through c for each agreement.)</p> <p>a. SPECIFIC SERVICE/CARE ARRANGED FOR:</p> <p>b. ENTITY WITH WHOM HAVE AN AGREEMENT:</p> <p>c. DATE RANGE OF AGREEMENT:</p> <p>d. HOW WILL YOU CONTINUE TO PROVIDE THESE SERVICES TO PERSONS OF ALL AGES ON A YEAR-ROUND BASIS:</p> <hr/> <p><b>EXEMPT FROM AND WILL CONTINUE TO BE EXEMPT FROM PROVIDING TO PERSONS OF ALL AGES ON A YEAR-ROUND BASIS DURING THIS GRANT PERIOD.</b></p> <p>a. SPECIFIC SERVICE/CARE UNABLE TO PROVIDE OR ARRANGE FOR:</p> <p>b. EFFORTS TO OBTAIN ESTABLISHED REFERRAL RELATIONSHIP:</p> <p>c. DEMONSTRATION THAT THERE ARE NO HEALTH CARE PROVIDERS IN THE COMMUNITY TO PROVIDE THE CARE:</p> <p>d. WHAT WAS DONE BY APPLICANT AGENCY FOR PATIENT NEEDING THIS SPECIFIC CARE DURING 52-WEEK PERIOD PRIOR TO SUBMISSION OF APPLICATION RESPONSE:</p>

<p>4. Adult Preventive Services</p>	<p><b>DIRECTLY PROVIDED AND WILL CONTINUE TO PROVIDE TO PERSONS OF ALL AGES ON A YEAR-ROUND BASIS DURING THIS GRANT PERIOD.</b></p> <p>a. SPECIFIC SERVICE/CARE PROVIDED:</p> <p>b. HOW PROVIDED:</p> <p>c. DATE RANGE FOR DIRECTLY PROVIDING SERVICE:</p> <p>d. HOW WILL YOU CONTINUE TO PROVIDE THESE SERVICES TO PERSONS OF ALL AGES ON A YEAR-ROUND BASIS:</p>
	<p><b>ARRANGED FOR AND WILL CONTINUE TO ARRANGE FOR PERSONS OF ALL AGES ON A YEAR-ROUND BASIS DURING THIS GRANT PERIOD.</b> (Include signed agreement(s) in Appendix B. If more than one agreement is required for this Comprehensive Primary Care service, repeat the following entries, a through c, and provide responses to a through c for each agreement.)</p> <p>a. SPECIFIC SERVICE/CARE ARRANGED FOR:</p> <p>b. ENTITY WITH WHOM HAVE AN AGREEMENT:</p> <p>c. DATE RANGE OF AGREEMENT:</p> <p>d. HOW WILL YOU CONTINUE TO PROVIDE THESE SERVICES TO PERSONS OF ALL AGES ON A YEAR-ROUND BASIS:</p> <hr/> <p><b>EXEMPT FROM AND WILL CONTINUE TO BE EXEMPT FROM PROVIDING TO PERSONS OF ALL AGES ON A YEAR-ROUND BASIS DURING THIS GRANT PERIOD.</b></p> <p>a. SPECIFIC SERVICE/CARE UNABLE TO PROVIDE OR ARRANGE FOR:</p> <p>b. EFFORTS TO OBTAIN ESTABLISHED REFERRAL RELATIONSHIP:</p> <p>c. DEMONSTRATION THAT THERE ARE NO HEALTH CARE PROVIDERS IN THE COMMUNITY TO PROVIDE THE CARE:</p> <p>d. WHAT WAS DONE BY APPLICANT AGENCY FOR PATIENT NEEDING THIS SPECIFIC CARE DURING 52-WEEK PERIOD PRIOR TO SUBMISSION OF APPLICATION RESPONSE:</p>
<p>5. Diagnostic Laboratory and Radiology Services</p>	<p><b>DIRECTLY PROVIDED AND WILL CONTINUE TO PROVIDE TO PERSONS OF ALL AGES ON A YEAR-ROUND BASIS DURING THIS GRANT PERIOD.</b></p> <p>a. SPECIFIC SERVICE/CARE PROVIDED:</p> <p>b. HOW PROVIDED:</p> <p>c. DATE RANGE FOR DIRECTLY PROVIDING SERVICE:</p> <p>d. HOW WILL YOU CONTINUE TO PROVIDE THESE SERVICES TO PERSONS OF ALL AGES ON A YEAR-ROUND BASIS:</p>

	<p><b>ARRANGED FOR AND WILL CONTINUE TO ARRANGE FOR PERSONS OF ALL AGES ON A YEAR-ROUND BASIS DURING THIS GRANT PERIOD.</b>  (Include signed agreement(s) in Appendix B. If more than one agreement is required for this Comprehensive Primary Care service, repeat the following entries, a through c, and provide responses to a through c for each agreement.)</p> <p>a. SPECIFIC SERVICE/CARE ARRANGED FOR:</p> <p>b. ENTITY WITH WHOM HAVE AN AGREEMENT:</p> <p>c. DATE RANGE OF AGREEMENT:</p> <p>d. HOW WILL YOU CONTINUE TO PROVIDE THESE SERVICES TO PERSONS OF ALL AGES ON A YEAR-ROUND BASIS:</p>
	<p><b>EXEMPT FROM PROVIDING PERSONS OF ALL AGES ON A YEAR-ROUND BASIS DURING THIS GRANT PERIOD.</b></p> <p>a. SPECIFIC SERVICE/CARE UNABLE TO PROVIDE OR ARRANGE FOR:</p> <p>b. EFFORTS TO OBTAIN ESTABLISHED REFERRAL RELATIONSHIP:</p> <p>c. DEMONSTRATION THAT THERE ARE NO HEALTH CARE PROVIDERS IN THE COMMUNITY TO PROVIDE THE CARE:</p> <p>d. WHAT WAS DONE BY APPLICANT AGENCY FOR PATIENT NEEDING THIS SPECIFIC CARE DURING 52-WEEK PERIOD PRIOR TO SUBMISSION OF APPLICATION RESPONSE:</p>
<p>6. Emergency Care for Minor Trauma (An arrangement with a hospital is not required.)</p>	<p><b>DIRECTLY PROVIDED AND WILL CONTINUE TO PROVIDE TO PERSONS OF ALL AGES ON A YEAR-ROUND BASIS DURING THIS GRANT PERIOD.</b></p> <p>a. SPECIFIC SERVICE/CARE PROVIDED:</p> <p>b. HOW PROVIDED:</p> <p>c. DATE RANGE FOR DIRECTLY PROVIDING SERVICE:</p> <p>d. HOW WILL YOU CONTINUE TO PROVIDE THESE SERVICES TO PERSONS OF ALL AGES ON A YEAR-ROUND BASIS:</p> <p><b>ARRANGED FOR AND WILL CONTINUE TO ARRANGE FOR PERSONS OF ALL AGES ON A YEAR-ROUND BASIS DURING THIS GRANT PERIOD.</b>  (Include signed agreement(s) in Appendix B. If more than one agreement is required for this Comprehensive Primary Care service, repeat the following entries, a through c, and provide responses to a through c for each agreement.)</p> <p>a. SPECIFIC SERVICE/CARE ARRANGED FOR:</p> <p>b. ENTITY WITH WHOM HAVE AN AGREEMENT:</p> <p>c. DATE RANGE OF AGREEMENT:</p> <p>d. HOW WILL YOU CONTINUE TO PROVIDE THESE SERVICES TO PERSONS OF ALL AGES ON A YEAR-ROUND BASIS:</p>

	<p><b>EXEMPT FROM AND WILL CONTINUE TO BE EXEMPT FROM PROVIDING TO PERSONS OF ALL AGES ON A YEAR-ROUND BASIS DURING THIS GRANT PERIOD.</b></p> <p>a. SPECIFIC SERVICE/CARE UNABLE TO PROVIDE OR ARRANGE FOR:</p> <p>b. EFFORTS TO OBTAIN ESTABLISHED REFERRAL RELATIONSHIP:</p> <p>c. DEMONSTRATION THAT THERE ARE NO HEALTH CARE PROVIDERS IN THE COMMUNITY TO PROVIDE THE CARE:</p> <p>d. WHAT WAS DONE BY APPLICANT AGENCY FOR PATIENT NEEDING THIS SPECIFIC CARE DURING 52-WEEK PERIOD PRIOR TO SUBMISSION OF APPLICATION RESPONSE:</p>
<p>7. Pharmaceutical Services (See Section A, 2, Definitions for definition. Coordinating access to pharmacy services may include getting patients on reduced drug-pricing programs and/or referring patients to patient assistance programs that help them in obtaining prescriptions. However, it is not sufficient for a clinic to provide sample medications.)</p>	<p><b>DIRECTLY PROVIDED AND WILL CONTINUE TO PROVIDE TO PERSONS OF ALL AGES ON A YEAR-ROUND BASIS DURING THIS GRANT PERIOD.</b></p> <p>a. SPECIFIC SERVICE/CARE PROVIDED:</p> <p>b. HOW PROVIDED:</p> <p>c. DATE RANGE FOR DIRECTLY PROVIDING SERVICE:</p> <p>d. HOW WILL YOU CONTINUE TO PROVIDE THESE SERVICES TO PERSONS OF ALL AGES ON A YEAR-ROUND BASIS:</p> <hr/> <p><b>ARRANGED FOR AND WILL CONTINUE TO ARRANGE FOR PERSONS OF ALL AGES ON A YEAR-ROUND BASIS DURING THIS GRANT PERIOD.</b> (Include signed agreement(s) in Appendix B. If more than one agreement is required for this Comprehensive Primary Care service, repeat the following entries, a through c, and provide responses to a through c for each agreement.)</p> <p>a. SPECIFIC SERVICE/CARE ARRANGED FOR:</p> <p>b. ENTITY WITH WHOM HAVE AN AGREEMENT:</p> <p>c. DATE RANGE OF AGREEMENT:</p> <p>d. HOW WILL YOU CONTINUE TO PROVIDE THESE SERVICES TO PERSONS OF ALL AGES ON A YEAR-ROUND BASIS:</p> <hr/> <p><b>EXEMPT FROM AND WILL CONTINUE TO BE EXEMPT FROM PROVIDING TO PERSONS OF ALL AGES ON A YEAR-ROUND BASIS DURING THIS GRANT PERIOD.</b></p> <p>a. SPECIFIC SERVICE/CARE UNABLE TO PROVIDE OR ARRANGE FOR:</p> <p>b. EFFORTS TO OBTAIN ESTABLISHED REFERRAL RELATIONSHIP:</p> <p>c. DEMONSTRATION THAT THERE ARE NO HEALTH CARE PROVIDERS IN THE COMMUNITY TO PROVIDE THE CARE:</p> <p>d. WHAT WAS DONE BY APPLICANT AGENCY FOR PATIENT NEEDING THIS SPECIFIC CARE DURING 52-WEEK PERIOD PRIOR TO SUBMISSION OF APPLICATION RESPONSE:</p>

<p>8. Coordination and Follow-up for Hospital Care (An arrangement with a hospital is not required.)</p>	<p><b>DIRECTLY PROVIDED AND WILL CONTINUE TO PROVIDE TO PERSONS OF ALL AGES ON A YEAR-ROUND BASIS DURING THIS GRANT PERIOD.</b></p> <p>a. SPECIFIC SERVICE/CARE PROVIDED:</p> <p>b. HOW PROVIDED:</p> <p>c. DATE RANGE FOR DIRECTLY PROVIDING SERVICE:</p> <p>d. HOW WILL YOU CONTINUE TO PROVIDE THESE SERVICES TO PERSONS OF ALL AGES ON A YEAR-ROUND BASIS:</p>
	<p><b>ARRANGED FOR AND WILL CONTINUE TO ARRANGE FOR PERSONS OF ALL AGES ON A YEAR-ROUND BASIS DURING THIS GRANT PERIOD.</b> (Include signed agreement(s) in Appendix B. If more than one agreement is required for this Comprehensive Primary Care service, repeat the following entries, a through c, and provide responses to a through c for each agreement.)</p> <p>a. SPECIFIC SERVICE/CARE ARRANGED FOR:</p> <p>b. ENTITY WITH WHOM HAVE AN AGREEMENT:</p> <p>c. DATE RANGE OF AGREEMENT:</p> <p>d. HOW WILL YOU CONTINUE TO PROVIDE THESE SERVICES TO PERSONS OF ALL AGES ON A YEAR-ROUND BASIS:</p> <p><b>EXEMPT FROM AND WILL CONTINUE TO BE EXEMPT FROM PROVIDING TO PERSONS OF ALL AGES ON A YEAR-ROUND BASIS DURING THIS GRANT PERIOD.</b></p> <p>a. SPECIFIC SERVICE/CARE UNABLE TO PROVIDE OR ARRANGE FOR:</p> <p>b. EFFORTS TO OBTAIN ESTABLISHED REFERRAL RELATIONSHIP:</p> <p>c. DEMONSTRATION THAT THERE ARE NO HEALTH CARE PROVIDERS IN THE COMMUNITY TO PROVIDE THE CARE:</p> <p>d. WHAT WAS DONE BY APPLICANT AGENCY FOR PATIENT NEEDING THIS SPECIFIC CARE DURING 52-WEEK PERIOD PRIOR TO SUBMISSION OF APPLICATION RESPONSE:</p>
<p>Provide the Average Cost per Patient Visit for Calendar Year 2008. List the services that are included in the average cost calculation.</p>	<p><b>AVERAGE COST FOR AGENCY PER PATIENT VISIT/ENCOUNTER</b></p> <p><b>THE SERVICES INCLUDED IN THE AVERAGE COST CALCULATION</b></p>

**Q4. Eligibility Screening.** Describe how the applicant agency currently completes a screening for patients' eligibility for Medicaid, CHP+, and the Colorado Indigent Care Program (CICP) and refers patients potentially eligible for any of these programs to the appropriate entity (e.g., county departments of human/social services) for eligibility determination.

Q4. RESPONSE

**Q5. Certifications and Licenses.** List the applicant agency's certifications or licenses. Include the certifications or licenses issued by the Colorado Department of Public Health and Environment and by the federal government. Common health care provider certifications or licenses include Hospital; Community Health Clinic; School-Based Health Center; Rural Health Clinic; and Federally Qualified Health Center (federal government certification).

Q5. RESPONSE:

**Q6. Quality Assurance Program**

Applicant agencies shall have an established Quality Assurance Program that ensures the delivery of quality and appropriate Comprehensive Primary Care in a defined medical setting. A Quality Assurance Program consists of formalized plan and processes designed to ensure the delivery of quality and appropriate Comprehensive Primary Care in a defined medical setting. This can be demonstrated by obtaining a certification or accreditation through the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or by the Accreditation Association for Ambulatory Health Care, Inc. (AAAHC). If such certification or accreditation is not available, then, at a minimum, the Quality Assurance Program shall be comprised of elements that meet or exceed the following components:

1. Establishment of credentialing/re-credentialing requirements for medical personnel;
2. Surveying and monitoring of patient satisfaction;
3. Establishment of a grievance process for patients, including documentation of grievances and resolutions;
4. Development of clinic operating policies and scheduled performance monitoring;
5. Review of medical records to check for compliance with established policies and to monitor quality of care;
6. Assessment of state and federal regulations to ensure compliance;
7. Establishment of patient safety procedures; and
8. Establishment of infection control practices.

If the applicant agency has earned certification or accreditation through the process administered by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or by the Accreditation Association for Ambulatory Health Care, Inc. (AAAHC), then the applicant agency shall submit a copy of official documentation that substantiates the certification or accreditation behind the tab labeled Appendix C.

Applicant agencies who have not received certification or accreditation through JCAHO or AAAHC shall complete the following table to demonstrate how all of the components set forth for a Quality Assurance Program, as defined by the Primary Care Fund, are met through the applicant agency.

Q6. RESPONSE:

**EVIDENCE OF QUALITY ASSURANCE PROGRAM  
FOR APPLICANT AGENCIES WITHOUT JCAHO OR AAAHC CERTIFICATION**  
(Expand the table as necessary in order to provide an adequate detailed response.)

<b>1. Establishment of credentialing/re-credentialing requirements for medical personnel</b>	
	RESPONSE
DEPARTMENT WHERE PLAN IS LOCATED	
SPECIFIC MANUAL/HANDBOOK WHERE PLAN IS RETAINED	
PARTY RESPONSIBLE FOR IMPLEMENTING AND OVERSEEING PLAN	
ORIGINAL EFFECTIVE DATE	
REVISION DATE(S)	
POLICY REVIEW SCHEDULE	
POLICY GOAL AND OBJECTIVES	
PROCEDURES/ACTIVITIES TO BE CONDUCTED ACCORDING TO POLICY	
PERFORMANCE MEASUREMENTS	
PERFORMANCE REVIEW SCHEDULE	
<b>2. Surveying and monitoring of patient satisfaction</b>	
	RESPONSE
DEPARTMENT WHERE PLAN IS LOCATED	
SPECIFIC MANUAL/HANDBOOK WHERE PLAN IS RETAINED	
PARTY RESPONSIBLE FOR IMPLEMENTING AND OVERSEEING PLAN	
ORIGINAL EFFECTIVE DATE	
REVISION DATE(S)	
POLICY REVIEW SCHEDULE	
POLICY GOAL AND OBJECTIVES	
PROCEDURES/ACTIVITIES TO BE CONDUCTED ACCORDING TO	

POLICY	
PERFORMANCE MEASUREMENTS	
PERFORMANCE REVIEW SCHEDULE	
<b>3. Establishment of a grievance process for patients, including documentation of grievances and resolutions</b>	
	RESPONSE
DEPARTMENT WHERE PLAN IS LOCATED	
SPECIFIC MANUAL/HANDBOOK WHERE PLAN IS RETAINED	
PARTY RESPONSIBLE FOR IMPLEMENTING AND OVERSEEING PLAN	
ORIGINAL EFFECTIVE DATE	
REVISION DATE(S)	
POLICY REVIEW SCHEDULE	
POLICY GOAL AND OBJECTIVES	
PROCEDURES/ACTIVITIES TO BE CONDUCTED ACCORDING TO POLICY	
PERFORMANCE MEASUREMENTS	
PERFORMANCE REVIEW SCHEDULE	
<b>4. Development of clinic operating policies and scheduled performance monitoring</b>	
	RESPONSE
DEPARTMENT WHERE PLAN IS LOCATED	
SPECIFIC MANUAL/HANDBOOK WHERE PLAN IS RETAINED	
PARTY RESPONSIBLE FOR IMPLEMENTING AND OVERSEEING PLAN	
ORIGINAL EFFECTIVE DATE	
REVISION DATE(S)	
POLICY REVIEW SCHEDULE	
POLICY GOAL AND OBJECTIVES	
PROCEDURES/ACTIVITIES TO BE CONDUCTED ACCORDING TO POLICY	
PERFORMANCE MEASUREMENTS	
PERFORMANCE REVIEW SCHEDULE	

**5. Review of medical records to check for compliance with established policies and to monitor quality of care**

	RESPONSE
DEPARTMENT WHERE PLAN IS LOCATED	
SPECIFIC MANUAL/HANDBOOK WHERE PLAN IS RETAINED	
PARTY RESPONSIBLE FOR IMPLEMENTING AND OVERSEEING PLAN	
ORIGINAL EFFECTIVE DATE	
REVISION DATE(S)	
POLICY REVIEW SCHEDULE	
POLICY GOAL AND OBJECTIVES	
PROCEDURES/ACTIVITIES TO BE CONDUCTED ACCORDING TO POLICY	
PERFORMANCE MEASUREMENTS	
PERFORMANCE REVIEW SCHEDULE	

**6. Assessment of state and federal regulations to ensure compliance**

	RESPONSE
DEPARTMENT WHERE PLAN IS LOCATED	
SPECIFIC MANUAL/HANDBOOK WHERE PLAN IS RETAINED	
PARTY RESPONSIBLE FOR IMPLEMENTING AND OVERSEEING PLAN	
ORIGINAL EFFECTIVE DATE	
REVISION DATE(S)	
POLICY REVIEW SCHEDULE	
POLICY GOAL AND OBJECTIVES	
PROCEDURES/ACTIVITIES TO BE CONDUCTED ACCORDING TO POLICY	
PERFORMANCE MEASUREMENTS	
PERFORMANCE REVIEW SCHEDULE	

<b>7. Establishment of patient safety procedures</b>	
	RESPONSE
DEPARTMENT WHERE PLAN IS LOCATED	
SPECIFIC MANUAL/HANDBOOK WHERE PLAN IS RETAINED	
PARTY RESPONSIBLE FOR IMPLEMENTING AND OVERSEEING PLAN	
ORIGINAL EFFECTIVE DATE	
REVISION DATE(S)	
POLICY REVIEW SCHEDULE	
POLICY GOAL AND OBJECTIVES	
PROCEDURES/ACTIVITIES TO BE CONDUCTED ACCORDING TO POLICY	
PERFORMANCE MEASUREMENTS	
<b>8. Establishment of infection control practices</b>	
	RESPONSE
DEPARTMENT WHERE PLAN IS LOCATED	
SPECIFIC MANUAL/HANDBOOK WHERE PLAN IS RETAINED	
PARTY RESPONSIBLE FOR IMPLEMENTING AND OVERSEEING PLAN	
ORIGINAL EFFECTIVE DATE	
REVISION DATE(S)	
POLICY REVIEW SCHEDULE	
POLICY GOAL AND OBJECTIVES	
PROCEDURES/ACTIVITIES TO BE CONDUCTED ACCORDING TO POLICY	
PERFORMANCE MEASUREMENTS	

**Q7. Unduplicated User/Patient Count**

The numbers in the Unduplicated User/Patient Count provided in rows 1, 2a, 2b, 2c, 2d, 3 and 4 of Q7 TABLE 1 shall be certified by an Outside Entity prior to the submission of the Primary Care Fund Application Response.

The Unduplicated User/Patient Count should be calculated on a specific point-in-time occurring between the end of the applicable calendar year and prior to the submission of the application—January 1, 2009 through May 31, 2009. The point-in-time will act as a “freeze date” in which data is fixed and definite so that a count can be made. A patient can be included in only one of the payment source designations listed in Q7 TABLE 1, rows 2a, 2b, 2c, 2d or 3. The patient’s payment source designation in the application response should be the payment source designation listed for the patient at the specific point-in-time in which the data was collected to make the calculation. The following examples use calendar year 2008 and 2009 to illustrate how to determine the payment source designation for patients.

**EXAMPLE #1:**

Specific point-in-time in which the data is collected for the calculation: **May 1, 2009**

If the payment source has changed for any patient that received services in calendar year 2008 and has returned for services between January 1, 2009 and May 1, 2009, the patient’s payment source at the visit closest to May 1, 2009 is to be the patient’s payment source for the application response. The table below shows examples of patients whose payment source has remained the same or changed. The Date of Visit column compared to the point-in-time date of May 1, 2009 determines the patient’s payment source designation for the application response.

PATIENT NAME	DATE OF VISIT	PAYMENT SOURCE AT TIME OF VISIT	PAYMENT SOURCE DESIGNATION IN APPLICATION RESPONSE
Patient A	January 20, 2008	Medicaid	
Patient A	December 11, 2008	Uninsured	
Patient A	February 15, 2009	Medicaid	Medicaid
Patient B	February 15, 2008	Third Party Payer	
Patient B	December 15, 2008	Uninsured	Uninsured
Patient C	March 10, 2008	Medicaid	
Patient C	February 15, 2009	Third Party Payer	
Patient C	March 23, 2009	Uninsured	Uninsured
Patient D	June 19, 2008	Uninsured	
Patient D	March 23, 2009	Third Party Payer	Third Party Payer
Patient E	August 25, 2008	Medicaid	Medicaid

**EXAMPLE #2:**

Specific point-in-time in which the data is collected for the calculation: **January 1, 2009**

Because the point-in-time selected is so close to the end of calendar year 2008, the patient's payment source at the visit closest to January 1, 2009 is to be the patient's payment source for the purposes of this application. The table below shows examples of patients whose payment source has remained the same or changed. The Date of Visit column compared to the point-in-time date of January 1, 2009 determines the patient's payment source designation for the application response.

PATIENT NAME	DATE OF VISIT	PAYMENT SOURCE AT TIME OF VISIT	PAYMENT SOURCE DESIGNATION IN APPLICATION RESPONSE
Patient A	January 20, 2008	Medicaid	
Patient A	December 11, 2008	Uninsured	Uninsured
Patient A	February 15, 2009	Medicaid	
Patient B	February 15, 2008	Third Party Payer	
Patient B	December 15, 2008	Uninsured	Uninsured
Patient C	March 10, 2008	Medicaid	Medicaid
Patient C	February 15, 2009	Third Party Payer	
Patient C	March 23, 2009	Uninsured	
Patient D	June 19, 2008	Uninsured	Uninsured
Patient D	March 23, 2009	Third Party Payer	
Patient E	August 25, 2008	Medicaid	Medicaid

**Q7 TABLE 1  
UNDUPLICATED USER/PATIENT COUNT - CATEGORIZATION**

	State the specific point-in-time selected for compiling the data for Q7 TABLE 1.	
STEP 1	Identify the total number of Unduplicated Users/Patients served by the applicant agency during the calendar year January 1, 2008 – December 31, 2008.	1) _____
STEP 2	Identify the number of Unduplicated Users/Patients who were <u>enrolled in</u> : <ul style="list-style-type: none"> <li>a. Medicaid,</li> <li>b. CHP+,</li> <li>c. Any other type of reimbursement for health care costs by a government program (i.e., Medicare, Social Security, Veterans Administration, Military Dependency [TRICARE or CHAMPUS], United States Public Health Service). NOTE: This number should not include CICP clients.</li> <li>d. Any other Third-Party Payer not mentioned above (such as private insurance)</li> </ul>	2a) _____ 2b) _____ 2c) _____ 2d) _____
STEP 3	Subtract all of the numbers identified in STEP 2 from the total identified in STEP 1 to compute the total number of <u>uninsured</u> patients served by the applicant agency.	3) _____
STEP 4	From the population identified in STEP 3, state the number of patients served by the applicant agency whose family incomes are above 200% of the Federal Poverty Level (200% FPL).  This number should also include the number of Medically Indigent Patients whose family incomes are exactly 200% FPL or are unknown or undetermined.	4) _____
STEP 5	Subtract the total listed in STEP 4 from the total identified in STEP 3 to compute the total number of Medically Indigent Patients with incomes below 200% FPL.  Note that this number will include CICP clients whose family income is below 200% FPL. Since the CICP provides discounted medical services to individuals up to 250% FPL (CICP rating H and I) the figure may not include all CICP patients served by the applicant agency.	5) _____

**Q7 TABLE 2**  
**UNDUPLICATED USER/PATIENT COUNT - PERCENTAGES**

Use the following formula to identify the percent of Unduplicated Users/Patients served by the applicant agency who are enrolled in Medicaid, enrolled in CHP+ or are Medically Indigent Patients.

ITEM A	<p>List the total number of Unduplicated Users/Patients served by the applicant agency during the calendar year January 1, 2008 – December 31, 2008 that were:</p> <p>1) Enrolled in Medicaid (Report STEP 2a from Q7 TABLE 1)</p> <p>2) Enrolled in CHP+ (Report STEP 2b from Q7 TABLE 1)</p> <p>3) Medically Indigent Patient (Report STEP 5 from Q7 TABLE 1)</p>	<p>A1) _____</p> <p>A2) _____</p> <p>A3) _____</p>
ITEM B	<p>Add the numbers from ITEM A1, A2, and A3 above to compute the total number of Unduplicated Users/Patients served by the applicant agency that are:</p> <p style="padding-left: 40px;">Enrolled in Medicaid ; Enrolled in CHP+ ; or Medically Indigent Patients</p>	<p>B) _____</p>
ITEM C	<p>List the total number of Unduplicated Users/Patients served by the applicant agency (STEP 1 from Q7 TABLE 1)</p>	<p>C) _____</p>
ITEM D	<p>Compute the percentage of the total number of Unduplicated Users/Patients served by the applicant agency that were enrolled in Medicaid, enrolled in CHP+ or are Medically Indigent Patients.</p> <p>Divide the number in ITEM B by the number in ITEM C and multiple by 100 to create a percentage.</p>	<p>D) _____%</p>



**Item 3. CERTIFICATION BY OUTSIDE ENTITY**

NOTE: This certification shall be signed by an authorized representative of the Outside Entity. The numbers in the Unduplicated User/Patient Count provided in rows 1, 2a, 2b, 2c, 2d, and 4 of Q7 TABLE 1 shall be verified by an Outside Entity prior to the submission of the Primary Care Fund Application Response.

The criteria for an Outside Entity are:

1. The business or professional shall not be classified as an employee of the applicant agency or the Department and shall not have a direct or indirect financial interest with the applicant agency; and
2. The business or professional shall have auditing experience or experience working directly with Medicaid or similar services or health care programs for the uninsured or Medically Indigent Patients.
3. If the applicant agency received funding totaling \$250,000 or more from the Primary Care Fund in the previous year (FY 2008-09), that agency must use a Certified Public Accountant (CPA) as their Outside Entity to verify their patient count.

The requirements for certification of the numbers of Unduplicated User/Patients Count are:

1. Reports/lists that comprise all patients that received Comprehensive Primary Care services within the applicable calendar year are sampled and patient records are compared to the criteria as defined by the Primary Care Fund to determine whether the patient is presented in the appropriate category in rows 1, 2a, 2b, 2c, 2d, and 4 of Q7 TABLE 1. The sample of patient files shall be at least 25.
2. A letter on the letterhead of the Outside Entity shall be provided behind a tab labeled Appendix D. The letter shall:
  - Explain how the business or professional meets the requirements for an Outside Entity, as defined for the Primary Care Fund;
  - Provide details on the methodology used for the certification process; and
  - List the total number of patients verified by the Outside Entity for each category in rows 1, 2a, 2b, 2c, 2d, and 4 of Q7 TABLE 1.
3. The Outside Entity shall sign this certification statement page.

I certify that I performed my agreed upon procedures of the documentation provided by the applicant agency, the purpose of which is to assist the Department with determining whether the totals in each category in rows 1, 2a, 2b, 2c, 2d, and 4 of Q7 TABLE 1 meet the criteria for the category as defined for the Primary Care Fund. I have provided a letter in which I have addressed all required items listed above.

\_\_\_\_\_  
Outside Entity Business Name

\_\_\_\_\_  
Outside Entity Representative's Name (printed)

\_\_\_\_\_  
Signature of Outside Entity Representative

\_\_\_\_\_  
Date

**Item 4. CONFIRMATION BY APPLICANT AGENCY**

NOTE: This confirmation shall be signed by an authorized representative of the applicant agency.

I confirm that all of the data and/or documentation included herein and submitted as my agency's Primary Care Fund Application Response are true and accurate.

I confirm that my agency is providing data and/or documentation according to all requirements and instructions specified within the Primary Care Fund Application Form. I agree to provide additional explanation or documentation should the Department decide it is necessary for determining my agency's eligibility or for verifying any data submitted herein.

I confirm that my agency's JCAHO or AAAHC accreditation or documentation and associated recordkeeping for our Quality Assurance Program shall be available for review by the Department upon request.

I agree that my agency shall abide by the Department's regulations for the Primary Care Fund found in the Code of Colorado Regulations (CCR) at 10 CCR 2505-10, Section 8.950, et seq., as they now exist or may hereafter be amended.

I agree to the conditions of the appeal rights specified under Section A, Item 6. I agree that the venue for any legal disputes related to the Primary Care Fund or the Primary Care Fund Application Response shall be in the City and County of Denver, Colorado.

I agree that at any time my agency is subject to performance and/or financial audits concerning this application and/or any funding received from the Primary Care Fund. I understand that the audits would be conducted at the discretion of the State of Colorado and may be performed by the Department or the Colorado Office of the State Auditor (OSA). (Statutes governing the State Auditor and specifics about the auditing process can be found in 2-3-101, et seq., C.R.S [2005]). I understand that access to files and documentation shall be made available for a period of five state fiscal years following the submission of this response.

I agree that at any time an authorized representative of my agency shall be made available, upon request, to appear before any member or committee of the Colorado General Assembly to testify concerning the Primary Care Fund Application Response and/or the funding received from the Primary Care Fund.

\_\_\_\_\_  
Legal Name of Applicant Agency

\_\_\_\_\_  
Applicant Agency's Authorized Representative's Name (printed)

\_\_\_\_\_  
Signature of Applicant Agency's Authorized Representative

\_\_\_\_\_  
Date

**Item 5. FY 2008-09 PRIMARY CARE FUND ACCOMPLISHMENTS**

If an applicant agency received funding from the Primary Care Fund in FY 2008-09, please describe below what the funding was used to accomplish.

This response is not scored. The Department is interested in any information you can provide on what your agency was able to accomplish with funding from the Primary Care Fund. This information will be used to answer questions and inform the public on accomplishments made by Qualified Providers that have been awarded funding through the Primary Care Fund.

Please use as much space as necessary to describe your agency's accomplishments.

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