CICP Provider Meeting
March 19, 2010

Handout 4

«Facility»

COLORADO INDIGENT CARE PROGRAM

FISCAL YEAR 2010-11 PROVIDER APPLICATION

JULY 1, 2010 THROUGH JUNE 30, 2011

Providers must meet the following criteria:

1. Licensed or Certified by the Department of Public Health and Environment as a General Hospital or Community Health Clinic.
2. Provider must be physically located outside the City and County of Denver.
   or
   Provider must offer either unique services or service a unique population. These providers must provide 50% of their indigent care to residents outside the City and County of Denver. A proposal must be submitted with this application identifying the unique feature(s) of the provider.
   or
   Provider is required by statute to participate; i.e. Denver Health Medical Center and University Hospital.
3. If the provider is a hospital, the hospital must have at least two obstetricians with staff privileges at the hospital who agree to provide obstetric services to individuals entitled to such services as Medicaid clients. In the case where a hospital is located in a rural area (that is, an area outside of a Metropolitan Statistical Area, as defined by the Executive Office of Management and Budget), the term "obstetrician" includes any physician with staff privileges at the hospital to perform non-emergency obstetric procedures. This obstetrics requirement does not apply to a hospital in which the patients are predominantly under 18 years of age; or which does not offer non-emergency obstetric services as of December 21, 1987.
4. Agree to follow the rules and regulations of the Colorado Indigent Care Program as detailed in Code of Colorado Regulations (CCR) at 10 CCR 2505-10, sections 8.900, et seq., as they now exist or may hereafter be amended. This information can be found on the Department's website at: www.colorado.gov/hcpf. Select HCPF, Partners & Researchers, Medicaid Rules and State Plan, Code of Colorado Regulation for Medicaid.

Completing This Application:

- ✓ **Administrator's signature is required on Page 2.**
- ✓ **Please note and complete requests for new contact information.**
- ✓ **Please update incorrect information or changes in staff.**

Return by April 15, 2010 to:

Safety Net Programs Section - CICP
Department of Health Care Policy and Financing
1570 Grant St.
Denver, CO 80203

Fax 303-866-4411

For questions, contact CICP at:
cicpcorrespondence@state.co.us or 303-866-2580

«Facility»

COLORADO INDIGENT CARE PROGRAM
PARTICIPATION VERIFICATION
FISCAL YEAR 2010-11
(JULY 1, 2010 THROUGH JUNE 30, 2011)

_____ **«Facility»** requests to participate in the Colorado Indigent Care Program for FY 2010-11.

_____ **«Facility»** does not request to participate in the Colorado Indigent Care Program for FY 2010-11.

This facility is licensed by the Colorado Department of Public Health and Environment as a:

____ General Hospital ____ Community Health Clinic _____ Other, Specify

I certify that **«Facility»** meets the following conditions during the FY 2010-11:

1. **«Facility»** will assure that medically necessary care as offered under the CICP guidelines will be available to all CICP clients throughout FY 2010-11.
2. If **«Facility»** is a hospital, I have indicated which of the below criterion apply to **«Facility»** and assure that the applicable criterion is met. (This condition does not apply to community health clinics.)

   _____ **«Facility»** is located in an urban county (counties with a population of more than 100,000) and has at least two obstetricians with staff privileges that provide obstetric services to Medicaid clients.

   _____ **«Facility»** is located in a rural area (counties with a population of less than 100,000). **«Facility»** has at least one physician with staff privileges to perform non-emergency obstetric procedures.

_____
Doing Business As (DBA)

_____
Signature of Administrator Date

This is the most current information from the CICP database. If the information below is NOT correct, please update it in the space provided. Your contact information will not be released to CICP clients. You will receive a copy of the CICP newsletter.

		Updated Contact Information
Administrator's Name:	**«Admin_Name»**	_____
Street Address:	**«Admin_Street»**	_____
City, State, Zip Code:	**«Admin_City»**	_____
Direct Phone Number:	**«Admin_Phone_Num»**	_____
Direct Fax Number:	**«Admin_Fax_Num»**	_____
E-Mail Address:	**«Admin_EMail»**	_____

«Facility»

COLORADO INDIGENT CARE PROGRAM
PROJECTION OF EMERGENCY AND NON-EMERGENCY UTILIZATION
FISCAL YEAR 2010-11 (JULY 1, 2010 THROUGH JUNE 30, 2011)

The CICP enabling legislation requires providers to furnish emergency services to all CICP eligible clients throughout the year. Non-emergency services furnished to CICP eligible clients must be prioritized within available funding, but provided throughout the entire year. This worksheet is used to monitor compliance with the legislation. Please complete the following projections of CICP activity for the 2010-11 contract year.

PROJECTED ADMISSIONS OF MEDICALLY INDIGENT PATIENTS:

	Number	Percent of Total Admissions
Emergency Admissions	_____	_____
Non-Emergency Admissions	_____	_____
Total	_____	____100%

PROJECTED VISITS OF MEDICALLY INDIGENT PATIENTS:

	Number	Percent of Total Visits
Emergency visits	_____	_____
Non-Emergency Visits	_____	_____
Total	_____	____100%

Please explain below how your facility will prioritize the following services within the available funding:

1. Emergency care
2. Medical care for conditions determined to be the most serious threat to the health of medically indigent persons
3. Any additional care

_____

_____

_____

_____

_____

_____

_____

Doing Business As (DBA)

COLORADO INDIGENT CARE PROGRAM
PROVIDER INFORMATION

Please remember that the provider names and addresses listed on pages 5 through 7 should reflect your business situation effective July 1, 2010. Information on satellite facilities should be listed only on the *Satellite Facility Information Worksheet*. The information already provided reflects our most recent data and must be reviewed/updated for accuracy. **Any missing or updated information should be completed directly on these pages.**

LEGAL AND ADMINISTRATIVE INFORMATION:

Legal Name of Business (the *business name that appears on contracts*):

«Legal_Name»

***Note: If you have a change in your legal name, there must be an official change to your existing contract.**

Legal Address *(the address that appears in contracts):*

«Legal_Address»
«Legal_City_State_Zip»

FACILITY SPECIFIC INFORMATION:

Our records indicate the following information for your **Main Facility**. Any information on satellite facilities should be listed on the *Satellite Facility Information Worksheet*.

Facility DBA name (the *"doing business as" name of facility*) and ***physical location*** address:

Required. The name and physical location address that clients will recognize to access services. This information will be published in the CICP Directory.

«Facility»
«Local_Address»
«Local_City_State_Zip»
County Located: «Local_County»

Phone Number: **«Local_Phone_Number»**
Fax Number: **«Local_Fax_Number»**

ELECTRONIC MAILING INFORMATION: *(NEW)*

Required: In our efforts to reduce paper waste and print costs the Department will begin sending documents such as newsletters, surveys, and various other correspondence to providers electronically. To ensure your facility receives relevant correspondence, please complete the following:

Email Contact's Name: _____
Email Address*: _____
Contact's Phone Number: _____

***Changes to the email address you indicate above must be reported to the Department immediately to ensure timely communications.**

COLORADO INDIGENT CARE PROGRAM
CONTACT INFORMATION

This is the most current information from the CICP database. If the information below is NOT correct, please update it in the space provided. Your contact information will not be released to CICP clients. As the CICP Financial Contact, you will receive CICP Rate or Reimbursement Letters and a copy of the CICP newsletter. Please print or type information.

- Chief Financial Officer: ***Required.***

		Updated Contact Information
Name:	**«CFO_Name»**	
Mailing Address:	**«CFO_Address»**	
City, State, Zip Code:	**«CFO_City_State_Zip»**	
Direct Phone Number:	**«CFO_Phone_Num»**	
Direct Fax Line:	**«CFO_Fax_Num»**	
E-Mail Address:	**«CFO_EMail»**	

This is the most current information from the CICP database. If the information below is NOT correct, please update it in the space provided. Please print or type information.

- Contract Contact:
  Required. *Individual responsible for overseeing the CICP contract and provider application process.*

		Updated Contact Information
Name:	**«Contract_Contact»**	
Mailing Address:	**«Contract_Address»**	
City, State, Zip Code:	**«Contract_City_State_Zip»**	
Direct Phone Number:	**«Contract_Phone_Num»**	
Direct Fax Line:	**«Contract_Fax_Num»**	
E-Mail Address:	**«Contract_EMail»**	

- Billing Contact:
  Required. *Individual responsible for overseeing the CICP billing process. This person will receive information on changes in the CICP rules, training sessions and the CICP Newsletter.*

Name:	**«Billing_Contact»**	
Mailing Address:	**«Billing_Address»**	
City, State, Zip Code:	**«Billing_City_State_Zip»**	
Direct Phone Number:	**«Billing_Phone_Num»**	
Direct Fax Line:	**«Billing_Fax_Num»**	
E-Mail Address:	**«Billing_EMail»**	

- Eligibility Contact:
  Required. *Individual responsible for overseeing the CICP client application and eligibility process. This person will receive information on changes to the CICP rules, training sessions and the CICP Newsletter.*

Name:	**«Eligibility_Name»**	
Mailing Address:	**«Eligibility_Address»**	
City, State, Zip Code:	**«Eligibility_City_State_Zip»**	
Direct Phone Number:	**«Eligibility_Phone_Num»**	
Direct Fax Line:	**«Eligibility_Fax_Num»**	
E-Mail Address:	**«Eligibility_EMail»**	

COLORADO INDIGENT CARE PROGRAM
CONTACT INFORMATION

- Complaint Representative: (*New)*
  Required. *Individual responsible for receiving CICP complaints/concerns in addition to communicating and/or preparing response. This person will receive information on changes to the CICP rules, training sessions and the CICP Newsletter.*

  Name: _____
  Mailing Address: _____
  City, State, Zip Code: _____
  Direct Phone Number: _____
  Direct Fax Line: _____
  E-Mail Address: _____

- Cost Report Accounting Contact: *(New)*
  Required. *Individual responsible for submitting provider's cost report worksheets and other supporting financial documents. This person will receive information on changes to the CICP rules, training sessions and the CICP Newsletter.*

  Name: _____
  Mailing Address: _____
  City, State, Zip Code: _____
  Direct Phone Number: _____
  Direct Fax Line: _____
  E-Mail Address: _____

- Annual Audit Contact: *(New)*
  Required. *Individual responsible for submitting facility's annual audit report to Department. This person will receive information on changes to the CICP rules, training sessions and the CICP Newsletter.*

  Name: _____
  Mailing Address: _____
  City, State, Zip Code: _____
  Direct Phone Number: _____
  Direct Fax Line: _____
  E-Mail Address: _____

- CICP Client Access:
  Required*. Phone Number clients should call for more information or make appointments to complete the CICP Application.* ***This number will be published in the CICP Phone Directory, available to clients.***

  Phone Number: _____

- Eligibility Contact II:
  Optional. *This person will receive information on changes to the CICP rules, training sessions and the CICP Newsletter.*

  Name: **«Eligibility_II_Name»** _____
  Mailing Address: **«Eligibility_II_Address»** _____
  City, State, Zip Code: **«Eligibility_II_City_State_Zip»** _____
  Direct Phone Number: **«Eligibility_II_Phone_Num»** _____
  Direct Fax Line: **«Eligibility_II_Fax_Num»** _____
  E-Mail Address: **«Eligibility_II_EMail»** _____

COLORADO INDIGENT CARE PROGRAM
SERVICE INFORMATION

- Health Care Services:
  Health care services available to CICP clients at «Facility». Please do not include care that is not available to CICP clients. *(Please list service limitations. Example: facility only provides emergency care, non-emergency care; facility provides children services, laboratory service, after hours care, or any specialty care of which clients should be aware.):*

  If your facility has a limited service area for non-emergency care, your facility is required to submit a written waiver to the CICP administration. No verbal waiver requests will be accepted.

- Outpatient Pharmacy Services:
  Does your facility offer an Outpatient Pharmacy Service at a Discount to CICP clients?
  (Yes, No, or Yes, but not as a covered benefit under the CICP)

  Please provide any relevant details on your Outpatient Pharmacy Service:

  Please note if your facility offers a discounted Outpatient Pharmacy Service, but not under the CICP guidelines. If your facility responds in the affirmative that an Outpatient Pharmacy Service is offered at a discount under the CICP, then your facility is required to submit the appropriate summary spreadsheet associated with those charges. The CICP Administration will contact your facility if your facility has not previously followed this requirement.

- Physician Services:
  Are physician charges discounted for services rendered by Physicians to CICP clients at **«Facility»**?
  (Yes, No, or Yes, but not as a covered benefit under the CICP)

  Please provide any relevant details or limitations on your Discounted Physician Service:

  Please note if your facility offers discounted Physician Services but not under the CICP guidelines. If your facility responds in the affirmative that Physician Services are offered at a discount under the CICP, then your facility is required to submit the appropriate summary spreadsheet associated with those charges. The CICP Administration will contact your facility if your facility has not previously followed this requirement.

- Satellite Facilities:

Our records show that your facility has **«Satellite_Count» satellite facility/facilities.** Any information on satellite facilities should be listed on the *Satellite Facility Information Worksheet*. A Satellite Facility cannot have a separate Employer Identification Number (EIN) from your main facility. The Satellite Facility is considered part of the main facility or a separate contract is required. Do not list nursing homes or mental health facilities. The facility must be licensed as a Community Health Clinic or Hospital by the Colorado Department of Public Health and Environment.