

## APPLICATION FORM

### *Delaware Behavioral Health Electronic Medical Records Incentive Program*

Application Type:	<input type="checkbox"/> Category 1 - No EMR <input type="checkbox"/> 1 - 3 Providers <input type="checkbox"/> 4 - 6 Providers <input type="checkbox"/> 7+ Providers	<input type="checkbox"/> Category 2 - Upgrades to EMR <input type="checkbox"/> 1 - 3 Providers <input type="checkbox"/> 4 - 6 Providers <input type="checkbox"/> 7+ Providers	<b>Are you interested in the DCHI BHI Testing Program?</b>  <input type="checkbox"/> Yes, see Appendix B <input type="checkbox"/> No
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Incomplete application packets will not be eligible for award consideration.  
 (Ensure all sections below are completely filled out)

<b>SECTION 1: APPLICANT INFORMATION (PROVIDER SITE)</b>
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**A. APPLICANT/PROVIDER INFORMATION**

Business Type: <input type="checkbox"/> Corporation <input type="checkbox"/> Limited Liability Company <input type="checkbox"/> Partnership <input type="checkbox"/> Sole Proprietor <input type="checkbox"/> Non-Profit <input type="checkbox"/> Other (Specify)				
Legal Business Name		Doing Business As (DBA)		
Tax Identification Number (TIN)		National Provider Number (NPI)	Delaware Vendor ID	
Business Address Line 1 (Street Name and Number)				
Business Address Line 2 (Building, Room, Suite, etc.)				
City/Town		State		Zip Code
Work Phone	Other Phone		Email	Website
Professional Business License Number			State Issued <input type="checkbox"/> Delaware <input type="checkbox"/> Other (Specify)	
Effective Date (mm/dd/yyyy)			Expiration/Renewal Date	
Certification <input type="checkbox"/> Marriage & Family Therapists <input type="checkbox"/> Licensed Professional Counselor <input type="checkbox"/> Psychiatrists <input type="checkbox"/> Psychologists <input type="checkbox"/> Other (Specify)				
Number of Active Practitioners in Location			Date Established in Delaware	
Total Number of Patient Visits Annually		Insurance Accepted <input type="checkbox"/> Highmark <input type="checkbox"/> Aetna <input type="checkbox"/> Coventry <input type="checkbox"/> Medicaid <input type="checkbox"/> Medicare <input type="checkbox"/> Other (Specify)		
Patient Population <input type="checkbox"/> Adolescents <input type="checkbox"/> Adults <input type="checkbox"/> Both				
Geographic Location <input type="checkbox"/> Rural <input type="checkbox"/> Suburban <input type="checkbox"/> Urban				

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**SECTION 2: PRACTITIONER INFORMATION**

*Note: Additional practitioners must be listed in similar format on a separate page titled "Appendix A Section 2 Continued"*

<b>No.</b>	<b>Print full Name</b>	<b>Profession/Specialty</b>	<b>NPI</b>	<b>DPR License #</b>
1				
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**SECTION 3: APPLICANT DECLARATIONS AND SIGNATURES**

- I agree to execute all required deliverables/actions within six (6) months of the awarded contract.
  
- I attest that the organization identified in this application is located within Delaware, that Practitioners are productively employed, and information provided on this application is true and correct within the confines of Delaware laws.
  
- I understand that funding for the DE BH EMR Incentive Program is contingent upon authorization of the federal CMMI Cooperative Agreement.
  
- I accept full responsibility for completion of this application, submission of supporting documents, and justifications for eligibility requirements. I am aware that incomplete applications will be deemed ineligible and will not progress through the award determination process.
  
- I attest that all EMR systems affiliated with, or purchased as a result of this RFP incentive program must be interoperable with the Delaware Health Information Network (DHIN).
  
- Check this box ONLY if "YES" was selected for participation in the Delaware Center for Health Innovation, Behavioral Health Integration Testing Program. I understand that this application will be forwarded to DCHI for further consideration.

\_\_\_\_\_  
**Signature** **Print Name/Title (AOR)** **Date**

DO NOT WRITE IN THIS AREA - For Proposal (Application) Evaluation Team ONLY

Application Status:  Application Complete  Application Incomplete

Practitioner(s)	Applicant	Application for further consideration
<input type="checkbox"/> Certificates & Licenses	<input type="checkbox"/> Location in Delaware <input type="checkbox"/> Certificates, Insurance & Licenses <input type="checkbox"/> Employment Verified <input type="checkbox"/> Project Narrative <input type="checkbox"/> Attachments and Appendices <input type="checkbox"/> Vendor Registration	<input type="checkbox"/> Yes <input type="checkbox"/> DCHI BHI <input type="checkbox"/> Notified <input type="checkbox"/> No <input type="checkbox"/> Notified Justification: _____ _____ _____