Print Form

Acute Hospital RFA Appendix G 2009

Key Quality Contacts Form

MassHealth

Executive Office of Health and Human Services

Hospital Name: _____

Street Address: _____

City: _____ State: _____

Zip Code: _____

Name of Hospital CEO: _____

Phone: _____

Fax: _____

E-mail: _____

Instructions Pursuant to Section 1 of Appendix G, each Hospital must complete and submit information on all designated staff reporting on Appendix G 2009 requirements. Please enter all information required of each designated staff in blank spaces under the section header. **All information must be typed**.

Key Hospital Quality Contact*

SECTION 1a	Name	Title/Dept.	E-mail	Phone	Fax	Effective Date

RFA Contract Manager (Chief Financial Officer)*

SECTION 1b	Name	Title/Dept.	E-mail	Phone	Fax	Effective Date

Measure Data Files (MassQEX Portal)

SECTION 2	MassQEX User 1 Name	Title/Dept.	E-mail	Phone	Fax	Effective Date
	MassQEX User 2 Name	**Title/Dept.**	**E-mail**	**Phone**	**Fax**	**Effective Date**

Health Disparities Measures (CCOSA Checklist)

SECTION 3	Name	Title/Dept.	E-mail	Phone	Fax	Effective Date

Note

(1) Only Section 1 contacts above with * are automatically entered into the **MassHealthhospitalquality@state.ma.us** e-mail distribution list.
(2) Any change to key contacts listed above during RY2009 must be submitted on this form to EOHHS as soon as it becomes available.