



The Commonwealth of Massachusetts
Bureau of Healthcare Safety and Quality
Office of Emergency Medical Services
Mobile Integrated Health Program
67 Forest Street, Marlborough, MA 01752

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Lieutenant Governor

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MIH PROGRAM COMPLIANCE AND CAPACITY

NOTE: COMMUNITY EMS APPLICANTS are NOT required to complete this form.

All Applicants for Department approval of an MIH Program must complete and submit this form and all supporting documentation. This form and all supporting documents (except for the DPH/MIH Program CORI Acknowledgment Form**) may be submitted via fax to the MIH Applications Reviewer at (617) 753-8170.

MIH applications will not be processed if the information on this form is not complete. **DO NOT EMAIL THIS FORM OR ANY OF THE ATTACHMENTS.**

****The completed DPH/MIH Program CORI Acknowledgment Form must be submitted by Fax or Mail. DO NOT EMAIL THE COMPLETED CORI ACKNOWLEDGMENT FORM.**

A. APPLICANT INFORMATION:

Program Name: _____
(name by which you will do business)

Address: _____
(street, city/town, zip code)

Applicant's Point of Contact: _____
(name of person DPH should contact regarding your Application)

Point of Contact's Telephone number

Point of Contact's email address

1. Is the Applicant or any health care entity identified in the Application as a partner to the proposed MIH program NOT licensed by the Department of Public Health?

YES ☐

NO ☐

If YES, please respond to Questions 1(a) through (d).

If NO, proceed to Part B of this form.

1(a). For each health care entity, provide the health care entity's ownership structure by checking one of the following:

- ☐ Sole Proprietorship (Individual)
- ☐ Partnership
- ☐ Limited Partnership
- ☐ Charitable (non-profit) Corporation
- ☐ Corporation (for profit)
- ☐ Limited Liability Corporation
- ☐ Other (please specify): _____

1(b). Provide the nine-digit identification number as registered with the Massachusetts Secretary of State's office (applicable to partnerships, limited partnerships, and corporations of any nature).

1(c). If a corporation, please list the officers and directors (or board if non-profit) of the corporation and their title.

Name #1 Title

☐ Completed DPH/Mobile Integrated Health Care CORI form has been submitted by mail.

Name #2 Title

☐ Completed DPH/Mobile Integrated Health Care CORI form has been submitted by mail.

Name #3 Title

☐ Completed DPH/Mobile Integrated Health Care CORI form has been submitted by mail.

Name #4 Title

☐ Completed DPH/Mobile Integrated Health Care CORI form has been submitted by mail.

See attached List of any additional officers or directors: Yes ☐ No ☐

1(d). Please list the name and ownership interest of individuals (both in an individual capacity or through another entity) with a 5% or more ownership interest.

Name #1 ownership interest (%)

☐ Completed DPH/Mobile Integrated Health Care CORI form has been submitted by mail.

Name #2 ownership interest (%)

☐ Completed DPH/Mobile Integrated Health Care CORI form has been submitted by mail.

Name #3 ownership interest (%)

☐ Completed DPH/Mobile Integrated Health Care CORI form has been submitted by mail.

Name #4 ownership interest (%)

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See attached List of additional 5% or greater owners: Yes ☐ No ☐

B. COMPLIANCE HISTORY:

The following definitions apply to questions 1 through 10 below:

- “*Healthcare related professional license*” includes any certification, registration, approval, or license issued by a governmental authority that authorizes or permits a person to practice or work in a healthcare related occupation in one or more states within the United States or in any other country or jurisdiction.
- “*Healthcare related facility license*” includes any certification, registration, approval, or license issued by a governmental authority that authorizes or permits a business or entity to operate a health care related facility, including but not limited to, a nursing home, hospital, clinic, or pharmacy, in one or more states within the United States or in any other country or jurisdiction.

Have any of the MIH Applicant's corporate officers, directors or owners, either individually or severally:	Yes	No	If yes to any, provide
1. Held an ownership interest of greater than 5% in a business or entity that holds a healthcare related facility license? If yes, has the healthcare related facility license issued to the business or entity ever been restricted, placed on probation, suspended, revoked or otherwise subjected to disciplinary action?	<input type="checkbox"/>	<input type="checkbox"/>	1. Detailed explanation with: <ul style="list-style-type: none">• Name of individual or corporation and how affiliated;• Facility name and address;• Medicare and Medicaid provider numbers;• The circumstances and how they were resolved. 2. Copies of all relevant court or administrative agency documents including but not limited to: <ul style="list-style-type: none">• Complaint or notice of agency action;• Applicant's response; and,• Settlement agreement, court decision or final agency action.
2. Applied for and been denied a health care related professional license?	<input type="checkbox"/>	<input type="checkbox"/>	
3. Had a healthcare related professional license issued to you restricted, placed on probation, suspended, revoked or otherwise subjected to disciplinary action?	<input type="checkbox"/>	<input type="checkbox"/>	
4. Held a healthcare related professional license that is the subject of a pending disciplinary action?	<input type="checkbox"/>	<input type="checkbox"/>	
5. Been the subject of a pending disciplinary action by any hospital or health care facility or professional medical association in the United States?	<input type="checkbox"/>	<input type="checkbox"/>	
6. Voluntarily surrendered a health care related professional license?	<input type="checkbox"/>	<input type="checkbox"/>	
7. Had your Medicare or Medicaid certification denied or revoked?	<input type="checkbox"/>	<input type="checkbox"/>	
8. Entered into a settlement agreement to avoid loss of license or Medicare or Medicaid certification?	<input type="checkbox"/>	<input type="checkbox"/>	

Have any of the MIH Applicant's corporate officers, directors or owners, either individually or severally:	Yes	No
9. Been the subject of a valid finding of abuse, neglect or misappropriation against a patient or resident within a health care facility or part of a health care program; or an elderly person (as defined under M.G.L. c.19A §14); or a disabled person (as defined under M.G.L. c.19C §1)?	<input type="checkbox"/>	<input type="checkbox"/>
10. *Been convicted of; entered a plea of guilty, nolo contendere, or no contest to; and/or, admitted to sufficient facts, in connection with a felony or misdemeanor in any jurisdiction, other than a minor traffic violation, even if the matter was continued without a finding or the court withheld adjudication so that you would not have a record or conviction?	<input type="checkbox"/>	<input type="checkbox"/>

*For purposes of question 10, the following traffic violations are not minor: driving under the influence, reckless driving, driving to endanger, and motor vehicle homicide.

The Applicant is responsible for notifying the Department, in writing, of any changes to the responses to questions 1-10. Notice of the change in response must be provided as soon as the Applicant becomes aware of the need for the change.

C. CAPACITY INFORMATION

IN SUBMITTING THIS MIH APPLICATION, APPLICANT ATTESTS TO THE FOLLOWING:	Yes	No
11. The Applicant has the financial capacity to operate the proposed MIH program in full accordance with 105 CMR 173.000, for the two (2) year approval period.	<input type="checkbox"/>	<input type="checkbox"/>
12. The Applicant has the operational capacity (at a minimum: location, personnel and equipment) to operate the proposed MIH program in full accordance with 105 CMR 173.000, for the two (2) year approval period.	<input type="checkbox"/>	<input type="checkbox"/>

The Applicant will immediately inform the Department should they become aware that they can no longer meet all applicable requirements pursuant to 105 CMR 173.000.

Signed under the penalties of perjury, this _____ day of _____, 20__

Signature of Individual

Print Name of Individual