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Governor

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Lieutenant Governor

The Commonwealth of Massachusetts

Bureau of Healthcare Safety and Quality
Office of Emergency Medical Services
Mobile Integrated Health Program
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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 Mail. DO NOT FAX OR 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

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_____ _____
Name #2 Title

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_____ _____
Name #3 Title

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

_____ _____
Name #4 Title

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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 (%)

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_____ _____
Name #2 ownership interest (%)

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_____ _____
Name #3 ownership interest (%)

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_____ _____
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, 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?	☐	☐	**1. Detailed explanation with:** • 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:** • 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?	☐	☐	
3. Had a healthcare related professional license issued to you restricted, placed on probation, suspended, revoked or otherwise subjected to disciplinary action?	☐	☐	
4. Held a healthcare related professional license that is the subject of a pending disciplinary action?	☐	☐	
5. Been the subject of a pending disciplinary action by any hospital or health care facility or professional medical association in the United States?	☐	☐	
6. Voluntarily surrendered a health care related professional license?	☐	☐	
7. Had your Medicare or Medicaid certification denied or revoked?	☐	☐	
8. Entered into a settlement agreement to avoid loss of license or Medicare or Medicaid certification?	☐	☐	

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)?	☐	☐	
10. Been convicted of, entered a plea of guilty, nolo contendere, no contest to or, admitted to sufficient facts to a criminal offense* in any jurisdiction. "Admitted to sufficient facts" includes those criminal cases where the court continued the case without a finding or the court withheld adjudication so that you would not have a record or conviction.	☐	☐	

** For purposes of Question 10, "criminal offense" excludes a minor traffic violation resulting in a fine or penalty less than $500.00, but does not exclude driving under the influence or driving while impaired.*

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.	☐	☐
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.	☐	☐

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