



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

MAURA T. HEALEY
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Lieutenant Governor

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Commissioner

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**MOBILE INTEGRATED HEALTH CARE
MODIFICATION REQUEST FORM
105 CMR 173.070**

INSTRUCTIONS

This request form is to be completed by a Department-approved Mobile Integrated Health Care (MIH) program or Mobile Integrated Health Care with ED Avoidance (MIH with EDA) ("Applicant") that wishes to apply for a modification to an approved MIH program.

Pursuant to 105 CMR 173.070, after receipt of a Certificate of Approval, a MIH program may seek approval of modifications in accordance with processes and criteria established in Department guidance.

Please label any attachments so as to identify the question to which it relates.

Mail, hand-deliver, or email the Modification Request Form, with any attachments, to:

Department of Public Health
Mobile Integrated Health Care Program
67 Forest Street
Marlborough, MA 01752

Email MIH@mass.gov, addressed to:
Attention: MIH Application Reviewer

REVIEW

Modification requests are reviewed in the order they are received.

After a completed request form is received by the Department of Public Health ("Department"), the Department will review the information and will contact the requestor if clarifications or updates to the submitted request are needed. The Department will notify the requestor whether it has met the standards necessary to receive the requested modification.

QUESTIONS

If additional information is needed regarding the modification process, please contact the MIH Application Reviewer at MIH@mass.gov or call 617-753-8124.

SECTION A: APPLICANT STATUS (REQUIRED)
Indicate with an "X" the status of the requestor: <input type="checkbox"/> Approved Mobile Integrated Health Program <input type="checkbox"/> Approved Mobile Integrated Health Program with ED Avoidance

SECTION B: APPLICANT INFORMATION (REQUIRED)		
1. Name of Applicant Organization:		
2. Approval number (if applicable):		
4. Telephone number: ()		
5. Address of Applicant Organization::	6. Applicant mailing address 2 (if applicable):	
7. City:	8. State:	9. Zip code:

SECTION C: APPLICANT CONTACT PERSON INFORMATION (REQUIRED)		
17. Last name of contact person:	18. First name of contact person:	
19. Phone number of contact person: ()	20. Alternate phone number of contact person: ()	
21. Contact person mailing address 1:	22. Contact person mailing address 2 (if applicable):	
23. City:	24. State:	25. Zip code:
26. Email address of contact person:		

SECTION D. GROUNDS FOR A MODIFICATION REQUEST

1. I, the undersigned, request the following modification from a Department approved MIH or MIH with EDA program:

ATTESTATION

Signed under the pains and penalties of perjury, I, the authorized signatory for the Applicant, agree and attest that all information included in this request form is complete and accurate. I understand that this is a modification to a previously approved MIH program and will expire on the same date as the previously approved MIH program.

Signature of Authorized Signatory

Date Signed

Print Name of Authorized Signatory

Title of Medical Director

Signature of Medical Director

Date Signed

Print Name of Medical Director

Title of Medical Director