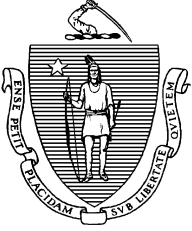


The Commonwealth of Massachusetts  
Bureau of Healthcare Safety and Quality  
Office of Emergency Medical Services  
Mobile Integrated Health Program  
67 Forest Street, Marlborough, MA 01752



**MAURA T. HEALEY**  
Governor

**KIMBERLEY DRISCOLL**  
Lieutenant Governor

**KATHLEEN E. WALSH**  
Secretary

**ROBERT GOLDSTEIN, MD, PhD**  
Commissioner

Tel: 617-624-6000  
[www.mass.gov/dph](http://www.mass.gov/dph)

**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](mailto: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](mailto:MIH@mass.gov) or call 617-753-8124.

**SECTION A: APPLICANT STATUS  
(REQUIRED)**

Indicate with an "X" the status of the requestor:

- ☐ Approved Mobile Integrated Health Program  
☐ 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

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Title of Medical Director