

Application for designation by the Minnesota Commissioner of Health as an
Essential Community Provider
Pursuant to Minnesota Statutes §62Q.19 and Minnesota Rules Chapter 4688

General Information

Minnesota Statute §62Q.19 authorizes the commissioner of health to designate providers as essential community providers. A copy of this statute is attached for your reference. Applicants must be a non-profit, tax-exempt entity or a local government unit, an Indian health service, service unit, an Indian tribal government or a community health board. All applicants must have a demonstrated ability to integrate applicable supportive and stabilizing services with medical care for uninsured persons, high-risk and special needs populations, and underserved and other special needs populations. Underserved refers to a population or group of people with inadequate access to health care services.

High risk and special needs populations include, but are not limited to: people on medical assistance, general assistance medical care, and MinnesotaCare; people with chronic conditions or disabilities; individuals within certain racial, cultural and ethnic communities; individuals and families with low income; adolescents; the elderly; individuals with limited or no English language proficiency; persons with high cost preexisting conditions; homeless persons; chemically dependent persons; persons with serious and persistent mental illness and children with severe emotional disturbance; and persons who are at high risk of requiring treatment.

Prior to designation, the commissioner is required to publish the name of each applicant in the State Register. The public must have 30 days to submit written comments to the commissioner on the application. The commissioner will either approve or deny the applications within 60 days after publication in the State Register. If this application meets the requirements you will be notified in writing of your designation as an essential community provider. If this application does not meet the requirements, you will be notified in writing and the specific reasons for disqualification will be given.

Application Instructions

1. Please provide all of the information requested as completely as possible. If a section is not applicable to you, mark it "Not Applicable" and explain why, if necessary. If you need additional space to answer a question, attach the information on a separate page(s) and clearly indicate which section(s) it is supplementing.
2. You are responsible for identifying current requirements of law or rules relating to essential community providers that may not be indicated in this application form. Copies of Minnesota Statutes §62Q.19 and Minnesota Rules Chapter 4688 are attached for your reference.
3. You must attach a non-refundable application fee of \$60, payable to Treasurer, State of Minnesota, to this application.
4. Submit one notarized copy and one additional copy of the completed application to:

Minnesota Department of Health
Managed Care Systems
P.O. Box 64882
Saint Paul MN 55164-0882

If you have questions about how to complete this application you may call (651) 201-5164.

PLEASE TYPE OR PRINT LEGIBLY IN BLACK INK

SECTION A

Name of organization			
Street Address			
Mailing Address if different			
City	State	Zip	County
Telephone	Fax	E-mail	
Contact Person		Title	
Date of submission of application			

SECTION B

Indicate if you are applying as a(n):

local government unit Indian tribal government Indian health service, service unit
 tax-exempt non-profit entity community health board

If you are applying as a tax-exempt non-profit entity, you must attach the following supporting documentation:

1. Evidence of Minnesota Statutes Chapter 317A non-profit status.
2. Evidence of Internal Revenue Code § 501(c) (3) tax-exempt status.
3. A copy of your current sliding fee schedule.
4. Evidence that you do not restrict access or services because of your clients' financial limitations.

SECTION C

On a separate sheet, list the medical services you provide by Current Procedural Terminology 2008 (CPT 2008) codes or categories of Current Procedural Terminology 2008 (CPT 2008) codes.

SECTION D

Please attach the required information to this application:

1. Provide evidence of your capacity and ability to provide medical services in a timely manner, consistent with the norms of the community in which you are located.
2. Include a list of the numbers and all types of health care professionals you have available to provide services to your clients.
3. Include a copy of your appointment scheduling guidelines and procedures.
4. Explain how you monitor appointment scheduling and waiting times, and how you take corrective actions when indicated.

SECTION E

Below is a list of different populations that an ECP might have served in the past 12 months. Please check all that are applicable to you.

- People on public assistance
- People with chronic health or medical conditions
- People with persistent serious mental health issues
- People who are chemically dependent
- Adolescents
- Elderly
- People from racial or ethnic minorities
- Uninsured people
- Underinsured people
- People with limited or no English language proficiency (list the languages)
- People living in medical shortage areas
- Other (explain)

SECTION F

1. An ECP must provide or coordinate the provision of supportive and stabilizing services that are appropriate to the population you serve. Please check all that are applicable to you from the list below. For each service that you check, please explain on a separate sheet if it is provided directly or through coordination with another entity. If specific services are not provided, please explain why these services are either not available or not needed by the population you serve.

- Transportation
- Child care
- Linguistic services
- Culturally sensitive and competent services
- Other services

2. On a separate sheet, indicate if, and in what way, professional staff are familiar with the culture of the clients you

serve.

3. On a separate sheet, indicate if, and in what way, you provide pre-service and in-service training for all professional and support staff on cultural awareness and health issues affecting high-risk and special-needs clients. State when and where training has taken place. Attach training curricula to the application.

I hereby swear that information submitted with this application is true to the best of my knowledge.

Signature of officer

Date

Signer and Title (typed or printed)

Name of Facility

Notary Public

Date

NOTARY STAMP HERE