Minnesota Department of Health
Health Care Homes
Letter of Intent for Certification

Welcome to the health care homes letter of intent. Please follow the instructions as you fill in the fields below. Submit your Letter of Intent as soon as your organization intends to seek certification. This will allow our team of planners and regional HCH nurse consultants to assist you as needed and provide resources and guidance as you proceed with the certification process. Detailed instructions, sample letters of intent, and the Rules are available in the Certification Guide and at the health care homes certification webpage: http://www.health.state.mn.us/healthreform/homes/certification/index.html.

I. Applicant Intent

The applicant for certification is the organization. The applicant name should be the broad legal organization name.

1. Please enter the applicant name in the intent statement below.

This letter signifies that _____intends to apply for certification for health care homes to the Minnesota Department of Health, pursuant to Minnesota Statutes 256B.0751-256B.0754 and Minnesota Rules Chapter 4764.

The certified entity can be a clinician(s), a department(s) or practice(s), or a clinic(s) within that organization. All clinician(s) must have fully implemented all of the standards and criteria required at certification in Minnesota Rules Chapter 4764 before applying.

2. Please specify who the applicant(s) for certification as a health care home will be as part of this letter of intent (choose only one):

   __ Individual Clinician(s) (1 or more clinicians or a department, not an entire primary care practice)

   __ Clinic(s)

   __ Practice System

   __ Other (specify) _____

*Note: If you select **Clinic(s)** or **Practice System,** every clinician (MD, DO, PA, NP, CNM, WHNP) who provides the full range of primary care services in the clinic must be fully implementing all of the standards and criteria required at certification.*

3. Primary practice type(s):
   __ Family Medicine
   __ Internal Medicine
   __ Pediatrics
   __ Med-Peds
   __ Geriatric
   __ Other (specify) _____

II. Applicant Demographic Information

Please complete the following demographic information about the applicant. Please only enter information related to where health care home services will be provided.

Clinic Information:

Clinic Name	**Clinic Tax ID** (numeric, nine digits. Example: 411765823)	**Clinic NPI Number** (numeric, ten digits. Example: 1268675753)	**Clinic Address** (street address, city, state, zip, county, primary tel, secondary tel, fax, website)	**Mailing Address** (street address, city, state, zip, county, primary tel, secondary tel, fax, website)
1.				
2.				
3.				
4.				

For each clinic, please estimate the applicant clinic's annual visit volume (use whole numbers):

Clinic 1. _____

Clinic 2. _____

Clinic 3. _____

Clinic 4. _____

Please check how you define "visit":

_____Total # of unique visits _____Total # of billable visits

_____ Other (explain): _____

Clinician Information: Please list all clinicians for each clinic who will apply for certification for health care homes. **Submit your Letter of Intent as soon as your organization intends to seek certification. This will allow our team of planners and regional HCH nurse consultants to assist you as needed and provide resources and guidance as you proceed with the certification process.**

Clinic Name	**Clinician First Name**	**Clinician Middle Initial**	**Clinician Last Name**	**Suffix**	**Credentials** (MD, DO, NP, PA, CNM, WHNP)	**Clinician NPI Number** (numeric ten digits. Example: 1268675753)	**Practice Type** (Family Medicine, Internal Medicine, Pediatrics, Med-Peds, Geriatric Medicine, Other-specify)
1.							
2.							
3.							
4.							

III. Health Care Home Information

To better assist you in the application process, we need to know more information about how you plan to implement health care homes.

1. Which of the following best describes your clinic? (Check all that apply)

__ Academic practice

__ Community Health Center or similar practice

__ Federally Qualified Health Center (FQHC)

__ Hospital-based clinic

__ Independent medical group (example: physician-owned)

__ Medical group component of integrated delivery system

__ Rural Health Clinic

__ Critical Access Hospital

__ Other (specify): _____

2a. Which of the following accreditations/ certifications does your organization currently have? (check all that apply)

__ Health Care Home Certification, State of Minnesota

__ Minnesota Department of Human Services (DHS) Primary Care Coordination (PCC) Registration

__ National Committee for Quality Assurance (NCQA) Physician Practice Connections Patient-Centered Medical Home (PCC-PCMH) Recognition

__ The Joint Commission Accreditation on Hospitals

__ The Joint Commission Accreditation on Ambulatory Care

__ Joint Commission Recognition for Patient-Centered Medical Home

__ Utilization Review Accreditation Commission (URAC) / American HealthCare Commission, Inc.

__ Bureau of Primary Care/Health Resources and Service Administration Office of Performance Review OPR

__ Other (specify): _____

2b. Does your organization plan to seek NCQA Physician Practice Connections Patient-Centered Medical Home (PCC-PCMH) Recognition?

____ Yes ____ No

3. Will all clinicians for whom you are submitting an application operate under the same health care homes policies and procedures?

____ Yes ____ No (please explain):_____

4. Will all clinicians for whom you are submitting an application operate under the same health care homes leadership structure?

____ Yes ____ No (please explain):_____

5. Will all clinicians for whom you are submitting an application implement health care homes roles and responsibilities for members of the care team the same?

____ Yes ____ No (please explain):_____

IV. Additional Information

In order for MDH to plan and track health care home implementation, we need to gather additional information from you.

1. When do you plan to submit your application for certification for health care homes (check one):

   ___ Within the next 30 days ___ Within the next 90 days

   ___ Within the next 60 days ___ other (explain): _____

2. Please indicate the optional pre-certification activities in which you have participated (check all that apply):

   ___ Attended pre-certification workshop (specify location and date): _____

   ___ Completed health care home certification assessment tool

   ___ Completed other self-assessment tool (specify):_____

   ___ Participated in the Health Care Home Learning Collaborative (forthcoming)

   ___ Other (specify): _____

V. Contact Person

Please list the main contact person(s) for the health care home application process. The contact person(s) listed below will receive all official email and other information from MDH throughout the process.

Primary Contact Information:

First Name, Middle Initial, Last Name, Suffix _____

Job Title _____

Address _____

City _____ State ____ County: _____Zip_____

Telephone Primary _____ Telephone Secondary _____

Fax _____Website _____

E-mail Address _____

Clinic Manager Information:

First Name, Middle Initial, Last Name, Suffix _____

Job Title _____

Address _____

City _____ State ____ County: _____Zip_____

Telephone Primary _____ Telephone Secondary _____

Fax _____Website _____

E-mail Address _____

Clinical Champion/ Medical Director Information:

First Name, Middle Initial, Last Name, Suffix _____

Job Title _____

Address _____

City _____ State ____ County: _____Zip_____

Telephone Primary _____ Telephone Secondary _____

Fax _____Website _____

E-mail Address _____

Finance Contact Information:

Please complete information for a financial contact. This person will be contacted for questions regarding Medicare numbers and codes.

First Name, Middle Initial, Last Name, Suffix _____

Job Title _____

Address _____

City _____ State ____ County: _____Zip_____

Telephone Primary _____ Telephone Secondary _____

Fax _____Website _____

E-mail Address _____

MDH will review your letter of intent and respond with next steps in one to two weeks. If you have questions, please contact MDH Health Care Homes by phone 651-201-5421, or by email: health.healthcarehomes@state.mn.us.