UTAH MEDICAID NURSING FACILITY
State Fiscal Year 2016
QUALITY IMPROVEMENT INCENTIVE (2)(X) APPLICATION
Outcome-Proven Awards, Rule R414-504-4

This form and all supporting documentation must be postmarked or faxed on or before May 31, 2016

Facility Name: _____

Medicaid Provider I.D. _____ Administrator: _____

Please mark all that are complete:

- ☐ This facility obtained an outcome-proven award; either the American Health Care Association Quality-First Award or the Malcolm Baldrige award.
- ☐ A detailed description of the Award is attached.
- ☐ The costs associated with the award (including preparing, reviewing, and submitting the application) were paid for by May 31, 2016.
- ☐ The award was granted between July 1, 2014 and May 31, 2016.
- ☐ Proof of purchase that includes receipts and invoices, is also attached. This includes proof of payment, i.e. cancelled check(s), financial debt instrument, etc.

Qualifying facilities may receive up to $100 per Medicaid Certified bed under this incentive (count as at 7/1/2015).
This incentive is part of incentive (2). The maximum a facility may receive from all incentives in incentive (2) combined, is $589.78 per Medicaid Certified bed (count as at 7/1/2015).
Facilities will not receive more than was expended under this incentive.

Attach Spreadsheet for detail expenditures

Total Reimbursement Requested (should match spreadsheet): $_____

Please ensure that all the supporting documentation is included. Failure to include all of the above detailed information will prevent the facility from qualifying.

By submitting this application I certify that all of the above criteria have been met.

Administrator Signature: _____ Date: _____

Note: Division staff will not request additional information relating to this submission. Please be sure to include all necessary information in order to qualify. Fax to: 801-323-1597 <or> Mail instructions: http://health.utah.gov/medicaid/stplan/longtermcare.htm