**CMP Project Application**

**BINGOCIZE**®

**Directions:** Complete this short application form and return via email attachment to [munna.yasiri@state.mn.us](mailto:munna.yasiri@state.mn.us)

**SECTION 1/2/5**

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| --- | --- |
| **Applicant Facility Name** |  |
| **Address** |  |
| **Telephone** |  |
| **Email address** |  |
| **Primary Point of Contact (name)** |  |
| **Contact Title** |  |
| **Contact Phone** |  |
| **Contact Email** |  |
| **Contact Address** |  |
| **Project Leader (complete ONLY if this is different than the Primary Point of Contact)** |  |
| **Leader Title** |  |
| **Leader Phone** |  |
| **Leader Email** |  |
| **National Provider Identifier (NPI)** |  |
| **Facility MN Taxpayer I.D. #** |  |
| **Facility website address** |  |
| **Does facility have any outstanding CMPs (Civil Monetary Penalties) due?**  **Y / N** |  |
| **Is the facility in receivership or bankruptcy?**  **Y / N** |  |

**SECTION 3**

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| **Organization history.** Provide a brief background and history of the applicant facility, including (but not limited to) the organization’s mission statement and number of years in service. |
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**SECTION 4**

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| **Facility’s capabilities.** Provide brief information about the facility’s capabilities, including staff competencies and/or previous use of similar products and services relevant to the proposed CMP project, that may contribute to the success of this project in your facility. |
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**SECTION 6/6a**

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| **Other sources of funding.**  Are you currently receiving federal or state funding for this project OR have you applied for or been granted funding for this project, from *any* other source of funding? If yes, please explain in more detail (at a minimum, include the source of the other funding, the amount of funding and any conditions of the funding for this project). |
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**SECTION 7**

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| **Project implementation:**  Please briefly address the following:  Identify which staff member/s will be responsible to Lead this project (names, emails, telephone numbers)  Identify how you will advertise this program and engage facility residents |
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**SECTION 8**

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| **Evaluation Plan.**  **Each participating facility has the responsibility to measure the project results and report on these measures in a timely manner (half-way through the project and at project end).**  **Project measures include 1) a general project assessment and 2) measures of the number of facility residents that participate in this program.**  **These results will in turn, be reported to the federal Centers for Medicare and Medicaid Services (CMS).**  ***You will receive a reporting form later in your project, to report these results measures.***  **(Please note this is an important component of all CMP projects. Failure to report on these measures in a timely manner may result in the facility being disqualified from receiving future CMP funding).**  *Below, please identify the staff member/s who will have the primary responsibility for collecting and reporting on this data*: | |
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|  | Please check the box to indicate that you understand and accept the reporting requirements and accept responsibility for submitting this information in a timely manner. |

**SECTION 9**

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| **Budget.**  This section specifies that you are requesting a grant to implement a facility Bingocize® program. Facilities are required to use these funds to pay for their Bingocize® program. (Please note: Facilities must submit the Bingocize® invoice along with the DHS CMP Invoice form, to obtain reimbursement for the qualifying expenditures made using these grant funds. Reimbursement can never exceed the amount of actual *qualifying* expenditures approved for this project. If approved to participate, your facility will be required to sign a full application form and complete a separate State of Minnesota contract amendment (to your APS contract), to proceed with the project. |
| |  |  | | --- | --- | |  | Check the box to indicate that you are requesting funds to implement a facility Bingocize® program. We understand that the facility is required to pay the grant monies to Bingocize® for their equipment/services. | |

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|  | Check the box to indicate that you understand you will be required to produce documentation of actual project expenses (such as an invoice), to obtain grant funds. |

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|  | If you have questions about this application or the application requirements, please contact the Minnesota CMP Administrator at: [munna.yasiri@state.mn.us](mailto:munna.yasiri@state.mn.us) |

Signature of individual authorized to commit the facility to this project:

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Title:

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Telephone/Email (if not listed in section one of this document):

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date:

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