**CMP Project Application**

**HCI-CARES**

**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 (or previous HCI-CARES implementation) 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 (name, email)  Identify how you will determine which staff members will receive this training |
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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 staff that access various aspects of the online training.**  **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 the grant amount being requested. Facilities are required to use these funds to pay HCI-CARES directly for the training and consultation associated with implementing this program.  (Please note: Facilities must submit an invoice from HCI-CARES 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 $4,987.45 per year for three years (a total of $14,962.35), to complete this project and that you understand the facility is required to pay this entire amount to HCI-CARES for their 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)  If you have questions about the HCI-CARES program itself, please contact HCI-CARES at:  [support@hcinteractive.com](mailto:support@hcinteractive.com) or (952) 928-7722 |

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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