

APPLICATION FOR ADDITIONAL PCAP SITE(S) FOR EXISTING PCAP PROVIDERS

APPLICANT INFORMATION

1. **Name of Applicant Organization** _____
2. **Address** _____ **Phone # ()** _____

3. **National Provider Identifier (NPI)** _____
4. **Executive Director or Administrator** _____ **Phone # ()** _____
 (Name and Title)
5. **Program Contact Person** _____ **Phone # ()** _____
 (Name and Title)

6. Check types of prenatal care providers comprising your comprehensive prenatal care service system:

- Diagnostic & Treatment Center
- Hospital OPD, Satellite, etc.
- City or County Health Agency

7. Primary prenatal care will be provided by private practitioner MD and/or CNM subcontractors: _____ yes; _____ no. If yes, attach subcontract or letter of intent for each provider, including Medicaid provider number.

8. Taking into account traditional Medicaid clientele, PCAP experience and expanded program in context of local area needs and services, estimate the number of Medicaid-eligible service recipients (**with household incomes up to 200% of the federal poverty level**) expected to enroll in applicant system during calendar year _____

- 9a. Total number of PCAP sites operated by Applicant. _____
- b. Total number of new sites for which this application is being submitted. _____
 (complete Table 1 and Table 2).
- c. Is prenatal listed on the operating certificate for each new site _____ yes no _____
- d. Site where prenatal care will be provided is listed on the operating certificate _____ yes _____ no
 Attached copy of operating certificate for site where prenatal care will be provided.

Revised: 9/08

Table 1: New Prenatal Sites/Practitioner Profile

Names and Address of New PCAP Site	Days and Hours of Services	Check Types of Staff Rendering Prenatal Medical Services
		OB-GYN _____ Other MD _____ CNM _____ PA _____ NP _____
		OB-GYN _____ Other MD _____ CNM _____ PA _____ NP _____
		OB-GYN _____ Other MD _____ CNM _____ PA _____ NP _____
		OB-GYN _____ Other MD _____ CNM _____ PA _____ NP _____

Table 2: Existing Prenatal Sites/Practitioner Profile

Names and Address of Previously Approved PCAP Sites	Days and Hours of Services	Check Types of Staff Rendering Prenatal Medical Services
		OB-GYN _____ Other MD _____ CNM _____ PA _____ NP _____
		OB-GYN _____ Other MD _____ CNM _____ PA _____ NP _____
		OB-GYN _____ Other MD _____ CNM _____ PA _____ NP _____
		OB-GYN _____ Other MD _____ CNM _____ PA _____ NP _____

ATTACH ADDITIONAL SHEETS AS NECESSARY

10. **Qualified Provider/Presumptive Eligibility**

Check items below to indicate status of applicant's preparation to apply for enrollment as a Qualified Provider (QP) in order to determine Medicaid presumptive eligibility (PE) for pregnant women:

a. staff at sites have completed training in presumptive eligibility Yes No

- If yes, indicate date completed

- If no, when do you expect training to be completed?

Responsible Staff

b. Identify responsible staff who will/have complete(d) the training

c. If designated staff have completed the on-line QP training, have you submitted the QP application to SDOH?

The web address for the on-line PE training is <http://www.bsc-cdhs.org/qpt/>

A QP application may not be submitted to DOH until the on-line training is completed. The QP application may be obtained at

http://www.health.state.ny.us/health_care/medicaid/program/docs/qualified_provider.pdf

11. **HIV Counseling and Testing Onsite:** All comprehensive service providers shall have a confidential program of HIV counseling and testing for all women.

List locations for counseling and testing	Have staff received NYS training		Is program operational?	
	<u>Yes</u>	<u>No</u>	<u>Yes</u>	<u>No</u>
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

12. **Coordination of Care**

In the broadest sense (i.e. beyond the physical exam and diagnostic testing) describe the principal responsibilities and mechanisms for overall care coordination, exchange of information between the primary prenatal care provider and other providers, continued access of client to information and support for obtaining needed medical, nutritional, psychosocial, health education, drug and substance abuse services.

Describe follow-up mechanisms to ensure women receive these services. Describe criteria for home visitation. **(limit to 1 page).**

13. **Missed visits**

Application care sites have a systematic and documented procedure to contact patients who have missed visits, and to reschedule visits: ____ **Yes** ____ **No** . Attach copy of procedure.

14. **After Hours Consultation; Emergency Services**

Submit policy which describes arrangements for 24 hour availability for urgent consultation and emergency services throughout the prenatal, intrapartum and postpartum period.

15. **Nutrition Services**

For each required element of nutrition services, complete the following information:

Title of Responsible Staff

a. Individual nutrition risk assessment including screening for specific nutritional risk conditions at the initial prenatal care visit and continuing reassessment as needed. _____

b. Professional nutrition counseling, monitor and follow-up of all pregnant women at nutritional risk. _____

16. Summarize WIC arrangements:

New prenatal care site	WIC immediately onsite		If no, indicate travel time from prenatal care site	
	Yes	No	Yes	No
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

17. **Health and Childbirth Education**

Health and Childbirth Education is provided on-site: ____ **Yes** ____ **No**

Indicate staff responsibility for required elements of maternal education:

	<u>Title of Responsible Staff</u>
a. Orientation to procedures at comprehensive care site and expected site of birth including mechanisms for emergency services;	_____
b. Rights and responsibilities of the pregnant woman;	_____
c. Signs of complication of pregnancy;	_____
d. Physical activity and exercise during pregnancy;	_____
e. Avoidance of harmful practices and substance including alcohol, drugs, non-prescribed medications and nicotine;	_____
f. Sexual activity and sexuality during pregnancy;	_____
g. Occupational and environmental issues, concerns;	_____
h. Risks of HIV infection and risk reduction behaviors;	_____
i. Signs of labor;	_____
j. Labor and delivery process;	_____
k. Relaxation techniques during labor;	_____
l. Obstetrical anesthesia;	_____
m. Preparation for parenting including infant development and care; parenting skills and options for feeding; and	_____
n. Reinforcement of the need for postpartum and family planning services	_____

18. **Psychosocial Services**

a. Psychosocial assessments are routinely conducted by professional staff:

_____ **Yes** _____ **No**

b. There are in-house resources for addressing commonly identified problems:

_____ **Yes** _____ **No**

c. What are the most frequently used referral resources for social, economic, psychological, drug and substance abuse problem?

Problem Area

Referral Resources

19. **Primary Medical Services**

Care site have a written protocol covering basic requirements for initial comprehensive assessment and subsequent low-risk and high-risk visits: _____ **Yes** _____ **No**

20. Access to primary services: the average time from first patient contact to first Medical appointment is _____ weeks. If this varies substantially in a multi-site system, the most timely access is approximately _____ weeks and the greatest delay is approximately _____ weeks.

21. **Laboratory and Diagnostic Testing**

Test/Procedure	Performed On-site	Referred Off-site
Complete blood count	_____	_____
Sickle cell screen	_____	_____
Blood group and Rh determination	_____	_____
Irregular antibody screen	_____	_____
Rubella antibody titre	_____	_____
Syphilis screen	_____	_____
Gonorrhea screen	_____	_____
Pap smear	_____	_____
Urinalysis	_____	_____
Urine culture	_____	_____
Hepatitis B Surface Antigen	_____	_____
Alpha-feto protein	_____	_____
Tuberculin testing	_____	_____
Blood glucose	_____	_____
Glucose challenge test	_____	_____
Obstetrical Ultrasound	_____	_____

Because the comprehensive prenatal visit rates established for hospitals or diagnostic and treatment centers in this program include payment for laboratory and ultrasound services provided to service recipients, all applicant sites of service must have in place mechanisms which ensure that laboratory and ultrasound services provided by outside vendors are not billed directly to Medicaid by the vendor.

22. **Other Services:** Indicate arrangements for the following services:

<u>Services</u>	<u>Onsite</u>		<u>Where not on-site, indicate source of referral</u>
	<u>Yes</u>	<u>No</u>	
a. Dental	_____	_____	_____
b. Mental health & related social services	_____	_____	_____
c. Emergency room services	_____	_____	_____
d. Home care	_____	_____	_____
e. Pharmacy	_____	_____	_____
f. Transportation	_____	_____	_____

23. **Postpartum Services**

In the applicant's care system, who is responsible for the following required components of postpartum services:

<u>Activity/Service</u>	<u>Responsible Staff</u>
a. A postpartum visit scheduled not later than 8 weeks after delivery;	_____
b. For the interim between delivery and the postpartum visit, a means of contacting the provider in case postpartum questions or concerns arise;	_____
c. A specific follow-up mechanism to contact mothers to maximize postpartum visits;	_____
d. Identification of any medical, psycho-social, nutritional, alcohol treatment, drug treatment, and educational needs of the mother or infant that are not being met;	_____
e. Direction of the mother or other infant caregiver to resources available for meeting such needs and providing assistance in meeting such needs where appropriate;	_____
f. Assessment of family planning needs and provision of advice and services or referral where indicated;	_____
g. Provision of preconception counseling as appropriate and encouragement of preconception visit prior to subsequent pregnancies for women who might benefit from such visit;	_____
h. Referral of infants at risk of physical and	_____

developmental delays to the Department of Health's Infant Health Assessment Program (IHAP). Such infants shall include, but not be limited to those whose mothers or who themselves have been diagnosed as Hepatitis B and/or HIV positive; and

i. Informing the mother of the availability of expanded Medicaid eligibility for infants up to age one and making appropriate referrals to child health care providers

24. Indicate status of applicant's internal quality assurance activities with respect to criteria below and attach written description of quality assurance plan.

	<u>Yes</u>	<u>No</u>
a. A documented and filed prenatal chart audit is performed quarterly on a target number or proportion of current client records;	<input type="checkbox"/>	<input type="checkbox"/>
b. An annual written summary evaluation of all components of such audits is prepared;	<input type="checkbox"/>	<input type="checkbox"/>
c. A system for deterring patient satisfaction and for resolving patient complaints is functioning;	<input type="checkbox"/>	<input type="checkbox"/>
d. A system for developing and recommending corrective actions to resolve identified problems is present, and there is;	<input type="checkbox"/>	<input type="checkbox"/>
e. A follow-up process to assure that recommendations and plans of correction are implemented and are effective; and there are;	<input type="checkbox"/>	<input type="checkbox"/>
f. Safeguards are in effect to maintain patient confidentiality requirements	<input type="checkbox"/>	<input type="checkbox"/>

25. **Assurance**

Applicant, participating sites and perinatal care subcontractors are encompassed in submission of this application and assurances below:

- a. Applicant, care sites and primary care subcontractors shall make available to representatives of the Department of Health any medical records, other records, documentation and reports related to comprehensive prenatal care services.
- b. Applicant has made certain that the attachment checklist has been completed and that necessary documentation has been filed with applicant.
- c. The signature of an individual authorized to bind the applicant is provided below.
- d. If applicant is to secure participation of Article 28 or subcontracting entities other than applicant, letters of intent/affiliation which include the signed "Applicant Assurances" shall be included with the application, affirming the recognition and intent to comply with Part 85.40 requirements by these entities.

I, _____, for and on behalf of
(Name of Authorized Individual)

_____, signify that applicant any sites of
(Application Organization)
service agree to abide by the terms of Part 85.40, Part 86 (reimbursement) as applicable, and the requirements/representations associated with the application.

(Signature)

(Title)

(Date)