



10. Indicate the availability of Part 85.40 required services:

	<u>Onsite</u>	<u>By Referral</u>
Prenatal Clinical Visits	_____	_____
Laboratory Tests	_____	_____
Diagnostic Procedures	_____	_____
Speciality Medical Services	_____	_____
Care Coordination	_____	_____
Nutrition Services	_____	_____
Health Education	_____	_____
Psychosocial Services	_____	_____
After-hours Consultation	_____	_____
Emergency Room Care	_____	_____
Inpatient Antepartum Care	_____	_____
Delivery Facility	_____	_____
Level III Delivery Facility	_____	_____
Postpartum Care	_____	_____
Family Planning*	_____	_____
Dental Services	_____	_____
Mental Health and Related Social Services	_____	_____
Home Care	_____	_____
Pharmacy	_____	_____
Pediatric Ambulatory Services	_____	_____

11. Complete Table 1 on page 3 which summarizes information on sites and practitioners comprising the primary medical service system.

\* Title 10 NYCRR Section 753 defines family planning services to mean the planning and spacing of children by medically acceptable methods and does not include the performance of abortion.

Table 1: Prenatal Sites/Practitioner Profile

Name and address of each Article 28 prenatal service site	Days and hours of services	Check types of staff rendering prenatal medical services
		OB-GYN _____ Other MD _____ Licensed Midwife _____ PA _____ NP _____
		OB-GYN _____ Other MD _____ Licensed Midwife _____ PA _____ NP _____
		OB-GYN _____ Other MD _____ Licensed Midwife _____ PA _____ NP _____
		OB-GYN _____ Other MD _____ Licensed Midwife _____ PA _____ NP _____
		OB-GYN _____ Other MD _____ Licensed Midwife _____ PA _____ NP _____

Attach additional sheets as necessary

12. 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 a calendar year. \_\_\_\_\_

13. **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:

- |   | <u>Yes</u>               | <u>No</u>                |
|---|--------------------------|--------------------------|
| a. staff at sites have completed training in presumptive eligibility  | <input type="checkbox"/> | <input type="checkbox"/> |
| - If yes, indicate date completed   |                          |                          |
| _____   |                          |                          |
| - If no, when do you expect training to be completed?   |                          |                          |
| _____   |                          |                          |
| b. Identify responsible staff who will/have complete(d) the training  | <u>Responsible Staff</u> |                          |
|   | _____                    |                          |
|   | _____                    |                          |
| c. If designated staff have completed the on-line QP training, have you submitted the QP application to SDOH? | <input type="checkbox"/> | <input type="checkbox"/> |

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

14. **Outreach**

Provide operational plan by which applicant will engage in community outreach to identify specific high-risk groups, barriers to early prenatal care and plans to reach unserved pregnant women and reduce barriers. Show how plan will facilitate early entry, reflect linkages with community-based resources and disseminate information on available services and initial enrollment procedures. (Limit 1 page).

15. **Risk Assessment**

- |  | <u>Yes</u>               | <u>No</u>                |
|--|--------------------------|--------------------------|
| a. A standardized, written risk assessment tool is used in the care of all women. Attach copy of tool and/or standard prenatal record. | <input type="checkbox"/> | <input type="checkbox"/> |
| b. All risk factors are linked to the plan of care and documented in the medical record.   | <input type="checkbox"/> | <input type="checkbox"/> |

16. **HIV Counseling and Testing Onsite**

All comprehensive service providers shall have a confidential program of HIV counseling and testing for all women. Submit policies and procedures regarding provision of HIV pretest counseling for prenatal clients with clinical recommendation for HIV testing. All clients who are HIV tested should receive HIV posttest counseling.

**List Locations for Counseling & Testing**

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17. **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 for abnormal lab results and to ensure women receive all indicated services. Describe criteria for home visitation. **(Limit to 1 page)**.

18. **Missed Visits**

Applicant 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.

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

Describe arrangements for 24 hour availability of urgent consultation and emergency services throughout the prenatal, intrapartum and postpartum period.

20. **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. Attach copy of nutrition assessment tool.

\_\_\_\_\_

b. Professional nutrition counseling, monitoring and follow-up of all pregnant women at nutritional risk. Submit criteria for referral to Registered Dietitian or Nutritionist.

\_\_\_\_\_

List any sites where this service is not available onsite:

**Site**

**Referral Source**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

c. Who is responsible for enrolling eligible women in the supplemental Food Program for Women, Infant and Children (WIC) at the first prenatal visit? Attach description of this process.

\_\_\_\_\_

d. Summarize WIC arrangements as follows:

<u>Prenatal Care Site</u>	<u>WIC Immediately Onsite</u>		<u>If no, indicate travel time from prenatal care site</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"/>	_____

21. **Health and Childbirth Education**

Health and Childbirth Education is provided on-site \_\_\_\_ yes \_\_\_\_ no  
 Attach copy of health education checklist/tool.

Indicate staff responsibility for required elements of maternal education:

<u>Topics</u>	<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 substances 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.

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22. **Psychosocial Services**

	<u>Yes</u>	<u>No</u>	<u>Title of Responsible Staff</u>
a. Psychosocial assessments are routinely conducted by professional staff. Attach copy of psychosocial assessment tool.	<input type="checkbox"/>	<input type="checkbox"/>	
b. There are in-house resources for addressing commonly identified problems.	<input type="checkbox"/>	<input type="checkbox"/>	<hr/>
c. What are the most frequently used referral resources for social, economic, psychological, drug and substance abuse and domestic violence problems?	<input type="checkbox"/>	<input type="checkbox"/>	<hr/> <hr/>

**Problem Area**

**Referral Resources**

<hr/>	<hr/>
<hr/>	<hr/>
<hr/>	<hr/>
<hr/>	<hr/>

23. **Primary Medical Services**

Care sites have a written protocol covering basic requirements for initial comprehensive assessments and subsequent low-risk and high-risk visits \_\_\_\_ yes \_\_\_\_ no. Attach copy of protocol.

Access to primary services: the average time from first patient contact to first primary services 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.

24. **Laboratory & Diagnostic Testing**

For each required laboratory and diagnostic test listed below, indicate if performed on-site or referred off-site. Attach additional sheets for each site of care.

<u>Test/Procedure</u>	<u>Performed On-Site</u>	<u>Referred Off-Site</u>
Complete blood count	_____	_____
Hemoglobin Electrophoresis	_____	_____
Blood group and Rh determination	_____	_____
Irregular antibody screen	_____	_____
Rubella antibody titre	_____	_____
Syphilis screen	_____	_____
Gonorrhea screen	_____	_____
Chlamydia screen	_____	_____
Pap smear	_____	_____
Urinalysis	_____	_____
Urine culture	_____	_____
Hepatitis B Surface Antigen	_____	_____
Alpha-feto protein	_____	_____
Tuberculin testing (PPD)	_____	_____
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 services 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. Please attach the following items:

- a. A summary of the steps that will be taken to prevent duplicate billing.
- b. A letter developed for the purpose of informing outside vendors of billing requirements for comprehensive prenatal care service recipients.
- c. A referral form which clearly identifies your agency as the party responsible for compensating the outside vendor for services provided to comprehensive prenatal care service recipients and which does not include any Medicaid billing information which would allow direct billing to Medicaid by the vendor.

25. **Other Services**

Indicate arrangement for the following services:

<u>Services</u>	<u>On-Site</u>		<u>Where Not On-Site, Indicate Source of Referral</u>
	<u>Yes</u>	<u>No</u>	
a. Dental	<input type="checkbox"/>	<input type="checkbox"/>	_____
b. Mental Health & Related Social Services	<input type="checkbox"/>	<input type="checkbox"/>	_____
c. Emergency Room Services	<input type="checkbox"/>	<input type="checkbox"/>	_____
d. Home Care	<input type="checkbox"/>	<input type="checkbox"/>	_____
e. Pharmacy	<input type="checkbox"/>	<input type="checkbox"/>	_____
f. Transportation	<input type="checkbox"/>	<input type="checkbox"/>	_____

26. **Hospital Services**

Provide data below on arrangements with hospitals for delivery and medical/obstetrical problems:

<u>Hospital</u>	<u>Level of Perinatal Provider</u>	<u>If different from applicant agency, is written agreement in place? Attach copy of each agreement</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"/>

There continue to be hospitals (approached by applicant) which decline to serve as delivery facilities:  
 \_\_\_\_ yes \_\_\_\_ no. If yes, list non-participating hospitals:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

27. **Informed Consent**

All care sites have policy/procedure and form(s) whereby women are advised of treatment options and render informed choice regarding mode of treatment, care and technological support \_\_\_\_ yes \_\_\_\_ no

28. **Consultation by Specialists; Transfers to Obstetrician**

All care sites without qualified obstetricians must have written protocols designating:

- a. The requirements for consultation with a qualified medical specialist when indicated by specific medical conditions, and
- b. Situations which require the transfer of the primary responsibility for patient care from a primary care professional who is a general practitioner, family practice physician, physician's assistant, licensed midwife or qualified nurse practitioner to a qualified obstetrician. Attach copy of protocol.

29. **Postpartum Services**

In the applicant's care system, indicate who is responsible for the following required components of postpartum services and attach a copy of the postpartum tool:

<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, psychosocial, 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 including the Child/Teen Health Plan. \_\_\_\_\_

30. **Internal Quality Assurance**

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 determining 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 in effect to maintain patient confidentiality requirements.	<input type="checkbox"/>	<input type="checkbox"/>

31. **Assurances**

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 this 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 "Application 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)** **(Applicant Organization)**

Signify that applicant and any sites of services agree to abide by the terms of Part 85.40, Part 86 (reimbursement) as applicable, and the requirements/representations associated with this application.

Attachments

\_\_\_\_\_  
**(Signature)**

\_\_\_\_\_  
**(Title)**

\_\_\_\_\_  
**(Date)**

**Attachment Check List**

<b><u>Reference Point in Application</u></b>	<b><u>Description</u></b>	<b><u>Check If Attached</u></b>
7.	Letters of Intent for each MD and licensed midwife subcontractor	_____
9.	Brief description of service catchment area by minor civil division, zip code, primary care analysis area, etc.	_____
14.	Plan for community outreach	_____
15.	Copy of risk assessment tool and/or standard prenatal record	_____
16.	Copy of HIV Counseling and Testing Policies and Procedures	_____
17.	Description of care coordination. Criteria for home visitation.	_____
18.	Procedure for missed visits	_____
19.	Description of arrangements for 24 hour availability of urgent consultation and emergency services	_____
20.	Copy of nutrition assessment tool. Criteria for referral to RD/nutritionist. Describe WIC enrollment process	_____
21.	Copy of health education checklist	_____
22.	Copy of psychosocial assessment	_____
23.	Protocol for primary medical services including initial comprehensive assessments and subsequent low-risk and high-risk visits	_____
24.	Summary of steps that will be taken to prevent duplicate billing of laboratory and diagnostic testing	_____
	Letter informing outside vendors of billing requirements for comprehensive prenatal care service recipients	_____
26.	Copy of written agreement with each hospital used for delivery and medical/obstetrical problems	_____
28.	Copy of protocol for consultation by specialists; transfers to obstetrician	_____
29.	Copy of postpartum tool.	_____
30.	Attach description of internal quality assurance plan	_____
31.	If applying to secure participation of Article 28 or subcontracting entities other than applicant, attach letters of intent/affiliation which include the signed "Application Assurances" affirming the recognition and intent to comply with Part 85.40 requirements by these entities.	_____