ONC Regional Extension Center Preliminary Application

Instructions: Please fill in all responses in the gray cells provided. For list responses please use a comma to identify different items (e.g. Apples,Oranges,Pears) For Yes/No answers, please indicate the appropriate response by typing an "x" into the correct cell.

Applicant Organization Name:	
Applicant Organization Address:	
Applicant Contact Name:	
Applicant Contact Email:	
Applicant Contact Phone Number:	

I. Geographic Diversity, Service Area Participation and Collaboration:

1. Please provide details about your proposed service area, using the largest increments appropriate (i.e. if a proposed service area is a state, applicants do not need to include counties or zip codes)

A	Specify State (s) by 2- letter United States Postal Service (USPS) abbreviation (s)*		
B	Specify Counties		
C	Specify Metropolitan Service Area Code (if available)		
		3 Digit Code(s)	5 Digit Code(s)
D	Specify Zip Codes (three or five digit zip-code)		

2. Number of Primary Care Providers in the proposed service area

A	Please estimate the total number of primary-care providers in the proposed service area:	# PCP's	
B	Please estimate the total number of priority primary-care providers in the proposed service area	# PCP's	

3. Proposed Federal Network

A	VA Hospitals (s) in service area?	Yes	
		No	
	If yes, please specify name(s) of facilities		
B	DOD/Department Military Treatment Facility(s) in service area?	Yes	
		No	
	If yes, please specify name(s) of facilities		
C	IHS or tribal health facility(s) in service area?	Yes	
		No	
	If yes, please specify name(s) of facilities		
D	Health Center Controlled Network in service area?	Yes	
		No	
	If yes, please specify name(s) of network		

E Other federally supported practice network(s) in service area? Yes [ ] No [ ]

If yes, please specify name(s) of network [ ]

4. Health Information Exchange

A Health information exchange organization(s) in the proposed service area? Yes [ ] No [ ]

If Yes (Specify name and operational stage-- planning, pilot, or operational-- for each (e.g. HIO 1, operational, HIO 2, planning) [ ]

B Participating in state-based health information exchange activities? Yes [ ] No [ ]

If Yes (Specify name and operational stage-- planning, pilot, or operational-- for each (e.g. HIO 1, operational, HIO 2, planning) [ ]

II. Proposed Service Offerings including Proposed Center Capacity:

1. Provide estimates for the minimum number of priority primary providers and the minimum number of individual incorporated practices that would receive each service below over the two year budget period.

	Service	# of providers	# of practices
A	Group purchasing of EHR software		
B	Onsite EHR Implementation Technical Assistance		
C	Onsite Practice and Workflow Redesign		
D	Functional Interoperability and Health Information Exchange		
E	Technical Assistance's around Federal and State Privacy and Security Requirements		
F	Other services Please Define:		

III. Organizational Mission, Capability, and Experience as Reflected by Current Service Offerings:

1. Please provide the mission of your organization:

[ ]

2. Experience

Please Indicate the type of services and number of full time equivalent (FTE) employees utilized in the those services that your organization provided between July 1, 2008 and June 30, 2009. Also indicate the number of practices and providers served by those service offerings.

		Service Provided? (Yes/No)	FTEs	Service Providing Organization Name	# Practices Served	#Providers Served
A	Outreach/ communications					
B	HIT implementation					
C	Quality improvement					
D	Interfaces and information exchange					
E	Hardware and network infrastructure					
F	Other					

Please Define Other Services :

3. Stakeholder engagement and support

Please specify the stakeholder organizations that your organization had engaged in developed the proposed REC

		No	Yes (Please list organizations)
A	State Primary Care Association		
B	Health Professional Societies		
C	Health Center Controlled Networks (HCCNs)		
D	State/Local/Tribal Public Health Agency		
E	State Medicaid Director (if applicable)		
F	Health Plans		
G	Hospital Systems		
H	Community colleges		
I	Medicare Quality Improvement Organizations		
J	Other: please specify		

IV. Additional Comments:

1. Any additional clarification comments about criteria above (if necessary)

A

Preliminary applicants must detail the source of all the information provided where indicated.

**If the applicant is proposing an entire state or multiple states as a Regional Center service area, the preliminary application must include a letter signed by the Medicaid State Director (sample letter is found in the Funding Opportunity Announcement Appendix) that the applicant has been designated as an adoption entity for the entire state.*