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| Participant Intake Form | | |
| Date: | | |
| KHIE Outreach Coordinator: | | |
| General Information | | |
| Organization Name: |  | **Organization Type:**  **Hospital**  **Physician Office or Clinic**   * **Practice Specialty \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**   **Behavioral Health**  **Pharmacy**  **Health Department**  **Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| Group or Facility NPI number: |  |
| Business Legal Name: |  |
| Main office phone number: |  |
| Address : | |
| Primary Contact Name & Title: | | **Phone Number:**  **Email:** |
| Secondary Contact Name & Title: | | **Phone Number:**  **Email:** |
| Participation Agreement Contact Name & Title:  *Who will be responsible for signing the KHIE legal agreement?* | | **Phone Number:**  **Email:** |
| Privacy Official Contact Name & Title:  *Who will manage HIPAA in your office? KHIE will contact If there is an identified need.* | | **Phone Number:**  **Email:** |
| MPI Contact Name & Title:  *Who will be responsible for entering patient demographics into your EMR/EHR?* | | **Phone number:**  **Email :** |
| Organization Admin for Training/Clinical Lead Contact Name & Title:  *Who will oversee the KHIE implementation in your organization?* | | **Phone Number:**  **Email:** |
| Event Notifications Admin Contact Name & Title:  *Who will manage the receipt of event notifications from KHIE?* | | **Phone Number:**  **Email:** |
| Direct Trusted Agent Contact Name & Title:  *Who will serve as the Direct Trusted Agent?  This person will be responsible for identity proofing your organization’s users of CareAlign Direct Secure Messaging (DSM portal).* *(A direct trusted agent must be appointed for each organization that wishes to receive DSM.)* | | **Phone number:**  **Email:** |

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| Additional Locations or Points of Care |

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| Location Name, Address, & Phone # | Providers | NPI # |
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| **EMR/EHR Data** | | |
| **Please specify the name of your EMR/EHR Vendor, specific product name, and/or the name of a third-party with whom you work.** | Click or tap here to enter text. | |
| **Is your EMR/EHR 2014 or 2015 CEHRT? If not, when will you upgrade?** | Click or tap here to enter text. | |
| **EMR/EHR Vendor Representative Contact Name, Title, Email Address, & Phone Number:** | Click or tap here to enter text. | |
| **Pharmacy Information Management System** | | |
| **Please specify the name of your Pharmacy Management System and list the name of any third party vendor that tracks your immunizations.** | | Click or tap here to enter text. |
| **IT Resources** | | |
| **Do you have in-house technical resources or do you outsource?** | Click or tap here to enter text. | |

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| Additional Information about your Practice |
| Is this practice a federally qualified Healthcare Center (FQHC) or a rural health clinic (RHC)?  Click or tap here to enter text. |
| Does your practice give immunizations?  Click or tap here to enter text. |
| Does your practice participate in the Vaccines for Children program?  Click or tap here to enter text. |
| Is your practice a 42 CFR Part 2 Program?  Click or tap here to enter text. |
| Does this practice participate in an ACO or PCMH? If so, please identify.  Click or tap here to enter text. |
| Which practices or hospitals in your medical trading area would you benefit from if they were connected to KHIE?  Click or tap here to enter text. |

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| **Status of Promoting Interoperability and Quality Payment Programs** | |
| **Do you participate in Promoting Interoperability? If yes, what is your current status?** | Click or tap here to enter text. |
| **If applicable, which Quality Payment Program are you following: MIPs or APM?** | Click or tap here to enter text. |
| **Do you want to participate in a Public Health measure? Check all that apply.**  **(1) immunization data**  **(2) query immunization registry**  **(3) syndromic surveillance data**  **(4) cancer data**  **(5) laboratory data**  **(6) other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | Click or tap here to enter text. |
| **Are you working with any consultants to help meet these program requirements? If yes, please specify.**  **(Ex: REC, QIO, Vendor support)** | Click or tap here to enter text. |

Revised: 03-20-2020