**Kentucky Health Information Exchange**

**Provider Assistance Program**

In collaboration with the Department for Medicaid Services (DMS) and Centers for Medicare & Medicaid Services (CMS), the Kentucky Health Information Exchange (KHIE) is offering Pharmacies, Eligible Providers (EPs), Eligible Hospitals (EHs) and Critical Access Hospitals (CAHs) the opportunity to apply for an incentive to offset the vendor fees associated with connecting to KHIE.

The Provider Assistance Program was created to help Pharmacies, EPs, EHs and CAHs to mitigate the challenges associated with interoperability. Our objective is to relieve a degree of the financial burden a healthcare facility experiences, which hinders engagement in Public Health and Clinical Data Registry reporting, as well as Health Information Exchange.

Applicants are required to be located and/or providing services in the Commonwealth of Kentucky and considered an EP, EH or CAH (as defined by CMS) or a licensed pharmacy. If approved, EHs and CAHs may be awarded up to $15,000 and Pharmacies and EPs may be awarded up to $8,000. Incentives will be awarded on a first come first serve basis until all funds are depleted. Incomplete applications will not be considered and only one incentive opportunity will be awarded per business entity.

If interested, please complete the Provider Assistance Program Application in its entirety and email it to Brandi Genoe at **Brandi.Genoe@ky.gov** with the subject line**: <Insert your Facility Name>: Application for the Provider Assistance Program**. Applications will considered through June 30, 2021, and should include all supporting documentation required.

 Revised: 2/8/21

**Provider Assistance Program Application**

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| **Legal Business Name:**Click here to enter text.

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|  **Applicant Business or Point of Care**  *(if different from above)* Click here to enter text. |
|  Address: Click here to enter text.  Email Address: Click here to enter text. | Phone: Click here to enter text.FAX: Click here to enter text. |

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| **Kentucky Tax ID #** Click here to enter text. | EHR Vendor: Click here to enter text.Product: Click here to enter text. Version: Click here to enter text. |
| **Federal Tax ID #** Click here to enter text. | NPI # Click here to enter text. |
| Project Lead: Click here to enter text. |
| Email Address: Click here to enter text. Phone: Click here to enter text.FAX: Click here to enter text.  |
| **Technical Lead:** Click here to enter text. |
| Email Address: Click here to enter text. Phone: Click here to enter text.FAX: Click here to enter text. |
| **Privacy Officer:** Click here to enter text. |
| Email Address: Click here to enter text. Phone: Click here to enter text.FAX: Click here to enter text. |
| **Budget Officer:** Click here to enter text. |
| Email Address: Click here to enter text. Phone: Click here to enter text.FAX: Click here to enter text. |
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| **Applicant is a(n):** [ ]  Eligible Hospital | Number of Beds: Click or tap here to enter text.[ ]  Critical Access Hospital | Number of Beds: Click or tap here to enter text.[ ]  Eligible Provider [ ]  Pharmacy [ ]  Other Healthcare Organization (please specify): Click here to enter text.

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| **Does your organization have a current Participation Agreement with KHIE?**  [ ]  **YES** [ ]  **NO** |
| **Does your organization currently have an interface with KHIE?** [ ]  **YES** [ ]  **NO** |
| **Does your organization currently have an EHR with a 2015 CEHRT?** [ ]  **YES** [ ]  **NO** |

**Does the U.S. Department of Health and Human Services deem the geographic area one of the following:** **Health Professional Shortage Area (HPSA)** [ ]  **YES** [ ]  **NO** **High Intensity Drug Trafficking Area (HIDTA)** [ ]  **YES** [ ]  **NO** |
| **Projected Budget:****Estimated Project Cost:** Click here to enter text.**Estimated Facility Contribution:** Click here to enter text.**Requested Provider Assistance Program Incentive Contribution:**  Click here to enter text. |
| **Primary Focus Area(s): *Please select all that apply***[ ]  New Interface with KHIE[ ]  Upgrade Technology[ ]  Other (please specify): Click here to enter text. |

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| **Project Connectivity Goals. Please Select all that Apply.**[ ]  **Immunization Registry Reporting (VXU)** [ ]  **Bidirectional Immunization Registry Reporting (QBP)** [ ]  **Electronic Lab Reporting**[ ]  **Kentucky Cancer Registry Reporting** [ ]  **KHIE’s Platinum Service (XDS.b)**[ ]  **KHIE’s Platinum Service (XCA)** [ ]  **Syndromic Surveillance Reporting**[ ]  **Other:** Click here to enter text. |
| **Statement of Need:** *Please provide any information that you wish to be considered in review of your application* Click here to enter text. |
| I certify that the information contained herein is true and accurate to the best of my knowledge and I have the authority to submit this application on behalf of the applicant.   Signature / Title Date |

**Statement of Commitment**

By submitting the Provider Assistance Program application, [**LEGAL BUSINESS NAME**] agrees to participate in the Kentucky Health Information Exchange’s Provider Assistance Program through September 2026 and commit to meet the following criteria:

1. Utilize the awarded incentive in its entirety from January 1, 2020 through June 30, 2022. Unused awarded incentive monies must be returned to KHIE by July 31, 2022.
2. Provide a detailed expenditure report indicating how the awarded funds were utilized by June 30, 2022.
3. Complete a post-project evaluation.
4. Maintain the established connectivity to KHIE for a minimum of five (5) years.
5. Provide a written testimonial of project success by June 30, 2022.

Printed Name/Title Date

Signature