Participant Eligibility Form

Please complete a form for each location.

Facility/Affiliation Name: ____________________
Address: ____________________
Mailing Address: ____________________
City: ____________________ State: __________ Zip: __________
Phone: (   )   -   Fax: (   )   -
Website: ____________________

☐ For Profit ☐ Not for Profit NYS DOH Operating Certificate # (If Applicable): ____________________

Tax ID #____________________ National Provider ID (NPI): ____________________

Organization Taxonomy Code: ____________________ Site Taxonomy Code: ____________________

Primary Contact:
Name: ____________________ Title: ____________________
Phone: (   )   -   Fax: (   )   -   Email: ____________________

IT Contact:
Name: ____________________ Title: ____________________
Phone: (   )   -   Fax: (   )   -   Email: ____________________

Accounts Payable Contact:
Name: ____________________ Title: ____________________
Phone: (   )   -   Fax: (   )   -   Email: ____________________

What type of facility? (Check all that apply)

☐ Hospital Number of Beds ________ Is this a Critical Access Hospital ☐Yes ☐No ☐ Federally Qualified Health Center
☐ Tribal Clinic ☐ Community Health Center/Clinic ☐ Mental Health
☐ Non-Profit Healthcare Provider (i.e. Physician Practice) ☐ Inpatient (________ %)
☐ Other (Please Describe Here) ____________________ ☐ Outpatient (________ %)

Description of Services:
____
____

Does your organization currently have an EMR/EHR System? ☐Yes ☐No
If No, do you plan to implement a system in the near future? ☐Yes ☐No

Does your organization currently have any Telemedicine programs? ☐Yes ☐No
If No, do you plan to implement any Telemedicine programs in the near future? ☐Yes ☐No

BELOW SECTION INTERNAL USE ONLY

RUCA: __________ CENSUS TRACT: ____________ STATE CODE: ____________ COUNTY CODE: ____________

Eligible for Subsidy? ☐ YES ☐ NO HCP Number: ____________________