

NEW YORK STATE DEPARTMENT OF HEALTH

APPLICATION TO PROVIDE HEALTH SUPPORTIVE SERVICES IN THE
MEDICAID OBSTETRICAL AND MATERNAL SERVICES PROGRAM (MOMS)

APPLICATION INFORMATION

1. Name of Applicant or Applicant Organization _____

2. Address _____

Phone () _____ Extension _____
3. National Provider Identifier (NPI) _____
4. Executive Director _____
- or Administrator Title: _____
Phone () _____ Extension _____
5. Program Contact Person _____
Title: _____
Phone () _____ Extension _____
6. Check types of prenatal care program comprising MOMS Health Supportive Service system:
- | | |
|--|--|
| <input type="checkbox"/> Diagnostic & Treatment Center | <input type="checkbox"/> Article 36 Certified Home Health Services |
| <input type="checkbox"/> Hospital OPD, Satellite, etc. | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> City or County Health Agency | |
7. Attach brief description of applicant's service catchment area by zip code, primary care analysis area or combination of same.

Revised: 9/08

8. Complete the table below describing the service system (attach additional sheets as needed):

MOMS Health Supportive Service Sites

Name/Address of Each Site	Days/Hours of Service	Type of Professional Staff Available

9. **Linkage with Practitioners**

a) Attach a one-page description of application linkage with private practitioners. Include names, practice locations and status of program discussion/agreement with private practice physicians/midwives/nurse practitioners who you believe may be linking with applicant (as MOMS providers). Attach referral form.

b) Are practitioners salaried by your facility ____ yes ____ no. If yes, are practitioners able to bill the Medicaid program separately for prenatal care services?

10. **Enrollment Projection**

Estimate the number of Medicaid-eligible service recipients (with household incomes up to 200% of the federal poverty level) expected to receive MOMS health supportive services during projected 12-month period _____.

11. **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

Responsible Staff

c. If designated staff have completed the on-line QP training, have you submitted the QP application to SDOH?

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

12. **Outreach**

Identify specific high-risk and underserved groups and barriers to early prenatal care. Provide operational plan to set outreach priorities and conduct a meaningful outreach program. Show how plan will bring about early entry, link with community-based resources and disseminate information on available services and initial enrollment procedures.

13. **HIV Counseling and Testing On-site**

MOMS Health Supportive providers shall have a confidential program of HIV counseling and testing for all women. (Reimbursement for these services is covered by a separate schedule for HIV services). 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.

14. **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 early in prenatal care 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.
- c. Who is responsible for enrolling eligible women in the Supplemental Food Program for Women, Infants and Children (WIC) early in prenatal care? Attach description of this process.
- d. Summarize WIC arrangements (attach extra sheet as needed)

MOMS Health Supportive Services Site	WIC Immediately On-site	
	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	<input type="checkbox"/> Yes	<input type="checkbox"/> No

15. **Psychosocial Services**

Title(s) of Responsible Staff

-
- a. Psychosocial assessments are routinely conducted by professional staff: ___ yes ___ no
Attach copy of tool.
 - b. There are in-house resources for addressing commonly identified problems: ___ yes ___ no
 - c. What are the most frequently used referral resources for social, economic, psychosocial, domestic violence, drug and substance abuse problems?

Program Area	Referral Resources

16. **Health and Childbirth Education**

Indicate staff responsible for required elements of maternal education (as coordinated with practitioners and appropriate for supportive services): Attach copy of health education checklist/tool.

<u>Topic</u>	<u>Title of Responsible Staff</u>
a. Orientation to program	_____
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. Sign of labor	_____
j. Labor and delivery process	_____
k. Relaxation techniques during labor	_____
l. Preparation for parenting including infant development and care; parenting skills and options for feeding	_____
m. Reinforcement of the need for postpartum and family planning services, with ongoing infant health care	_____

17. **Coordination of Care**

Describe on one page the principal responsibilities and mechanisms for 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, WIC, daycare, psychosocial, health education, drug and substance abuse services. Describe follow-up mechanisms to ensure women receive these services.

18. **Missed Visits**

Applicant care sites must have a procedure to contact patients who have missed visits, and to reschedule visits. Attach copy of procedure indicating steps to be taken, staff responsibilities and documentation.

19. **Transportation**

Attach a brief review of transportation needs, MA authorization practices and applicant agency role/resources for assisting clients with prenatal transport to prenatal/postpartum care.

20. **Postpartum Services**

List titles of responsible staff. Attach a copy of the postpartum tool.

Responsible Staff

- | | |
|--|--|
| a. For the interim between delivery and the postpartum visit, a means of contacting the provider in case postpartum questions or concerns arise | |
| b. A specific follow-up mechanism to contact mothers to maximize attendance at postpartum visits | |
| c. Identification of any medical, psychosocial, nutritional, alcohol treatment, drug treatment, and educational needs of the mother or infant that are not being met | |
| d. Direction of the mother or other infant caregiver to resources available for meeting such needs where appropriate | |
| e. Assessment of family planning needs and provision of advice or referral where indicated | |
| f. Provision of inter-conception counseling as appropriate and encourage of interconception visit prior to subsequent pregnancies for women who might benefit from such visit | |
| g. Referral of infants at risk of physical and developmental delays to the Department of Health's Infant Child Health Assessment Program (ICHAP) | |
| h. Informing the mother of the continued availability of expanded Medicaid eligibility for infants up to age one and making appropriate referrals to child health care providers | |

21. **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 client record audit is performed quarterly on a target number or proportion of current clients records. | ___ | ___ |
| b. An annual written summary evaluation of all components of such audits is prepared | ___ | ___ |
| c. A system for determining patient satisfaction and for resolving patient complaints is functioning | ___ | ___ |
| d. A follow-up process to assure that recommendations and plans of corrections are implemented and are effective | ___ | ___ |
| e. Safeguards are in effect to maintain patient confidentiality requirements | ___ | ___ |

22. **Applicant Assurances and Signature**

In submission of this application, the applicant represents and agrees that:

- a. Applicant and applicant's services sites will make all records, reports and requested program and fiscal information available to Department of Health representatives
- b. Applicant will operate in accordance with initial (interim or proposed) and ongoing program and reimbursement standards.
- c. Filing of application followed by subsequent letter of acceptance from Department of Health constitutes provider agreement for MOMS Health Supportive Services.
- d. Applicant has reviewed "Application checklist" and included required attachment as follows:

<u>Application Question #</u>	<u>Description</u>	<u>Applicant Check if Attached</u>
7	Service Area	_____
9	Linkage with private practitioners; referral form	_____
12	Outreach Plan	_____
13	HIV Counseling & Testing Policies and Procedures	_____
14(a)	Nutrition Tool	_____
14(c)	Description of WIC Enrollment	_____
15(a)	Psychosocial Tool	_____
16	Health Education List	_____
17	Coordination of Care	_____
18	Missed Visits	_____
19	Transportation	_____
20	Postpartum Tool	_____
21	Internal Quality Assurance Plan	_____

- e. The signature of an individual to bind the applicant is provided below:

I, _____, for and behalf of _____
(Name of Authorized Individual) **(Applicant Organization)**

signify that applicant and any sites of services agree to abide by the program requirements associated with this application for MOMS Health Supportive Services.

Signature

Title

Date