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| Collective Medical Discovery Form |  |  |  |

This ‘Discovery’ form is intended to collect important information about your organization as well as confirm key contact information so the Collective Medical team can better understand your organization and provide assistance in the future.

Your Information

|  |  |  |  |
| --- | --- | --- | --- |
| Name: | [ your full name ] | Title: | [ your title ] |
| Email: | [ your email address ] | Phone: | [ your phone ] |
| How did you learn about Collective Medical?: [ answer ] |

 Who is sponsoring your organization?: [ answer ]

Organization Information

|  |  |  |  |
| --- | --- | --- | --- |
| Organization Name: | [ your organization ] | Organization NPI: | [ your organization’s NPI ] |
| DBA / Preferred Name: | [ DBA or preferred name ] | NPI Taxonomy Description: | [ NPI taxonomy ] |
| Address 1: [ address 1 ] |  | Address 2: | [ address 2 ] |
| City: [ city ] |  | State: | [ state ] |
| Zip Code: [zip code] |  | Email (optional): | [ general email address ] |
| Phone: [phone] |  | Website (optional): | [ organization’s website ] |
|  |  |  |  |
| 1. What Health Plan (or ACO) is sponsoring your implementation on the Collective Platform? [ organization]

Who is your contact at the Health Plan (or ACO)? (If no sponsor reject)

|  |  |  |  |
| --- | --- | --- | --- |
| Name: | [ name ] | Title: | [ title ] |
| Email: | [ email address ] | Phone: | [ phone ] |

1. Does your organization have multiple locations?:[ ]  **YES /** [ ]  **NO**
 |
| If yes, provide names and locations: [ answer ] |
| 1. Is your organization affiliated with any other organizations?:[ ]  **YES /** [ ]  **NO**
 |
| If yes, provide details: [ answer ] |

Contact Information

|  |  |  |  |
| --- | --- | --- | --- |
| **Primary Contact:** |  |  |  |
| Name: | [ name ] | Title: | [ title ] |
| Email: | [ email address ] | Phone: | [ phone ] |
| **Clinical Contact:** |  |  |  |
| Name: | [ name ] | Title: | [ title ] |
| Email: | [ email address ] | Phone: | [ phone ] |
|  |  |  |  |
| **IT Contact:** |  |  |  |
| Name: | [ name ] | Title: | [ title ] |
| Email: | [ email address ] | Phone: | [ phone ] |
| **Account Managers** |  |  |  |
| Name: | [ name ] | Title: | [ title ] |
| Email: | [ email address ] | Phone: | [ phone ] |
|  |  |  |  |
| Name: | [ name ] | Title: | [ title ] |
| Email: | [ email address ] | Phone: | [ phone ] |

Patient Services, Personnel, & Program Information

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| --- |
| 1. Does your organization have a direct healthcare relationship with a patient population?
 |
| 1. Please provide a brief description of patient services provided by your organization:

 [ answer ]1. How would you classify the ‘Primary’ entity type of your organization? (e.g. PCP, FQHC, SNF etc.): [ answer ]
 |
| 1. Are any of your providers or patient services protected under 42 CFR Part 2 (e.g., substance abuse treatment, etc.): [ answer ]
2. Are all staff or personnel employed directly by your organization?:[ ]  **YES /** [ ]  **NO**

 If no, please explain: [ answer ] |
| 1. Does your organization have staff who participate in case management or utilization review?: [ ]  **YES /** [ ]  **NO**
 |
| 1. Does your organization participate in any national, state, or other incentive or innovation programs? (e.g., CPC+, ED reduction grants, chronic condition management, etc.):[ ]  **YES /** [ ]  **NO**

 If yes, please describe the program(s): [ answer ]1. What Health Plans (or ACO) is your organization a contracted provider for? (Note: this information will only be used internally to identify network subscription): [ answer ]
2. Are you fully capitated, or receive capitated payments, for any population of patients under your organization's care?

 [ answer ] |
|  |

Technical Information

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| --- |
| 1. Does your organization have IT resources available?:[ ]  **YES /** [ ]  **NO**
 |
| 1. Are the IT resources provided by an outside or contracted party?:[ ]  **YES /** [ ]  **NO**
 |
| 1. Collective requires a ‘Patient File’ to be provided to Collective Medical on a regular interval (.e.g, daily, weekly, or monthly). This file includes basic patient demographic information (Name, DOB, Address, Phone, etc.). Would your organization be able to meet this requirement and provide an updated patient file on a regular interval?:[ ]  **YES /** [ ]  **NO**
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Additional Information

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| --- |
| Is there any other information you feel would be beneficial to provide at this time?: [ answer ] |
| Collective Medical reviews your responses to ensure you have Operational and IT resources to support your staff in using The Collective Platform. We may follow up with additional questions, based on the answers you provide. |