Partnership HealthPlan of California

Application to be a Contracted Outpatient Palliative Care Provider

Please submit the following to contracting@partnershiphp.org

Organization Information

1. **Name of Organization**

2. **Contact Information:**
   Administrative Contact of Parent Organization (if applicable)
   Name

   Title

   Phone

   e-mail

   Billing Department
   Name

   Title

   Phone

   e-mail

   Palliative Care Program Director

   Name

   Title

   Phone

   e-mail

   Palliative Care Medical Director
   Name

   Title

   Phone

   e-mail

3. Does your organization currently contract with Partnership HealthPlan of California?

   Yes ☐ No ☐

4. Medi-Cal provider number:

Palliative Care Program Description

5. Describe any palliative care services *currently provided* by your organization. Include current volume of services, the service delivery model, outcomes and the criteria for enrollment.

6. Number of patients enrolled annually in your organization's palliative care program (if applicable)

   Medicare:

   Medi-Medi:

   Medi-Cal only:

   Uninsured:

   Total:

   Not applicable ☐

7. Number of patients enrolled annually in your organization's ☐ hospice or ☐ home care program (if applicable)

   Medicare:

   Medi-Medi:

   Medi-Cal only:

   Uninsured:

   Total:

   Not applicable ☐

8. Does your organization provide palliative care services to children? ☐ Yes ☐ No
   If Yes, please describe level of experience and training in pediatric palliative care:

Program Information

9. What strategies will your organization use to identify patients who may be eligible and interested in community-based palliative care?

10. What geographic areas will your palliative care program serve?

11. Describe how your organization will partner with local hospice agency(s) and/or home health agencies.

12. Provide a narrative outlining:
(1) Staff disciplines and FTE your organization will use to provide 24/7 telephonic care (with access to a nurse), assessments, pain/symptom management, advance care planning, POLST, acute management plan, assess caregiver support, transition support, case management and medical oversight? If your organization will contract for some of these services, please describe the contractual arrangements. Include description of current and planned training and/or certification in palliative care.

13. How will your palliative care program be distinct from chronic disease case management and hospice programs? How will this distinction be communicated to providers and patients?

14. Attachments:

    a. C.V. of Medical Director of program
    b. Letter of commitment from applicant's parent organization or major funder of a new organization not affiliated with a larger corporate sponsor
    c. Letters of support from major expected referral sources (hospitals, health centers, at least one oncologist, at least one other specialist from this group: gastroenterology, pulmonology, cardiology)
    d. If organization is not a hospice organization, a letter or memorandum of understanding with local hospice organizations who can accept patients who need hospice care.
    e. Annual Audited Financial Statements