NORTH COUNTRY INITIATIVE

Provider Incentive Program Application

APPLICANT INFORMATION				
Applicant Name:				
Applicant Address:				
City:		State:	ZIP Code:	
Applicant Phone:		Applicant E-mail:		
Applicant Type:	☐ Hospital		☐ Independent Physician Practice	
	☐ Hospital Based Clinic		☐ Federally Qualified Health Center	
	☐ Group Medical Practice		☐ Dental Office	
	☐ NYS OMH Facility			
Provider Name:				
Site Location of Provider (facility where provider will be practicing):				
NYS DOH/OMH Operating Certificate Number:				

PROVIDER TYPE (*Check all that apply)*	
☐	1. Primary Care Provider (Internal Medicine or Family Practice)
☐	2. Nurse Practitioner
☐	3. Physician Assistant
☐	4. Dentist
☐	5. Psychiatrist
☐	6. Psychologist
☐	7. Certified Diabetes Educator

PRACTICE SUPPORT OPTIONS (*Check all that apply)*		
		Total Amount Requested for Duration of Contract
☐	1. Signing Bonus (up to $50,000 dependent on discipline)	
☐	2. Retention Bonus (up to $50,000 dependent on discipline)	
☐	3. Relocation Expense (up to $15,000 on basis of receipts)	
☐	4. Salary Guarantee (national benchmark 50th to 70th percentile)	
☐	5. Education Loan Repayment (up to $20,000/year)	

☐	6. Support Stipend During Final Years of Residency of Fellowship Training (up to $1,000/month)	
☐	7. Immigration Support (up to $25,000 over duration of contract)	
☐	8. Continuing Education Savings Account (up to $15,000 over duration of contract)	
☐	9. Incurred Employer Recruitment Expenses (up to $25,000 with receipts & proof of hire based on program eligibility criteria)	
☐	10. Innovation	
	TOTAL REQUESTED	0

JUSTIFICATION OF NEED
In 500 words or less, please provide justification for your application with reference to regional or facility specific need (i.e. geographic need, professional shortage area, social disparities, capacity challenges, etc.)

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SUCCESSION/SUSTAINABILITY PLAN PROPOSAL

In 500 words or less, please provide your succession/sustainability plan beyond DSRIP Year 5 (March 2020).

TOTAL MEDICAID POPULATION BEING SERVED *Please describe the provider's total Medicaid population to be/being served, and/or the provider's commitment and ability to serve the Medicaid population at a rate of at least 35% of their total patient panel.*	
SIGNATURE & ATTESTATION	
Provide the name, title and signature of the individual authorized to attest to the accuracy and potential audit of the information in this application and to bind the practice to any memorandum of agreement resulting from this application. *By signing below, I attest that the contractual agreement with the provider will incorporate all applicable eligibility criteria as outlined in this program.*	
Name:	
Title:	
Signature:	Date: