ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM AMERICAN INDIAN MEDICAL HOME REGISTRATION FORM

I. PROVIDER INFORMATION	☐ **INITIAL APPLICATION**	☐ **ANNUAL RENEWAL**
AHCCCS Provider ID:	Provider Name:	TIN:
Service Address:		
City:	State: AZ	ZIP Code:

II. PROVIDE A FINANCIAL POINT OF CONTACT	
Name:	
Phone:	Email:

III. PROVIDE A POINT OF CONTACT FOR MAIL CORRESPONDENCE AND QUESTIONS REGARDING YOUR APPLICATION	
Name:	
Phone:	Email:

IV. PLACE AN "X" ON THE REQUESTED SERVICE LEVEL TIER OF YOUR MEDICAL HOME

Documentation that supports an accredited Diabetes Education Program and/or Proof of enrollment in the HIE, as applicable, must be included with your application packet.

_____	**Tier Level 1** – Primary Care Case Management services and 24 hour telephonic access to the care team.
_____	**Tier Level 2** – All services described in the first level and diabetes education. This level will require an AIMH to have proof of a diabetes education accreditation through a recognized accreditation agency.
_____	**Tier Level 3** – All the services described in the first level and proof of participation in the Arizona State Health Information Exchange (HIE). A bi-directional relationship with the HIE is required.
_____	**Tier Level 4** – All services described in the first three levels above.

For more information on the PMPM payment level rates, please click on the link below and select the 'Information for Medical Home Providers' tab - https://www.azahcccs.gov/AmericanIndians/AmericanIndianMedicalHome/

V. PROVIDE THE 24 HOUR CARE MANAGEMENT TELEPHONE NUMBER ACCESS TO THE CARE TEAM

Please provide your 24 hour Care Management Telephone Access line number: _____

VI. PLACE AN "X" ON THE APPROPRIATE PRIMARY CARE CASE MANAGEMENT (PCCM) QUALIFICATION

Proof of accreditation or attestation that supports the PCCM qualification must be included with your application packet

_____	Patient Centered Medical Home recognition through an appropriate accreditation body
_____	IHS IPC Patient Medical Home annual attestation

VII. SIGNATURE

I agree that submission of this application does not guarantee the applicant's acceptance into the American Indian Medical Home ("AIMH") program. If accepted into the AIMH program, I agree that this application packet and the affirmations made therein will be incorporated into the Intergovernmental Agreement (IGA). I further agree that participation in the AIMH program does not diminish or replace any obligations of the applicant under any Provider Participation and/or Group Biller Agreement(s) between the applicant and AHCCCS. I affirm that I have the authority to submit this application packet and bind the applicant to the obligations created by participation in the AIMH program. I affirm under penalty of law that the information I have provided in the application packet (including this form) is true, accurate and complete to the best of my knowledge.

Signature of Applicant:	Application Date:

_____ I have included a current IRS Form W-9 with my application packet. You may find the IRS Form W-9 at this link: IRS Form W-9

_____ I have included my DFSM AIMH (EDI) Checklist.

_____ I have included a signed and dated copy of my Intergovernmental Agreement (IGA).

_____ I have included evidence of participation in an accredited Diabetes Education Program, if applicable.

_____ I have included evidence of bi-directional participation with the Health Information Exchange (HIE), if applicable.

_____ I have included evidence of the Patient Centered Medical Home recognition or the IHS IPC Patient Medical Home annual attestation.

ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM - AMERICAN INDIAN MEDICAL HOME REGISTRATION FORM INSTRUCTIONS

Please provide the following information in the corresponding application sections:

I. Provider Information:

Please select if this is an initial application or a renewal.

(Please note that for a renewal application, it is not necessary to complete and submit a new IRS Form W-9, EDI Checklist, or IGA agreement unless the initial information submitted has changed.)

Please provide your 6 digit AHCCCS Provider ID Number, Provider Name, Taxpayer ID Number (TIN), Service Address, City, and Zip Code as indicated.

(Please note that the Service Address is where correspondence such as notifications of new member assignment to your medical home will be sent.)

II. Please provide a Finance Point of Contact for correspondence with the AHCCCS Division of Business and Finance.

III. Please provide a Contact for mail correspondence and any questions that the AHCCCS Division of Fee-For-Service Management may have regarding your application materials.

IV. Please place an “X” next to the Tier Level that you are requesting. For Diabetes Education, please include evidence that your facility provides an accredited Diabetes Education Program. For the Health Information Exchange (HIE), please provide evidence that your facility is participating in the HIE. A Bi-directional relationship with the HIE is required. This means that your facility has to be able to upload and share information as well as view the available information found on the HIE. Please include proof of this relationship with the HIE as part of your application.

V. Please provide your 24 hour Care Management Telephone Access line number. This will be a line that an AHCCCS American Indian Health Program Member has access to in order to contact their care team. The 24 hour Care Management Telephone Access line should be answered by an individual with sufficient medical expertise to direct an AHCCCS American Indian Health Program Member to emergency services or to a medical professional who can address their needs.

VI. Please place an “X” next to the appropriate Primary Care Case Management (PCCM) qualification category. Include documentation of Patient Centered Medical Home recognition through an accredited body or a copy of your Indian Health Services (IHS) Improving Patient Care (IPC) annual attestation.

VII. Please review and sign the American Indian Medical Home application; be sure to include all application documents and a copy of the signed and dated Intergovernmental Agreement (IGA).