



Medical Society *of* Delaware

## Primary Care Investment Initiative (PCII) Grant Application

Practice Name :			
Federal Tax ID Number (TIN):		County:	
Primary Office Location:		Total number of office locations:	
Office Phone #	Office Fax #		
Point of contact for application:	Email address:		Phone:
Number of Providers in the practice:			
Physician PCPs:      NPs:      PAs:      Other:			
<p>Please list the names of all <b>Physician Providers</b> within the practice or attach a separate sheet:          ( Each Physician must be a full active member of MSD )</p> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/>			
<b>Please check off one or more areas that best describes what you intend to use the grant funds:</b>			
<input type="checkbox"/> Staffing (clinical staff support, care coordination, social worker, drug/alcohol counseling, community health worker, quality improvement, data support, and information technology staff). Please describe: <hr/> <hr/>			
<input type="checkbox"/> Information Technology (upgrades to EMR system to support report creation, population health, telehealth implementation, other). Please describe: <hr/> <hr/>			
<input type="checkbox"/> Service Deployment (co-located or integrated behavioral health, holistic and/or enabling supports). Please describe : <hr/> <hr/>			

Minor Alterations to Repurpose or expand office space Please describe: \_\_\_\_\_

Other Please describe: \_\_\_\_\_

**Amount of Grant Dollars Requested:**

**(up to \$25, 000)**

Based upon your selection(s) above, please provide a detailed overview of how you intend to use the grant funding and how it will better prepare your practice in value-based care:

(you may add additional pages if necessary)

There may be additional funding for primary care practices that would help secure a professional grant writer. The grant writer can assist your practice in applying for State or Federal grants that may provide additional financial support to practices. If you are interested in learning more about this, please CIRCLE YES. If you were assigned a grant writer at no charge, are there other areas within your practice that you wish to improve upon that would require additional financial assistance: (describe)

If grant funds are awarded to your practice, you must provide proof/documentation that supports how the funds were used.

- Are you prepared to provide this required documentation to MSD? Yes / No / Other (Circle one)
- Will your practice be willing to provide a testimonial about how your practice utilized these funds and how it helped your practice? Yes / No (Circle one)

*(Practices that are approved for the grant will be required to sign a separate agreement that outlines the attestation protocols and documentation needed for release of grant funds).*

*I agree that the above information is true to the best of my knowledge:*

Signed:

Printed Name:	Date:
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**For Office Use Only:**

Application Received Date:	By:	Status:
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Grant Amount Awarded:	Date Notified:	Funds Release Date:
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