



**APPLICANT INFORMATION:**

<b>Name of Organization:</b> <i>(Include the full name of the legal entity)</i>	
<b>Physical Address:</b> <i>(Street, Suite No., City, State, Zip Code)</i>	
<b>Mailing Address:</b> <i>(Street, Suite No., City, State, Zip Code) If different than Physical Address</i>	
<b>Phone Number:</b>	
<b>Legal Status:</b> <i>(For Profit or Non-Profit Entity)</i>	<b>Federal Employer Identification Number (FEIN):</b>
<b>Organization Web Address:</b>	

**POINT OF CONTACT:**

<b>Point of Contact Name:</b> <i>(Last, First)</i>	<b>Point of Contact Title:</b>
<b>Phone Number:</b>	
<b>Email Address:</b>	

**GENERAL INFORMATION:** Answer ALL questions and if not applicable, insert N/A. Responses to questions requiring additional information and pages or attachments, must be labeled with the question number, and organized in accordance with Subsection 4.7 in the Open Enrollment.

<p><b>1. Does your organization fit the following definition of “Local or regional health information exchange?”</b></p> <p><i>A health information exchange operating in this state that securely exchanges electronic health information, including information for patients receiving services under the child health plan program or Medicaid, among hospitals, clinics, physicians' offices, and other health care providers that are not owned by a single entity or included in a single operational unit or network.</i></p> <p><input type="checkbox"/> YES   <input type="checkbox"/> NO</p>
<p><b>2. How long has your organization sustained active status as a Non-Profit Local HIE Organization in Texas?</b></p> <p> </p>
<p><b>3. Does your Local HIE meet all requirements listed in Subsections 7.1 and 7.2 of the Open Enrollment (OE)? If no, list the requirements your Local HIE does not meet.</b></p> <p><input type="checkbox"/> YES   <input type="checkbox"/> NO</p>

Exhibit F: Application for Enrollment

<p><b>4. List all Electronic Health Record (EHR) systems exchanging Consolidated Clinical Document Architecture (C-CDA) and Admission, Discharge, Transfer (ADT) data with your Local HIE:</b></p>
<p><b>5. List all Hospitals exchanging ADT and C-CDA data with your Local HIE (specify data type. For example, Hospital A: ED ADTs &amp; C-CDAs –Hospital B: C-CDAs – Hospital C: ED ADTs. Please note when multiple hospitals share an interface.</b></p>
<p><b>6. List all ambulatory practices exchanging C-CDA data with your Local HIE. For each practice, include providers sharing data (provider name, National Provider Identifier (NPI), billing NPI, Texas Provider Identifier, and addresses of practices, if multiple).</b></p>
<p><b>7. List all Managed Care Organizations (MCOs) that your Local HIE is sharing ADT and C-CDA data with (specify data type. For example, MCO A: ED ADTs and C-CDAs; MCO B: C-CDAs; MCO C: ED ADTs):</b></p>
<p><b>8. Describe your Local HIE's service area, by county, for exchange of patient health information. (include a map or a listing)</b></p>
<p><b>9. Describe your Local HIE's structure, in terms of ownership, number of employees, number of years in business, and other relevant details. List the full names of your Board of Directors and indicate for each what organization they represent.</b></p>
<p><b>10. Provide the following for the Board of Directors' Chair.</b></p>
<p>Full Name of Board of Directors' Chair: Phone number: Email address:</p>
<p><b>11. Provide a current organizational chart including all key staff (e.g. CEO, CFO, CIO, Project Management, etc.) bios and descriptions of each key staff member's duties.</b></p>
<p><b>12. Does your Local HIE currently provide web-based access to patient health data through a query-based system?</b></p>
<p><input type="checkbox"/> YES   <input type="checkbox"/> NO</p>
<p><b>13. Does your Local HIE currently provide query-based access to patient health data from within a provider's EHR?</b></p>
<p><input type="checkbox"/> YES   <input type="checkbox"/> NO</p>
<p><b>13a. If YES, provide a list of all EHR vendors currently querying the Local HIE for patient data.</b></p>
<p><b>14. Does your Local HIE currently provide query-based access to patient health data through a mobile application?</b></p>
<p><input type="checkbox"/> YES   <input type="checkbox"/> NO</p>
<p><b>15. Does your Local HIE currently provide encounter alerting services, such as notifying primary care physicians when their patients visit an emergency department?</b></p>



Exhibit F: Application for Enrollment

<input type="checkbox"/> YES <input type="checkbox"/> NO
<b>16. Provide a detailed description and workflow diagram of your Local HIE's current onboarding process for hospitals and ambulatory providers.</b>
<b>17. Provide any documentation involved in hospital and ambulatory provider onboarding, such as Data Use Agreement (DUAs) and Terms of Service.</b>
<b>18. Describe any fees involved with your Local HIE's membership and data exchange for both hospitals and ambulatory providers.</b>
<b>19. Please provide a copy of your Local HIE's sustainability plan.</b>

Signature:

<b>Signature of Authorized Representative:</b>	<b>Date:</b>
<b>Printed Name of Authorized Representative:</b>	<b>Printed Title of Authorized Representative:</b>
<b>Phone Number of Authorized Representative:</b>	<b>Email of Authorized Representative:</b>