EXPEDITED VITAL ACCESS PROVIDER ASSURANCE PROGRAM (VAPAP) APPLICATION
SAFETY NET HOSPITALS IN NEED OF APRIL/MAY 2015 CASH ASSISTANCE

This application is for VAPAP funding, which ends March 31, 2016.

Applicant Information

Applicant: Name of Operator ______________________

Facility Address ______________________ City ______________ NY Zip __________

Operating Certificate Number __________ Federal Employer ID Number (FEIN) __________ NYS Charities Registration Number __________

Authorized Contact Person First Name ______________ Last Name ______________

Contact Title ______________________

Facility Address ______________________ City ______________ NY Zip __________

Phone __________ Fax __________ Email ______________

Eligibility Category

Indicate for which of the following categories the applicant qualifies:

- ☐ **Public Hospital defined as a general hospital operated by a county or municipality, but not by a public benefit corporation**
- ☐ **Federally Designated Critical Access Hospital (CAH)**
- ☐ **Federally Designated Sole Community Hospital (SCH)**
- ☐ **Safety Net Hospital defined as meeting at least one of the following two (2) requirements:**
  - ☐ Medicaid, Uninsured or Medicaid Dual eligible patients comprise at least 35% of all outpatient visits **and** Medicaid, Uninsured or Medicaid Dual eligible patients comprise at least 30% of all inpatient discharges.
  - ☐ Provided services to at least 30% of the Medicaid, Uninsured or Medicaid Dual eligible population residing in the target county or counties for the 12 month reporting period indicated below.

Fill in the end date for the most recent reporting year for which you submitted cost reporting data to the New York State Department of Health and on which your eligibility statement and application are based:

Month	Year
	2013
	2014
	2015

Certification to be signed by the Hospital Chief Executive Officer or Designee:

I hereby affirm that I have reviewed all material submitted as part of this application and that these documents contain accurate information to the best of my knowledge. I certify that the applicant hospital is in compliance with sections 405.2, 610.3 and 610.4 of Title 10 of NYCRR. Additionally, on behalf of the applicant hospital, I commit to participate with other entities in the development of a proposal for funds under the Delivery System Reform Incentive Payment (DSRIP) program that would require that applicants become participants in a system of integrated services delivery. I also understand that as a condition of receiving VAPAP the applicant must secure Department approval, no later than September 30, 2015, of a multi-year transformation plan. I hereby affirm that the hospital applicant has available resources of less than 15 days cash and/or equivalents, that I have reviewed all financial documents submitted as part of this application, and that these documents are accurate to the best of my knowledge

______________________ ______________
Notarized Signature **Date**

____
Printed Name

____
Title

VITAL ACCESS PROVIDER ASSURANCE PROGRAM (VAPAP) APPLICATION
SAFETY NET HOSPITALS ASSISTANCE

This application is for VAPAP funding, which ends March 31, 2016.

Applicant Information

Applicant: Name of Operator ______________________________

Facility Address ____________________ City ______________ NY Zip ________

Operating Certificate Number ________ Federal Employer ID Number (FEIN) ________ NYS Charities Registration Number ________

Authorized Contact Person First Name ______________ Last Name ______________

Contact Title ______________________________

Facility Address ____________________ City ______________ NY Zip ________

Phone ____________ Fax ____________ Email ______________

Eligibility Category

Indicate for which of the following categories the applicant qualifies:

- ☐ **Public Hospital defined as a general hospital operated by a county or municipality, but not by a public benefit corporation**
- ☐ **Federally Designated Critical Access Hospital (CAH)**
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  - ☐ Provided services to at least 30% of the Medicaid, Uninsured or Medicaid Dual eligible population residing in the target county or counties for the 12 month reporting period indicated below.

Fill in the end date for the most recent reporting year for which you submitted cost reporting data to the New York State Department of Health and on which your eligibility statement and application are based:

Month	Year
	2013
	2014
	2015

Certification to be signed by the Hospital Board Chair or Secretary:

I hereby affirm that I have reviewed all material submitted as part of this application and that these documents contain accurate information to the best of my knowledge. I certify that the applicant hospital is in compliance with sections 405.2, 610.3 and 610.4 of Title 10 of NYCRR. Additionally, on behalf of the applicant hospital, I commit to participate with other entities in the development of a proposal for funds under the Delivery System Reform Incentive Payment (DSRIP) program that would require that applicants become participants in a system of integrated services delivery. I also understand that as a condition of receiving VAPAP the applicant must secure Department approval, no later than September 30, 2015, of a multi-year transformation plan.

______________________________ ______________

Notarized Signature **Date**

____

Printed Name

____

Title

VITAL ACCESS PROVIDER ASSURANCE PROGRAM (VAPAP) APPLICATION

Financial Information and Justification

Amount of funding requested, and supported by attached budget, to maintain operations through March 31, 2016. Funding may not be used for capital projects, retirement of debt, consultants or program expansion. **$**

Submit *all* of the following:

- Project Narrative (see below)
- Latest Full Audited Financial Statements
- Latest Internal Balance Sheet, Income Statement, and Statement of Cash Flow
- 2014 Breakdown of Utilization (Inpatient and Outpatient by payer and service line, as applicable)
- April 1, 2015 – March 31, 2016 Budget by Month (form attached)
- April 1, 2015 – March 31, 2016 Monthly Utilization Projections

Certification to be signed by the Chief Financial Officer or equivalent

I hereby affirm that the hospital applicant has available resources of less than 15 days cash and/or equivalents, that I have reviewed all financial documents submitted as part of this application, and that these documents are accurate to the best of my knowledge.

Notarized Signature **Date**

Printed Name

Title

Project Narrative (Not to exceed 5 pages, in 12-point font or larger)

Describe the applicant's overall financial status, scope of services and service model. This should include background and projections of the applicant's finances, level of financial need to maintain vital operations, the justification for the amount of funds requested through March 2016 and the consequences of not receiving the requested funds, and other sources and amounts of financial assistance the applicant can pursue, including but not limited to corporate parents and affiliated entities. Include a list of foundations, referral arrangements, shared service agreements, and active or passive corporate relationships. This project narrative should also include a description of the geographic area and population served and of the need for services provided by the applicant. (Narrative may be attached and may not exceed 5 pages).