**2020 Innovation/Integrated Delivery System Improvement Fund**

**Proposal Cover Sheet**

**Proposal Type:**

*Please Select* ***One****:*

Innovation Fund Proposal

Innovation Fund: Program Extension from Previously Implemented Project

Integrated Delivery System (IDS) Proposal

**Organization Information:**

1. Lead Organization Name: Click or tap here to enter text.
2. Lead Organization’s Mailing Address: Click or tap here to enter text.
3. Are you applying as an Administrative Lead? No  Yes

If yes, please list downstream Non-Safety-Net partner: Click or tap here to enter text.

**Proposal Information:**

1. Proposal/Project Title: Click or tap here to enter text.
2. Has this Proposal/Project been previously funded by CNYCC? No  Yes

If yes, when: Click or tap here to enter text.

1. Proposal Targets CNYCC Identified Priority Area(s)? No  Yes

If yes, please list all: Click or tap here to enter text.

1. Amount Requested: Click or tap here to enter text.
2. County/Counties Where Services will be Provided (Select All that Apply):

County 1: Choose an item.

County 2: Choose an item.

County 3: Choose an item.

County 4: Choose an item.

County 5: Choose an item.

County 6: Choose an item.

1. Please list approximate number of individuals to be served for this project:

Medicaid/Medicaid Managed Care: Click or tap here to enter text.

Uninsured: Click or tap here to enter text.

Dual Eligible (Medicaid & Medicare): Click or tap here to enter text.

Other (Medicare, private payor): Click or tap here to enter text.

**Letters of Support/ Required Engagement Information:**

1. Please list all organizations with whom you are partnering for this project:

|  |  |
| --- | --- |
| 1. Click or tap here to enter text. | Letter of Support Included No  Yes |
| 1. Click or tap here to enter text. | Letter of Support Included No  Yes |
| 1. Click or tap here to enter text. | Letter of Support Included No  Yes |
| 1. Click or tap here to enter text. | Letter of Support Included No  Yes |
| 1. Click or tap here to enter text. | Letter of Support Included No  Yes |

\*If partnering with more than 5 organizations, please provide an additional document with remaining partners.

1. Did your organization complete the required engagement with the CNY Director’s Planning Group (CNY DPG), LGU, or local Health Department?

No  Yes, the CNY DPG  Yes, the LGU Yes, the Health Department

If the LGU or Health Department, please provide details:

County: Click or tap here to enter text.

Individual: Click or tap here to enter text.

Title of Individual: Click or tap here to enter text.

Letter of Support Included (if applicable): No  Yes

**Contact Information:**

Individual Submitting Proposal:

Name: Click or tap here to enter text.

Title: Click or tap here to enter text.

Phone: Click or tap here to enter text.

Email: Click or tap here to enter text.

Additional Individual(s) to Receive RFP Correspondence:

|  |  |
| --- | --- |
| Name: Click or tap here to enter text. | Name: Click or tap here to enter text. |
| Title: Click or tap here to enter text. | Title: Click or tap here to enter text. |
| Phone: Click or tap here to enter text. | Phone: Click or tap here to enter text. |
| Email: Click or tap here to enter text. | Email: Click or tap here to enter text. |

I hereby certify that the information in the Proposal (Cover Sheet, Narrative, Budget, and Letters of Support) is correct to the best of my knowledge, and that I am authorized to sign and submit this proposal.

Organization’s Authorized Representative: Non-Safety-Net Organization’s Authorized Representative\*:

|  |  |
| --- | --- |
| Name: Click or tap here to enter text. | Name: Click or tap here to enter text. |
| Title: Click or tap here to enter text. | Title: Click or tap here to enter text. |
| Email: Click or tap here to enter text. | Email: Click or tap here to enter text. |

Signature of OAR: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature of OAR: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­­­­­­\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­­­­­­\_\_\_\_\_\_\_\_\_\_

\*Required if applying/partnering with an Administrative Lead.