



# Integrated Delivery Network: Region 7

## Region 7 IDN Sub-Recipient Concept Paper Cover Sheet

Please read through the entire cover sheet and instructions before you begin the application process. This form should be saved to your computer file before you complete it. You must complete the cover sheet in full and submit it along with the required attachments by 3 p.m. on the day of the deadline. E-mail is the preferred method of transmission.

|  |                          |  |
|--|--------------------------|--|
| <b>Primary Applicant:</b>  |                          |  |
| <b>Date:</b>   |                          |  |
| <b>Physical address:</b>   |                          | <b>Mailing address: (if different)</b>   |
| <b>Telephone number:</b>   |                          | <b>Website:</b>  |
| <b>Which of the following best describes your organization type:</b><br><input type="checkbox"/> Mental Health Organization<br><input type="checkbox"/> Healthcare Facility<br><input type="checkbox"/> Substance Use Disorder Treatment Facility<br><input type="checkbox"/> Social Service Organization<br><input type="checkbox"/> Other- please specify: |                          | <b>Tax ID:</b><br><br><b>What is your corporate structure?</b><br><input type="checkbox"/> 501©3<br><input type="checkbox"/> LLC<br><input type="checkbox"/> Corporation |
| <b>Has your organization completed a Certificate of Authorization?</b>   |                          | Yes <input type="checkbox"/> No <input type="checkbox"/>   |
| <b>Is your organization a Statewide Agency? If yes, please state how you will ensure your organization will not accept duplicative payments from multiple IDNs for providing the same services to the same beneficiary throughout a project activity.</b>  |                          |  |
| <b>Primary organization contact person:</b>  |                          |  |
| <b>Primary organization contact person:</b>  | <b>Name:</b>             |  |
|  | <b>Title:</b>            |  |
|  | <b>Email:</b>            |  |
|  | <b>Telephone number:</b> |  |





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**Organizational Capacity:** Provide a brief overview (2-3 paragraphs) of your organization including mission, year founded, organization type and size.



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|   |   |
|---|---|
| <b>Project Title:</b>   |   |
| <b>Please select what funding category best addresses your project? (only pick one) – see <a href="http://region7idn.com">region7idn.com</a> for additional information on project criteria and metrics.</b>  | <input type="checkbox"/> Core Competency - Integrated Healthcare<br><input type="checkbox"/> Behavioral Health Workforce Capacity<br><input type="checkbox"/> Health Information Technology<br><input type="checkbox"/> Care Transition Teams<br><input type="checkbox"/> Expansion in Intensive Substance Use Disorder Treatment Options<br><input type="checkbox"/> Enhanced Care Coordination in High Needs Population |
| <b>The following are identified needs for Region 7 IDN. Please explain in a few sentences which need(s) you will be addressing in your proposal:</b> <ul style="list-style-type: none"><li>• Access to Mental Health Services</li><li>• Access to Primary Care Services</li><li>• Opioid Crisis</li><li>• Supportive Housing</li><li>• Addressing Social Determinants of Health (financial security, housing, education, social isolation, transportation, employment, legal)</li></ul> |   |



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**Brief summary of proposal (300 words):**

**How does your proposed project align with the goals and objectives of the NH Delivery System Reform Incentive Payment (DSRIP) Program? (200 words) - (1) deliver integrated physical and behavioral health care that better addresses the full range of individuals' needs; (2) expand capacity to address emerging and ongoing behavioral health needs in an appropriate setting; (3) reduce gaps in care during transitions across care settings by improving coordination across providers and linking Medicaid beneficiaries with community supports; and (4) Advanced Payment Models for 50% of Medicaid payments by 12/31/2020.**



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**List 3 measurable outcomes you expect to achieve as a result of this funding:**

**Collaboration: Describe the collaborative relationships needed for the project to be successful, and who you will be partnering with, if anyone. Explain what partnerships have already been established, and what additional partners bring to the project. (250 words)**

