



IMPACT HEALTH'S HSO NETWORK APPLICATION & INSTRUCTIONS

BACKGROUND INFORMATION

The North Carolina Department of Health and Human Services' Healthy Opportunities Pilot Program is designed to give payers, providers, and human service organizations (HSOs) the opportunity to work together to improve the health of Western North Carolinians more effectively and efficiently.

As the nation's first comprehensive program to test the effectiveness of non-medical interventions, this program will provide support to individuals who need assistance accessing healthy food, reliable transportation, safe and stable housing, and receiving support after experiences of violence and trauma. Considering that unmet social needs have a direct correlation to health outcomes, this program is designed to reduce costs and improve the health of Medicaid beneficiaries through the implementation of these essential, non-medical services. Serving as the Network Lead for Western North Carolina, Impact Health will support a robust network of HSOs across the region and ensure that the needs of eligible Medicaid members are met.

HSO Network Application Instructions

IMPACT HEALTH OVERVIEW

Impact Health will serve as the Network Lead (NL) for WNC, and will oversee, support, and coordinate the work of the participating HSOs, manage the payment process to those HSOs, and ensure the network can respond to the needs of eligible Medicaid Members.

PILOT AND APPLICATION OVERVIEW

The Pilot Program has the potential to strengthen social supports, deepen collaboration, and improve the population health of WNC. We encourage you to participate in our application process to become an HSO provider within the WNC network and partner with Impact Health to change the future of healthcare in our region.

Helpful Application Tips:

- Note that this application requests detailed information. There are fields that are marked with two asterisks (**) indicating that they are not mandatory fields and may be answered at a later date. The information requested in the application is intended to give us information on what type of technical assistance each organization may need. It is in no way a disqualifying event if your organization cannot complete the information requested.
- As you are working to complete the application, you can save your progress at any time and return to it.
- Before starting your application, please read the [example contract](#) and FAQ.
- If you have questions or technical difficulties, please contact Devon Malloy at devon.malloy@sevenya.com.
- Before you begin the application, it will be helpful to gather key documents and information. The following tables outline required information as well as optional information that can be included at a later date.

Required Information	
Organization Information - Contact	<ul style="list-style-type: none"> • Contact information for main and all satellite locations • A list of the counties your organization currently serves
Organization Information - Cultural	<ul style="list-style-type: none"> • Cultural competency information including languages spoken
Services Information	<ul style="list-style-type: none"> • Service provided and service type <ul style="list-style-type: none"> ○ # Served 2019 ○ # Served 2020 ○ # Served YTD (2021)
Demographic Information	<ul style="list-style-type: none"> • List of board of directors members (including positions and length of service)

Optional Information	
Organization Information - Staff	<ul style="list-style-type: none"> • Staff resumes for employees who will be delivering pilot-related services
Organization Information - Cultural	<ul style="list-style-type: none"> • Cultural competency information including equity policies and practices, and documentation of compliance with non-discrimination state and federal laws, regulations, guidelines, and standards
Financial Information	<ul style="list-style-type: none"> • Most recent annual report and recent strategic planning documents • Recent financial documents including organizational budget (previous 3 years), most recent audited financials, and financial policies and procedures • Compliance documents including most recent IRS Form 990 and business licensing, accreditation, or credentials that you have in order to meet industry standards for applicable Pilot Program services
Demographic Information	<ul style="list-style-type: none"> • Board of directors roster • Organizational chart

Application – General Information Section

The general information section is designed to help Impact Health understand the service area of your organization, identify an agency contact responsible for leading pilot activities, and gather foundational documents to help us better understand your organization’s mission and activities. For this section you will be asked to provide:

- Organizational contact information for your primary location
- A primary contact for your organization to serve as the Pilot Program Transformation Manager, and a description of how the transformation manager will ensure robust implementation of pilot service by working with organizational leaders and staff.
The Transformation Manager must be an executive or other individual with decision-making authority within the organization and Pilot Program who will serve as and is the point of accountability for the success of the agency’s Pilot Program participation.
- All the counties your organization currently provides services in
- The addresses of any satellite locations and their hours of operation
- Indicate whether your organization would like to be considered for Phase 1 delivery of services, beginning February 1, 2022
Saying yes does not commit you to Phase 1 delivery if approved for HSO Network, and replying no will not be held against you in the assessment of your network application.
- Languages your organization provides services in
- Your organization’s mission statement
- **Provide examples of how your organization uses to data to make programmatic and

strategic decisions about your work

The Pilot Program is designed to use data to help DHHS understand the impact of providing non-medical care to eligible participants and includes both quality improvement and evaluation activities. Using data to improve services and outcomes is an essential part of the process.

- List all staff who will provide services and oversight of services related to the pilot
- **A description of your agencies staff capacity to meet the pilot services included in the [contract](#).
- For the General Information section please attach the following documents (if available, this information can also be provided at a later date):
 - a. **Your organization's most recent annual report
 - b. **Your organization's most recent strategic plan
 - c. **Evaluation plans and any tools used to track outcomes
 - d. **Individual resumes of staff who will provide services, or oversight of services, related to the pilot
 - e. A list of all members on the board of directors, including their position on the board, the length of time they have served on your board

Application – Financial Information Section

The financial information section is designed to assist Impact Health in understanding your organization's financial context, the policies and procedures your organization uses to steward its financial health and compliance with state and federal law, as well as your ability to invoice for pilot services. For this section you will be asked to provide:

- Your total annual operating budgets for the last three years
- Current funding provided to your organization by Dogwood Health Trust (Y/N)
- For the Financial section please attach the following documents (if available):
 - a. **A copy of the organizations most recent audit
 - b. **A copy of your organizations financial policies
 - c. **A copy of your organizational IRS 990 Form

Application – Services Information Section

The Services Information section is designed to assist Impact Health in understanding what services your organization currently provides and what services you intend to provide as part of the Pilot Program. In addition, you will be asked to provide information about the population(s) you serve. For this section you will be asked to provide:

- Changes in your operations, capacity, or service numbers as a result of the COVID-19 pandemic (Y/N) *Description is optional.*
- Indication of what services your organization currently provides, and the total number of Individuals served (unduplicated by service type)
 - a. *The Healthy Opportunities Pilot will focus on five domains of services: Housing, Food, Transportation, Interpersonal Violence/Toxic Stress, and Cross-Domain Services that overlap more than one of these domains. You will be asked to report on services that fall within these domains.*

- ****A description of how your organization assess potential need for the services you provide**
- Indicate whether your organization has Workers Compensation or liability insurance (Y/N)
- Indicate whether your organization has business licensing or accreditation (Y/N)
- A description of priority partners your organization will engage with to ensure the success of the Pilot Program
- For the Services section please attach the following documents (if available):
 - a. ****Any business licensing, accreditation, or credentials that you have in order to meet industry standards for applicable Pilot Program services.**
 - b. ****Copy of worker’s compensation and business liability insurance.**

Application – Organizational Capacity Information Section

The organizational capacity section is intended to assist Impact Health in understanding the current capacity of your organization to provide services under the Pilot Program. Additionally, this section will help Impact Health understand where resources surrounding capacity development may be needed to prepare your organization for participation in the program. For this section you will be asked to provide:

- A checklist of how your organization currently receives referrals/requests for services, including service wait times and denial of services related to organizational capacity limits
- ****How many service requests has your organization had to turn away in the past 12 months**
- Indicate whether you expect a large increase in demand for services for Pilot participants from your organization (Y/N)
- Your organization’s potential need for capacity building support, including the need for training, technical assistance, and/or funding
- Potential ability of your organization to expand services and/or hours of service availability and the resources needed to expand (Y/N)

Application – Billing & Technology Information Section

The Billing Information section is designed to give Impact Health an understanding of your organizations ability to engage the billing and reporting systems required by the Pilot Program. These systems include [NCCARE360](#) and [NCTracks](#). NCCARE360: The Pilot program will utilize NCCARE360 for referrals, as well as for invoicing requirements of this program. NCTracks: NCTracks is the multi-payor Medicaid Management Information System for the North Carolina Department of Health and Human Services. All contracted HSO’s must enroll as a Medicaid provider into NCTracks and adhere to any guidance issued by the Department or its NCTracks vendor to ensure timely enrollment. For this section you will be asked to provide:

- Current use of NCCARE360 and NCTracks
- Training received on the use of NCCARE360
- A description of your experience billing Medicaid or private health care payors for services provide.

Application – Demographic Information Section

The Demographic Information section is intended to help Impact Health understand the extent to which the makeup of your organization reflects the communities most in need of the services you provide. For this section you will be asked to provide:

- ****Demographic background for your board of directors, executive leadership, and staff**
- ****Demographic information for your client base**
- **For the Demographic Information section please attach the following documents (if available):**
 - a. ****List of board of directors (including positions and length of service)**
 - b. ****Current Organizational Chart**

Application – Diversity/Equity Information Section

The Diversity/Equity section is intended to provide Impact Health with information on your current efforts to advance racial and health equity in WNC. For this section you will be asked to provide:

- **Indicate whether your organization serves a specific population and provides culturally specific services**
- **Specific disparities – racial, systemic, or others – your organization works to address (Y/N)**
- **A checklist of written non-discrimination policies that comply with state and federal rules that your organization has in place**
- **If you do not have these policies in place, please indicate if you would like assistance**

Application – Attestations

The Attestations section outlines contractual elements that will be required during service delivery. We are seeking that if your organization does not have these elements in place, that you intend to work with the Impact Health team to satisfy these requirements. For this section you will be asked to provide:

- **Agreement that staff will participate in annual cultural competency and diversity, equity & inclusion training provided through Impact Health (Y/N)**
- **Confirmation that your organization is able to meet the above, time, distance, and wait time standards (Y/N)**
- **Agreement to work with Impact Health to meet the Pilot Program's reporting requirements (Y/N)**
- **Agreement to enroll in NCTracks, if not already enrolled (Y/N)**

If you have any questions during the application process, please reach out to our team so that we can assist you in submitting all required materials within a timely manner.

HSO APPLICATION REVIEW PROCESS

Applications will be reviewed by the **Human Service Organizations (HSO) Application Review Committee** (the Committee). The Committee consists of Dogwood Health Trust (DHT) and Impact Health staff members who are responsible for reviewing submitted applications from HSOs that want to join Impact Health's network. Please note, it will take two days to review applications for completeness and five days to finalize scoring. HSOs will be notified of a final decision within two weeks.

IMPORTANT DATES & DEADLINES

The following chart outlines information sessions as well as application submission deadlines.

Domains	Application Info Sessions	Last Chance Application Info Sessions	Application Submission Deadline
FOOD INSECURITIES	October 12 at 9:00 am October 12 at 5:00 pm	October 19 at 9:00 am October 19 at 4:00 pm OR October 20 at 9:00 am October 20 at 4:00 pm	October 29, 2021
TRANSPORTATION	October 13 at 9:00 am October 13 at 5:00 pm		October 29, 2021
CROSS DOMAIN	October 14 at 9:00 am October 14 at 5:00 pm		October 29, 2021
HOUSING	October 15 at 9:00 am October 15 at 5:00 pm		October 29, 2021
INTERPERSONAL SAFETY TOXIC STRESS	TBD	TBD	TBD



HSO Network Application

Thank you for your interest in participating in the Healthy Opportunities Pilot (HOP) as a Human Service Organization (HSO) with the Impact Health network. All HSOs (community based or social service agencies) that engage in the application process must plan to join the HSO Network for the length of this pilot and be willing to invest time and resources using capacity building funds to participate in implementation, training, and service delivery. The HSOs in the Network will serve one or more counties in the approved 18-county region in one or more approved service delivery areas.

Participating organizations must:

- Operate or provide services in the sub-categories within the 18 county pilot service area
- Maintain a physical presence in North Carolina, with one or more offices located in or serving the Local Pilot Region for the term of the Contract
- Have an annual budget of at least \$25,000
- Have at least one paid employee

Any question with 2 asterisks ** in front of the question are **optional fields** during the initial submission of this application. Please note, we will likely need this information in the future but it is not required to meet the initial application deadline.

Applications are due by midnight, October 29, 2021.

General Information	
Organization/Legal Entity Name	
Doing Business As	
Primary Address (Street)	
City/State/Zip	
Hours of service at this location	
Mailing Address (street) –(if different than above)	
City/State/Zip	
Contact Email	
Website URL	

Entity Information	
Non-profit status	
EIN Number/Tax ID Number	
Does your organization use any subcontractors to carry out services?	Yes No
Legal name of the subcontractor	
Does your organization have an active contract with this subcontractor?	
How many years has this arrangement been in place?	

Contacts:	
Agency Director Name	
Phone Number	
Email	
<i>Primary Contact-Transformation Manager</i>	
Prefix & Name	
Title	
Phone	
Email	

****Describe how the Pilot Program Transformation Manager will work with other organization executives and leaders to ensure robust implementation of pilot services.**

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Please check to indicate all North Carolina counties your organization serves:				
Avery	Buncombe	Burke	Cherokee	Clay
Graham	Haywood	Henderson	Jackson	Macon
Madison	McDowell	Mitchell	Polk	Rutherford
Swain	Transylvania	Yancey	Qualla Boundary	Other:

<i>Other Sites</i>						
Street Address	City	County	Zip	Phone	Days/ Hours of Operation	Site Staff Lead

<p>If your organization operates a shelter that serves as a confidential safehouse for clients that you serve (i.e., a shelter for survivors of domestic violence), please indicate how many sites you have like this and in what county they operate. Please do not include the street address.</p>

Service delivery for the Pilot is slated to begin on February 1, 2022. However, the NC Department of Health & Human Services is considering a phased approach in rolling out services. This means some HSOs accepted into the Network would begin all or a portion of the services in February while other HSOs that may require additional time to prepare for service delivery would phase in at a later time. There is no penalty or incentive given to HSOs depending on when they start service delivery.

The Implementation Team will be looking for early adopters to begin services on February 1, 2022. These organizations should consider the following when indicating their readiness to rollout services in February:

- NCCARE360, the platform through which a HSO receives and closes referrals and invoices for services will have some functionality on February 1, 2022 but we anticipate updates and improvements as the Pilot progresses. HSOs starting services in February may have to work with us on glitches and be flexible to iterations of the system as it progressively becomes fully functional.
- HSOs that are early adopters ideally should already be providing some services that align with the 29 reimbursable services. An HSO that is launching or starting new services, which is allowable under the Pilot, may not be prepared to deliver that service or services on February 1, 2022.
- Similar to the consideration above, HSOs should be providing services in the county or counties where they have applied to provide services in February. An HSO scaling to a new geographic region, also allowable under the Pilot, may have challenges being ready to deliver those services in a new county by February 1.

<p>After reviewing the above items, would your organization like to be considered for Phase 1 delivery of services, beginning February 1, 2022? Saying yes does not commit you to Phase 1 delivery if approved for HSO Network, and replying no will not be held against you in the assessment of your network application</p>	<p>Yes, starting in Phase 1 No, starting in a later Phase I am unsure, and would like to discuss with someone at Impact Health</p>
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<p>Languages</p>	
<p>Does your organization have the capacity to provide services to individuals in languages other than English?</p>	<p>Yes (through Agency staff) Yes (through language line/translation service) No</p>
<p>If you answered yes above, which languages?</p>	
<p>Does your organization have an ongoing contract?</p>	<p>Yes No</p>
<p>Please provide the name of the translation company (if applicable)</p>	

Please enter the Organization's Mission Statement	
Date Organization was established:	
**Please attach your organization's most recent Annual Report	

**If your annual report is not available, please describe 5 key highlights of your organization's work in the last budget year.

**Please attach the most recent Organizational Strategic Plan	
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**If a recent strategic plan is not available, please describe 3-5 strategic objectives that guide your organization's work

<p>**Please describe how your organization uses evaluation and/or measures outcomes related to this work.</p>	
<p> </p>	
<p>**Please attach any supporting documents related to outcome tracking:</p>	
<p>Does your organization use data to make programmatic and strategic decisions about your work?</p>	<p>Yes No</p>
<p>**Please provide examples of how your organization uses data to make programmatic and strategic decisions about your work.</p>	
<p> </p>	

<p>Staff-please list all staff who will provide services and oversight related to the Pilot. **Attach individual resumes in the attachment section at the end of the application.</p>				
Staff Name	Title	Role in Pilot	Time with organization	Status
				FT PT
				FT PT
				FT PT
				FT PT
				FT PT
				FT PT

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Financial Information		
2019 Budget	2020 Budget	2021 Budget
<p>**Please attach the following documents that demonstrate a history of financial stewardship and integrity. This may include: 1) A copy of the organizations most recent audit, if available. 2) A copy of your organizations financial policies 3) Copy of Organizational IRS 990 Form</p>		
<p>**If a recent audit is not available, please describe in detail how your organization maintains financial stewardship and integrity</p>		

Current Funding	
Does your organization have current funding from Dogwood Health Trust?	Yes No
<p>**Please describe funding received</p>	

Services Information	
Did you experience major changes to your operations, capacity, or client base as a result of Covid-19?	Yes No
<p>**Please describe if you answered yes above.</p>	

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Please indicate which area(s) of service your organization currently provides. In addition, for each service you indicate that you provide, include the TOTAL Number of Individuals Served (unduplicated by service type)

Service Provided	Service Name	# Served 2019	# Served 2020	# Served 2021
Housing				
	Housing Navigation, Support, Sustaining Services			
	Inspection for Housing Safety and Quality			
	Hosing Move-in support			
	Essential utility set-up			
	Home Remediation Services			
	Home Accessibility & Safety Modifications			
	Health Home Goods			
	One-time payment for Security Deposit & 1 st Month's Rent			
	Short-term Post Hospitalization Housing			
Interpersonal Violence/Toxic Stress				
	IPV Case Management Services			
	Violence Intervention Services			
	Evidence-Based Parenting Curriculum			
	Home Visiting Services			
	Dyadic Therapy			
Food				
	Food & Nutrition Access Case Management Services			
	Evidenced-Based Group Nutrition Class			
	Diabetes Prevention Program			
	Fruit & Vegetable Prescription			
	Healthy Food Box (For Pick-up)			
	Health Food Box (For Delivery)			
	Healthy Meal (For Pick-up)			
	Healthy Meal (For Delivery)			
	Medically Tailored Home Delivered Meal			
Transportation				
	Reimbursement for Health-Related Public Transportation			
	Reimbursement for Health-Related Private Transportation			
	Transportation PMPM Add-on for Case Management Services			
	General Transportation			
	NEMT			

Cross-Domain				
	Holistic High Intensity Enhanced Case Management			
	Medical Respite			
	Linkages to Health-Related Legal Supports			

****For each of the services you indicated in the table above, describe how your organization assesses/anticipates need/demand?**

Does your organization have Worker’s Compensation and liability insurance? **Please attach copies of your worker’s compensation and liability insurance.	Yes No
If applicable, does your organization have business licensing or accreditation to provide services?	Yes No
**Provide a copy of business licensing, accreditation, or credentials that you have to meet industry standards for delivery of Pilot Services.	

Partnerships – what organizations do you currently/will you partner with to ensure success of the Pilot?			
Name of Organization	Services they provide to complement	How does their service add value?	How long has the partnership existed?

Organizational Capacity
How does your organization currently receive referrals/requests for services?
Case manager referrals Direct calls from clients From health plans From other community partners From other healthcare providers Other

If other, please describe:	
**How many service requests has your organization had to turn away in the past 12 months?	
Based on what you know about the need for the services you provide, the populations you currently provide services to, and your service area context, do you expect a large increase in demand for services for Pilot participants from your organization?	Yes No Unsure
Do you anticipate your organization will request capacity building support to participate in the Pilot Program in any of the following areas?	Training Technical Assistance Funding
**Please describe anticipated needs based on your previous selection.	
If necessary, will you be able to offer extended hours (some weekends & evenings) to accommodate the needs of Pilot participants?	Yes No Unsure
What kind of support would you need to extend hours?	Funding Physical space Staffing

<i>Billing & Technology Information</i>	
NCCARE360: The Pilot program will utilize NCCARE360 for referrals, as well as for invoicing requirements of this program. NCTracks: NCTracks is the multi-payor Medicaid Management Information System for the North Carolina Department of Health and Human Services. All contracted HSO's must enroll as a Medicaid provider into NCTracks and adhere to any guidance issued by the Department or its NCTracks vendor to ensure timely enrollment.	
Does your organization currently use NCCARE360?	Yes No
Have you had formal training on NCCARE360?	Yes No
Does your organization have experience with billing Medicaid or private healthcare payers (i.e. insurance companies)?	Yes No
Which payers?	
Is your organization currently enrolled as a provider in NCTracks?	Yes No

Demographic Information

****Please share any additional information about your Board of Directors, Executive Leadership, or staff that you would like for Impact Health to know.**

****Demographic Information-Client Base**

Race	Number of Members	% of Members
Ethnicity		
Gender		
Age (Under 18; 19-25; 26-40; 41-65; 66+)		

Employed/Unemployed/Retired		
Veteran Status		
Veteran		
Non-Veteran		
Disability		
Disabled		
Non-disabled		

<p>**Please provide copies of the following documents, as applicable. 1) A list of all Board of Directors members, including their position on the Board and the length of time they have served on your Board 2) A current organizational chart.</p>	
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<i>Diversity/Equity</i>	
Please describe the populations you serve	
Does your organization provide culturally specific services/programming?	Yes No
If you answered yes to the above question, please describe programming.	
Are there specific disparities you are addressing—racial, systemic, or otherwise?	Yes No

**If you answered yes to the above question, please describe.

The contract held with the state of North Carolina requires non-discrimination policies and procedures. Below is a list of those federal laws and regulations. If your organization does not have these policies and procedures, please skip this question and indicate below that this is an area of assistance that will be required.

Do you have documented compliance of state & federal laws, regulations, guidelines, & standards for non-discriminatory practice? Please mark which regulations below are covered in your organization's policies.

Title VI of the Civil Rights Act of 1964, as amended, 42 U.S.C. 2000d et seq., which prohibits discrimination on the basis of race, color, or national origin	Section 504 of the Rehabilitation Act of 1973, as amended, 29 U.S.C. 794, which prohibits discrimination on the basis of handicap
Title IX of the Education Amendments of 1972, as amended, 20 U.S.C. 1681 et seq., which prohibits discrimination on the basis of sex	The Age Discrimination Act of 1975, as amended, 42 U.S.C. 6101 et seq., which prohibits discrimination on the basis of age
Section 654a of the Omnibus Budget Reconciliation Act of 1981, as amended, 42 U.S.C. 9849, which prohibits discrimination on the basis of race, creed, color, national origin, sex, handicap, political affiliation or beliefs	The Americans with Disabilities Act of 1990, P.L. 101-336, which prohibits discrimination on the basis of disability and requires reasonable accommodation for persons with disabilities.
Section 1557 of the Patient Protection and Affordable Care Act, which prohibits discrimination on the basis of race, color, national origin, sex, age, or disability in certain health programs or activities	The North Carolina Persons with Disabilities Protection Act, Chapter 168A of the North Carolina General Statutes, which prohibits disability discrimination
The North Carolina Equal Employment Practices Act, Article 49A of Chapter 143 of the North Carolina General Statutes, which prohibits employment discrimination on the basis of race, religion, color, national origin, age, sex or handicap by employers which regularly employ 15 or more employees	The North Carolina Retaliatory Employment Discrimination Act, Article 21 of Chapter 95 of the North Carolina General Statutes, which prohibits employer retaliation against employees who in good faith take or threaten to take protected action under the law.

<p>If you do not have any of the policies above, please select the below box if you would like assistance in developing these policies for your organization</p>	<p>Yes, we need assistance No, we do not need assistance</p>
<p>Attestations</p>	
<p>Below are contractual elements that will be required during service delivery. We are seeking that if your organization does not have these elements in place, that you intend to work with the Impact Health team to satisfy these requirements.</p>	
<p>Check the box 'Yes' each attestation statement to indicate your agreement</p>	
<p>Do you agree that your staff involved in service delivery will participate in annual training provided through Impact Health to ensure understanding of the demographics, background, cultural identities, health, and health-related needs of potential Pilot Participants in the region? Please note, we refer to this training as cultural competency/ diversity, equity and inclusion training.</p>	<p>Yes No</p>
<ul style="list-style-type: none"> • All NCCARE360 referrals from PHP/Care Management Entities must be responded to within 2 business days (48 hours); note that this is a requirement of the platform NCCARE360. • HSOs must make best efforts to provide services within 3 business days (72 hours) or must contact client within 3 business days (72 hours) after accepting referral from NCCARE360. • Services provided in which a client must travel to receive services should be within 10 miles of person's residence, if at all possible. • Where distance standards cannot be met, telephonic services, enhanced transportation services, or home-based delivery systems must be maximized. 	
<p>Do you certify that your organization is able to meet the above, time, distance, and wait time standards?</p>	<p>Yes No</p>
<p>Do you agree to work with Impact Health to meet the Pilot Program's reporting requirements? Please note, most reporting requirements are captured in NCCARE360.</p>	<p>Yes No</p>
<p>Do you agree to enrolling in NCTracks (if you are not already enrolled)?</p>	<p>Yes No</p>

Affirmations

Check the box for each attestation statement to indicate your agreement

By submitting this application, I attest to my organization's willingness to serve all Pilot Participants referred to my organization in accordance with our capacity constraints and our contract with Impact Health.

By submitting this application, I attest that I will not use Pilot Program funds to refinance or displace activities already in process or performed by my organization.

I attest that all of the information in this application is correct.

Signature	
Print Name	
Today's Date	

Attachments: Check all attachments provided with this application (note, this information can be provided at a later date)

A list of all Board of Directors members, including their position on the Board and the length of time they have served on your Board.

Organizational chart

A preliminary budget for providing services you identified in application (if available)

A copy of your organization's non-discriminatory practices policy (if available)

Copies of any applicable business licenses/certifications for service delivery

Your organization's most recent Annual Report (if available)

Your organization's most recent Strategic Plan (if available)

Existing evaluation plans and tools you use to track outcomes

Individual resumes for staff delivering Pilot Program services

Documents that demonstrate a history of financial stewardship including:

A copy of your organization's most recent audit

A copy of your organization's financial policies

A copy of your organizational IRS 990 Form