**SMALL RURAL HOSPITAL IMPROVEMENT GRANT PROGRAM (SHIP)**

***Revised* Hospital Grant Application for FY 2013**

***Due back to State Office of Rural Health (SORH) by:*** March 2, 2012

To help facilitate the awards process the SORH will submit one SHIP application on behalf of all eligible hospital applicants to the Health Resources and Services Administration, Office of Rural Health Policy**.** ***This form must be completed and returned to the SORH for inclusion in the FY13 SHIP application*.** The SORH will award equal funding to each eligible hospital.

**A. Hospital Information:**

**CAH status**: Yes [ ]  No [ ]

 **(**Check one) Returning SHIP hospital(funded in FY12) ❒ ***Or*** *New* SHIP hospital (not funded in FY 12) ❒

If *Returning* hospital, is there a change in hospital address? Yes [ ]  No [ ]

If *Returning* hospital, is there a change in Administrator/CEO information since FY11 SHIP application? Yes [ ]  No [ ]

**Hospital Name:**

**Address:**

**City:**       **State:**       **Zip:**       **County:**

**Phone:**       **Fax:**

**Administrator / CEO:**       **E-mail:**

Number of beds per Line 12 of the most recently filed Medicare Cost Report:

Cost Reporting Period of most recently filed Medicare Cost Report: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ - \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Attach part I of Worksheet S-3 from most recently filed Medicare Cost Report. (PPS Hospitals only)***

***Note:*** *If hospital reports a licensed bed count greater than 49 on Line 12 but staffs 49 beds or fewer, you may certify eligibility by submitting a written statement to the SORH that includes: 1) the number of staffed beds at the time of the most recent cost report submission, 2) the cost reporting period of the most recently filed cost report, and 3) the signature of the certifying official.*

**B. Expenditures**

Indicate the percent and dollar amount of FY13 budget that will be used to support activities in the following categories. You may use all funds in one category or split the funds across categories. ***Budget estimate: $9,000 per hospital.***

Percent / Amount allocated to implementation of Prospective Payment Systems (PPS)       % $

Percent **/** Amount allocated to Value-based Purchasing (VBP)       % $

Percent / Amount allocated to Accountable Care Organizations (ACOs)       % $

Percent / Amount allocated to Bundled Payments       % $

 **TOTALS: 100 % $**

**C. Use of Funds**

***Fully*** describe all grant activities by category.

|  |  |
| --- | --- |
| **Value Based Purchasing (VBP)** |       |
| **Accountable Care Organization (ACO)** |       |
| **Bundled Payments** |       |
|  |  |

 **D. SHIP Network / Consortium Affiliation**

1. Is the hospital affiliated with a *SHIP* *network/consortium*? (A network/consortium formed solely for the purposes of SHIP?) **Yes[ ]**  **No[ ]**
* If *Yes,* network name*:*
* If *Yes*, is this a new network/consortium (forming in FY 12)? **Yes[ ]  No[ ]**
* Are FY 13 funds allocated to this network/consortium? **Yes[ ]  No[ ]**
1. Are FY 13 SHIP funds allocated to any *Other* *network/consortium*? (A network/consortium formed for purposes other than SHIP that offers programs/services that SHIP hospital can “buy into” with SHIP funds?

**Yes** **[ ]** Network name*:*  **No** **[ ]**

1. Would you like assistance from the SORH in becoming part of a SHIP network/consortium? **Yes[ ]  No[ ]**

**E.** **Additional Needs**

In addition to the activities listed in section C above– Use of Funds, identify any additional needs that will not be addressed with FY 13 funds.

|  |  |
| --- | --- |
| VBP |       |
| ACOs |       |
| Bundled Payments |       |
|  |  |

**F.** **Report on FY12 Year Hospital Activities**:

1. Discuss progress in executing FY 12 activities by SHIP category (VBP, ACO, Payment bundling). Discuss any adjustments to FY12 activities.
2. Discuss any challenges (current or anticipated)to completing FY12 activities and how they were or will be resolved, if applicable.
3. Briefly summarize any coordination of activities between SHIP and Flex programs, *if applicable*.

**G.** **Report on FY12 Network/Consortium Activities** *(if applicable):*

Discuss progress on FY 12 network/consortium activities by SHIP category (VBP, ACO, Payment bundling, and PPS), including any needed adjustments. Indicate if network/consortium is a ***SHIP*** *network/consortium* (formed solely for the purposes of SHIP) or ***Other*** *network/consortium* (formed for purposes other than SHIP and offers programs/services that SHIP hospitals “bought into” with grant funds.

1. Discuss challenges (current or anticipated) to completing FY12 network/consortium activities and how they were/will be resolved, if applicable.
2. Briefly summarize any coordination of activities between SHIP and Flex programs, *if applicable*.

**H. Recommendations**

List recommendations for improving SHIP

**I. Award Preference**

[ ]  My hospital would like to allocate FY 13 SHIP funds (*check one:* **full** [ ]  or **partial** [ ]  ) in the amount of $      to the following network/consortium     .

**[ ]**  My hospital would like all grant funds awarded directly to the hospital.

**J. Signature**

**CEO Signature:**       **Date:**

**Or**

The undersigned represents and confirms that he/she is the SORH-designated authorizing official of the hospital and is fully authorized to sign this application for participation in the Small Rural Hospital improvement Grant Program (SHIP) on behalf of the hospital’s Chief Executive Officer.

**Authorizing Official Name (please type):**

Title (CFO, Other):

**Phone:**       **Ext.**       **Email Address:**

**Authorizing Official Signature:**       **Date:**