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| For Office Use OnlyPlan Code:  |
| Received: | Due: | Approved: | Renewal: |



**Coordinated Quality Improvement Program**

**Department of Health
Attn: Office of the Secretary\PLR**

PO Box 47890

Olympia, Washington 98504-7890

Email

**Application for**

###### Coordinated Quality Improvement Program (CQIP)

|  |  |
| --- | --- |
| **1** | Name of Applicant Group |
| **Name**  | Address | City | **County** | StateWA | Zip |

|  |  |
| --- | --- |
| **2** | Program Type: [ ]  Original Application $250 [ ]  Alternative Application $40 [ ]  Modification $65 [ ]  Renewal $75  |
| **Program Information** | Total Number of Personnel (check applicable total number of health care personnel)[ ]  5-25 [ ]  26-50 [ ]  51-100 [ ]  101-250 [ ]  251-500+Number of Licensed Health Care Providers: |
| Category of Applicant Group(Check appropriate program type)**[ ]  Professional Society or Organization** **[ ]  Health Care Service Contract (HCSC)****[ ]  Health Maintenance (HMO)****[ ]  Health Carrier** |  **[ ]  Provider Group:**  [ ]  Physician Group  [ ]  ARNP Group [ ]  Laboratory [ ]  Other:  | [ ]  Health Care Institution or Medical Facility:  [ ]  Ambulance and Aid Service  [ ]  Public Health Department [ ]  Other:       |

|  |  |  |
| --- | --- | --- |
| **3** | Applicant Contact Name | Title |
| **Contact Information** | Address | City | State | Zip |
| Telephone | Mobile Phone | Email |
| Contact Person (if different from applicant) | Title |
| Address | City | State | Zip |
| Telephone | Mobile Phone | Email |

|  |  |
| --- | --- |
| **4** | Applicant Attestation |
| Applicant Attestation | I, **Your Name Here,** **Your Title Here** declare under penalty of perjury under the laws of the state of Washington, that the Quality Improvement Program attached to this application is a true and correct copy of the plan to be used by the applicant; that the applicant intends to use the Quality Improvement Program as described in this application; and that all responses in this application are true and correct.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(Signature) (Date) |
| For Accounting Use Only Quality Improvement Program Revenue Code: 05 97 912040 |

Please make check or money order payable to **Department of Health.**  DOH 820-061 April 2021

**Instructions for completing the
Department of Health Coordinated Quality Improvement Program Application**

### Block 1 – Name of Applicant Group

* Enter name of Applicant Group.
* Enter the physical address of the Applicant Group Address.

### Block 2 – Program Information

* Select the program type original program $250, alternative program $40, modification $65, renewal $75.
* Select number of health care personnel that are not licensed health care providers and write the number of licensed health care providers.
* Select Category of Applicant Group (if other, please indicate).

### Block 3 – Applicant/Contact Information

* Enter the applicant’s name, title, mailing address, phone & mobile number, and email address. If the applicant is not the main point of contact, please enter the contact information below the applicants.
* Enter the contact person’s name, title, mailing address, phone & mobile number and email address. If this portion of the application is filled out, this will be our main point of contact.

Block 4 – Applicant Attestation

* Please type name & title, print this application, sign & date.

**Instructions for submitting your CQIP Application + CQIP Plan and Fee**

1. Please send your CQIP application and attached CQIP plan to the designated email: **CQIP@doh.wa.gov**
2. Fees must be paid by check or money order to: **Department of Health**. The check must reference the name of the applicant group in Box 1 of the application. Also, the check should be for the CQIP program and write the **Revenue Code: 05 97 912040** on the check. The check must be mailed to:

 **Department of Health**

**Revenue Unit**

**PO Box 1099**

**Olympia, Washington 98507**

Fee Information:

* Original Program $250
* Alternative Program $40
* Modification to Department Approved Plan $65
* Renewal Application every 5 years $75

If you have any questions, please email us.