

## MANAGED CARE SYSTEMS

P.O. Box 64975

St. Paul, MN 55164-0975

Essential Community Provider

**2024 Annual Report**

Essential Community Providers are required to file an annual report. Complete and return this form with any attachments to the address above or to health.mcs@state.mn.us . **Reports must be received by April 15, 2024.** If you have questions, you may contact us at health.mcs@state.mn.us.

|  |
| --- |
| Name of Facility |
| Address of Primary Location (Do not use PO Box address) |
| City | State | Zip Code |
| Contact Person Name | Contact Phone Number |
| Contact Email Address | Facility Phone Number |
| Organization’s Web Site Address |

# Verification of Tax Exempt, Non-Profit Status

*Check “Does not apply” if your organization DID NOT qualify for ECP designation as a non-profit, tax-exempt entity.*

1. Minnesota Statutes Chapter 317A non-profit status since application for ECP designation.
	* Changed ☐ Unchanged ☐ Does Not Apply
2. Internal Revenue Code, section 501(c)(3) tax-exempt status since application for ECP designation.
	* Changed ☐ Unchanged ☐ Does Not Apply

# Sliding Fee Scale

*Complete this section ONLY IF your organization qualified for ECP designation as a non-profit, tax-exempt entity.*

Has the sliding fee included with your most recent ECP application or annual report hanged? **If the sliding fee scale has changed, attach any new sliding fee scale to this report.**

* + Changed ☐ Unchanged ☐ Does Not Apply

# CPT Codes

Have health services provided by your organization changed since your most recent ECP application or annual report? **If services have changed, submit a new CPT list.**

* Changed ☐ Unchanged

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# High-Risk, Special Needs, and Underserved; Insurance Status

Numbers requested in this section allow us to evaluate whether the ECP program is effective in reaching uninsured, underserved, high-risk, and special needs populations. Use calendar years in responding.

|  |  |  |  |
| --- | --- | --- | --- |
| **Total Number of Clients, 2023** |  |  | **Projected Number of Clients, 2024** |

“High-risk/special needs” includes but is not limited to:

* People with chronic health or medical conditions
* People with persistent serious mental health issues
* People who are chemically dependent
* People with high-cost preexisting conditions
* Adolescents and elderly
* People at high risk of requiring treatment

“Underserved” means individuals who:

* Face barriers to health care due to income, culture, ethnicity, language, or race;

OR

* Live in an area with a shortage of primary care health services

Provide numbers for the following. A client may be both high-risk/special needs and underserved, so the last row may be less than the sum of the first two.

|  |  |  |
| --- | --- | --- |
| **High-risk and/or Special Needs Clients** | **Underserved Clients** | **Total High-risk, Special Needs, Underserved Clients\*** |
| **Income, culture, ethnicity, race, etc.** | **Geographical Location** |
|  |  |  |  |

Pick any point in the past calendar year. Estimate the number of clients who had:

|  |  |
| --- | --- |
| **Public Insurance** |  |
| **No Insurance** |  |

If you assist clients in applying for insurance (either public or commercial), respond to the following question. You may estimate.

## Complete the client column OR the encounter column. Use data from the preceding calendar year:

**In the past year, how many clients obtained insurance with your assistance**?

|  |  |  |  |
| --- | --- | --- | --- |
| **Number of :** | **Clients** | **OR** | **Encounters** |
| **Utilizing sliding fee scale\*** |  |  |  |
| **Receiving any other type of financial assistance\*\*** |  |  |  |

\* Only entities qualifying as tax-exempt, non-profits must offer a sliding fee scale. Others may enter “0.”

\*\* Count any assistance other than sliding fee scales and payment plans under which the client will pay the full amount they were billed; for example, write-offs, charity care**.**

# Supportive and Stabilizing Services

Have supportive or stabilizing services changed since your most recent ECP application or annual report changed? If information has changed, attach a sheet explaining how and why.

Transportation services Child care services Linguistic services

Culturally sensitive and competent services

* Changed
* Changed
* Changed
* Changed
* Unchanged
* Unchanged
* Unchanged
* Unchanged

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# NEW THIS YEAR

\*Clinics under Your ECP Designation\*

**Please provide the information in the table below for ALL locations associated with the organizations ECP Designation.**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Name** | **NPI** | **Street** | **City** | **Zip Code** | **Telephone** | **County** | **Mental Health Services** | **Chemical Dependency** | **Primary Care Services** | **Medical Services** | **Dental Care** | **Physical Rehab Services** | **Family Planning** | **Home Care Services** | **Indian Health Provider** | **Serving Students Only** |
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