Children's Miracle Network Hospitals®

Market Alignment Process: Binding Decision Application for Initiating Hospital

INSTRUCTIONS

- The Initiating Hospital CDO may begin the Binding Decision Option by completing and submitting this application which must be signed by the Initiating Hospital's CDO and Chief Executive Officer.
- With this application, the Initiating Hospital will pay a non-refundable administrative fee in the amount of $12,150 as outlined in Appendix 1 of the 4th Amendment to the Membership Agreement.
- When submitting this application, please attach the following:
  - **Narrative.** Any information that might be helpful in considering the market alignment request. These comments must be limited to 5 pages in a 12 point font.
  - **Supporting Materials (optional).** As outlined in Appendix 1 of the 4th Amendment to the Membership Agreement, if the Initiating Hospital arranged for an audit or survey, these should also be attached.
- Email your completed application and all attachments to Jessica McKnett, Vice President, Experience Operations at jmcknett@cmnhospitals.org. The Initiating Hospital will copy the CDO of the Respondent Hospital on the email.

TIMELINE

The timeline below is a summary of the information detailed in the 4th Amendment of the Membership Agreement.

- **Response from Respondent Hospital.** Within sixty (60) days of receiving the application, the Respondent Hospital will submit a response to CMN Hospitals addressing the application from the Respondent Hospital's perspective. The Respondent Hospital will copy the CDO of the Initiating Hospital when submitting their response.
- **Compilation of Materials by CMN Hospitals.** Following receipt of the Initiating Hospital's application and Respondent Hospital's response, CMN Hospitals staff will forward all materials to the CDO Market Alignment Process (MAP) Council.
- **CDO MAP Council Telephone Conference.** After receiving the materials from CMN Hospitals, the CDO MAP Council will schedule a telephone conference to take place within thirty (30) days after receiving the Respondent Hospital's response.
- **Recommendation to the Board of Trustees.** The CDO MAP Council will make a recommendation to the CMN Hospitals Board of Trustees within fourteen (14) business days after the telephone conference for consideration at the next regularly schedule meeting of the Board of Trustees.
- **Notification of Decision.** The CDO MAP Council will notify the Initiating Hospital and Respondent Hospital of the decision following approval by the Board of Trustees.
- **Effective Date.** Decisions made by the CDO MAP Council and then ratified by the Board of Trustees by October 1 will be effective on January 1 of the following year.

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INITIATING HOSPITAL INFORMATION

Member Name:	
Benefiting Hospital: (if different from Member Name)	
Address:	
City, State & Zip:	
Hospital's EIN: (Employer Identification #)	

Please list the territory you are requesting through the market alignment process.

Respondent Hospital:	
County (Counties):	
State:	

About Your Hospital

Which description below best represents your facility:

	Freestanding children's hospital (comprehensive pediatric care)	
	Major Pediatric Teaching or University Hospital (AAMC accredited)	
	Major Institutional pediatric care facility	
	Pediatric hospital within a hospital (significant pediatric care)	
	Other. Please explain:	

Does your pediatric facility have the following? (Check all that apply)

	An independent exterior entrance.
	An independent interior entrance.
	An independent children's wing.
	An independent children's floor.

Awards and Recognition

Please list any recent awards or recognition received by your hospital, doctors or staff.

Staffing for CMN Hospitals Activities

CMN Hospitals requires a minimum of one (1) full-time employee dedicated to implementing CMN Hospitals fundraising and awareness activities in the fundraising territory. Is your hospital currently dedicating one FTE to CMN Hospitals' activities?

	Yes
	No

Comments:	

CMN Hospitals Engagement

Within your current territory, please describe your CMN Hospitals partner level of engagement.

	Excellent and continuing to grow.
	Stable/average.
	New and showing potential
	Below average

Comments:	

PATIENT SERVICES DATA

Please provide the following information annually by the county (counties) under review for the past three years.

Services for (indicate county) ***Please duplicate this table for each county at issue***	**(indicate year)**	**(indicate year)**	**(indicate year)**
In-Patient Visits - unduplicated			
Out-Patient Visits - unduplicated			
Emergency Room Visits			
Pediatric Subspecialty Visits (ex., pediatric cardiology)			

Unique Pediatric Patients by County (Counties) *Please add rows as needed.*	**(indicate year)**	**(indicate year)**	**(indicate year)**
(indicate county)			
(indicate county)			
(indicate county)			

Total Pediatric In-Patient Days by County (Counties) *Please add rows as needed.*	**(indicate year)**	**(indicate year)**	**(indicate year)**
(indicate county)			
(indicate county)			
(indicate county)			

Pediatric Services Provided

Please identify the level of pediatric care provided by your hospital as of the end of your most recent fiscal year.

Services	**Level I**	**Level II**	**Level III**	**Not Available**
Neonatal Intensive Care				
Pediatric Intensive Care				
Pediatric Trauma Care				
Pediatric/Neonatal Intensive Care Transport Services				

	Number of Licensed PICU Beds.
	Number of Licensed NICU Beds.
	Total Number of Pediatric Licensed Beds.

Other Facilities

Please tell us about other pediatric facilities or care provided in the county (counties) under review. Location types may include clinics, critical access hospitals, physician group affiliations, telemedicine affiliations, prescription programs, medical equipment, home care, and pet therapy.

In addition to location types, please describe the types of services provided in these locations.

CONTACT INFORMATION AND SIGNATURES

Top Hospital Leader (CEO, President, Administrator or Equivalent)	
Name:	
Title:	
Email:	
Phone:	
Signature:	

Top Development Leader (Chief Development Officer, Foundation CEO or President)	
Name:	
Title:	
Email:	
Phone:	
Signature:	

Application Completed By

Top Hospital Leader (CEO, President, Administrator or Equivalent)	
Name:	
Title:	
Address:	
City, State, Zip:	
Email:	
Phone:	