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

[](http://www.doh.wa.gov/)

**Coordinated Quality Improvement Program**

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

PO Box 47890

Olympia, Washington 98504-7890

[Email](mailto:CQIP@DOH.WA.GOV)

**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**](mailto: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](mailto::CQIP@DOH.WA.GOV).