

CoE-PHI Community of Practice Application

Healthcare Organization Information

1. Name of Healthcare Organization*

**If you are representing a state agency, please list your state agency name here.*

*

2. Organization Website *

3. Location *

Street

City

State

Zip
Code

4. Organization Type *

- Dedicated SUD Treatment Center
- Integrated SUD Treatment Services Provider (In Primary Care)
- Designated SUD Unit within Hospital
- Other - Write In (Required)

Applicant Key Contact Information

5. Name of Key Contact (Who will be Responsible for all Activities Associated with the CoP if Selected) *

6. Name of Person Filling out Application (*if different from Key Contact*)

7. Key Contact Information *

Title

Email

Phone Number

Proposed Team Members

8. Please use the table below to record your organization's proposed team members (this does not need to be a final list), including Name, Title, and Email.

*

	Name	Title	Email
Team Member 1	<input type="text"/>	<input type="text"/>	<input type="text"/>
Team Member 2	<input type="text"/>	<input type="text"/>	<input type="text"/>
Team Member 3	<input type="text"/>	<input type="text"/>	<input type="text"/>
Team Member 4	<input type="text"/>	<input type="text"/>	<input type="text"/>
Team Member 5	<input type="text"/>	<input type="text"/>	<input type="text"/>

Reason for Applying

9. Why is your team interested in participating in the CoE-PHI Community of Practice focused on implementing the changes to the Final Rule? (Maximum 250 Words)

10. What do you hope to gain from participating? (Maximum 250 Words)

Current Context

11. To what extent has your healthcare organization implemented changes to your organizational consent form for uses and disclosures of Part 2 records (check one)?

- Not Started
- Planning in Progress
- Planning Completed
- Implementing Updated Consent Forms
- Not Sure
- Optional: Please share any additional information about progress here

12. To what extent has your healthcare organization implemented changes to your Notice of Privacy Practices/ Part 2 Patient Notice (Check One)?

- Not Started
- Planning in Progress
- Planning Completed
- Implementing Updated Consent Forms
- Not Sure
- Optional: Please share any additional information about progress here

13. To what extent has your healthcare organization implemented changes to your Staff Training Plan to ensure knowledge of the updated regulatory requirements and how to use new forms (Check One)?

- Not Started
- Planning in Progress
- Planning Completed
- Implementing Updated Consent Forms
- Not Sure
- Optional: Please share any additional information about progress here

14. What are the main challenges or barriers your organization has had, or is experiencing in adoption of the new requirements? *

- Updating Template Consent Forms
- Updating Policies and Procedures
- Lack of Time
- Don't have key staff or legal consultants to make necessary changes
- Not sure where to start
- Other

Additional Information

15. Is there anything else you would like us to know about you or your healthcare organizations application? (Write-in)

16. If your application is selected for further review, please indicate when you are available for a brief virtual (30 minute) meeting to review your application with the CoE-PHI Team (select all that apply).

- April 2nd 2 - 2:30pm Eastern
- April 2nd 2:30 - 3:00pm Eastern
- April 2nd 3 - 3:30pm Eastern
- April 3rd 12:30-1pm Eastern
- April 3rd 1 - 1:30pm Eastern
- April 3rd 1:30 - 2 pm Eastern
- April 3rd 2 - 2:30pm Eastern
- April 3rd 3 - 3:30pm Eastern
- April 6th 11-11:30am Eastern
- April 6th 12-12:30pm Eastern
- April 6th 1-1:30pm Eastern
- April 6th 2-2:30pm Eastern
- April 10th 12-12:30pm Eastern
- April 10th 1-1:30pm Eastern
- April 10th 1:30-2:00pm Eastern
- I am not available any of these times.