**PPLP Program Application: LeadCare ll Point of Care Testing Device**

**Name of Applicant Parent Organization**:

**Name/Email of Chief Medical Officer**:

**Name/Title/Email of Contact Person for this Application**:

**Eligibility:** The Partnering for Pediatric Lead Prevention (PPLP) program is open to primary care providers in the Partnership HealthPlan of California network who meet the following criteria:

* Serve a pediatric patient population which includes members 0-3 years of age.
* Do not currently have access to point of care (POC) testing or have purchased a LeadCare II device within the past four months and are requesting reimbursement for that purchase (please include documentation of purchase when submitting application).
* Have a current Clinical Laboratory Improvement Amendments (CLIA) certificate of waiver for other POC testing and are able to add LeadCare II to their CLIA waived testing panel OR are willing to apply for a CLIA certificate of waiver.

**Please respond to the following questions:**

1. For each site you are applying for, please fill out the following information:
   * *Site/Location Name:* 
     + *Site/Location Physical Address:*
     + *Site/Location Mailing Address:*
     + *Number of Partnership assigned children age 0 – 3:*
     + *Current method of collecting lead samples, if any:*
2. Identify key individuals who will oversee the program including their titles, contact information, and a brief description of their background.
   * *Clinical leads:*
   * *Operational leads:*
   * *Contact for ongoing program communication:*
3. What is your current method of collecting lead samples?
   * *If you currently have lead testing equipment on site, please explain why additional equipment is needed.*
   * *If you currently submit capillary specimens to Public Health Lab Testing in your county, why are you requesting to change this process?*
   * *If you have access to submit capillary specimens to Public Health Lab Testing in your county but choose not to, please explain why.*
4. Describe the planned office practice flow for testing (from identifying patients who need testing to collecting and running the specimens).
   * *If more than one of your sites will be sharing use of the LeadCare ll POC device (i.e. one site will be sending specimens to another to be ran), please include the site names within the workflow that will be using the equipment and a detailed plan to share use between them.*
5. Do you currently have electronic capabilities to report lead testing results to CDPH or are you willing to establish? *Please note: This is a requirement.*
6. If your organization has previously used a LeadCare II machine for lead testing, describe any challenges you may have had, and how you responded to these challenges.

**Next Steps:**

1. Review PPLP program materials on the [Lead Poisoning and Prevention](https://www.partnershiphp.org/Providers/HealthServices/Pages/Health%20Education/Lead-Poisoning-and-Prevention.aspx) site and complete application.
2. Submit application to [leadPOC@partnershiphp.org](mailto:leadPOC@partnershiphp.org?subject=(Org%20Name)%20Lead%20POC%20Application) with your organization’s name and “Lead POC Application” in the subject line.
3. Expect notification within three weeks after submission with information regarding next steps.

Upon submission you are attesting that the above is a true and complete representation of your current services and needs, along with formally requesting Partnership HealthPlan of California’s support in obtaining Lead Care point of care devices. You are also pledging that your PCP site is committed to following through on the compliance, certification, and reporting requirements as specified by the Department of Public Health.

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| **Internal Partnership Use Only** | | | | |
| **Parent Organization** | | | | |
| **Site Name** | **2024 QIP NUM/DEN as of DD/MM** | **2024 QIP Score as of DD/MM** | **2024 QIP % as of DD/MM** | |
|  |  |  | |
| **2023 QIP NUM/DEN** | **2023 QIP Score** | **2023 QIP %** | |
|  |  |  | |
| **# of Partnership assigned Children Ages 0 - 3** |  | **ID #** |  |
| **Comments** |  | | |
| **Approval Status**  **w/ Notes** |  | | | |