Appendix C: GP Focused Practice Designation Application and Consent form

Please submit an electronic application only to Anna Carnovale at anna.carnovale@oma.org. Your application and supporting documents must be submitted as one (1) PDF document.

Section 1 – Physician Information and Signature:		
Last Name:	***Given Name(s):***	***Middle Initial:***
Practice Mailing Address:		
Unit #:	***Building/Complex:***	
Street #:	***Street:***	
City / Town:	***Province:*** ON	***Postal Code:***
Telephone, Fax, E-mail:		
Telephone: ***Ext:*** ( ) -	***Fax:*** ***Ext:*** ( ) -	
E-mail Address:	***Preferred method of correspondence:*** ***Mail*** ☐ ***Fax*** ☐ ***E-mail*** ☐	
Additional Information:		
OMA Section:	***OHIP Billing Number:***	
"I certify that the information contained in this application is true and accurate".		
☐ ☐ ☐ ***Physician Signature***	***Date***	

Section 2 - Focused Practice Information:
1. Please indicate your area of focused practice.
2. Eligible physicians must practice a minimum of 20% of their practice time in their focused area. Please declare what percentage of your time is spent practicing in your focused area. _____Days or_____%
3. How many distinct General Practitioners in the community routinely refer patients to you over the course of a year? _____General Practitioners

4. How many distinct patients per week do you treat in your focused area of practice?

_____Patients

5. Which main fee codes in your focused area of practice have the largest impact on access bonus?

_____ _____ _____ _____

Section 3 - Community Need:

1. Approximately how many distinct patients in your community require services in your area of focused practice?

_____Patients or_____%

2. Approximately how many physicians in your community provide care in your focused area of practice?

_____General Practitioners _____Specialists

3. Please estimate the average patient wait time in your community to receive the services in your focused area of practice.

_____Weeks

4. Please estimate the average travel time to the nearest area outside of your community where the patients can receive the services in your focused area of practice.

<30 minutes 30-59 minutes > 60 minutes

Section 4 - Supporting Documents:

1. In a separate cover letter accompanying this form, please discuss any information relevant to your specific situation that the committee should be aware of when reviewing your application.

2. Please attach documents for any educational seminars, CME programs, internships, or related training activities that you have attended in support of your focused area of practice.

3. Please attach three (3) letters from your community supporting your application for the exemption status in your area of practice. These could include letters from local Specialists, Family Physicians, LHINs, CCACs, and hospitals.

Section 6 – Signature and Declaration

1. Please fill out and sign the attached form, “Consent to Disclosure of Billing and Financial Information.”
2. Please fill out and sign the attached Declaration form.

CONSENT TO DISCLOSURE OF BILLING AND FINANCIAL INFORMATION

TO: THE GENERAL MANAGER OF THE ONTARIO HEALTH INSURANCE PLAN
(the "**General Manager**")

AND TO: THE MINISTER OF HEALTH AND LONG-TERM CARE

AND TO: MOHLTC/OMA GP FOCUSED PRACTICE COMMITTEE

I,_____, hereby authorize the General Manager to disclose to the GP Focused Practice Committee, the following information relating to amounts paid by the Plan to me for Insured Services rendered by me during the past two (2) years:

- date of service;
- fee code for service, where applicable;
- amount paid for service;
- base rate payment amounts, where applicable;
- diagnostic code, where applicable;
- encrypted patient numbers;
- facility number, where applicable; and
- group number, where applicable.

This consent shall be valid until I revoke this consent in writing to the General Manager.

I acknowledge and understand that the purpose of the disclosure of this information by the General Manager to the GP Focused Practice Committee is to assist the Committee to assess my eligibility as a GP Focused Practice physician.

Dated at_____this_____day of_____,_____.

_____
(Signature of physician)

_____
(Name)

_____
(Address)

_____

_____

MINISTRY OF HEALTH AND LONG-TERM CARE/ONTARIO MEDICAL ASSOCIATION
GP FOCUSED PRACTICE REVIEW COMMITTEE DECLARATION AND ACKNOWLEDGEMENT

I,_____, M.D., have applied to the GP Focused Practice Review Committee for designation under the GP Focused Practice Designation program and declare that my focused practice area is _____.

The Physician Services Committee has established a process whereby a physician will be designated a GP Focused Practice Physician ("Designation") if he or she meets the eligibility criteria, including the requirement to spend a minimum of 20% of his or her practice time providing medical services in their focused practice area.

I declare that at least 20% of my practice time is devoted to my focused practice area. If, at anytime during my Designation, I do not meet the minimum practice time requirement, I will agree to notify the Ministry of Health of the change in circumstance to **undergo Designation review**.

Dated at_____, Ontario

this_____day of_____, 202_.

_____

(Signature of physician)

_____

(OHIP Billing Number)