BRITISH COLUMBIA | Ministry of Health

EXPRESSION OF INTEREST

Practicing Family Physician Group Contract

The Ministry of Health and the regional Health Authorities are committed to increasing patient access to primary care and expanding primary care capacity across British Columbia via the implementation of Primary Care Networks (PCN) and Patient Medical Homes (PMH). As part of the strategy to deliver on these commitments, Physicians who have an established primary care practice will have the opportunity to transition from fee-for-service model to a contract with the relevant Health Authority, if they are committed to transitioning their practice into a PMH, and integrating it with the PCN in their community once established.

By signing this form, the undersigned hereby consents to and acknowledges that personal information will be collected under the authority of the *Medicare Protection Act* and section 26(a), (c) and (e) of the *Freedom of Information and Protection of Privacy Act* for the purposes of administration of the Medical Services Plan. Personal information will be used for assessing a clinic's eligibility to enter into a Practicing Family Physician Group Contract. The Province may disclose physicians' personal information to the physicians listed herein, the clinic, and to any relevant regional health authority for the purposes described above. The Province may also disclose non-personal information, collected in Section A and Section D, to the relevant PCN Steering Committee.

☐ Consent to disclose non-personal information, collected in Section A and Section D, to DoBC for the purpose of providing support for clinic transition to Practicing Family Physician Group Contract.

All consent shall be valid for one calendar year from the date of the undersigned's signature. If you have any questions about the collection and use of your personal information, please contact the Health Insurance BC Chief Privacy Office at Health Insurance BC, Chief Privacy Office, PO Box 9035 STN Prov Govt, Victoria BC V8W 9E3 or call 604-683-7151 (Vancouver) or 1-800-663-7100 (toll free).

SECTION A: CLINIC INFORMATION (REQUIRED)

Clinic Name			Number of FTE Contracts
Clinic Address (Number and Street)	City	Postal Code	Health Authority

SECTION B: PHYSICIAN INFORMATION (SIGNATURE REQUIRED IN SECTION F, PAGE 2)

	PHYSICIAN NAME (LAST, FIRST)	LOCUM	NEW TO PRACTICE	PRACTITIONER NUMBER	ANTICIPATED FTE	RELEVANT PAYMENT NUMBER(S)*
1		☐	☐			
2		☐	☐			
3		☐	☐			
4		☐	☐			
5		☐	☐			
6		☐	☐			
7		☐	☐			
8		☐	☐			

* Payee numbers that are relevant to the contract work physicians will be doing (community based clinic payees).

The Ministry of Heath advises clinics to use the secure transmission instructions.
Send completed form to: **PCN.Compensation@gov.bc.ca**

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SECTION C: LEAD PHYSICIAN / ADMINISTRATOR INFORMATION (REQUIRED)

Last Name of the Lead Physician/Administrator	First Name of the Lead Physician/Admin	Practitioner Number	Signature
Email	Phone Number	Date Signed (YYYY / MM / DD)	

SECTION D: CLINIC DECLARATION (REQUIRED FOR LEAD PHYSICIAN/ADMINISTRATOR)

The Lead Physician/Administrator must initial beside the description(s) that best represent their practice.

DECLARATION	INITIAL
I hereby confirm that our practice is (check and initial all that apply):	
☐ Currently working toward advancing the attributes of the Patient Medical Home (PMH) including team based care.	
☐ Connecting with our local division, PCN (Primary Care Network) steering committee and/or Collaborative Services Committee to contribute to community discussions on PCN planning, development and priority setting (minimum annually).	
☐ Contributing to co-developed community level primary care service delivery to advance the attributes of the PCN (attachment, access, comprehensiveness etc.) — this may include using the zero dollar attachment fee code to indicate new patient attachments to our group.	
☐ Willing to share non-identifiable aggregate patient information, as outlined in an information sharing agreement, for the benefit of community planning and Quality Improvement (QI).	
OR	
☐ Not currently participating in PMH/PCN but are willing to commit to transitioning to PMH and participating in PCN development and/or implementation.	

SECTION E: CLINIC DETAILS (REQUIRED)

Select all that apply:

☐ All physicians practice at the same physical location

☐ The practice physicians own the clinic

☐ All physicians at the clinic intend to join the Practicing Family Physician Group Contract

Additional Information

SECTION F: PHYSICIAN SIGNATURES (REQUIRED FOR ALL PHYSICIANS LISTED IN SECTION B, PAGE 1)

	PHYSICIAN SIGNATURE	DATE SIGNED (YYYY / MM / DD)
1		
2		
3		
4		

	PHYSICIAN SIGNATURE	DATE SIGNED (YYYY / MM / DD)
5		
6		
7		
8		

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