A Public Entity
Inland Empire Health Plan

Provider Network Expansion Fund Program
Application

Please complete the information below to apply for funding from the IEHP Provider Network Expansion Fund Program. Refer to the Program Description of the IEHP Provider Network Expansion Fund Program for information regarding the program. For any questions regarding this program please contact:

Beth Taylor, Business Analyst at (909) 269-3622 or Coline Ingalla, Business Analyst at (909) 890-2155

Send completed applications by e-mail to taylor-f@iehp.org & ingalla-c@iehp.org

EMPLOYING/CONTRACTING ENTITY INFORMATION

Entity Name: _____
Entity Address: _____
Entity City & Zip: _____
Entity TIN: _____
Contracted with IEHP: ◯ **Yes** ◯ **No**

Contact Person: _____
Contact Phone #: _____
Contact Email: _____

POSITIONS TO BE FUNDED

Have you identified a candidate? ◯ **Yes** ◯ **No** *If yes, please write their name(s) below and attach a CV.*

Provider Type (MID, PCP, SPEC)	**Specialty**	**Name**	**Practice Address**

FUNDING JUSTIFICATION

Please provide specific information to justify why these positions should be funded, including but not limited to case load of current providers at practice, work schedule/office hours, access times for appointments, etc. (attach additional pages as needed)