

# USE STIMULUS FUNDS TO PREPARE YOUR PRACTICE FOR THE FUTURE

Stimulus funds are available for physicians, PAs and ARNPs in priority primary care specialties (Family, Internal Medicine, Pediatrics, & OB/GYN)... *but time is of the essence, so act now!*

One important goal of the Federal Stimulus package is improving the quality of health care. As a result, a portion has been specifically designated to developing Health Information Technology (HIT). *PaperFree Florida*, a broad collaborative of USF Health, rural health networks, community health centers, state-wide organizations, and others, is applying for funds to promote HIT development in Central Florida. Take advantage of this exciting opportunity and position your practice for the future—get paid to implement and use the newest, most innovative Electronic Health Record (EHR) systems in your office.

Sign this letter of support now for *PaperFree Florida* – this is an indication of your interest in participating in *PaperFree Florida* and learning more about how EHRs can function meaningfully in your practice.

## HOW YOUR PRACTICE WILL BENEFIT:

- Receive Medicare/Medicaid incentives toward the cost of purchasing or upgrading certified EHR technology, software training and technical support (\$44,000-\$65,000 over 5 years)
- Receive an additional “pay-for-performance” Medicare Reimbursement bonus of up to 3%
- Reliable on-site technical support
- Superior electronic security & privacy best practices

**Please fill out this form today and return to *PaperFree Florida* by Wednesday, January 20, 2010.**

Email form to: CLESKO@HEALTH.USF.EDU or FAX: 813-974-3886

[www.health.usf.edu/paperfree/index.htm](http://www.health.usf.edu/paperfree/index.htm)

### **CHECK ONE:**

Solo practice, one (1) National Practitioner Identification (NPI) number—Complete Section A

Group practice w/Single Tax Identification Number—Complete Section B

Group practice w/Multiple Tax Identification Number—Complete Section C

### **SECTION A: Solo Practice, Single Tax Identification Number**

Do you **currently** have an EHR/EMR in place?                      Yes                      No

Physician Name \_\_\_\_\_

Specialty/Department (Family, General Internal, Pediatric, OB/GYN) \_\_\_\_\_

National Practitioner Identification (NPI) \_\_\_\_\_ Primary Phone # \_\_\_\_\_ Primary FAX # \_\_\_\_\_

Physical Street Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ ZIP+4 \_\_\_\_\_

Email address \_\_\_\_\_

Authorized Representative Signature \_\_\_\_\_

Printed Name of Provider/Organization's Authorized Representative \_\_\_\_\_ Title \_\_\_\_\_



Sign this letter of support now for *PaperFree Florida* – this is an indication of your interest in participating in *PaperFree Florida* and learning more about how EHRs can function meaningfully in your practice.

**Please fill out this form today and return to *PaperFree Florida* by Wednesday, January 20, 2010.**

Email form to: CLESKO@HEALTH.USF.EDU or FAX: 813-974-3886

**SECTION B: Group Practice w/Single Tax Identification Number**

– List all clinicians with their specialty and NPI on separate page

Do you **currently** have an EHR/EMR in place?      Yes      No

Practice or Organization Name \_\_\_\_\_

Tax Identification # \_\_\_\_\_ Primary Phone # \_\_\_\_\_ Primary FAX # \_\_\_\_\_

Physical Street Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ ZIP + 4 \_\_\_\_\_

Email address: \_\_\_\_\_

Authorized Representative Signature \_\_\_\_\_

Printed Name of Provider/Organization's Authorized Representative \_\_\_\_\_ Title \_\_\_\_\_

**SECTION C: Group Practice w/Multiple Tax Identification Number**

– List all Tax Payer Identification Numbers and clinicians with their specialty and NPI on separate page

Do you **currently** have an EHR/EMR in place?      Yes      No

Practice or Organization Name \_\_\_\_\_

Primary Phone # \_\_\_\_\_ Primary FAX # \_\_\_\_\_

Physical Street Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ ZIP + 4 \_\_\_\_\_

Email address: \_\_\_\_\_

Authorized Representative Signature \_\_\_\_\_

Printed Name of Provider/Organization's Authorized Representative \_\_\_\_\_ Title \_\_\_\_\_

