MERIDIAN

REQUEST FOR MANAGEMENT DECISION

SUBMITTED BY: _____ **DATE SUBMITTED:** _____

Email: _____ **Contact Number / Ext.:** _____

Vice President Approval (if VP/SVP not submitting Form 20): _____

REQUESTED CHANGE *(check all that apply):*

☐ NEW BUSINESS LINE, SERVICE, PROGRAM, CONTRACT/GRANT

☐ CHANGE TO EXISTING STAFFING GROUP, BUDGET, SERVICE, PROGRAM, CONTRACT/GRANT

Brief description of proposal: _____

PROPOSED EFFECTIVE DATE: _____

In each section below, identify actions needed to implement the proposed changes. *FOR EMT USE* sections are for final review and sign off.

FOR EMT SPECIAL ASSISTANT USE: Date Received: _____ Form 20 #: _____

☐ Complete ☐ Incomplete – Returned for: _____

HUMAN RESOURCES:

☐ *No Human Resources issues – No personnel changes needed.*

☐ Add FTE (Title & FTE number); if new position(s), Position Description(s) must be attached prior to approval: _____

☐ Delete FTE (indicate position numbers to be eliminated): _____

☐ Transfer of staff, supervision, program location (indicate position numbers & "from" & "to" of positions):

_____

FOR EMT USE:

☐ Approve ☐ Disapprove – Comment: _____

☐ Need more information: _____

Chief Human Resources Officer: _____

Date: _____

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FINANCE & ACCOUNTING:

☐ *No Fiscal issues – No action needed.*
☐ New program or contract proposal. Please see Procedures IX-M and IX-N.
  ☐ Requires equipment and/or supplies (furniture, computers, software, cell phones, other electronic equipment, educational or patient supplies, marketing materials and supplies, etc.).
  Start-up: _____
  On-going/recurring: _____
  ☐ Requires additional support or billing staff.
☐ Change existing revenue/expenses.
  ☐ Add Revenue: *Complete page 5 of this form.*
  ☐ Add Expense: *Complete page 5 of this form.*
  Source of Funds to pay for expense: _____
  ☐ Recurring ☐ Non-recurring
☐ Personnel Changes:
  ☐ Add or delete positions: *Complete page 5 of this form.*
  ☐ Transfer of staff, supervision, or location of program
  From: _____ To: _____

FOR EMT USE:
☐ Approve ☐ Disapprove – Comment: _____
☐ Need more information: _____
☐ Funding Codes and Reporting Units changes to be input in Datis (specify): _____
_____
Chief Financial Officer: _____
Date: _____

CLINICAL:

☐ *No action needed – No clinical services or protocols involved.*
☐ New program or contract proposal – Please see Procedure VIII-X and attach the required information.
  ☐ Clinical training needs for staff: _____
☐ Change existing clinical protocol – Describe change, include any EBP to be dropped or added.
  ☐ Clinical training needs for staff: _____
_____

FOR EMT USE:
☐ Approve ☐ Disapprove – Comment: _____
☐ Need more information: _____
Chief Clinical Officer: _____
Date: _____

☐ Approve ☐ Disapprove – Comment: _____
☐ Need more information: _____
SVP Clinical & Community Services: _____
Date: _____

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MEDICAL:

☐ *No action needed – No medical services or protocols involved.*
☐ New program or contract proposal – Please see Procedure VIII-X and attach the required information.
  ☐ Training needs for staff: _____
☐ Change existing clinical protocol – Describe change, include any EBP to be dropped or added.
  ☐ Training needs for staff: _____

_____

FOR EMT USE:
☐ Approve ☐ Disapprove – Comment: _____
☐ Need more information: _____

SVP Medical Services: _____
Date: _____

OPERATIONS:

☐ *No action needed – No operational needs or requirements.*
☐ New program
☐ Advertising needs
  ☐ Brochures ☐ Flyers ☐ Promo Items
☐ Contract language requirement, specific logo or verbiage on collateral materials or website.
☐ Reporting requirements (attach report formats if applicable): _____
  ☐ Data for reports exists in EMR ☐ Requires other tracking mechanism
  Who is responsible for reporting? _____
  Reporting frequency: _____
☐ Key performance indicators (outcomes) will be measured/reported (list specific indicators/measures):

_____

_____

☐ Site monitoring and/or audits will be conducted for this service/program (indicate type and frequency):

_____

_____

☐ Service/activity/program is high risk and/or generates liability (describe the specific risk management concerns – e.g., physical restraints used, physical activity with fall risks involved, high litigation risk area):

_____

_____

_____

FOR EMT USE:
☐ Approve ☐ Disapprove – Comment: _____
☐ Need more information: _____

Chief Operating Officer: _____
Date: _____

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FINAL REVIEWS:

Special Assistant to the President:

☐ Required attachments complete.

☐ Requested information by reviewers attached.

Chief Operating Officer Review:

☐ Required attachments complete.

☐ Consistent with mission and scope.

☐ Adequately resourced, protocols achievable, interdepartmental issues addressed appropriately.

☐ Requires new contract: _____

☐ Requires Attorney Review: _____

Date Referred to Attorney: _____

Date Attorney Review Complete: _____

Chief Operating Officer Approval:

☐ Approve ☐ Disapprove – Comment: _____

☐ Need more information: _____

Chief Operating Officer: _____

Date: _____

Chief Executive Officer Review:

Budget changes: ☐ Amend Current Year Budget ☐ No amendment needed

☐ Requires Board Approval: _____

Board Meeting (Date): _____

Board Action: ☐ Approved ☐ Disapproved

☐ Need more information: _____

Chief Executive Officer Approval:

☐ Approve ☐ Disapprove

Comment: _____

Final Approval: _____

Date: _____

DISTRIBUTION

Special Assistant to the President:

Original to: _____

Copies to: _____

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FOR EXISTING PROGRAMS AND SERVICE LINES ONLY

CHANGES IN FTE

Program(s) #	**Program Name(s)**	**Current Year** Incr/(Decr)	**Annual** Incr/(Decr)
TOTALS			

CHANGES IN REVENUES

Program(s) #	**Program Name(s)**	**Current Year** Incr/(Decr)	**Annual** Incr/(Decr)
TOTALS			

CHANGES IN EXPENSES

Program(s) #	**Program Name(s)**	**Current Year** Incr/(Decr)	**Annual** Incr/(Decr)
TOTALS			