ACS TQIP Collaborative Information Form

Please note that the completion of this information form is only the first step for TQIP Collaborative participation. Collaboratives must have a completed cooperation agreement and payment prior to full participation.

Contact Information

Administrative Leader _____ Title _____

E-mail _____ Phone Number _____

Address (line 1) _____

Address (line 2) _____

City _____ State _____ Zip Code _____

Surgeon/Clinical Leader _____

Title _____

E-mail _____ Phone Number _____

Additional Contact Name _____ Title _____

E-mail _____ Phone Number _____

Additional Contact Name _____ Title _____

E-mail _____ Phone Number _____

Hospital Information

How many trauma centers will be included in your TQIP Collaborative? _____ All Adult or All Peds centers? _____

Verification/ Designation/ Accreditation:

How many ACS I _____ How many State I _____

How many ACS II _____ How many State II _____

Collaborative Structure *Select one of the following options:*

◯ Hospital Paid and Administered (Self Administered)

◯ Third Party Paid and Administered *(If third party structure selected, please answer the following two questions)*

Which third party entity will be contracting with the ACS for the collaborative? (e.g. Department of Health, trauma commission) _____

Will the third party/system pay for hospitals to participate in TQIP? ◯ Yes ◯ No

Please note any questions or comments you have regarding TQIP:

Please attach a list of the trauma centers interested in participating in your TQIP Collaborative. When the Information Form is complete, please print your form and scan a copy to tqip@facs.org.