



ARKANSAS DEPARTMENT OF HEALTH

Arkansas Charitable Clinics Program

REQUEST FOR APPLICATIONS

RFA-14-0004

Issue Date: October 15, 2013

Application Timelines

| Event | Date |
|--|---|
| RFA Issued | October 15, 2013 |
| Submittal of Written Questions must be received by the ADH Issuing Officer | By 2:00 p.m. November 15, 2013 |
| Due date for Applications to be received by the Issuing Officer | By 2:00 p.m. December 17, 2013 |
| Anticipated Completion of Application reviews, recipient selection and award notices mailed | To be determined at a later date |
| Start date of Sub-Grant Award | July 1, 2014 |

Acronyms Used in this RFA

| Acronym | Description |
|----------------|-------------------------------|
| ADH | Arkansas Department of Health |
| FY | Fiscal Year |
| RFA | Request for Application |

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Arkansas Charitable Clinics Grant Program Guidelines

I. INTRODUCTION

This program guide explains the requirements and provides guidelines for the Arkansas Charitable Clinics Grant Program. It is recommended that this guide, enclosed checklist (see page 17) and the application materials be reviewed before preparing an application. Charitable Clinics that are located in Arkansas are eligible to submit applications under this program. Eligible applicants to this program must remain in good standing with the Arkansas Department of Health (ADH). Each clinic is entitled to submit one application. Submittal information must be received by the Arkansas Department of Health /Office of Procurement on or before **2:00 p.m., December 17, 2013**. Failure to submit the application on or before **2:00 p.m., December 17, 2013** shall result in a disqualification of the application and it will be returned as being non-responsive. No electronic submissions will be accepted. Grant applicants may request technical assistance from the ADH/Office of Procurement. Personnel will be available to provide assistance and/or arrange for consultative services in completing the grant application. Questions regarding this RFA must be emailed to bob.broughton@arkansas.gov. Answers to frequently asked questions will be posted on the ADH website-<http://www.healthy.arkansas.gov/about ADH/Pages/GrantBidOpportunities.aspx> and click on Grant and Bid Opportunities.

II. PURPOSE OF THE PROGRAM

The Arkansas Charitable Clinics Grant Program is funded by general revenues as a result of Act 180 of 2009, Tobacco Excise Tax Act. The intention of the Program is to strengthen healthcare systems and services at the local level for Charitable Clinics, thereby increasing the number of Arkansans receiving health care services such as basic primary care, dental and behavioral health services for free or at low cost to those persons unable to pay for medical care. This grant period covers July 1, 2014 through June 30, 2015.

The focus of this FY 2015 funding cycle of the Arkansas Charitable Clinics Grant Program is to target primary needs of Charitable Clinics such as:

- Prescription assistance – pharmaceutical program fees; purchase of stock medications
- Equipment and supplies for lab testing; costs of referral labs done at hospitals
- Diabetic testing equipment and supplies
- Health Education materials and supplies
- X-Ray equipment and supplies
- Medicaid application assistance
- Dental equipment and supplies
- Diagnostic tests or procedures
- Behavioral health counseling
- Maintenance and operations
- Computer equipment and/or software and training
- Health Information Technology and training
- Optometry Services
- Other services (example: translation, transportation, etc.)

III. FUNDING

Initial maximum state funding for this grant is \$33,000. Funds requested shall be matched on a dollar for dollar cash basis by the applicant. No state dollars may be used as cash match. Federal, county, foundation, private contributions as well as any other cash resources may be used as cash match. Grant funds must be used toward purchases outlined in the grant agreement. Cash matching funds may be used toward expenditures of clinic services and operations. Grant payments will be made from General Revenue Funds and are contingent on availability of funds. The grant award will be made directly to the successful sub-grant recipient. **This program cannot fund salaries but will accept individual contracts. No reimbursement will be made for the purchase of equipment or services made prior to the sub-grant award date of effectiveness.** The Arkansas Department of Health will have the final decision on allowable costs.

Other funding restrictions include:

- professional services such as legal or financial consultants;
- indirect and administrative costs and fees such as, but not limited to, membership fees/dues to professional organizations, country clubs, etc., financial audits, subscription fees, and license renewals;
- payment to any state agency for professional registrations, fees and licenses;
- real property, construction or renovation costs;
- promotional/'give away' items (clothing, pens, cups, bags, umbrellas, etc) promoting health center name or logo. This does not apply to educational materials.

IV. ELIGIBILITY REQUIREMENTS

To be eligible to obtain assistance from this program, **one of the following requirements must be met at the time of application:**

- The clinic must be a volunteer-based, safety-net health care organization located in Arkansas that provides a range of medical, dental, pharmacy, and/or behavioral health services to economically disadvantaged individuals who are predominately uninsured. The clinic must be a 501 (c) 3 tax-exempt organization, or operate as a program component or affiliate of a 501 (c) 3 organization. Entities that otherwise meet the above definition, but charge a nominal administrative fee to patients, may still be considered charitable clinics provided essential services, as mentioned above, are delivered regardless of the patient's ability to pay.
- The clinic is a member of the Arkansas Association of Charitable Clinics
- The clinic is a member of National Association of Free Clinics

AND

All applicant clinics must be in good standing with ADH and fully operational at the time of application (these are not planning grants). The clinic **does not** receive public or private reimbursement from **third party** payer sources. Applications from clinics not meeting these requirements will not be considered.

V. SUBMISSION REQUIREMENTS

Applications and supporting documents should be in an easily readable typed format on white paper. To be considered for funding, applications and all supporting documentation must be received on or before **2:00 p.m., December 17, 2013** by the ADH/ Office of Procurement. Failure to meet the submission requirements shall result in a disqualification from consideration of the application.

Number of Copies: Include one (1) original and five (5) single-sided copies unbound. Applicants are encouraged to include 1 copy of the application in Microsoft format on a CD in their packet.

Submission Address and Contact Information

Be sure to indicate on the outside of your sealed proposal the RFA# 14-0004 and mail the completed application and all supporting documents and materials to be received by the Issuing Officer on or before **2:00 pm December 17, 2013** to:

Arkansas Department of Health
Procurement Branch **RFA-14-0004**
Attn: Bob Broughton
4815 West Markham, Slot 58
Little Rock, AR 72205-3867

Applications that are hand delivered should be delivered to:

Arkansas Department of Health Slot 58
Bob Broughton **RFA-14-0004**
4815 West Markham Street, Room L156
Little Rock, AR 72205

Failure to meet the submission requirements shall result in a disqualification from consideration of the application.

For more information regarding this RFA, Please contact the Issuing Officer:

Name: Bob Broughton
Title: ADH Contract Support Manager
E-mail: bob.broughton@arkansas.gov
Phone: 501-280-4594

VI. REVIEW PROCESS

Applications will undergo review by the ADH/Office of Procurement and a Review Panel. Grant funds requested must not exceed **\$33,000** and will be awarded based on the projected needs described in the grant application and available funding of up to \$988,000, with an equitable distribution among all approved applications. For purposes of estimating needs, plan for \$33,000 with an ability to increase or decrease this amount once notified of grant application acceptance. Only applicants requesting the maximum amount of \$33,000 will be eligible for increased funding if available.

Steps

1. Review by the ADH/Office of Procurement personnel to determine if eligibility requirements have been met.
2. The Evaluation Committee will evaluate each application.
3. The Evaluation Committee will make a recommendation for funding to the ADH Program/Center for final approval by the Office of the Director of the Arkansas Department of Health.

VII. REPORTING REQUIREMENTS

Applicants receiving funding are required to submit Expenditure Reports to the Office of Rural Health and Primary Care with accompanying copies of receipts, cancelled checks and bank statements for items and services purchased with grant funds. In the letter accompanying receipts include a brief description of what was purchased, when it was purchased, where it is located and how it is being used. For purchases of intangibles such as events, the same applicable information should be provided.

The Grant Guidelines for the receipt of these funds requires a completion of Quarterly Reports on Patient Data – Direct Care Services and Cash Match (see following page) and a Final Report covering the grant period July 1, 2014 through June 30, 2015 which must be submitted to the State Office of Rural Health and Primary Care no later than August 31, 2015.

VIII. PAYMENTS

Payments will be made after the last month of each quarter based on invoices and documentation received. Reimbursement is based on actual costs not to exceed ¼ of the total grant amount without prior ADH approval of expenditures. Final payments must occur prior to June 30, 2015. State funds for this grant are available for the time period July 1, 2014 through June 30, 2015. All expenditures for this program must occur prior to June 30, 2015. Grant payments will be made from General Revenue Funds and are contingent on availability of funds.

| | | | |
|--|---|--|--|
| FIRST QUARTER <u>July, 2014</u> <u>August 2014</u> | SECOND QUARTER <u>October 2014</u> <u>November 2014</u> | THIRD QUARTER <u>January, 2015</u> <u>February, 2015</u> | FOURTH QUARTER <u>April, 2015</u> <u>May, 2015</u> |
|--|---|--|--|

| | | | |
|-----------------------|----------------------|--------------------|-------------------|
| <u>September 2014</u> | <u>December 2014</u> | <u>March, 2015</u> | <u>June, 2015</u> |
|-----------------------|----------------------|--------------------|-------------------|

Arkansas Charitable Clinics Grant Program Guidelines Grant Application

I. Clinic Overview

1. Please provide the following details about your clinic:

Legal Name of Clinic: _____
Address: _____
Name of Clinic: _____
Clinic Address: _____
Name of Executive Director: _____
Name of President of Board: _____
Total number of Board Members: _____
Federal ID number: _____
Grant Requestor Contact Name and Title: _____
Phone: _____ Fax: _____
Email: _____ Web Address: _____

2. IRS 501c (3) nonprofit? _____

A copy of designation letter from IRS must be provided.

3. End of year income (clinic): _____ End of year expenses (clinic): _____

4. Total annual operating budget (clinic): _____ Dates of fiscal year: _____

5. List the amounts and sources of your four largest sources of income.

| Income Source | Income Amount |
|---------------|---------------|
| | |
| | |
| | |
| | |

III. Description of Clinic Operations

1. Describe the staffing within your clinic. Specify the **total** number of volunteer staff and hours currently providing services through your clinic

| <i>Staff</i> | <i>Volunteer Staff</i> | <i>Volunteer Hours Last Fiscal Year</i> | <i>Volunteer Hours Fiscal Year to Date</i> |
|---|------------------------|---|--|
| Physicians | | | |
| Dentists | | | |
| Nurse Practitioners | | | |
| Pharmacists | | | |
| Behavioral Health Professionals | | | |
| RNs | | | |
| LPNs | | | |
| Physician Assistants | | | |
| Dental Assistants | | | |
| Administrative (intake, scheduling, clerical, etc.) | | | |
| Optometry Services | | | |
| <i>Other (please specify)</i> | | | |
| | | | |

Specify the **total** number of paid/contracted staff currently providing services through your clinic.

| <i>Staff</i> | <i>Employed/Contracted Last Fiscal Year</i> | <i>Employed/Contracted Fiscal Year to Date</i> |
|---|---|--|
| Physicians | | |
| Dentists | | |
| Nurse Practitioners | | |
| Pharmacists | | |
| Behavioral Health Professionals | | |
| RNs | | |
| LPNs | | |
| Physician Assistants | | |
| Dental Assistants | | |
| Administrative (intake, scheduling, clerical, etc.) | | |
| Optometry Services | | |
| <i>Other (please specify)</i> | | |
| | | |

2. Does your clinic currently utilize an electronic medical record (EMR) system? If yes, describe the system used.

3. List all current services and programs provided by your clinic, as well as any key affiliations with other hospitals or health care providers:

Services Provided Onsite:

| | | |
|----------------------------------|-------------------|-----------------------------|
| Primary Care | Social Work | Optometry Services |
| Dental Care | Pharmacy Program | Other (please specify all): |
| Behavioral Health and Counseling | Patient Education | |

| | |
|--------------------------|--|
| Programs: | |
| Key Affiliations: | |

4. Please specify your clinical hours of operation.
**If clinical hours vary by program, please specify the clinical hours provided by each program.*

5. Are there any eligibility requirements a patient must meet in order to receive care at your clinic?
If yes, please attach requirements.

6. Does your clinic help clients apply for government or private programs? If yes, please list.

7. How does your clinic handle client referrals? Attach a copy of your current referral policy if applicable.

IV. Patient Data – Direct Care Services

Please use the grid below to summarize your clinic’s patient data for *your last fiscal year* and *the current fiscal year to date*. This will capture the impact that your clinic has made and enable us to measure future improvements made by your team.

| | <u>Last Fiscal Year</u> | <u>Current Fiscal Year to Date</u> |
|--|-------------------------|------------------------------------|
| Total Patients Served (unduplicated) | | |
| | | |
| Total Visits/Encounters** | | |
| Primary Medical Care Services | | |
| Dental Services | | |
| Pharmacy Services | | |
| Behavioral Health Services | | |
| Patient Education Services | | |
| Optometry Services | | |
| Social Work Services | | |
| Other (please specify) | | |
| <p><i>**Total visits/encounters include the number of services each patient receives. If a patient receives primary care, dental and education service, the patient would be counted for each service received. If this same patient returns at a later date, he/she is not counted as an additional patient, but each service he/she receives is an additional service that should be counted as a visit/encounter.</i></p> | | |

Authorized Representative

Date

Authorized Representative Printed Name and Title

Arkansas Charitable Clinics Grant Program Guidelines

Grant Application Narrative – Description of Grant Purpose

Please provide the following information in this order. Do not use more than three pages for all categories, exclusive of attachments.

I. Project Summary

Provide a brief description of the proposed project. Include how the need was determined.

II. Goals and Objectives

State the key objectives of your grant proposal.

Provide a description of the measurable activities through which you will accomplish each objective.

- List specific time frames and responsible parties for completion of objectives
- Explain how the proposed activities will impact the designated community or population.

III. Project Management

Provide a description of the management structure, financial systems, and facilities that are essential to the management of the project. Also provide a brief history of your successes and experience in managing grant funds.

IV. Evaluation

Explain how you will measure success in achieving your goals and objectives.

How will your results be used, disseminated, or publicized?

Arkansas Charitable Clinics Grant Program Guidelines List of Supporting Documents

Please submit the following information along with the completed application in the order below.

I. Clinic Information

Please provide the following descriptions in two pages or less:

1. Brief summary of the clinic's history and mission.
2. Description of current programs, activities, strengths/accomplishments, and challenges faced by your clinic (highlighting the past year).
3. An organizational chart (if applicable) and a one-paragraph description of key staff.

II. Financial Information

1. The source(s) of the cash match must be verified and documented by a letter from the Executive Director or Board Chairman/President. (1 page) This grant year, matching funds may be verified from July 1, 2014 through June 30, 2015.
2. Itemized budget spreadsheet showing planned grant fund cash match expenditures. An example spreadsheet is attached. (1 page)
3. A justification for all requested budget expenditures. (1-2 pages)
4. A completed Form A: Grant Application Budget Sheet. (1 page)
5. A completed W-9 for the applicant clinic. (1 page)
6. Annual operating budget and actual income and expenses for most recently completed fiscal year **AND** for current year-to-date. (1 – 2 pages)
7. Clinic's most recent AUDITED financial statement (if budget greater than \$500,000) or IRS Form 990 (if required by Federal tax law). If neither document is available, include unaudited financial statements. (no limit)
8. A sustainability plan describing how the project will continue after funds are expended. (1 page)

III. Other Supporting Materials

The following information is optional.

1. Offer evidence of community participation in identifying the needs to be addressed and demonstrating support for the project. Partnerships with local hospitals, churches, non-profits and other clinics are encouraged. Community participation can be demonstrated through town meetings, community surveys, focus groups; community needs assessments, or community participation in the planning process. Summarize community participation in this portion of the application with supporting documentation (news articles, minutes from community meetings, letters of support, etc.).
2. Latest annual report or summary of the clinic's prior year activities.
3. Letters of agreement from any collaborating or affiliated agencies, if applicable.

IV. Certification

1. Certification of Eligibility

FORM A

Arkansas Charitable Clinics Grant Program

Grant Application Budget Sheet
(Print or Type Answers)

SECTION ONE: Summary

Amount of State Grant Funds Requested: \$ _____

Community's Cash Match (Dollar for Dollar) \$ _____

Total Project Cost: \$ _____

Arkansas Charitable Clinics Grant Program Guidelines Sample Budget Spreadsheet and Explanation of Match

A budget that breaks out how support to the program will be utilized shall be provided. A sample spreadsheet has been provided. You may divide the program budget into the two separate columns of Grant Funds and Cash Match.

Cash Match may be used for the purchase of goods or services that are considered an inappropriate use of State funds, (e.g. Salaries, travel for out-of-State training, seminars, conferences, training related to certification or licensure of program personnel, etc.)

NOTE: The table below is provided as a sample spreadsheet that represents a dollar for dollar Grant/Cash Match. Cash Match is the amount of actual certified Cash provided as Matching to the project that is or will be deposited into an account for this project and then expended for goods or services. No In-Kind Match, such as donated goods and services, is calculated.

The manner in which these funds are distributed within the table should not be taken as indicative of how your spreadsheet should be broken out for expenses. This table will assist reviewers in seeing how Grant and Cash Match were utilized and assists in clarification of your Budget Narrative.

NO SALARIES MAY BE PAID WITH GRANT FUNDS. FUNDS MAY BE USED FOR CONTRACTED SERVICES.

Grant awards are subject to review by the Arkansas State Legislature. If your project involves an Out-of-State provider of services, it should be noted that this may involve additional Legislative review.

SAMPLE BUDGET

| ITEM/SERVICE TO BE PURCHASED | GRANT FUNDS | CASH MATCH | ROW TOTAL |
|---|-------------------|-------------------|-------------------|
| One lap-top computer | \$1,000.00 | | \$1,000.00 |
| One color printer | \$1,000.00 | | \$1,000.00 |
| Contracted trainer | \$2,000.00 | \$1,550.00 | \$3,550.00 |
| Travel & lodging for contracted trainer | | \$750.00 | \$750.00 |
| Materials for training | | \$450.00 | \$450.00 |
| Catered food for training | | \$250.00 | \$250.00 |
| Space for training | | \$1,000.00 | \$1,000.00 |
| COLUMN TOTAL | \$4,000.00 | \$4,000.00 | \$8,000.00 |

Application Deadline/Check List

Applications must be received by 2:00 p.m. on December 17, 2013. Applications received after this date and time will NOT be reviewed and will be returned to the applicant. An original and five (5) single-sided copies including the following items must be submitted for a complete application:

- Signed and completed grant application
- Completed grant application narrative
- Description of clinic information
- Organizational Chart
- Letter from Executive Director/a board chairman/President documenting cash match
- Itemized budget spreadsheet including justification
- Completed Form A
- Completed W-9
- Current operating budget including most recent income and expenses for current and most recently completed fiscal year.
- Most recent audited financial statement or IRS form 990 or unaudited financial statements whichever is applicable.
- Sustainability Plan
- Signed Certification of Eligibility
- Electronic copy in Microsoft format (Word/Excel)

Arkansas Charitable Clinics Grant Program Guidelines
Certification of Eligibility

_____ The clinic is a volunteer-based, safety-net health care organization that provides a range of medical, dental, pharmacy and/or behavioral health services to the economically disadvantaged individuals that are predominantly uninsured. The clinic is a 501 (c) 3 tax-exempt organization, or operates as a program component or affiliate of a 501 (c) 3 tax-exempt organization. Clinics that meet the definition, but charge a nominal administrative fee to patients, may still be considered free clinics provided essential services are delivered regardless of the patient’s ability to pay.

_____ The clinic is a member of the Arkansas Association of Charitable Clinics.

_____ The clinic is a member of National Association of Free Clinics.

_____ The clinic does not receive public or private reimbursement from third party payer sources.

_____ The clinic is located within Arkansas and provides health care services to the uninsured.

Authorized Representative

Date

Authorized Representative Printed Name and Title

| |
|--------------------------|
| FOR DEPT USE ONLY |
|--------------------------|

Date Received: _____

ASSIGNED APPLICATION #: _____

Date Reviewed: _____

Date of Applicant Notification: _____

OUTCOME: _____

Details: