# ARKANSAS DEPARTMENT OF HEALTH

## Center for Local Public Health

## Office of Rural Health and Primary Care

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**NOTICE OF FUNDS AVAILABILITY**

**For**

Arkansas Charitable Clinics Grant Program

**Date Issued**

**November 30, 2015**

**Notice of Available Funds for Arkansas Charitable Clinics**
**November 30, 2015**

The Arkansas Charitable Clinics Grant Program will offer funding to support Charitable Clinics that are located in Arkansas and are in good standing with the Arkansas Department of Health (ADH). The Arkansas Charitable Clinics Grant Program is funded by State General Revenue 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 for free or at low cost to those persons unable to pay for medical care. This proposal grant period covers the period July 1, 2016 – June 30, 2017. One proposal per clinic is allowed and maximum state funding available per entity is $33,000. The focus of proposals should be to target the following primary needs of Charitable Clinics:

- 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.)

**Funding Criteria**:
Maximum state funding for this proposal is $33,000 per entity. 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. Funds must be used toward purchases outlined in the grant agreement. Cash matching funds may be used toward expenditures of clinic services and operations. Payments will be made from State General Revenue funds and are contingent on availability. The award will be made directly to the successful applicant. **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**. ADH 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 such as clothing, pens, cups, bags, umbrellas, etc or promoting health center name or logo. This does not apply to educational materials.

**Eligibility Criteria**:
To be eligible to obtain funding 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 must be a member of the Arkansas Association of Charitable Clinics.
- The clinic must be a member of National Association of Free Clinics.

**AND**

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

**Submission Criteria**:
Proposals and supporting documents should be in an easily readable typed format on white paper. To be considered for funding, proposals and all supporting documentation must be received on or before **2:00 p.m., Friday, January 1, 2016** by the ADH/ Office of Rural Health and Primary Care. **NOTE: Proposal acceptance will close when which ever criteria are met first (i.e. deadline date or maximum number of proposals targeted is received)**. Failure to meet the submission requirements shall result in a disqualification from consideration of the application. Applicants are encouraged to include 1 copy of the proposal in Microsoft format on a CD in their submission packet.

Submit proposals & supporting documents to:
Arkansas Department of Health
Office of Rural Health and Primary Care
Daniel Trotta
4815 W. Markham Street, Slot 22
Little Rock, AR 72205-3867

Questions regarding this proposal can be phoned or emailed to Daniel Trotta, at 501-280-4705 or via email at daniel.p.trotta@arkansas.gov.

## ADDITIONAL REQUIREMENTS

**Reporting**:
Applicants receiving funding are required to submit Expenditure Reports to the Office of Rural Health and Primary Care (ORHPC) 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.

Receipt of these funds requires the completion of Quarterly Reports on Patient Data – Direct Care Services and Cash Match and a Final Report covering the grant period July 1, 2016 through June 30, 2017 which must be submitted to the ORHPC no later than August 31, 2017.

**Reimbursement**:
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 each quarter without prior ADH approval of expenditures. Final payments must occur prior to June 30, 2017. State funds for this grant are available for the time period July 1, 2016 through June 30, 2017. All expenditures for this program must occur prior to June 30, 2017. Submission for the final quarter invoice will be in 2 invoices in June prior to official closing date noted at a later time once awards have been made. Grant payments will be made from State General Revenue funds and are contingent on availability. Quarters are divided as follows:

FIRST QUARTER (July – September 2016)
SECOND QUARTER (October – December 2016)
THIRD QUARTER (January – March 2017)
FOURTH QUARTER (April – June 2017)

**Arkansas Charitable Clinics Grant Program Guidelines**
**Proposal Narrative – Description of Purpose**

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

**I. Project Name -** List (If applicable)

**II. Project Summary -** Provide a brief description of the proposed project including a summary of the clinic's history, mission, and description of current programs, activities, strengths/accomplishments and challenges faced by the clinic. Include how the need was determined.

**III. Target Area –** List target population, constituents and all counties served in alphabetical order.

**IV. Goals and Objectives -** State the key objectives of your grant proposal and 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.

**V. 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.

**VI. 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**
**Sample Budget Spreadsheet and Explanation of Match**

A budget that lists the total grant amount requested through the application year and breaks out how support to the program will be utilized must 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 with explaining how Grant and Cash Match funds will be 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 |

**Arkansas Charitable Clinics Grant Program Guidelines**
**List of Required Supporting Documents**

Please include the following information with the completed application in the order below.

## I. Organizational Information

1. 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, 2016 through June 30, 2017.
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 W-9 for the applicant clinic (1 page).
5. Annual operating budget and actual income and expenses for most recently completed fiscal year **AND** for current year-to-date (1–2 pages).
6. Clinic's most recent AUDITED financial statement (if organization's budget is greater than $500,000) or IRS Form 990 (if required by Federal tax law). If neither document is available, include unaudited financial statements (no page limit).
7. A sustainability plan describing how the project will continue after funds are expended (1 page).
8. A copy of the organization's 501(c)3 designation letter from the IRS.

## III. Forms (Complete and Sign as Required)

1. Proposal Overview
2. Description of Clinic Operations (2 pages)
3. Patient Data – Direct Care Services
4. Certification of Eligibility

## IV. Other Supporting Materials (Optional)

1. Letters of agreement from any collaborating or affiliated agencies, if applicable.

**Arkansas Charitable Clinics Grant Program Guidelines**
**Proposal Overview**

**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 501(c)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 |
|---|---|
| | |
| | |
| | |
| | |

**Arkansas Charitable Clinics Grant Program Guidelines**
**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

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

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

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

| | | |
|---|---|---|
| | | |

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.

**Arkansas Charitable Clinics Grant Program Guidelines**
**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.

| | **Last Fiscal Year** | **Current Fiscal Year to Date** |
|---|---|---|
| **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) | | |

***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.*

_____ _____

Authorized Representative Signature Date

_____

Authorized Representative Printed Name and Title

**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 Signature Date

_____

Authorized Representative Printed Name and Title