State of Arkansas
ARKANSAS DEPARTMENT OF HEALTH
4815 West Markham
Little Rock, Arkansas 72205

APPLICATION PACKET
DH-19-0013

Purpose of Sub-Grant:
The Arkansas Department of Health (ADH) issues this Notice of Funds Availability (NOFA) on behalf of Arkansas Charitable Clinics Grant Program to obtain applications for funding to assist Charitable Clinics in providing basic primary care, dental and behavioral health services for free or at low cost to those persons unable to pay for medical care.

NOTE: WORD version of Application Packet available on request

APPLICATION SIGNATURE PAGE

Type or Print the following information.

APPLICANT'S INFORMATION					
Company:					
Address:					
City:		State:		Zip Code:	
Business Designation:	☐ Individual ☐ Partnership	☐ Sole Proprietorship ☐ Corporation		☐ Public Service Corp ☐ Nonprofit ☐ Intergovernmental	
Minority and Women-Owned Designation*:	☐ Not Applicable ☐ African American	☐ American Indian ☐ Hispanic American	☐ Asian American ☐ Pacific Islander American	☐ Service Disabled Veteran ☐ Women-Owned	
	AR Certification #: ______________________		* See *Minority and Women-Owned Business Policy*		

APPLICANT CONTACT INFORMATION *Provide contact information to be used for bid solicitation related matters.*			
Contact Person:		Title:	
Phone:		Alternate Phone:	
Email:			

ILLEGAL IMMIGRANT CONFIRMATION

By signing and submitting a response to this solicitation, the applicant agrees and certifies that they do not employ or contract with illegal immigrants. If selected, the recipient certifies that they will not employ or contract with illegal immigrants during the aggregate term of a contract.

ISRAEL BOYCOTT RESTRICTION CONFIRMATION

By signing and submitting a response to this solicitation, the applicant agrees and certifies that they do not boycott Israel, and if selected, will not boycott Israel during the aggregate term of the contract.

Geographical Coverage Area: Indicate geographical coverage area as either statewide or by individual counties, alphabetically.

____

____

____

____

An official authorized to bind the prospective recipient to a resultant contract shall sign below.

By signing and submitting a response to this Notice of Funds Availability (NOFA), the applicant agrees to comply with all requirements, and that any exception that conflicts with a requirement of this NOFA will cause the application to be disqualified.

Authorized Signature: ______________________________ **Title:** ______________________
Use Ink Only.

Printed/Typed Name: ______________________________ **Date:** ______________________

Agreement and Compliance

CERTIFICATION REGARDING LOBBYING

The undersigned certifies, to the best of his or her knowledge and belief, that:

1. No federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of any agency, a member of Congress, an officer or employee of Congress, or an employee of a member of Congress in connection with the awarding of any federal contract, the making of any federal sub-grant, the making of any federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any federal contract, sub-grant, loan, or cooperative agreement.

2. If any funds other than federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a member of Congress, an officer or employee of Congress, or an employee of a member of Congress in connection with this Federal contract, sub-grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure Form to Report Lobbying," attached hereto, in accordance with its instructions. This disclosure form must be filed with the Arkansas Department of Health (ADH) at the end of each calendar quarter in which there occurs any event that requires disclosure or that materially affects the accuracy of the information contained in any disclosure form previously filed. An event that materially affects the accuracy of the information reported includes:

    a. A cumulative increase of $25,000 or more in the amount paid or expected to be paid for influencing or attempting to influence a covered federal action; or,

    b. A change in the person(s) or individuals(s) influencing or attempting to influence a covered federal action; or,

    c. A change in the officer(s), employee(s), or member(s) contracted to influence or attempt to influence a covered federal action.

3. The undersigned shall require that the language of this certification be included in the award documents for all sub awards at all tiers (including subcontracts, sub-grants, and contracts under grants, loans, and cooperative agreements) and that all sub recipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, Title 31, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

By signature below, vendor agrees to and **shall** fully comply with all Requirements as shown in this section.

Authorized Signature: ____
Use Ink Only.

Printed/Typed Name: ____ **Date:** ______________________________

INSTRUCTIONS FOR COMPLETION OF SF-LLL, DISCLOSURE OF LOBBYING ACTIVITIES

This disclosure form shall be completed by the reporting entity, whether subawardee or prime Federal recipient, at the initiation or receipt of a covered Federal action, or a material change to a previous filing, pursuant to title 31 U.S.C. section 1352. The filing of a form is required for each payment or agreement to make payment to any lobbying entity for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with a covered Federal action. Complete all items that apply for both the initial filing and material change report. Refer to the implementing guidance published by the Office of Management and Budget for additional information.

1. Identify the type of covered Federal action for which lobbying activity is and/or has been secured to influence the outcome of a covered Federal action.

2. Identify the status of the covered Federal action.

3. Identify the appropriate classification of this report. If this is a follow-up report caused by a material change to the information previously reported, enter the year and quarter in which the change occurred. Enter the date of the last previously submitted report by this reporting entity for this covered Federal action.

4. Enter the full name, address, city, State and zip code of the reporting entity. Include Congressional District, if known. Check the appropriate classification of the reporting entity that designates if it is, or expects to be, a prime or subaward recipient. Identify the tier of the subawardee, e.g., the first subawardee of the prime is the 1st tier. Subawards include but are not limited to subcontracts, subgrants and contract awards under grants.

5. If the organization filing the report in item 4 checks “Subawardee,” then enter the full name, address, city, State and zip code of the prime Federal recipient. Include Congressional District, if known.

6. Enter the name of the federal agency making the award or loan commitment. Include at least one organizational level below agency name, if known. For example, Department of Transportation, United States Coast Guard.

7. Enter the Federal program name or description for the covered Federal action (item 1). If known, enter the full Catalog of Federal Domestic Assistance (CFDA) number for grants, cooperative agreements, loans, and loan commitments.

8. Enter the most appropriate Federal identifying number available for the Federal action identified in item 1 (e.g., Request for Proposal (RFP) number; Invitations for Bid (IFB) number; grant announcement number; the contract, grant, or loan award number; the application/proposal control number assigned by the Federal agency). Included prefixes, e.g., “RFP-DE-90-001.”

9. For a covered Federal action where there has been an award or loan commitment by the Federal agency, enter the Federal amount of the award/loan commitment for the prime entity identified in item 4 or 5.

10. (a) Enter the full name, address, city, State and zip code of the lobbying registrant under the Lobbying Disclosure Act of 1995 engaged by the reporting entity identified in item 4 to influence the covered Federal action.

    (b) Enter the full names of the individual(s) performing services, and include full address if different from 10(a). Enter Last Name, First Name, and Middle Initial (MI).

11. The certifying official shall sign and date the form, print his/her name, title, and telephone number.

According to the Paperwork Reduction Act, as amended, no persons are required to respond to a collection of information unless it displays a valid OMB control Number. The valid OMB control number for this information collection is OMB No. 0348-0046. Public reporting burden for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the Office of Management and Budget, Paperwork Reduction Project (0348-0046), Washington, DC 20503

Approved by OMB
0348-0046

Disclosure of Lobbying Activities

Complete this form to disclose lobbying activities pursuant to 31 U.S.C. 1352
(See reverse for public burden disclosure)

1. Type of Federal Action: a. contract ____ b. grant c. cooperative agreement d. loan e. loan guarantee f. loan insurance	**2. Status of Federal Action:** a. bid/offer/application _____ b. initial award c. post-award	**3. Report Type:** a. initial filing _____ b. material change **For material change only:** Year _______ quarter _______ Date of last report__________

4. Name and Address of Reporting Entity: ____ Prime _____ Subawardee Tier______, if Known: **Congressional District,** ***if known*:**	**5. If Reporting Entity in No. 4 is Subawardee,** Enter Name and Address of Prime: **Congressional District,** ***if known*:**
6. Federal Department/Agency:	**7. Federal Program Name/Description:** CFDA Number, *if applicable*: ____________
8. Federal Action Number, *if known:*	**9. Award Amount,** *if known:* **$**
10. a. Name and Address of Lobbying Registrant *(if individual, last name, first name, MI):*	**b. Individuals Performing Services** *(including address if different from No. 10a)* *(last name, first name, MI):*
11. Information requested through this form is authorized by title 31 U.S.C. section 1352. This disclosure of lobbying activities is a material representation of fact upon which reliance was placed by the tier above when this transaction was made or entered into. This disclosure is required pursuant to 31 U.S.C. 1352. This information will be reported to the Congress semi-annually and will be available for public inspection. Any person who fails to file the required disclosure shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.	**Signature:** ________________________________ **Print Name:** _____ **Title:** _____ **Telephone No.:** ____________ **Date:** _______
Federal Use Only	**Authorized for Local Reproduction** **Standard Form - LLL (Rev. 7-97)**

PROPOSED SUBCONTRACTORS FORM

- ***Do not*** *include additional information relating to subcontractors on this form or as an attachment to this form.*

PROSPECTIVE CONTRACTOR PROPOSES TO USE THE FOLLOWING SUBCONTRACTOR(S) TO PROVIDE SERVICES.

Type or Print the following information

Subcontractor's Company Name	Street Address	City, State, ZIP

☐**PROSPECTIVE CONTRACTOR DOES NOT PROPOSE TO USE SUBCONTRACTORS TO PERFORM SERVICES.**

RESTRICTION OF BOYCOTT OF ISRAEL CERTIFICATION

Pursuant to Arkansas Code Annotated § 25-1-503, a public entity **shall not** enter into a contract valued at $1,000 or greater with a company unless the contract includes a written certification that the person or company is not currently engaged in, and agrees for the duration of the contract not to engage in, a boycott of Israel.

By signing below, the Contractor agrees and certifies that they do not boycott Israel and will not boycott Israel during the remaining aggregate term of the contract.

If a company does boycott Israel, see Arkansas Code Annotated § 25-1-503.

Bid Number/Contract Number	DH-19-0013
Description of product or service	Arkansas Charitable Clinics Grant Program
Contractor name	

Contractor Signature: ____________________________________ Date: _________________
Signature must be hand written, in ink

ADDITIONAL INFORMATION

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 as well as budget form. The budget form is divided into two separate columns of Grant Funds and In-Kind.

In-Kind 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 75% to 25% Grant/In-Kind. In-Kind is the amount of actual In-Kind Matching to the project that is or will be done for this project and then expended for goods or services. In-Kind Match, such as volunteer hours, depreciation, rent, etc., can be used.

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 In-Kind 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	IN-KIND	ROW TOTAL
One lap-top computer	$1,000.00		$1,000.00
One color printer	$1,000.00		$1,000.00
Contracted trainer	$3,550.00		$3,550.00
Travel & lodging for contracted trainer		$750.00	$750.00
Office Supplies	$450.00		$450.00
Catered food for training		$250.00	$250.00
Space for training		$1,000.00	$1,000.00
COLUMN TOTAL	$6,000.00	$2,000.00	$8,000.00

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?

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

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 in the total patients served number, but each service he/she receives is an additional service that should be counted as a visit/encounter.*

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

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 In-Kind 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, 2019 through June 30, 2020.
2. Itemized budget spreadsheet showing planned grant fund In-Kind expenditures. Budget form is provided. (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. Clinics 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.

State of Arkansas
ARKANSAS DEPARTMENT OF HEALTH
4815 West Markham
Little Rock, Arkansas 72205

ATTACHMENT A

CONTRACT AND GRANT DISCLOSURE AND CERTIFICATION FORM

Failure to complete all of the following information may result in a delay in obtaining a contract, lease, purchase agreement, or grant award with any Arkansas State Agency.

SUBCONTRACTOR: ☐ Yes ☐ No SUBCONTRACTOR NAME:

TAXPAYER ID NAME: IS THIS FOR: ☐ Goods? ☐ Services? ☐ Both?

YOUR LAST NAME: FIRST NAME: M.I.:

ADDRESS:

CITY: STATE: ZIP CODE: COUNTRY:

AS A CONDITION OF OBTAINING, EXTENDING, AMENDING, OR RENEWING A CONTRACT, LEASE, PURCHASE AGREEMENT, OR GRANT AWARD WITH ANY ARKANSAS STATE AGENCY, THE FOLLOWING INFORMATION MUST BE DISCLOSED:

FOR INDIVIDUALS*

Indicate below if: you, your spouse or the brother, sister, parent, or child of you or your spouse *is* a current or former: member of the General Assembly, Constitutional Officer, State Board or Commission Member, or State Employee:

Position Held	Mark (√)		Name of Position of Job Held [senator, representative, name of board/ commission, data entry, etc.]	For How Long?		What is the person(s) name and how are they related to you? [i.e., Jane Q. Public, spouse, John Q. Public, Jr., child, etc.]	
	Current	Former		From MM/YY	To MM/YY	Person's Name(s)	Relation
General Assembly							
Constitutional Officer							
State Board or Commission Member							
State Employee							

☐ None of the above applies

FOR AN ENTITY (BUSINESS)*

Indicate below if any of the following persons, current or former, hold any position of control or hold any ownership interest of 10% or greater in the entity: member of the General Assembly, Constitutional Officer, State Board or Commission Member, State Employee, or the spouse, brother, sister, parent, or child of a member of the General Assembly, Constitutional Officer, State Board or Commission Member, or State Employee. Position of control means the power to direct the purchasing policies or influence the management of the entity.

Position Held	Mark (√)		Name of Position of Job Held [senator, representative, name of board/commission, data entry, etc.]	For How Long?		What is the person(s) name and what is his/her % of ownership interest and/or what is his/her position of control?		
	Current	Former		From MM/YY	To MM/YY	Person's Name(s)	Ownership Interest (%)	Position of Control
General Assembly								
Constitutional Officer								
State Board or Commission Member								
State Employee								

☐ None of the above applies

Contract and Grant Disclosure and Certification Form

Failure to make any disclosure required by Governor's Executive Order 98-04, or any violation of any rule, regulation, or policy adopted pursuant to that Order, shall be a material breach of the terms of this contract. Any contractor, whether an individual or entity, who fails to make the required disclosure or who violates any rule, regulation, or policy shall be subject to all legal remedies available to the agency.

As an additional condition of obtaining, extending, amending, or renewing a contract with a *state agency* I agree as follows:

1. Prior to entering into any agreement with any subcontractor, prior or subsequent to the contract date, I will require the subcontractor to complete a CONTRACT AND GRANT DISCLOSURE AND CERTIFICATION FORM. Subcontractor shall mean any person or entity with whom I enter an agreement whereby I assign or otherwise delegate to the person or entity, for consideration, all, or any part, of the performance required of me under the terms of my contract with the state agency.

2. I will include the following language as a part of any agreement with a subcontractor:

   Failure to make any disclosure required by Governor's Executive Order 98-04, or any violation of any rule, regulation, or policy adopted pursuant to that Order, shall be a material breach of the terms of this subcontract. The party who fails to make the required disclosure or who violates any rule, regulation, or policy shall be subject to all legal remedies available to the contractor.

3. No later than ten (10) days after entering into any agreement with a subcontractor, whether prior or subsequent to the contract date, I will mail a copy of the CONTRACT AND GRANT DISCLOSURE AND CERTIFICATION FORM completed by the subcontractor and a statement containing the dollar amount of the subcontract to the state agency.

I certify under penalty of perjury, to the best of my knowledge and belief, all of the above information is true and correct and that I agree to the subcontractor disclosure conditions stated herein.

Signature_______________________________________ Title_______________________ Date____________

Vendor Contact Person___________________________ Title_______________________ Phone No.________

Agency use only

Agency Number______	Agency Name__________________	Agency Contact Person______________	Contact Phone No.___________	Contract or Grant No._____