



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

APPLICATION PACKET

Notice of Funds Availability

Purpose of Sub-Grant:

The Arkansas Department of Health (ADH) issues this Notice of Funds Availability (NOFA) on behalf of Arkansas Medicare Flex Grant Program to obtain applications for funding to assist Critical Access Hospitals (CAHs) in providing improvement of quality of care in Arkansas' CAHs, providing educational health/medical information and guidance verbally and in written form, identify methods to correct system failures and improve publicly reported quality measures.

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APPLICATION SIGNATURE PAGE

Type the following information.

APPLICANT'S INFORMATION						
Company (as listed with IRS) with dba if applicable						
Federal Tax-ID#		AASIS Vendor Number (if known)				
Is your Company 501(c) 3 Nonprofit?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If, yes, your IRS designation letter must be submitted			
Your Agency Fiscal Year Dates:						
Address:				P.O. Box		
City:			State:		Zip Code:	
Business Designation:	<input type="checkbox"/> Individual	<input type="checkbox"/> Sole Proprietorship		<input type="checkbox"/> Public Service Corp		
	<input type="checkbox"/> Partnership	<input type="checkbox"/> Corporation		<input type="checkbox"/> Nonprofit <input type="checkbox"/> Intergovernmental		
Minority and Women-Owned Designation: *	<input type="checkbox"/> Not Applicable	<input type="checkbox"/> American Indian	<input type="checkbox"/> Asian American		<input type="checkbox"/> Service-Disabled Veteran	
	<input type="checkbox"/> African American	<input type="checkbox"/> Hispanic American	<input type="checkbox"/> Pacific Islander American		<input type="checkbox"/> 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:						
Alternate 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: _____

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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.

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Arkansas Medicare Flex (Quality Improvement) 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 organization's history, mission, and description of current programs, activities, strengths/accomplishments and challenges faced by the organization.

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

IV. 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.

V. Evaluation - Explain how you will measure success in achieving your goals and objectives. How will your results be used, disseminated, or publicized?

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Arkansas Medicare Flex (Quality Improvement) 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 with a one-paragraph description of key staff.

II. Financial Information

1. Itemized budget spreadsheet. Budget form is provided. (1 page).
2. Justification for all requested budget expenditures (1–2 pages).
3. A completed W-9 for the applicant .
4. Annual operating budget and actual income and expenses for most recently completed fiscal year AND for current year-to-date (1–2 pages).
5. Organization'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).
6. A sustainability plan describing how the project will continue after funds are expended (1 page).
7. A copy of the organization's 501(c)3 designation letter from the IRS.

III. Other Supporting Materials

1. Letters of agreement from any collaborating or affiliated agencies