

STATE PRIMARY CARE GRANT PROGRAM

Primary Care Grant Application and Instructions For Primary Health Care Provider Agencies

***Before you begin, please be sure you have thoroughly read through the Guidance.**

Only one application will be accepted per Agency

A COMPLETE ORIGINAL APPLICATION must be submitted by **April 4, 2016 5:00 pm MST, to the Office of Primary Care and Rural Health.**

The Application must be submitted by email to opcrh@utah.gov. **(Hand delivered, faxed and mailed copies will NOT be accepted):**

Applications that are incomplete, submitted after the deadline, or requesting more funding than they are eligible to request may be delayed or denied review.

Agency projects must include primary medical care services, mental health services, or dental health services in order to be considered for funding. Projects who only identify enabling services will be denied review and are considered ineligible for an award.

Agencies who have contracts to have services provided by another agency must include a copy of the agreement/contract with the application.

Funding from the State Primary Care Grant Program CANNOT be used to supplant other existing funding sources. This means that the number of encounters or visits funded by the State Primary Care Grant Program should be over and above the number of encounters or visits covered by other funding sources available to the Applicant Agency.

Primary health care services not covered by CHIP, Medicaid, Medicare, PCN, other public health care coverage, or private insurance WILL be considered, IF the primary health care services and costs are clearly detailed and listed in the Application.

State Primary Care Grant Program funding CAN ONLY BE USED to provide primary health care services to legal residents of the State of Utah.

Public Entities and Community Based Organizations are eligible for funding
(Section 26-10b-101(2), UCA).

1 "Encounter" means a face-to-face contact between an eligible individual and the awarded Agency's health care provider who exercises independent judgment in the provision of primary care services to the eligible individual and where the services provided under the Project are rendered and recorded in the eligible individual's record.

2 "Clients" are defined as Eligible Individuals, and means any person, or member of a family, served by the Awarded agency and receives at least one face-to-face encounter.

3 "Eligible Individual" is defined as: low income, without health insurance including CHIP and Medicaid, or without health insurance that covers primary health care services, or without health insurance that covers a particular primary health care service; has not received primary health care services on an uncompensated basis in the last 24 months; and is a resident of the State of Utah.

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ATTACHMENTS FOUND ON WEBSITE

ATTACHMENT A **Determination of 200% of Poverty Table**

ATTACHMENT B **Utah Code Annotated, 26-10b**

ATTACHMENT C **Utah Administrative Code, R434-30**

ATTACHMENT D **Definitions Used for the State Primary Care Grant Program**

ATTACHMENT E **State Primary Care Grant Program Reviewer Score Sheet and Criteria – Primary Care, Dental, and Mental Health** *(Please be aware that this criteria may be changed or modified at any time)*

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Application Instructions Checklist for Primary Health Care Provider Agencies

Please note: A cover letter is NOT necessary.

Please submit the Application in the following order in ONE .pdf attachment:

- Agency Identification Information, completed.
- Project Budget Summary Information Sheet, completed.
- Project Services to be Provided list, completed.
- Project Projections forms, completed.
- Project Application *Narrative Questions*, Project Applications that fail to adequately answer ALL questions will NOT be considered for review. Responses to the Project Application *Narrative Questions* should be NO MORE than four (4) pages total with one inch margins. The font should NOT be smaller than 10-point. Lines should be double-spaced. Each narrative question must be answered in the order presented. Each page should be numbered and have the name of the Project and Applicant Agency within the top one inch margin. Include number of encounters expected as well as the average cost per encounter.
- Project Sliding Fee Scale used to determine *actual fee to be charged to clients*. Please include a copy of the Sliding Fee Scale that a client uses to determine charges. *If the Project Applicant does not require their clients to pay a co-payment, please explain why.* **DO NOT INCLUDE ACTUAL LIST OF FEES CHARGED PER PROCEDURE.**
- Agency Balance Sheet; a one (1) page Balance Sheet is all that is needed.
- Checklist for Non-Profit Entity Contracts.
- Agency Proof of Non-Profit Status. **ALL NON-PROFIT** agencies must supply a copy of proof of non-profit status. Proof of non-profit status can include, but is not limited to, correspondence from the Internal Revenue Service determining your exemption from federal income tax under section 501 (a) of the Internal Revenue Code as an organization described in section 501 (c) (3).
- Taxpayer Identification Number. **ALL** Applicant Agencies **MUST** supply a currently dated and completed W-9 form, "Request for Taxpayer Identification Number and Certification." The form is available from the Internal Revenue Service (IRS) web site at: <http://www.irs.gov/pub/irs-pdf/fw9.pdf>.
- Grantee Assurances. **ALL** Applicant Agencies **MUST** supply a currently dated and completed "Grantee Assurances for Sub-grantees to the Utah Department of Health." The form is available from our web site at: http://health.utah.gov/primarycare/pdf/State_Primary_Care_Grants_Program/2014-2015/Grantee%20Assurances.pdf.

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Project Application Narrative Questions 2016-2017

The responses to the items listed below for the Project Application should be NO MORE than four (4) pages total with one inch margins. The font should NOT be smaller than 10-point. Lines should be double-spaced. The count of the four (4) pages total *does not include* the required forms that must be included with the Project Application (see Application Instructions Checklist). Each narrative question must be answered in the order presented. Each page should be numbered and have the name of the Project and the name of the Agency applying for funding. Please be concise and succinct with your responses. Note that the Project budget narrative (described on the following page) does not count towards your four page maximum. Project Applications that are submitted after the deadline may be delayed or denied review.

Each question must be answered and numbered in the following order:

1. **SUMMARY PARAGRAPH DESCRIBING THE PARENT AGENCY.** Briefly describe the parent agency of the Project. Paragraph should include: Agency mission, goals, and objectives; how the Agency is managed (county owned, managed by a board or commission, etc.); length of time Agency has been established (been in business); and populations served by Agency. *This section is for Agency information, not Project information.* Please list three individuals (top administrator, grant administrator, one other), their position, and contact information (work phone, cell phone, email) that work within the agency.

The following questions must be answered for the Project, not for the parent agency.

2. **PROJECT TARGET POPULATION(S):** Briefly describe the medically underserved population(s) that the Project objective(s) will serve **and** include an assessment of need for this population.
3. **PROJECT OBJECTIVES:** Provide specific, measurable objective(s), as well as activities, outcomes, and measures for each Project objective. Please assure to describe the Project objectives that you are requesting funding for, **not** the objectives of your entire Agency.
4. **PROJECT EVALUATION/QUALITY REVIEW:** Provide a brief description of the evaluation/quality review program that your Agency will use for the Project objective(s). Evaluation/quality review programs, may include but are not limited to, the capacity to examine topics such as patient satisfaction and access; quality of clinical care; quality of the work force and work environment; cost and productivity; and health status outcomes.
5. **PROJECT INNOVATION:** Provide a description of innovative aspects that your Agency will use to complete the Project objectives(s). Innovative aspects may include, but are not limited to: creating value out of new or different ideas, new products, new services, or new ways of doing things. These innovative aspects are determined based on whether they are new or different, efficient, and have significant benefit to the community and the underserved populations served by the Project.
6. **PROJECT COLLABORATION:** Provide information about any existing or future partnerships, collaborative efforts, use of volunteers, or other resources that your Agency will use to complete the Project objective(s). Include in this section any contractual work that might be performed, who your agency has an agreement with, and your plan for keeping patient financial records separate.
7. **PROJECT SUSTAINABILITY OF FUNDING:** Provide a plan of financing for the target population(s), *if State Primary Care Grant Program funding were no longer available.* Also provide evidence of

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"Other Sources of Funding" for the primary care services provided by your Project (e.g., funding from the Utah Department of Health for blood pressure screening).

8. **PROJECT BUDGET NARRATIVE:** *State Primary Care Grant Program* applications will not be considered if the Applicant Agency applies for more funding than they are eligible to apply for. This application is for one-time funding for the period July 1, 2016 through June 30, 2017. The funding for the State Primary Care Grant Program allows for an award up to the maximum amount of \$100,000, which includes awards from the State Primary Care Grant I Program for agencies that have an award in that program.

Please provide a brief Project budget narrative. The Project budget narrative must explain each Line Item Category of the Project budget (see the Project Budget Summary Information Sheet on the following page). Briefly describe the personnel who will oversee and/or complete Project activities. Explain other sources of funding included in the Project budget, such as grants, third party payments (e.g., CHIP, Medicaid, Medicare, PCN, other public health care coverage, private insurance), donations, etc.

Describe any contractual costs, how they will be paid, how you will track clients and payments, and how you will keep separate accounting records for clients utilizing the SPCGP from other clients, as well as clients served by the contracting agency and their grant award.

Explain the cost per visit for each service you plan to provide as well as your anticipated number of clients and total encounters for each service for the project period. Provide an average cost per encounter for your project including all costs associated with a client visit.

Please be aware that:

1. Funding from the SPCGP **CANNOT** be used for research.
2. Funding from SPCGP **CANNOT** be used to purchase equipment.
3. Funding from the SPCGP **CANNOT** be used exclusively for health education or education classes. Health education is covered at the time of the primary medical care, dental, and mental health client visits only.
4. The SPCGP does **not** cover inpatient substance abuse treatment. Health education or education classes are **not** a cost covered under SPCGP.
5. Funding **CANNOT** be used for staff travel or transportation costs. Travel expenditures **MAY** be granted to mobile clinics with a reasonable justification and explanation of costs.
6. Funding can **ONLY** be used for legal residents of Utah.
7. SPCGP funding is to be placed in a "specified" account so that funds are drawn down for the SPCGP patients only. SPCGP awarded agencies must already have in place a "methodology" for tracking SPCGP patients and encounters that must be maintained.
8. Any pharmaceutical costs are considered part of the charge per encounter.

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Agency Identification Information

IDENTIFYING INFORMATION	
Title of Project: <i>(Please provide descriptive title)</i>	
Name of Agency/Organization:	
Contact Name <i>and</i> Title:	
Mailing Address:	
Street Address (if different than mailing address):	
City, State, Zip:	
Telephone:	Fax:
Email Address:	Tax ID Number:
Please provide the Name <i>and</i> Title of the Individual that would sign your Grant Agreement:	

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Project Budget Summary Information Sheet

Name of Applicant Agency _____

Name of Project _____

PROJECT BUDGET SUMMARY INFORMATION		
Dollar amount requested for project: \$ _____		
SPCGP1 <input type="checkbox"/>		SPCGP2 <input type="checkbox"/>
PROJECT EXPECTS TO SERVE:	Number of Project "Clients": _____	Number of Project "Encounters": _____
	The number of medically underserved individuals the project expects to serve.	The <u>total</u> number of "encounters" that the project expects to provide.
The precise boundaries of the area to be served by the project [you <i>MUST</i> specify the City(s) and/or County(ies)]. <i>Answer Required:</i>		

Is your agency a recipient of the previous year grant from SPCGP I or II?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No

Is your agency directly providing services or are they being contracted out to another agency?	
<input type="checkbox"/> Provided directly	<input type="checkbox"/> Contracted

Are you willing to accept an award that is less than your requested amount?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No

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PROJECT BUDGET SUMMARY INFORMATION			
Line Item Category	Column A	Column B	Column C Column A + Column B = Column C
	Project Requested Funding	Other Sources of Project Funding	Total Project Funding
Salary & Fringe Benefits	\$	\$	\$
Travel	\$	\$	\$
Equipment	\$ N/A	\$	\$
Supplies	\$	\$	\$
Contractual	\$	\$	\$
Total Costs	\$	\$	\$

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Project Services to be Provided

Project Services to be Provided		
In Column A, please check (✓) all corresponding services that the Project expects to provide to eligible individuals. <i>Please note Project services ONLY, NOT Agency-wide services.</i>		
SERVICE TYPE		COLUMN A
Primary Medical Care Services	General Primary Medical Care	
	Diagnostic Laboratory	
	Diagnostic X-ray	
	Diagnostic Tests/Screens/Analysis	
	Family Planning	
	Following Hospitalized Patients	
	HIV Testing	
	Immunizations	
	Mammography	
	Tuberculosis Therapy	
	Urgent Medical Care	
	24 Hour Coverage	
OB/GYN Care	Gynecologic Care	
	Pap Smear	
	Obstetric Care	
	Prenatal Care	
	Labor and Delivery Professional Care	
	Postpartum Care	
Dental Services	Preventive	
	Restorative	
	Emergency	
Mental Health Services (Outpatient Services Only)	Mental Health Treatment/Counseling	
	Developmental Screening	
	24 Hour Crisis Intervention/Counseling	
	Other Mental Health Services	
	Substance Abuse Treatment/Counseling	
	Other Substance Abuse Services	
Other Professional Services	Hearing Screening	
	Nutrition Services Other than WIC (Women, Infants, and Children Supplemental Nutrition Program)	
	Occupational/Vocational Therapy	
	Physical Therapy	
	Pharmacy Services	

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Project Services to be Provided		
In Column A, please check (✓) all corresponding services that the Project expects to provide to eligible individuals. <i>Please note Project services ONLY, NOT Agency-wide services.</i>		
SERVICE TYPE		COLUMN A
	Vision Screening	
Enabling Services	Case Management	
	Child Care (during visit to clinic)	
	Discharge Planning	
	Health Education (<u>at time of service is provided only</u> , as part of services provided during visit only)	
	Home Visiting	
	Interpretation/Translation Services	
	Nursing Home and Assisted-Living Placement	
	Outreach (describe <i>in detail</i> under Narrative Questions, Project Objectives, the outreach services provided)	
	Parenting Education (<u>at time of service is provided only</u> , as part of services provided during visit only)	
	Transportation	

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Project Projections

Name of Applicant Agency _____

Name of Project _____

1. Expected “Encounter” information:

BASELINE DATA FOR YOUR AGENCY	SPCGP PROJECT	
Agency-wide data, NOT Project data	Expected Project Encounters	
Total number of encounters for your Agency’s most recent fiscal year	Total number of expected Project encounters	
	New Client Encounters (first time visits)	Follow-up Encounters (additional visits)

Please Use Best Estimates (Projections) of “Clients” Expected to be Served by your Project.

2. Expected project “New Clients” by age:

Age Groups	Number of Project “Clients”
0 – 19	
20 – 64	
65 and over	
Total Project “Clients”	

3. Expected project “New Clients” by income level:

Percent of Poverty Level	Number of Project “Clients”
100% and below	
101 - 200%	
Above 200%	
Unreported/unknown	
Total Project “Clients”	

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Project Projections

Name of Applicant Agency _____

Name of Project _____

4. Expected Total Project “New Clients” by Insurance Status:

Number of Project “Clients” Uninsured	Number of Project “Clients” Underinsured

5. Expected Project “New Clients” by Members of Race/Ethnicity Who Suffer Health Care Disparities (see “Definitions” of underinsured and uninsured):

Race/Ethnicity	Number of Project “Clients”
American Indian or Alaska Native	
Black or African American	
Native Hawaiian or Other Pacific Islander	
Hispanic or Latino	
Total Project “Clients” by Race/Ethnicity	

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Completion of this document is required by every applicant, no matter what your profit status is.

Checklist for Nonprofit Entity Grant Contracts*

Y N

- Did you receive more than 50% of your funds from federal, state, and local government entities in your previous fiscal year?
- Do you anticipate receiving more than 50% of your funds from federal, state, and local government entities in the fiscal year in which the grant for which you have applied will be issued?
- Did you receive more than \$500,000 from state entities in the previous fiscal year?
- Do you anticipate receiving more than \$500,000 from state entities in the fiscal year in which the grant for which you have applied will be issued?
- Do you acknowledge that the state auditor will be notified if you have answered Yes to any of the preceding four questions?
- Do you agree to comply with the requirements of Utah Code Title 63J, Chapter 9, Nonprofit Entity Receipt of State Money Act?
- Do you acknowledge and agree that you may be required to return to the state any money that is expended in violation of the Nonprofit Entity Receipt of State Money Act?
- Do you agree to provide an annual report detailing the expenditure of state grant funds you receive?
- Do you certify that you have, at the time of receipt of state grant money, adopted bylaws (as "bylaws" are defined in Section 63J-9-102) that provide for the financial oversight of state money and compliance with state laws related to state money?
- Do you certify that you have, at the time of receipt of state grant money, procedures for the governing board of the nonprofit entity to designate an administrator who manages state money, and procedures for the governing board to dismiss the administrator who manages state money?

What is the name and contact information (address, phone number, and email) of nonprofit administrator who manages state money?

* Required by 2014 House Bill 283. Depending on the amount of government funding received by nonprofit organizations from various sources, they may be audited by the State Auditor.

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**PLEASE BE AWARE THAT YOU MUST COMPLETE AND
RETURN A GRANTEE ASSURANCES FORM FOR
SUBGRANTEES TO THE UTAH DEPARTMENT OF HEALTH**

Rev. 9/16/09
Doc # 99-002 Assur.Grts.

The form is located at:

http://health.utah.gov/primarycare/pdf/State_Primary_Care_Grants_Program/2014-2015/Grantee%20Assurances.pdf

**PLEASE BE AWARE THAT YOU MUST COMPLETE AND
RETURN A DEPARTMENT OF THE TREASURY INTERNAL
REVENUE SERVICE REQUEST FOR TAXPAYER
IDENTIFICATION NUMBER & CERTIFICATION**

Form W-9
(Rev. December 2014)

The form is located at:

<http://www.irs.gov/pub/irs-pdf/fw9.pdf>