pennsylvania
DEPARTMENT OF HEALTH

August 30, 2011

Dear Potential Applicant:

You are invited to submit an application to the Pennsylvania Department of Health in accordance with the enclosed Request for Applications (RFA) # **10-07-07.**

A pre-application conference will be held on **Tuesday, September 20, 2011** at **1:00pm – 3:00pm** in Conference Room 125B, Keystone Building, 400 North Street, Harrisburg, Pennsylvania. Since facilities are limited, it is requested that you limit your representation to two individuals. Applicant attendance is optional.

All questions regarding this RFA must be directed in writing to **Katrina Kyle, Public Health Program Administrator, Bureau of Health Planning, Division of Health Professions Development**, Pennsylvania Department of Health, **Room 1033,** Health and Welfare Building, 625 Forster Street, Harrisburg, Pennsylvania 17120-0701, or by e-mail at **katkyle@state.pa.us**, no later than Monday, September 12, 2011. All questions must include the specific section of the RFA about which the potential applicant is questioning. Answers to all questions will be posted at www.emarketplace.state.pa.us. Click on 'Solicitations' and search for the above RFA number.

Please submit one (1) original and eleven (11) copies of your application, (Part 2 of this RFA) in a sealed package to the address below. Your application must arrive in the designated room at the following address no later than 2:30 p.m. on **Wednesday, October 5, 2011**.

RFA # 10-07-07
Director, Division of Contracts
Bureau of Administrative and Financial Services
Pennsylvania Department of Health
Room 824, Health and Welfare Building
625 Forster Street
Harrisburg, Pennsylvania 17120-0701

LATE APPLICATIONS WILL NOT BE ACCEPTED REGARDLESS OF THE REASON.

ALL APPLICANTS: FAILURE TO COMPLY WITH THE FOLLOWING MANDATORY SUBMISSION REQUIREMENTS WILL RESULT IN REJECTION OF THE APPLICATION. THE APPLICATION WILL NOT BE EVALUATED AND THE APPLICANT WILL BE NOTIFIED IN WRITING OF SAME:

- (1) Original application and (11) copies
- Applicant Information Form with signature
- Certification Form with signature
- 501 (c) (3) Form issued in the name of the applicant
- Federal Employer Identification Number (EIN) issued in the name of the applicant

SUBMISSION OF AN APPLICATION FOR FUNDING FOR A PROJECT THAT FITS INTO ONE OF THE FOLLOWING CATEGORIES WILL RESULT IN REJECTION OF THE APPLICATION. THE APPLICATION WILL NOT BE EVALUATED AND THE APPLICANT WILL BE NOTIFIED IN WRITING OF SAME.

- Projects that are primarily research oriented
- Projects that are intended to improve the quality of service and/or practice management
- Projects that are intended to be implemented state-wide
- Projects that request funding for equipment only

SUBMISSION OF AN APPLICATION FOR CONTINUATION OF FUNDING FOR A PROJECT PREVIOUSLY FUNDED BY THE DEPARTMENT WITH COMMUNITY PRIMARY CARE CHALLENGE GRANT FUNDING WILL RESULT IN REJECTION OF THE APPLICATION. THE APPLICATION WILL NOT BE EVALUATED AND THE APPLICANT WILL BE NOTIFIED IN WRITING OF SAME.

FAILURE TO DEMONSTRATE COMPLIANCE WITH THE BASIC ELIGIBILITY REQUIREMENTS FOR TIER 1 OR TIER 2 FUNDING WILL RESULT IN REJECTION OF THE APPLICATION. THE APPLICATION WILL NOT BE EVALUATED AND THE APPLICANT WILL BE NOTIFIED IN WRITING OF SAME.

TIER 1 APPLICANTS:

- Failure to establish that the location of the TIER 1 proposed project is in a **current** HPSA or MUA/P, or
- If the proposed project is outside a HPSA or MUA/P, failure to establish that either 30% of current patients reside in a HPSA or MUA/P *or* 30% of current patients are low income

TIER 2 APPLICANTS:

- Failure to propose that the Community Health Center that will serve an MUA/P; or
- Failure to provide a letter of support from the Board of Directors of any existing FQHC(s) or FQHC-LA(s), when the Applicant is proposing a Community Health Center to serve an MUA/P that currently has an existing FQHC or FQHC-LA serving the MUA/P.

Please write "**APPLICATION ENCLOSED RFA #10-07-07**" in large block letters on the envelope or overnight/priority mail label.

We expect that the evaluation of applications and the selection of grantees will be completed within eight weeks of the submission due date.

Sincerely,

Terri A. Matio
Director
Bureau of Administrative and Financial Services

Enclosure

REQUEST FOR APPLICATION

COMMUNITY PRIMARY CARE CHALLENGE GRANTS

RFA Number
10-07-07

Date of Issuance
August 30, 2011

ISSUING OFFICE:

Pennsylvania Department of Health
Bureau of Administrative and Financial Services
Division of Contracts
Room 824 Health & Welfare Building
625 Forster Street
Harrisburg, PA 17120-0701

RFA PROJECT OFFICER:

Katrina Kyle
Pennsylvania Department of Health
Bureau of Health Planning
Division of Health Professions Development
Room 1033, Health and Welfare Building
625 Forster Street
Harrisburg, Pennsylvania 17120-0701
Email address: katkyle@state.pa.us

Community Primary Care Challenge Grants

CONTENTS

Any grant resulting from this RFA will include certain standard terms and conditions, which will either be attached as paper appendices or incorporated by reference through internet links. These terms and conditions are listed below and are either attached to this RFA or available at the identified internet address for the information of prospective applicants.

- Payment Provisions (Rev. 6/09)
- Program Specific Provisions
- Standard General Terms and Conditions (Rev.11/10)
  http://www.portal.state.pa.us/portal/server.pt/document/993190/standard_general_terms_and_conditions_%2811-10%29_doc
- Audit Requirements (Rev. 8/09)
  http://www.portal.state.pa.us/portal/server.pt/document/773953/audit_requirements_%288-09%29_doc
- Commonwealth Travel and Subsistence Rates (Rev. 7/07)
  http://www.portal.state.pa.us/portal/server.pt/document/598438/commonwealth_travel_and_subsistence_rates__287-07_29_doc
- Minimum Personal Computer Hardware, Software, and Peripherals Requirements (Rev. 3/09)
  http://www.portal.state.pa.us/portal/server.pt/document/598443/personal_computer_hardware_software_and_peripherals_requirements__283-09_29_doc
- Federal Lobbying Certification and Disclosure(Rev. 12/05)
  http://www.portal.state.pa.us/portal/server.pt/document/598440/federal_lobbying_certification_and_disclosure__2812-05_29_doc
- Pro-Children Act of 1994 (Rev. 12/05)
  http://www.portal.state.pa.us/portal/server.pt/document/598444/pro-children_act_of_1994__2812-05_29_doc
- Right To Know Law – Grant Provisions (Rev. 2/1/10)
  http://www.portal.state.pa.us/portal/server.pt/document/773955/right_to_know_law_-_grant_provisions_%28rev__2-1-10%29_doc

PART ONE

Community Primary Care Challenge Grants

General Information

A. Information for Applicants

1. Introduction

In December 1992, the Children's Health Care Act, Act 1992-113, 62 P.S. §5001.101 *et seq*., became law. Chapter 13 of that Act established a Primary Health Care Practitioners Program, which gave the Pennsylvania Department of Health (DOH) the responsibility for the development of programs that address the problems of supply and distribution of primary health care practitioners.

The Community Primary Care Challenge Grant Program was developed to provide assistance to communities to increase access to primary medical and dental care services by developing primary care medical or dental clinics and increasing the number of health care practitioners in federally designated health professional shortage areas.

Through this RFA process the Pennsylvania Department of Health (Department) is soliciting Community Primary Care Challenge Grant Program applications. For the purposes of the Community Primary Care Challenge Grant Program, primary medical care refers to primary physical health medical services. Primary physical health medical services do not include behavioral health services, mental health services, patient education, counseling, or outreach services. Moreover, the Community Primary Care Challenge Grant Program does not seek to fund research-based, state-wide, or quality improvement projects. Primary physical health medical services do include primary dental services. Primary dental services include general and pediatric dental services. Primary dental services do not include orthodontry, endodontic services, periodontics or other dental specialty services.

The Department is interested in funding:

Tier 1 - Establishment or expansion of a site providing access to primary medical or dental services or both. The following caveats apply:

- If the application is for funding to establish a new site, the applicant must propose to establish the site in a federally designated [as defined by Health Resources and Services Administration (HRSA)] Primary Care (PC) Health Professional Shortage Area (HPSA); a Dental HPSA; a Medically Underserved Area/Population (MUA/P); a Federally Qualified Health Center (FQHC)/ Federally Qualified Health Center Look Alike (FQHC-LA); or a Rural Health Clinic (RHC) with a "facility HPSA designation".
- If the application is for funding to expand operations of an existing site, the applicant may propose to expand a site in or outside a HPSA or MUA/P. However, if the site is located outside a HPSA or MUA/P, the applicant must be able to provide documentation to establish that the site is currently serving (1) a minimum of 30% low-income patients or (2) a minimum of 30% of patients residing in a HPSA or MUA/P.

Tier 2 - The establishment of a Community Health Center (CHC) that will serve or be located within an area that is a federally designated MUA/P which lacks a FQHC or FQHC-LA providing services to that MUA/P. The Department will also consider an application to establish a CHC that will serve or be located in a federally designated MUA/P with an existing FQHC or FQHC-LA if the applicant includes with the application a letter from the existing FQHC or FQHC-LA supporting the project and the eventual establishment of another FQHC or FQHC-LA within or serving the MUA/P.

The Department defines a Community Health Center as follows: "Community Health Centers are community-based and consumer-run organizations that serve populations with limited access to health care. These include low income populations, the uninsured, those with Limited English proficiency,

migrant and seasonal farm workers, individuals and families experiencing homelessness, and those living in public housing." (HRSA)

The Department anticipates that the CHC, once established by this funding opportunity, will eventually apply for FQHC or FQHC-LA status through the United States Department of Health and Human Services, Health Resources and Services Administration (HRSA). FQHC and FQHC-LA status is approved by HRSA based upon HRSA criteria and funding opportunities. FQHC and FQHC-LA criteria, definitions and funding opportunities can be found on the HRSA, Bureau of Primary Health Care website: www.bphc.hrsa.gov. In addition, a summary of HRSAs Key Health Center Program Requirements is found in Appendix 3 of this RFA. **An application for Tier 2 funding shall demonstrate the Applicant's knowledge and understanding of HRSA's Key Health Center Program requirements; that is, the proposed CHC as described in the application shall be consistent with the Key Health Center Program Requirements: Need, Services, Management and Finance, and Governance.**

The overall goal of this funding is to increase access to primary medical and dental care for underserved populations by:

a) Increasing the number of primary care medical and dental practitioners

b) Increasing the number of primary care medical and/or dental clinics

c) Expanding services at existing primary care medical and/or dental clinics

The anticipated grant agreement term is from July 1, 2012 to June 30, 2014, subject to the availability of funding.

The Department is **NOT** interested in funding:

a) Projects that are primarily research oriented

b) Projects that are intended to improve the quality of service and/or practice management

c) Projects that are intended to be implemented state-wide

d) Projects that request funding for equipment **only**

Applicants may apply for more than one grant, provided each application is for a project at a separate and distinct site. Applicants may apply for a Tier 1 grant, a Tier 2 grant, or both. Applications are welcomed from not-for-profit community-based organizations and health centers, local county/municipal governments, and/or community-based health improvement partnerships. Additional information about how to apply, relevant and specific instructions, and stated preferences regarding applicants are noted and outlined in Section B.

This RFA provides interested organizations with information to prepare and submit applications to the Department. Questions about this RFA can be directed in writing to Katrina Kyle, Public Health Program Administrator, Bureau of Health Planning, Division of Health Professions Development, Pennsylvania Department of Health, Room 1033, Health and Welfare Building, 625 Forster Street, Harrisburg, Pennsylvania 17120-0701 or e-mail address at katkyle@state.pa.us no later than Monday, September 12, 2011. Answers to all questions will be posted at www.emarketplace.state.pa.us. Each

applicant shall be responsible to monitor the website for new or revised RFA information. The Department shall not be bound by any information that is not either contained within the RFA or formally issued as an addendum by the Department.

In order to do business with the Commonwealth of Pennsylvania, providers are required to enroll in the SAP system. Applicants may enroll at www.vendorregistration.state.pa.us/ or by calling toll free at 1-877-435-7363 or locally at 717-346-2676.

2. Availability of Funds

Current state funding is a maximum of $200,000 per Tier 1 grant for the entire 24-month project period and a maximum of $500,000 per Tier 2 grant for the entire 24-month period. Tier 1 and Tier 2 funding is contingent upon availability of funding.

Matching funds for both Tier 1 and Tier 2 funding must be in the ratio of one (1) dollar of local community funds for each four (4) dollars of Commonwealth funding through the grant. The source of the matching funds must be identified in the budget portion of the application. Matching funds must be used to pay for costs directly incurred to support the proposed project.

All matching funds must be committed at the time of the grant application via a signed letter, included with the application, from an individual with signatory authority from the organization providing the matching funds. If the applicant is the organization providing the matching funds, the letter must be signed by an officer of the Board of Directors. Any letters that are sent separate from the application will be returned to the sender and will not be accepted.

The applicant may propose to use third party insurance reimbursements for matching funds. If the applicant intends to use third party insurance reimbursements as a source of matching funds, the applicant must include in the Additional Appendices section of the application a letter from an officer of the Board of Directors indicating the total amount of third party insurance reimbursements the applicant organization will commit as matching funds.

Projects may not exceed 24 months**.**

3. Grant Eligibility

APPLICATIONS THAT DO NOT MEET THE FOLLOWING ELIGIBILITY REQUIREMENTS WILL NOT BE REVIEWED AND WILL BE REJECTED.

Applicants must be not-for-profit community-based organizations and health centers, local county/municipal government entities, or community health improvement partnerships within Pennsylvania.

Tier 1 Establishment or expansion of a site providing access to primary medical or dental services or both:

- If the application is for funding to establish a new site, the practice site at which new primary care and/or new dental services are to be provided **MUST** be located within an area which has a **current** federal designation (as defined by HRSA) as a PC HPSA; a Dental HPSA; a MUA/P designation; a FQHC/ FQHC-LA or RHC with a "facility HPSA designation". The **new** practice site may not be in

a PC or Dental HPSA categorized by HRSA with a status of "Proposed Withdrawal", "No Data Provided" or "Withdrawn" (www.hpsafind.hrsa.gov).

- If an applicant for a Tier 1 grant proposes to expand primary care and/or dental services at an existing practice site, the practice site may be in or outside a HPSA or MUA/P. However, if the site is located outside a HPSA or MUA/P, the applicant must establish that not less than 30% of patients served at the site from July 1, 2010 to June 30, 2011 were either (1) low income or (2) residents of an area with a current federal designation as defined above. Low income patients are defined as Medicaid (MA) patients, discounted/sliding fee scale patients and no pay patients. Patients residing in an area with a current federal designation shall be identified in supporting documentation by township, borough and census tract (CT) with correlating specific HPSA and/or MUA/P, if applicable.

The form to document low income patient profile study or patient of origin study is found in the Tier 1 - Project Impact Form (Attachment III of this RFA). Use the downloadable Tier 1-Project Impact Form attached to this RFA.

Tier 2 Applicants:

The applicant must propose that the CHC will serve or be located within an area which has an existing federally designated MUA/P which lacks a FQHC or FQHC-LA providing services to that MUA/P. **The only exception to this requirement is if the applicant proposes to serve an area within a MUA/P that is not currently being served by an existing FQHC or FQHC-LA. In this case, the following must be submitted as part of the application:**

- A map of the MUA/P that identifies the area on the map that an existing FQHC or FQHC-LA is currently serving.
  - Identify the area on the map that the applicant proposes to serve.
  - Identify on the map any service area overlap or competition
- Documentation describing the population to be served that is not currently being served by an existing FQHC or FQHC-LA (i.e. demographic, social, and economic data for the population of the proposed service area).
- A letter from the Board of Directors of the existing FQHC or FQHC-LA serving in the MUA/P that the applicant organization proposes to serve that supports the proposed CHC. The letter must support the applicant's plan for the proposed CHC to eventually become a FQHC or FQHC-LA.

An applicant for a Tier 2 grant **MUST,** as part of the Tier 2 -Project Impact Form (Attachment IV of this RFA), document the MUA/P that the proposed site is to be located in, or serves. Use the downloadable Tier 2-Project Impact Form attached to this RFA.

All Applicants:

Administrative offices may be located outside of the HPSA/MUA/P. In order to determine the location of your specific site relative to currently designated primary care/dental HPSAs or MUA/Ps, please contact the Bureau of Health Planning at (717) 772-5298 or refer to the HRSA website: www.hpsafind.hrsa.gov for current PC and Dental HPSAs; and www.muafind.hrsa.gov for MUA/P designations. HPSA/MUA/P criteria and definitions may be found on the HRSA website at www.bphr.hrsa.gov/shortage.

Each organization submitting an application must have its own distinct federal Employer Identification Number (EIN). Federal, State, Foundation or other grant funds may be used as match. However, a letter

from the entity supplying the other grant funds approving the use of those funds for the matching requirement of this grant must be included in the Additional Appendices section of the application.

Letters of financial commitment from organization(s) (including the applicant organization) agreeing to provide matching funds are required and must:

- Be included in the Additional Appendices section.
- Be signed by an individual with signatory authority for that organization.
- Include specific amounts of matching funding with specific time periods when match funding will be provided (i.e. by budget year).
- Note any specific restrictions for the use of match funds in this grant (for example, if the organization providing matching funds requests that those funds be used only for direct patient care and not for renovations or equipment, this must be noted in the signed letter of commitment).

Fund raising may not be used for match.

APPLICANTS WITH AN EXISTING COMMUNITY PRIMARY CARE CHALLENGE GRANT ENDING ON OR BEFORE JUNE 30, 2012 ARE ELIGIBLE TO SUBMIT AN APPLICATION IN RESPONSE TO THIS RFA. APPLICANTS WITH AN EXISTING COMMUNITY PRIMARY CARE CHALLENGE GRANT ENDING JUNE 30, 2013 OR AFTER MAY ONLY APPLY FOR TIER 2 FUNDING OR FOR TIER 1 FUNDING FOR A PROJECT WHICH HAS NOT YET BEEN FUNDED. THE NEW PROJECT MAY BE AT AN EXISTING OR DIFFERENT SITE.

B. Application Procedures

1. General

a) Applications must be received by the Department by the time and date stated in the cover letter.
b) If it becomes necessary to revise any part of the application guidelines, an amendment will be posted on the DGS website.
c) The decision of the Department with regard to selection of applicants is final. The Department reserves the right to reject any and all applications received as a result of this request and to negotiate separately with competing applicants.
d) Grantees whose applications are selected are not permitted to issue news releases pertaining to this project prior to official written notification of award by the Department. Any subsequent publication or media release issued by the grantee throughout the life of the grant using funding from this grant must acknowledge the Department as the granting agency, and be approved in writing by the Department.

2. Evaluation of Applications

All applications meeting stated requirements in this RFA and received by the designated date and time will be reviewed by a committee of qualified personnel selected by the Department. The Review Committee will recommend applications that most closely meet the evaluation criteria developed by the Department. If the Review Committee needs additional clarification of an application, Division of Health Professions Development staff and staff from the Division of Contracts will schedule an oral presentation and/or assign a due date for the submission of written clarification.

a) Evaluation criteria used by Review Committee for Tier 1 Applicants:

Eligibility: Applicant meets eligibility requirements (Refer to Part I, Section A 3, pages 4-5)

Work Statement: Applicant Work Statement includes clear and concise information addressing each of the following topics in the **order** listed and **labeled as listed** (Refer to Part 1, Section C 2 e (i), Pages 10-16):

Project Abstract
Delivery of Primary Medical and Dental Care Services
Workplan
Access
Community Involvement/Network Development
Project Impact
Capacity to Implement
Sustainability Plans
Additional Appendices
Budget
Budget Justification

b) Evaluation criteria used by Review Committee for Tier 2 Applicants:

Eligibility: Applicant meets eligibility requirements (Refer to Part I, Section A 3, page 5)

Work Statement: Applicant Work Statement includes clear and concise information addressing each of the following topics in the **order** listed and **labeled as listed** (Refer to Part I, Section C 2 e (ii), Pages 17-23):

Project Abstract
Map of Service Area Identifying MUA/P
Delivery of Primary Care Services
Workplan
Access
Community Involvement/Network Development
Project Impact
Capacity to Implement
Sustainability Plans
Additional Appendices
Budget
Budget Justification

3. Awards

Grants will be administered through the Department.

All applicants will receive official written notification of the status of their application from the Department. Unsuccessful applicants may request a debriefing. This request must be in writing and must be received by the Division of Health Professions Development within 30 calendar days of the written official notification of the status of the application. The Division of Health Professions Development will determine the time and place for the debriefing. The debriefing will be conducted by the Division of Health Professions Development staff. Comparison of applications will not be provided.

Applicants will not be given any information regarding the evaluation other than the position of their application in relation to all other applications and the strengths and weaknesses in their application.

4. Reporting Requirements

Applicants selected for funding will be required to comply with the following reporting requirements to be included in the Grant Agreement with the Applicant.

a) The Applicant, once a Grantee, shall be expected to submit a written quarterly report of progress, issues and activities, and, at a minimum, identify if activities are proceeding according to the project plan, and explain any deviations from the project plan. The specific format for these reports shall be provided prior to the start of the Grant Agreement. Any changes to the scope or methodology of the project during the term of the Grant Agreement must be approved in writing by the Department.

b) The Applicant, once a Grantee, shall submit a final written report within 30 days after the close of the Grant Agreement. The final report shall include the last 3 months of the grant period, shall provide an over-all summary of the project, and shall include the total number of patients and patient visits during the term of the grant.

c) The Applicant, once a Grantee, shall request written approval from the Department prior to any changes in key personnel.

C. Application Instructions and Required Format

1. Application Instructions

The following is a list of requirements.

a) The Applicant must submit an Original (clearly labeled as "Original") and 11 complete copies (each clearly labeled as "Copy") of the application (Part Two of this RFA).
b) The application must be in a sealed package.
c) The application must be received by mail or in person at Division of Contracts by the date and time specified in the cover letter. Applicants mailing applications should allow sufficient mail delivery time to ensure timely receipt. **(Late applications will be rejected, regardless of the reason).**
d) The application must be submitted using the format described in subsection 2, below- Application Format.
e) The Certifications Form must be completed and signed by an official authorized to bind the organization to the application. Use the downloadable Certifications Form attached to this RFA.

Applicants are strongly encouraged to be brief and clear in the presentation of ideas.

2. Application Format

Applicants must follow the format as described below to complete Part Two of this RFA. Applications must be typewritten on 8 ½" by 11" paper, with a font size no smaller than **12 points** and margins of at least **1 inch**.

a) Applicant Information Form – Please complete the form in its entirety. This form is used to provide identifying information and to ensure completeness of the application. When listing the applicant's name, please make certain the full and correct legal name appears. Documentation of location of services must be included. Use the downloadable Applicant Information Form attached to this RFA.

b) Project Impact Form– Applicants for Tier 1 must complete the Tier 1 - Project Impact Form (Attachment III). Use the downloadable Tier 1-Project Impact Form attached to this RFA. Applicants for Tier 2 must complete the Tier 2 - Project Impact Form (Attachment IV). Use the downloadable Tier 2 – Project Impact Form attached to this RFA.

c) Certifications Form – The Certifications Form must be completed and signed by an official authorized to bind the organization to the application. Use the downloadable Certifications Form attached to this RFA.

d) 501(c)(3) Form - Applicant must document its status as a not-for-profit community-based organization or county or municipal government. A not-for-profit organization must submit a copy of its Internal Revenue Service 501(c)(3) Tax Exempt Verification Letter. If a not-for-profit organization is a unit of a foundation or corporation, and is not a separate legal entity, the application, the 501(c)(3) and federal Employer Identification Number (EIN) must be that of the foundation or corporation. If the applicant is a separate legal entity, even if it is a subsidiary of a parent organization, the application, 501(c)(3), and federal EIN must be that of the applicant itself. The applicant for the Community Primary Care Challenge Grant funds must have the fiscal and administrative ability to receive funds and to carry out the purpose of the grant. It will be the applicant's responsibility to execute the Grant Agreement and assume the obligations included in that Agreement. The Certifications Form, (see c above), will serve as documentation for county/municipal governments.

e) Work Statement – The Work Statement may not exceed 20 single spaced pages, 12 font type, 1 inch margins, single sided, and numbered consecutively starting with Page #1. **Applications for Tier 1 must include all of the information required under Section "e) i" (beginning on page 10). Applications for Tier 2 must include all of the information required under Section "e) ii" (beginning on page 17). All information supplied must be separated according to topic, clearly labeled by topic, and submitted in the order identified in the RFA.** All tables in Sections "e) i" and "e) ii" must be in the same format found in the RFA.

i. Tier 1 Applicants:

(1) Project Abstract (maximum of one (1) page):

Summary of entire application, to include:

- Proposed site location
- Succinct description of proposed project including the needs to be addressed
- Succinct description of proposed services
- Succinct description of how state and matching funds will be applied in the project

(2) Delivery of Primary Medical and Dental Care Services:

A narrative description of the proposed project should include:

- Description of how grant funds will be used
- Description of the population to be served and the needs to be addressed
- Description of primary medical or dental services currently provided and/or proposed
- Description of how implementation of the project will increase access to primary medical or dental services
- Description of plans to increase primary medical or dental practitioners for the service area
- Description of the job responsibilities of each position in the project as well as any specialized training and/or licenses required for the specific positions
- Resumes or position descriptions of proposed staff positions in Additional Appendices section

(3) Workplan:

The workplan included in the application should be reflective of the proposed project for the entire grant term from July 1, 2012 through June 30, 2014 and address the goals of the RFA:

- **Increase the number of primary care medical and/or dental practitioners**
- **Increase the number of primary care medical and/or dental clinics**
- **Expand services at existing primary care medical and/or dental clinics**

Use the following format for the project workplan:

- **Identify Measurable Objectives.**
- **Identify the Methodology of Measure for each Objective.**
- **Identify activities to achieve each Objective.**
- **Identify the person/position responsible for each activity.**

TIME PERIOD	MEASUREABLE OBJECTIVE(S)	METHOD OF MEASURE	ACTIVITIES TO ACHIEVE OBJECTIVES	RESPONSIBLE PERSON/POSITION (FOR EACH ACTIVITY)
July, Aug, Sept 2012				
Oct, Nov, Dec 2012				

TIME PERIOD	MEASUREABLE OBJECTIVE(S)	METHOD OF MEASURE	ACTIVITIES TO ACHIEVE OBJECTIVES	RESPONSIBLE PERSON/POSITION (FOR EACH ACTIVITY)
Jan, Feb, March 2013				
Apr, May, June 2013				
July, Aug, Sept 2013				
Oct, Nov, Dec 2013				
Jan, Feb, March 2014				
Apr, May, June 2014				

(4) Access:

- The narrative must include a statement of intent to provide services to all, regardless of ability to pay and a written policy to this effect must be included in the Additional Appendices section of the application.
- The narrative must include a statement that the organization is enrolled in (or will enroll) and remain enrolled throughout the grant period in:
  - Medicare
  - Medical Assistance (MA)
  - Children's Health Insurance Program (CHIP)
- A discounted/sliding fee scale must be included in the Additional Appendices section of the application.
  - The discounted/sliding fee scale must be developed using current federal poverty guidelines with discounts to those with income up to 200% of poverty.
  - The discounted/sliding fee scale must include a "**no pay" or "$0 fee" option** for those unable to pay.
  - Further information on discounted/sliding fee scale requirements are found in the Appendices of this RFA.

The only exception to the requirements that the applicant be enrolled in public insurance (Medicare, MA, and CHIP) and include with the application a discounted/sliding fee scale is for clinics that provide services to patients at no charge (free clinics), in which case the application shall include documentation establishing that the clinic provides services to patients at no charge and that individuals with Medicare, MA, and CHIP have access to care in the community that the clinic serves. Documentation regarding access to care must be included in the Additional Appendices section of the application. The Primary Care Provider Survey Form provided in the Appendices section of this RFA must be used to document this

information. Use the downloadable Primary Care Provider Survey Form attached this RFA. (Appendix 2 of this RFA)

(5) Community Involvement/Network Development:

Description of collaborative involvement by the following in project development and implementation:

- community organizations
- local and county governments
- providers
- state agencies
- community members

Do not include letters of support in the application.

(6) Project Impact:

Complete Tier 1 - Project Impact Form (Attachment III of this RFA). Consult Appendix 4 for instructions on counting patient and patient visit numbers. Use the downloadable Tier 1-Project Impact Form attached to this RFA. (Attachment III of this RFA)

(7) Capacity to Implement:

Description of applicant's capacity to implement project:

- Description of applicant's organizational structure
- Description of current clinical, administrative and support staff
- Description of applicant's governance structure
- Description of applicant's fiscal status demonstrating capacity to implement (Note: Grant funds provide reimbursement for expenditures; applicant should describe plan to pay for expenses incurred prior to reimbursement.)
- Description of Project Director's role in the supervision and administration of the project
- Description of proposed site to include:
  - Address of proposed site
  - Ownership of property
  - Status of any lease agreement (or potential agreement)
  - Conditions necessary for the site to be an operational clinic, if applicable
  - Steps needed to take place in order for the site to be an operational clinic, if applicable
- Identification of renovations required, if applicable. Provide contractor estimated cost and proposed timeline for completion of renovations
- Detailed plan for practitioner recruitment and retention

(8) Sustainability Plans:

Description of plans to sustain project beyond the grant period to include:

- Collaboration/commitment of community partnerships and other agencies for continuation of the project beyond the 24 month grant period
- **Detailed** plans for maintaining long-term operation of the project:
  - Project growth projections (facilities, personnel, services, etc)
  - Funding sources
  - Fiscal plan

(9) Additional Appendices (Attachment VIII):

The following must be included:

- Letters of financial commitment for matching funds
- Letters of approval to use other grant funds as matching funds
- Resumes of key staff for the project
- Position description for vacant key positions
- Copy of discounted/sliding fee scale and policy to ensure services to those unable to pay
- Primary Care Provider Survey Form (free clinics only)
- Contractor estimate for minor renovations, if applicable
- *Community/Migrant Health Centers and other Grantees funded under Section 330 of the Public Health Service Act must include a copy of their federal award authorization revising their "Scope of Project". Refer to Bureau of Primary Health Care (BPHC) Policy Information Notice 2008-01, dated December 31, 2007 Document Title: Defining Scope of Project and Policy for Requesting Changes.
  *As applicable

DO NOT INCLUDE LETTERS OF SUPPORT.

(10) Budget Template (Attachment IX):

A preformatted downloadable budget is available at the following internet address: www.emarketplace.state.pa.us to present your budget request. Instructions regarding completion of the budget can be found in the last worksheet of the Excel budget file.

The anticipated Grant Agreement term is July 1, 2012 to June 30, 2014. The overall 24-month budget for the application shall not exceed $200,000. The budget must contain an Overall Summary in addition to a Summary with Budget Details for each year.

		Maximum Amounts
Overall Summary	July 1, 2012 to June 30, 2014	$200,000
Year 1 Summary	July 1, 2012 to June 30, 2013	$100,000
Year 2 Summary	July 1, 2013 to June 30, 2014	$100,000

(11) Budget Justification (Attachment X):

A narrative of the budget, by category, describing budget requests. The Budget Justification must relate to the workplan goals, objectives and activities to include:

- explanation of personnel expenses
- explanation and justification for equipment and supplies
- written estimates for equipment, supplies, and any renovations included in the project
- identification of consultants and contractors with written estimates

(**12) Budget Definitions:**

- Personnel: The personnel section shall identify each position by job title, hourly rate, and the number of hours per year allocated to the project. Fringe benefits are to be shown as a separate line item by percentage and shall include a detailed listing of the benefits being covered.

- Consultant Services: This budget category shall identify each consultant by classification, hourly rate and number of hours to be utilized under this grant.

- Subcontractor Services: This budget category shall identify each subcontractor to be utilized under this grant. If the subcontractor is not known at this time, please indicate by saying "To Be Determined" along with a description of work to be performed and hourly rate if applicable.

- Patient Services: This budget category is not applicable to this RFA.

- Equipment: This budget category shall reflect the actual or projected cost of any medical and/or dental equipment equal to or greater than $5,000, needed to support this project. Justification for the purchase of any equipment must be included. Requested equipment must be directly related to the proposed project. Purchase of equipment is not a priority of the Department. **DO NOT SUBMIT APPLICATIONS FOR FUNDING FOR EQUIPMENT ONLY.**

- Supplies: This budget category shall reflect expected costs for medical and/or dental supplies, as well as for general office supplies including personal computers and facsimile machines valued at less than $5,000, needed to support this project.

- Travel: This budget category shall include anticipated expenditures for travel, specifically mileage between clinical sites included in this project for the provision of direct patient services.

- Other: This budget category shall be used to anticipate expenditures that do not fit into any of the other budget categories such as telephone, printing, postage, **minor** office renovations, malpractice insurance and rental costs. Indirect costs are also listed in this category; however, they may not be paid for from grant funding.

(13) Allowable Use of Funds:

Requested funding must be **directly** related to the specified goals of the project, which are to increase access to direct primary care medical and dental services. Moreover, requested funding, as itemized in the Budget Justification, must relate directly to workplan objectives and activities.

Grant funds may only be used for the following:

- Primary Health Care Practitioner Salaries and Fringe Benefits:
  - Physician
  - Physician Assistant-Certified (PA-C)
  - Certified Registered Nurse Practitioner (CRNP)
  - Certified Nurse Midwife (CNM)
  - Registered Nurse (RN)
  - Licensed Practical Nurse (LPN)
  - Dentist/Pedodontist
  - Registered Dental Hygienist (RDH)
  - Expanded Function Dental Assistant (EFDA)
  - Dental Assistants

- Medical Assistants
- Medical Interpreters

- Medical and/or Dental Equipment and Supplies
- Other Costs Directly Related to the Provision of Services
  - Travel-mileage between clinical sites for the provision of services detailed in the workplan
  - Minor office renovations (e.g. renovation of interior office space to accommodate more equipment; additional patient exam rooms/dental operatories)
  - Copier
  - Computer/Printer
  - Telephone/Fax Machine
  - Rental Costs
  - Office Supplies
  - Up to $10,000 for electronic medical record technology and equipment

In order to ensure the most appropriate use of funds, there are certain categories of costs that will not be funded. Funding may not be requested for continuation of a project funded with State funds or from other Department of Health grants or contracts. Funding also may not be requested to supplant funds currently being used to support similar activities. Funding may not be requested for salaries for existing positions unless the funds requested are to provide **new or expanded** services by an existing position and there will be an increase in the salary and hours for that position.

If your application is for an outreach/educational services program, behavioral health services, mental health services, counseling, clinical or practice quality improvement, research-based or state-wide projects, <u>do not</u> submit an application for funding, as these are not considered as a means to increasing access to direct primary medical and dental care services.

The Department recognizes that certain costs, such as those listed below, may be a necessary part of the project, and although these costs cannot be paid with grant funds, they may be included in the budget and paid for by a Community Primary Care Challenge Grant Program Grantee from its "matching funds". This must be explained in detail in the budget narrative, and directly related to the goals of the RFA and work statement deliverables. Matching funds must be used to pay for costs directly incurred to support the proposed project.

Grant funds <u>may not</u> be used for the following:

- Administrative or Support Staff Salaries and fringe benefits:
  - Executive Director
  - Project Director
  - Clinical Director
  - Project Coordinator
  - Outreach or Education Coordinator
  - Office Manager
  - Accountants
  - Billing Office
  - Front Office Staff
  - Maintenance Staff

- Loan Repayment/Scholarships
- Employee recruitment
- Real Estate purchases
- New building construction or construction of building additions
- Ambulance/Transportation services
- Printing/Advertising costs
- Costs for direct patient services, i.e. hospital bills, lab fees, pharmacy fees, x-ray fees, phlebotomy fees, prosthodontic fees, etc.
- Vehicle purchases
- Attendance at trainings, conferences, symposiums, meetings
- Purchase of journals, magazines, other publications

(14) Matching Funds Requirements:

- Matching funds must be in the ratio of one (1) dollar for each four (4) dollars of Commonwealth funding and shall not exceed this ratio.
- **Matching funds requirement applies to each budget year as well as the overall grant period.**
- The source of the matching funds must be identified on the Budget Summary form for the overall grant period and each budget year.
- **Fund raising may not be used for match.**
- **Matching funds must be committed at the time of the grant application via a signed letter of financial commitment from an individual with signatory authority from the organization providing the matching funds.**
- **If the applicant is the organization providing matching funds the letter of financial commitment must be signed by an officer of the Board of Directors.**
- Matching funds must be used for direct expenses incurred to support the proposed project and may not be used to allocate existing expenses to this project. For example, if the salary of the Executive Director will be funded at $1,000 per year from matching funds, the $1,000 must represent a sum of money being paid to the Director over and above the Executive Director's current salary and must correspond to work related to the project being funded.
- The applicant may propose to use third party insurance reimbursements for matching funds. If the applicant intends to use third party insurance reimbursements as a source of matching funds, the applicant must include in the Additional Appendices section of the application a letter from an authorized official indicating the total amount of third party insurance reimbursements the applicant organization will commit as matching funds.
- Federal, state, foundation or other grant funds may be used as match. However, a letter from the entity supplying the other grant funds approving the use of those funds for the matching requirement of this grant must be included in the Additional Appendices section of the application.

ii. Tier 2 Applicants:

(1) Project Abstract (maximum of one (1) page):

Summary of entire application must include:

- Succinct description of proposed project
- Succinct description of proposed services
- Succinct description of how state and matching funds will be applied in the project
- Proposed Location of CHC with identified MUA/P to be served
- Stated intention to seek FQHC or FQHC-LA status
- Projected opening date of the CHC

(2) Map of Service Area Identifying MUA/P (maximum of one (1) page):

A map of the proposed service area identifying the MUA/P should be included:

- Ensure that map is legible on all copies of the application.
- Note: If a FQHC or FQHC-LA currently exists in the MUA/P then applicant must clearly identify the service area of the existing FQHC or FQHC-LA and identify the applicant's proposed service area.

(3) Delivery of Primary Care Services:

A narrative description of the proposed project should include:

- Description of how grant funds will be used
- Description of services to be provided by the CHC
- Description of the population to be served
- Description of how the CHC will increase access to care
- If applicant proposes to serve a MUA/P that has an existing FQHC or FQHC-LA the applicant must provide the following:
    - Description of the population to be served that is not currently being served by the existing FQHC or FQHC-LA. (i.e. demographic, social, and economic data for the population of the proposed service area)
    - A letter from the Board of Directors of the existing FQHC or FQHC-LA currently serving the MUA/P that the applicant organization also proposes to serve that supports the proposed CHC. The letter must be included in the Additional Appendices section of the application. The letter must support applicant's plans for the proposed CHC to eventually become a FQHC or FQHC-LA.
- Description of the job responsibilities of each position in the project as well as any specialized training and/or licenses required for the specific positions
- Resumes or position descriptions of proposed staff position should be included in the Additional Appendices section of the application

(4) Workplan:

The workplan included in the application should be reflective of the proposed project for the entire grant term from July 1, 2012 through June 30, 2014 and address the goal of the RFA, which is:

The establishment of a CHC that will eventually seek status as a FQHC or FQHC-LA.

Keep in mind the applicant must propose the following:

The CHC will serve or be located in a MUA/P that lacks a FQHC or FQHC-LA unless the applicant is able to include with the application a letter from the existing FQHC(s) or FQHC-LA(s) supporting the project and eventually establishment of another FQHC or FQHC-LA within or serving the MUA/P.

Use the following format for the project workplan.

- **Identify Measurable Objectives.**
- **Identify the Methodology of Measure for each Objective.**
- **Identify activities to achieve each Objective.**
- **Identify the person/position responsible for each activity**

TIME PERIOD	MEASUREABLE OBJECTIVE (S)	METHOD OF MEASURE	ACTIVITIES TO ACHIEVE OBJECTIVES	RESPONSIBLE PERSON/POSITION (FOR EACH ACTIVITY)
July, Aug, Sept 2012				
Oct, Nov, Dec 2012				
Jan, Feb, March 2013				
Apr, May, June 2013				
July, Aug, Sept 2013				
Oct, Nov, Dec 2013				
Jan, Feb, March 2014				
Apr, May, June 2014				

(5) Access:

- The narrative must include a statement of intent to provide services to all, regardless of ability to pay and a written policy to this effect must be included in the Additional Appendices section of the application.
- The narrative must include a statement that the organization is enrolled in (or will enroll) and remain enrolled throughout the grant period in:
  - Medicare
  - Medical Assistance
  - Children's Health Insurance Program (CHIP)
- A discounted/sliding fee scale must be included in the Additional Appendices section of the application
  - The discounted/sliding fee scale must be developed with current federal poverty guidelines with discounts to those with income up to 200% of poverty.

- The discounted/sliding fee scale must include a "**no pay" or "$0 fee" option** for those unable to pay.
- Further information on discounted/sliding fee scale requirements are found in the Appendices of this RFA.

(6) Community Involvement/Network Development:

Description of collaborative involvement by the following in project development and implementation:

- community organizations
- local and county governments
- providers
- state agencies
- community members

(7) Project Impact:

Complete Tier 2 - Project Impact Form (Attachment IV of this RFA). Use the downloadable Tier 2 – Project Impact Form attached to this RFA (Attachment IV of this RFA). Consult Appendix 4 for instructions on counting patient and patient visit numbers.

(8) Capacity to Implement:

Description of applicant's capacity to implement project:

- Description of applicant's organizational structure
- Description of current clinical, administrative and support staff
- Description of applicant's governance structure
- Description of applicant's fiscal status demonstrating capacity to implement (Note: Grant funds provide reimbursement for expenditures; applicant should describe plan to pay for costs incurred prior to reimbursement.)
- Description of Project Director's role in the supervision and administration of the project
- Description of proposed site to include:
  - Address of proposed site
  - Ownership of property
  - Status of any lease agreement (or potential lease agreement)
  - Conditions necessary for the site to be an operational CHC
  - Steps required to be an operational CHC, if applicable
- Identification of renovations required, if applicable. Provide contractor estimated cost, and proposed timeline for completion of renovations (see Allowable Use of Funds for Tier 2 renovations on pages 21-22 of this RFA)
- Detailed plan for practitioner recruitment and retention

(9) Sustainability Plans:

Description of plans to sustain project beyond the grant period to include:

- Collaboration/commitment of community partnerships and other agencies for continuation of the project beyond the 24 month grant period
- **Detailed** plans for maintaining long-term operation of the project:
  - Project growth projections (facilities, personnel, services, etc)
  - Funding sources
  - Fiscal plan

(10) Additional Appendices (Attachment VIII):

The following must be included:

- Letters of financial commitment for matching funds
- Letter of approval to use other grant funds as matching funds
- Letter(s) of support from Board of Directors of **any** existing FQHC(s) or FQHC-LA(s)currently serving proposed MUA/P (only if proposed MUA/P has an existing FQHC or FQHC- LA)
- Resumes of key staff for the project
- Position description for vacant key positions
- Copy of discounted/sliding fee scale and policy to ensure services to those unable to pay
- Contractor estimate for office renovations, if applicable
- *Community/Migrant Health Centers and other Grantees funded under Section 330 of the Public Health Service Act must include a copy of their federal award authorization revising their "Scope of Project". Refer to Bureau of Primary Health Care (BPHC) Policy Information Notice 2008-01, dated December 31, 2007 Document Title: Defining Scope of Project and Policy for Requesting Changes.

*As applicable

DO NOT INCLUDE LETTERS OF SUPPORT. THE ONLY EXCEPTION TO THIS IS THE REQUIRED LETTER OF SUPPORT FROM AN EXISTING FQHC OR FQHC-LA (see Section C 2 e *ii* (3)).

(11) Budget Template (Attachment IX):

A preformatted downloadable budget is available at the following internet address: www.emarketplace.state.pa.us to present your budget request. Instructions regarding completion of the budget can be found in the last worksheet of the Excel budget file.

The anticipated Grant Agreement term is July 1, 2012 to June 30, 2014. The overall 24-month budget for the application shall not exceed $500,000. Your budget needs to contain an Overall Summary in addition to a Summary with Budget Details for each year.

		Maximum Amounts
Overall Summary	July 1, 2012 to June 30, 2014	$500,000
Year 1 Summary	July 1, 2012 to June 30, 2013	$250,000
Year 2 Summary	July 1, 2013 to June 30, 2014	$250,000

(12) Budget Justification (Attachment X):

Narrative of the budget, by category, describing budget requests. The Budget Justification must relate to the workplan goals, objectives and activities to include:

- explanation of personnel expenses
- explanation and justification for equipment, supplies, and office renovations
- written estimates for equipment, supplies, and for any renovations included in this project
- identification of consultants and contractors with written estimates

(13) Budget Definitions:

- Personnel: The personnel section shall identify each position by job title, hourly rate, and the number of hours per year allocated to the project. Fringe benefits are to be shown as a separate line item by percentage and shall include a detailed listing of the benefits being covered.

- Consultant Services: This budget category shall identify each consultant by classification, hourly rate and number of hours to be utilized under this grant.

- Subcontractor Services: This budget category shall identify each subcontractor to be utilized under this grant. **If the subcontractor is not known at this time, please indicate by saying "To Be Determined" along with a description of work to be performed and hourl**y rate if applicable.

- Patient Services: This budget category is not applicable to this RFA.

- Equipment: This budget category shall reflect the actual or projected cost of any medical and/or dental equipment equal to or greater than $5,000, needed to support this project. Justification for the purchase of any equipment must be included. Requested equipment must be directly related to the proposed project.

- Supplies: This budget category shall reflect expected costs for medical and/or dental supplies, as well as for general office supplies including personal computers and facsimile machines valued at less than $5,000, needed to support this project.

- Travel: This budget category shall include anticipated expenditures for travel, specifically mileage between clinical sites included in this project for the provision of direct patient services.

- Other: This budget category shall be used to anticipate expenditures that do not fit into any of the other budget categories such as telephone, printing, postage, office renovations, malpractice insurance and rental costs. Indirect costs are also listed in this category; however, they may not be paid for from grant funding.

(14) Allowable Use of Funds:

Requested funding must be **directly** related to the specified goal of the project which is to establish a Community Health Center serving populations with limited access to health care. Moreover, requested funding, as itemized in the Budget Justification, must relate directly to workplan objectives and activities.

Grant funds may only be used for the following:

- Primary Health Care Practitioner, Administrative and Support Salaries and Fringe Benefits:
  - Physician
  - Physician Assistant-Certified (PA-C)
  - Certified Registered Nurse Practitioner (CRNP)
  - Certified Nurse Midwife (CNM)
  - Registered Nurse (RN)

- Licensed Practical Nurse (LPN)
- Dentist/Pedodontist
- Registered Dental Hygienist (RDH)
- Expanded Function Dental Assistant (EFDA)
- Dental Assistants
- Medical Assistants
- Medical Interpreters
- Executive Director
- Project Director
- Project Coordinator
- Outreach or Education Coordinator
- Office Manager
- Accountants
- Billing Office staff
- Front Office staff
- Maintenance staff

- Medical and/or Dental Equipment and Supplies
- Other Costs Directly Related to the Provision of Services
  - Travel-mileage between clinical sites for the provision of services detailed in the workplan
  - Office renovations (modification of interior office space to accommodate more equipment; additional patient exam rooms/dental operatories; external additions or modifications to an existing building to accommodate a health center)
  - Copier
  - Computer/Printer
  - Telephone/Fax Machine
  - Rental Costs
  - Office Supplies
  - Up to $20,000 for electronic medical record technology and equipment

In order to ensure the most appropriate use of funds, there are certain categories of costs that will not be funded. Funding may not be requested for continuation of a project funded with State funds or from other Department of Health grants or contracts. Funding also may not be requested to supplant funds currently being used to support similar activities. Funding may not be requested for salaries for existing positions unless the funds requested are to provide **new or expanded** services by an existing position and there will be an increase in the salary and hours for that position.

The Department recognizes that certain costs, such as those listed below, may be a necessary part of the project, and although these costs cannot be paid with grant funds, they may be included in the budget and paid for by a Community Primary Care Challenge Grant Program Grantee from its "matching funds". This must be explained in detail in the budget narrative, and directly related to the goals of the RFA and work statement deliverables. Matching funds must be used to pay for costs directly incurred to support the proposed project.

Applicants <u>may not</u> use Grant Funds for the following:

- Loan Repayment/Scholarships
- Real Estate purchases

- Construction of new buildings
- Ambulance/Transportation services
- Printing/Advertising costs
- Costs for direct patient care, i.e. hospital bills, lab fees, pharmacy fees, x-ray fees, phlebotomy fees, prosthodontic fees, etc.
- Vehicle purchases
- Attendance at conferences, symposiums, meetings
- Purchase of journals, magazines, other publications

(15) Matching Funds Requirements:

- Matching funds must be in the ratio of one (1) dollar for each four (4) dollars of Commonwealth funding and **shall not exceed this ratio**.
- **Matching requirement applies to each budget year as well as the overall grant period.**
- The source of the matching funds must be identified on the Budget Summary form for the overall grant period and each budget year.
- **Fund raising may not be used for match.**
- **Matching funds must be committed at the time of the grant application via a signed letter of financial commitment from an individual with signatory authority from the organization providing the matching funds.**
- **If the applicant is the organization providing matching funds the letter of financial commitment must be signed by an officer of the Board of Directors.**
- Matching funds must be used for direct expenses incurred to support the proposed project and may not be used to allocate existing expenses to this project. For example, if the salary of the Executive Director will be funded at $1,000 per year from matching funds, the $1,000 must represent a sum of money being paid to the Director over and above the Executive Director's current salary and must correspond to work related to the project being funded.
- The applicant may propose to use third party insurance reimbursements for matching funds. If the applicant intends to use third party insurance reimbursements as a source of matching funds, the applicant must include in the Additional Appendices section of the application a letter from an authorized official indicating the total amount of third party insurance reimbursements the applicant organization will commit as matching funds.
- Federal, state, foundation or other grant funds may be used as match. However, a letter from the entity supplying the other grant funds approving the use of those funds for the matching requirement of this grant must be included in the Additional Appendices section of the application.

D. APPENDICES

1. BUREAU OF HEALTH PLANNING DISCOUNTED/SLIDING FEE REQUIREMENTS

2. PRIMARY CARE PROVIDER SURVEY FORM

3. SUMMARY OF KEY HEALTH CENTER PROGRAM REQUIREMENTS

4. PATIENT AND PATIENT VISIT INSTRUCTIONS

BUREAU OF HEALTH PLANNING
DISCOUNTED/SLIDING FEE SCALE REQUIREMENTS

The Bureau of Health Planning administers the following programs with the goal of providing a safety-net for access to health care for low income populations, including those without health insurance: Community Primary Challenge Grant Program, Health Practitioner Loan Repayment Program, Conrad 30 J-1 Visa and National Interest Waiver Programs. As such, the Bureau requires organizations wishing to participate in these programs comply with the following requirements:

- Use of a **discounted/sliding fee scale** based upon **current** Federal Poverty Guidelines to ensure that no financial barriers to care exist for those who meet certain financial eligibility criteria;
- Posting a **statement indicating that no one who is unable to pay will be denied access** to services;
- Having a **policy of non-discrimination** in the delivery of health care services.

What is a discounted/sliding fee schedule?

Discounted/sliding fee schedules are locally driven mechanisms (discounts) to address how to equitably charge patients for services rendered. The mechanism must be in writing. Fees are set based upon current, annual federal poverty guidelines; patient eligibility is determined by annual income and family size. Schedules are established and implemented to ensure that a non-discriminatory, uniform, and reasonable charge is consistently and evenly applied, on a routine basis. For patients whose income and family size place them below poverty, a "typical" nominal fee is often between $7 and $15; patients between 101-200% of poverty are expected to pay some percentage of the full fee. **Patients who document no ability to pay should be treated without charge**. A discounted/sliding fee schedule applies only to amounts assessed to patients. Billing for third party coverage, i.e. Medicare, Medicaid, private insurance carriers, etc., is set at the usual and customary full charge.

Why have a discounted/sliding fee schedule?

Program requirements prescribe that a locally determined discounted/sliding fee schedule be used, and that services be provided either at no fee or a nominal fee, as determined by the provider to ensure access to health care for those who cannot afford full charges. The reasonableness of fees, and the percent of a full fee that is assessed, may be subject to review/challenge by the Department during the program application process or during routine programmatic reviews by Department project officers or program administrators.

To which patients does a discounted/sliding fee schedule apply?

By participating in any of the Department programs requiring a discounted/sliding fee schedule, you are agreeing to apply the schedule equally, consistently, on a continuous basis, to all recipients of services in the entirety of the site/location, without regard to the particular practitioner that treats them.

Where can I find more information on developing a discounted/sliding fee schedule and policy?

The National Health Service Corps has developed a Discounted/Sliding Fee Schedule Information Package which can be accessed at: http://nhsc.hrsa.gov/communities/discountedfee.pdf

Where can I find more information on Federal Poverty Guidelines?

Federal Poverty Guidelines are updated and published annually in the Federal Register. They can be accessed through the Department of Health and Human Services at: http://aspe.hhs.gov/poverty/

PRIMARY CARE PROVIDER SURVEY FORM

(Outpatient providers only. Do not survey hospital providers.)

Name, Degree Primary Address, Telephone #, and Additional Office Locations (Specify municipality or census tract)	**Specialty[1]**	**Office Hours[2]**	Accepting New Patients[3]				
			Medicare Y/N	**MA Y/N**	**CHIP Y/N**	**Free, Discounted, or Sliding Fee Y/N**	**Commercial Insurance Y/N**

[1] Specialty (Family Practice, General Practitioner, Internal Medicine, OB/GYN, Pediatrics, Dentist, Pedodontist)
[2] Days and hours patients are provided services i.e. Monday, Wednesday and Friday 11:00-2:00 and Tuesday and Thursday 9:00-12:00 and 4:00-7:00
[3] Indicate if practice is accepting new patients in the following columns: Medicare, MA, CHIP, Free, Discounted, or Sliding Fee and/or Commercial Insurance (Y/N)

INSTRUCTIONS FOR PRIMARY CARE PROVIDER SURVEY FORM (FOR TIER 1 APPLICATIONS - FREE CLINICS ONLY)

If the application is for primary care medical services then survey only primary care physicians. If the application is for primary care dental services then survey only general dentists. If the application is for both primary care medical services and primary care dental services then applicant must survey both physicians and dentists.

Primary Care Providers include: Family Practice, General Practice, General Internal Medicine, Obstetrician/Gynecologist, Pediatrics, General Dentist and Pedodontist, only. DO NOT INCLUDE Certified Registered Nurse Practitioners, Physician Assistants, Certified Nurse Midwives, Dental Hygienists, Dental Assistants or Specialty or Hospital/Inpatient physicians.

Office Hours-are the hours that the physician or dentist is actually available to see patients.

If physician/dentist splits time between 2 locations, please obtain hours worked at each location.

Under "Accepting New Patients" indicate Y (yes) or N (no) for each of the following: Medicare, MA, CHIP, Free/Discounted/Sliding Fee and/or Commercial Insurance if the new patients are accepted in these categories.

Note: If offices refuse to answer, indicate that in the "office hours" column.

Be sure to add any physicians and/or dentists that you know are in the proposed service area.

SUMMARY OF KEY HEALTH CENTER PROGRAM REQUIREMENTS

Health centers are non-profit private or public entities that serve designated medically underserved populations/areas or special medically underserved populations comprised of migrant and seasonal farmworkers, the homeless or residents of public housing. A summary of the key health center program requirements is provided below. For additional information on these requirements, please review:

- Health Center Program Statute: Section 330 of the Public Health Service Act (42 U.S.C. §254b)
- Program Regulations (42 CFR Part 51c and 42 CFR Parts 56.201-56.604 for Community and Migrant Health Centers)
- Grants Regulations (45 CFR Part 74)

	NEED
1.	**Needs Assessment:** Health center demonstrates and documents the needs of its target population, updating its service area, when appropriate. (Section 330(k)(2) and Section 330(k)(3)(J) of the PHS Act)
	SERVICES
2.	**Required and Additional Services:** Health center provides all required primary, preventive, enabling health services and additional health services as appropriate and necessary, either directly or through established written arrangements and referrals. (Section 330(a) of the PHS Act) **Note:** Health centers requesting funding to serve homeless individuals and their families must provide substance abuse services among their required services (Section 330(h)(2) of the PHS Act)
3.	**Staffing Requirement:** Health center maintains a core staff as necessary to carry out all required primary, preventive, enabling health services and additional health services as appropriate and necessary, either directly or through established arrangements and referrals. Staff must be appropriately credentialed and licensed. (Section 330(a)(1) and (b)(1), (2) of the PHS Act)
4.	**Accessible Hours of Operation/Locations:** Health center provides services at times and locations that assure accessibility and meet the needs of the population to be served. (Section 330(k)(3)(A) of the PHS Act)
5.	**After Hours Coverage:** Health center provides professional coverage during hours when the center is closed. (Section 330(k)(3)(A) of the PHS Act)
6.	**Hospital Admitting Privileges and Continuum of Care:** Health center physicians have admitting privileges at one or more referral hospitals, or other such arrangement to ensure continuity of care. In cases where hospital arrangements (including admitting privileges and membership) are not possible, health center must firmly establish arrangements for hospitalization, discharge planning, and patient tracking. (Section 330(k)(3)(L) of the PHS Act)
7.	**Sliding Fee Discounts:** Health center has a system in place to determine eligibility for patient discounts adjusted on the basis of the patient ability to pay. • This system must provide a full discount to individuals and families with annual incomes at or below 100% of the poverty guidelines (only nominal fees may be charged) and for those with incomes between 100% and 200% of poverty, fees must be charged in

NOTE: Portions of program requirements notated by an asterisk **"*"** indicate regulatory requirements that are recommended ***but not required*** for grantees that receive funds solely for Health Care for the Homeless (section 330(h)) and/or the Public Housing Primary Care (section 330(i)) Programs.

Accessed April 15, 2011
http://bphc.hrsa.gov/administration/requirements.pdf

	accordance with a sliding discount policy based on family size and income.* • No discounts may be provided to patients with incomes over 200 % of the Federal poverty level.* (Section 330(k)(3)(G) of the PHS Act and 42 CFR Part 51c.303(f))
8.	**Quality Improvement/Assurance Plan:** Health center has an ongoing Quality Improvement/Quality Assurance (QI/QA) program that includes clinical services and management, and that maintains the confidentiality of patient records. The QI/QA program must include: • a clinical director whose focus of responsibility is to support the quality improvement/assurance program and the provision of high quality patient care;* • periodic assessment of the appropriateness of the utilization of services and the quality of services provided or proposed to be provided to individuals served by the health center; and such assessments shall: * ○ be conducted by physicians or by other licensed health professionals under the supervision of physicians;* ○ be based on the systematic collection and evaluation of patient records;* and ○ identify and document the necessity for change in the provision of services by the health center and result in the institution of such change, where indicated.* (Section 330(k)(3)(C) of the PHS Act, 45 CFR Part 74.25 (c)(2), (3) and 42 CFR Part 51c.303(c)(1-2))
MANAGEMENT AND FINANCE	
9.	**Key Management Staff:** Health center maintains a fully staffed health center management team as appropriate for the size and needs of the center. Prior review by HRSA of final candidates for Project Director/Executive Director/CEO position is required. (Section 330(k)(3)(H)(ii) of the PHS Act and 45 CFR Part 74.25 (c)(2), (3))
10.	**Contractual/Affiliation Agreements:** Health center exercises appropriate oversight and authority over all contracted services, including assuring that any subrecipient(s) meets Health Center program requirements. (Section 330(k)(3)(I)(ii), 42 CFR Part 51c.303(n), (t)), Section 1861(aa)(4) and Section 1905(l)(2)(B) of the Social Security Act, and 45 CFR Part 74.1(a) (2)))
11.	**Collaborative Relationships:** Health center makes effort to establish and maintain collaborative relationships with other health care providers, including other health centers, in the service area of the center. The health center secures letter(s) of support from existing Federally Qualified Health Center(s) in the service area or provides an explanation for why such letter(s) of support cannot be obtained (Section 330(k)(3)(B) of the PHS Act)
12.	**Financial Management and Control Policies:** Health center maintains accounting and internal control systems appropriate to the size and complexity of the organization reflecting Generally Accepted Accounting Principles (GAAP) and separates functions appropriate to organizational size to safeguard assets and maintain financial stability. Health center assures an annual independent financial audit is performed in accordance with Federal audit requirements, including submission of a corrective action plan addressing all findings, questioned costs, reportable conditions, and material weaknesses cited in the Audit Report. (Section 330(k)(3)(D), Section 330(q) of the PHS Act and 45 CFR Parts 74.14, 74.21 and 74.26)

NOTE: Portions of program requirements notated by an asterisk **"*"** indicate regulatory requirements that are recommended ***but not required*** for grantees that receive funds solely for Health Care for the Homeless (section 330(h)) and/or the Public Housing Primary Care (section 330(i)) Programs.

13.	**Billing and Collections:** Health center has systems in place to maximize collections and reimbursement for its costs in providing health services, including written billing, credit and collection policies and procedures. (Section 330(k)(3)(F) and (G) of the PHS Act)
14.	**Budget:** Health center has developed a budget that reflects the costs of operations, expenses, and revenues (including the Federal grant) necessary to accomplish the service delivery plan, including the number of patients to be served. (Section 330(k)(3)(D), Section 330(k)(3)(I)(i), and 45 CFR Part 74.25)
15.	**Program Data Reporting Systems:** Health center has systems which accurately collect and organize data for program reporting and which support management decision making. (Section 330(k)(3)(I)(ii) of the PHS Act)
16.	**Scope of Project:** Health center maintains its funded scope of project (sites, services, service area, target population and providers), including any increases based on recent grant awards. (45 CFR Part 74.25)
GOVERNANCE	
17.	**Board Authority:** Health center governing board maintains appropriate authority to oversee the operations of the center, including: • holding monthly meetings; • approval of the health center grant application and budget; • selection/dismissal and performance evaluation of the health center CEO; • selection of services to be provided and the health center hours of operations; • measuring and evaluating the organization's progress in meeting its annual and long-term programmatic and financial goals and developing plans for the long-range viability of the organization by engaging in strategic planning, ongoing review of the organization's mission and bylaws, evaluating patient satisfaction, and monitoring organizational assets and performance;* and • establishment of general policies for the health center. (Section 330(k)(3)(H) of the PHS Act and 42 CFR Part 51c.304) **Note:** In the case of public centers (also referred to as public entities) with co-applicant governing boards, the public center is permitted to retain authority for establishing general policies (fiscal and personnel policies) for the health center. (Section 330(k)(3)(H) of the PHS Act and 42 CFR 51c.304(d)(iii) and (iv)) **Note:** Upon a showing of good cause the Secretary may waive, for the length of the project period, the monthly meeting requirement in the case of a health center that receives a grant pursuant to subsection (g), (h), (i), or (p). (Section 330(k)(3)(H) of the PHS Act)
18.	**Board Composition:** The health center governing board is composed of individuals, a majority of whom are being served by the center and, who as a group, represent the individuals being served by the center in terms of demographic factors such as race, ethnicity, and sex. Specifically: • Governing board has at least 9 but no more than 25 members, as appropriate for the complexity of the organization.* • The remaining non-consumer members of the board shall be representative of the community in which the center's service area is located and shall be selected for their

NOTE: Portions of program requirements notated by an asterisk **"*"** indicate regulatory requirements that are recommended ***but not required*** for grantees that receive funds solely for Health Care for the Homeless (section 330(h)) and/or the Public Housing Primary Care (section 330(i)) Programs.

	expertise in community affairs, local government, finance and banking, legal affairs, trade unions, and other commercial and industrial concerns, or social service agencies within the community. * • No more than one half (50%) of the non-consumer board members may derive more than 10% of their annual income from the health care industry.* **Note:** Upon a showing of good cause the Secretary may waive, for the length of the project period, the patient majority requirement in the case of a health center that receives a grant pursuant to subsection (g), (h), (i), or (p). (Section 330(k)(3)(H) of the PHS Act and 42 CFR Part 51c.304)
19.	**Conflict of Interest Policy:** Health center bylaws or written corporate board approved policy include provisions that prohibit conflict of interest by board members, employees, consultants and those who furnish goods or services to the health center. • No board member shall be an employee of the health center or an immediate family member of an employee. The Chief Executive may serve only as an ex-officio member of the board.* (45 CFR Part 74.42 and 42 CFR Part 51c.304(b))

COMMUNITY PRIMARY CARE CHALLENGE GRANT PROGRAM
Patient & Patient Visit Instructions

*For Community Primary Care Challenge Grant Program data reporting, report data only from the **location** (i.e. the **specific practice site address**) and type of **service** (i.e. **primary medical or dental**). Follow specific definitions and instructions below when reporting **patient** and **patient visit** data.*

DEFINITIONS

Patient – *An individual who has received **at least one visit** with a Provider during the reporting year. **An individual patient may be counted only once**.*

People who only receive services from large-scale efforts such as immunization programs, screening programs, and health fairs are not counted as patients.

Provider – *A licensed medical professional who assumes primary responsibility for **assessing the patient**, exercises independent **judgment as to the services that are rendered** and is **responsible for documenting the patient's record**.*

Providers of patient visits for the Community Primary Care Challenge Grant Program may be:

Physicians with specialties of:
Family Practice, Osteopathic General Practice, Ob-Gyn, General Pediatrics, General Practitioner, General Internal Medicine

Physician Assistant (primary care only)
Nurse Practitioner (primary care only)
Nurse Midwife
Registered Nurse
General Dentist
Dental Hygienist

Patient Visit – *A face-to-face contact between a Patient and a Provider, when the Provider exercises independent professional judgment **in the provision of services** to the Patient. To be included as a visit, services rendered **must be documented in a Patient Record** possessed by the clinical practice site.*

INSTRUCTIONS

Counting Patients:

- Do not count the same patient in more than one category (i.e. Medicare, Medical Assistance, CHIP, Commercial Insurance, etc.)
- Count an individual patient only once in a given year

Counting Visits:

- A visit may take place only at the Community Primary Care Challenge Grant Program site.
- If there is more than one Provider involved in the visit (for example, a dental hygienist and dentist seeing same patient for same purpose) it counts as one visit.
- Count only one visit per Patient per Provider per day. If a patient has multiple procedures on a single day it counts as one visit only. For example, if a patient was seen by a dental hygienist for a cleaning and a dentist for a filling on the same day, this would count as a single patient visit.

General Instructions:

- If the Community Primary Care Challenge Grant Program funding is for primary medical services at a specific address, count all patients and patient visits that are primary medical care services at that location.
- If the Community Primary Care Challenge Grant Program funding is for primary dental services at a specific address, count all patients and patients visits that are primary dental care services at that location.
- If the Community Primary Care Challenge Grant Program funding is for both primary medical and dental services at a specific address, count all patients and patient visits that are primary medical care services and primary dental care services at that location.

PART TWO

Pennsylvania Department of Health
Bureau of Health Planning
Division of Health Professions Development

Community Primary Care Challenge Grant

Request for Applications (RFA) # 10-07-07

Mailing Label:

THIS LABEL MAY BE USED FOR MAILING THE APPLICATION. THIS LABEL MAY BE CUT OUT AND FIRMLY AFFIXED TO THE APPLICATION PACKAGE, OR COPY THIS EXACT FORMAT FOR THE MAILING LABEL.

FROM:

APPLICATION ENCLOSED RFA 10-07-07

BID

TO: PA DEPARTMENT OF HEALTH
DIRECTOR
DIVISION OF CONTRACTS
ROOM 824, HEALTH AND WELFARE BUILDING
625 FORSTER STREET
HARRISBURG, PA 17120-0701

Grant Proposed Amount $_____

RFA#10-07-07
Attachment II

APPLICANT INFORMATION FORM
Community Primary Care Challenge Grant
RFA #10-07-07

APPLICATION TYPE: □ **TIER 1** **OR** □ **TIER 2**

Organization Submitting Application: _____

Applicant Address: _____
& Street Address City Zip Code

Federal EIN #:_____ SAP Vendor #:_____

Proposed Project _____
Site Address: # & Street Address City Zip Code

County of Proposed Project Site _____

City/ Borough/Township of Proposed Project Site_____

Census Tract of proposed Project Site_____

Project Director: _____

Mailing Address: _____
& Street Address City Zip Code

Telephone #_____ Fax #: _____ E-Mail: _____

Organization Submitting Application Type (check applicable):

FEDERALLY-FUNDED
____CHC (330)
____Housing Project (340)
____Homeless Shelter (340)

HEALTH DEPARTMENT
____County
____City

OTHER
____Hospital Based Clinic
____Community-Based Clinic
____University Based Clinic
____Certified Rural Health Clinic (Not for Profit)
____FQHC Look-alike
____Free Clinic
____ Health Improvement Partnership
____School Based Health Center
____Other

As an individual with signatory authority of (Fill in your Organization Name), I certify that the information provided in this application and all of its attachments are true and correct as of the date set forth opposite my signature. I also understand that any intentional or negligent misrepresentation (s) of the information contained in this application may result in forfeiture and/or penalty of any grant awarded based on the information provided.

_____ _____
Signature Date

_____ _____
Print Name Title

TIER 1 – PROJECT IMPACT FORM

If Application is for more than one site location then applicant must complete a separate Tier 1 – Project Impact Form for each site location.

Project Type: ☐ Primary Care ☐ Dental ☐ Both

IN ORDER TO BE ELIGIBLE FOR TIER 1 FUNDING APPLICANT MUST CHECK *ONE* OF THE FOLLOWING, BY COMPLETING THE APPROPRIATE SECTIONS:

A. This application is to provide Primary Care Services at a *New* Practice Site located in an area with a current federal designation.
☐ Yes ☐ No
If applicant answered "yes" then fill out Section I and Section II

B. This application is for an *Expansion* of Primary Care Services at an *Existing* Practice Site located in an area with a current federal designation. ☐ Yes ☐ No
If applicant answered "yes" then fill out Section I and Section II

C. This application is for an *Expansion* of Primary Care Services at an *Existing* Practice Site NOT located in an area with a current federal designation *and* 30% of patients served from July 1, 2010 to June 30, 2011 were identified as low-income. ☐ Yes ☐ No
If applicant answered "yes" then fill out Section II and Section III

D. This application is for an *Expansion* of Primary Care Services at an *Existing* Practice Site NOT located in an area with a current federal designation *and* 30% of patients served from July 1, 2010 to June 30, 2011 were residents of an area with a current federal designation.
☐ Yes ☐ No
If applicant answered "yes" then fill out Section II and Section I V

SECTION I:

If applicant answered "yes" to A or B then fill out this section.

Primary Care Project: PC HPSA Name & #_____
OR
Dental Care Project: Dental HPSA Name & #_____
OR
MUA/P Name & #_____

To determine if proposed clinic site address is in a designated area use the following websites: DOH website at www.health.state.pa.us/pco or Health Resources Service Administration (HRSA) website at http://datawarehouse.hrsa.gov/geoadvisor/ .

SECTION II:

If applicant answered "yes" to A, B, C, or D then fill out both Tables 1 and 2.

- **TABLE 1 – PATIENT NUMBERS: Provide current number of <u>unduplicated</u> patients and projections of the total number of unduplicated patients during each year of the project period by coverage type in the following format.**

Coverage Type	Current # Patients (07/01/10-6/30/11)	Proposed # Patients (07/01/12-06/30/13)	Proposed # Patients (07/01/13-06/30/14)
Number of patients served with Medicare			
Number of patients served with Medical Assistance (MA)			
Number of patients served with Children's Health Insurance Program (CHIP)			
Number of patients served not charged due to inability to pay			
Number of patients served that could not pay full amount but paid something (discounted/sliding fee scale)			
Number of patients with full pay/commercial insurance			
TOTAL Number of Patients			

- **TABLE 2 – PATIENT VISITS: Provide current number of patient visits and projections of the total number of patient visits during each year of the project period by coverage type in the following format.**

Coverage Type	Current # Patient Visits (07/01/10-6/30/11)	Proposed # Patient Visits (07/01/12-06/30/13)	Proposed # Patient Visits (07/01/13-06/30/14)
Number of visits for patients with Medicare			
Number of visits for patients with Medical Assistance (MA)			
Number of visits for patients served with Children's Health Insurance Program (CHIP)			
Number of visits for patients not charged due to inability to pay			
Number of visits for patients that could not pay full amount but paid something (discounted/sliding fee scale)			
Number of visits for patients with full pay/commercial insurance			
TOTAL Number of Patient Visits			

SECTION III:

If applicant answered "yes" to C then fill out this section.

PATIENT PROFILE STUDY: The proposed site location is a safety net health care provider to the community and the surrounding area by providing primary care services to the underserved populations as evidenced by the table below:

Coverage Type	# Patients Served (07/01/10-6/30/11)	% Patients Served (07/01/10-6/30/11)
1. Number of patients served with Medicare		
2. Number of patients served with Medical Assistance (MA) *		
3. Number of patients served with Children's Health Insurance Program (CHIP)		
4. Number of patients served not charged due to inability to pay *		
5. Number of patients served that could not pay full amount but paid something (discounted/sliding fee scale) *		
6. Number of patients with full pay/commercial insurance		
TOTAL Number of Patients		

**The total sum of Rows 2, 4, and 5 must be at least 30% of total patients served.*

SECTION IV:

If applicant answered "yes" to D then fill out this section.

PATIENT OF ORIGIN STUDY: In determining if the proposed site (from July 1, 2010 to June 30, 2011) has served a minimum of 30% of patients that reside in a current HPSA or MUA/P then the applicant must complete a patient of origin study. The patient of origin study must be conducted by following the procedures in completing the table below:

- To determine if patient address is in a designated area use the following websites: DOH website at www.health.state.pa.us/pco or Health Resources Service Administration (HRSA) website at http://datawarehouse.hrsa.gov/geoadvisor/ . (mental health HPSA does not apply)
- To determine which township, borough or census tract the patient resides in for the study, use the following websites: American FactFinder (US Census Bureau) at www.factfinder.census.gov. (On the far left of the screen in the box that says "Address Search" click onto the words "street address". On the next screen enter the street address, city, state, and zip code. This will provide the township, borough and census tract (CT).) An additional website for this purpose is

www.ffiec.gov/geocode. **You will not be able to access the information using a post office box.**

- In the table below in Column A identify all census tracts or minor civil divisions where all of the patients reside.
- In the table below identify the HPSA or MUA/P by name and identifying number in the grey of Columns B and C.
- If a census tract or minor civil division in Column A is in a current HPSA or MUA/P, provide the number of patients residing in that perspective census tract or minor civil division in Column B.
- If a census tract or minor civil division in Column A is not in a current HPSA or MUA/P, provide the number of patients residing in that perspective census tract or minor civil division in Column D.
- After identifying all of the census tracts or minor civil divisions with all of the patients that reside in them, calculate the total # of patients in Columns B and D and enter those numbers at the bottom of table in Total row.
- In Column C provide the overall percentage of patients served based on Column B.
- In Column E provide the overall percentage of patients served based on Column D.

From July 1, 2010 to June 30, 2011 the (Fill in Organization Name Here) located at (Fill in Address of Proposed Site Address) served a total of (insert number) patients. From July 1, 2010 to June 30, 2011 a percentage of (insert percentage of patients served that resided in the closest HPSA or MUA/P) % patients were residents of a current federal designation as evidenced below:

A. Census Tract or Minor Civil Division (borough or township) where Patients reside	B. # of Patients served that reside in [Insert name and identification number of HPSA or MUA/P]	C. % of Patients served that reside in [Insert name and identification number of HPSA or MUA/P]	D. # of Patients that do not reside in HPSA or MUA/P	E. % of Patients that do not reside in HPSA or MUA/P
TOTAL				

RFA#10-07-07
Attachment IV

TIER 2 - PROJECT IMPACT FORM

IN ORDER TO BE ELIGIBLE FOR TIER 2 FUNDING APPLICANT MUST CHECK *ONE* OF THE FOLLOWING, AND COMPLETE SECTIONS I AND II:

A. The proposed Community Health Center (CHC) site is located in an area which has an existing federally designated Medically Underserved Area/Population (MUA/P) that lacks a Federally Qualified Health Center (FQHC) and a FQHC- Look Alike (LA):
☐ Yes ☐ No

B. The proposed CHC site is not located within an area which has an existing federally designated MUA/P; however the proposed CHC intends to serve residents of an area which has an existing federal designation as a MUA/P that lacks a FQHC or a FQHC-LA:
☐ Yes ☐ No

C. The proposed CHC intends to serve residents of an area which has an existing federal designation as a MUA/P that has a FQHC or a FQHC-LA and all requirements in this RFA pertaining to such a proposal have been met:
☐ Yes ☐ No

SECTION I:

The Proposed CHC will serve or be located in:

MUA/P Name & #_____

To determine if proposed clinic site address or proposed service area is located in or near a federally designated MUA/P use the following websites: DOH website at www.health.state.pa.us/pco or Health Resources Service Administration (HRSA) website at http://datawarehouse.hrsa.gov/geoadvisor/ .

SECTION II:

Complete Table 1 and Table 2.

- **TABLE 1 – PATIENT NUMBERS: Provide projections of the total number of unduplicated patients during each year of the project period by coverage type in the following format.**

Coverage Type	**Proposed # Patients (07/01/12-06/30/13)**	**Proposed # Patients (07/01/13-06/30/14)**
Number of patients with Medicare		
Number of patients with Medical Assistance (MA)		
Number of patients served with Children's Health Insurance Program (CHIP)		
Number of patients not charged due to inability to pay		
Number of patients at reduced fee according to discounted/sliding fee scale		
Number of patients with full pay/commercial insurance		
TOTAL Number of Patients		

- **TABLE 2 – PATIENT VISITS: Provide projections of the total number of patient visits during each year of the project period by coverage type in the following format.**

Coverage Type	**Proposed # Patient Visits (07/01/12-06/30/13)**	**Proposed # Patient Visits (07/01/13-06/30/14)**
Number of visits for patients with Medicare		
Number of visits for patients with Medical Assistance (MA)		
Number of visits for patients served with Children's Health Insurance Program (CHIP)		
Number of visits for patients not charged due to inability to pay		
Number of visits for patients at reduced fee according to discounted/sliding fee scale		
Number of visits for patients with full pay/commercial insurance		
TOTAL Number of Patient Visits		

CERTIFICATIONS

1. **Certification Regarding Debarment and Suspension**

   a. The contractor must certify, in writing, for itself and all its subcontractors, that as of the date of its execution of any Commonwealth contract, that neither the contractor, nor any subcontractors, nor any suppliers are under suspension or debarment by the Commonwealth or any governmental entity, instrumentality, or authority and, if the contractor cannot so certify, then it agrees to submit, along with the bid/proposal, a written explanation of why such certification cannot be made.

   b. The contractor must also certify, in writing, that as of the date of its execution, of any Commonwealth contract it has no tax liabilities or other Commonwealth obligations.

   c. The contractor's obligations pursuant to these provisions are ongoing from and after the effective date of the contract through the termination date thereof. Accordingly, the contractor shall have an obligation to inform the contracting agency if, at any time during the term of the contract, it becomes delinquent in the payment of taxes, or other Commonwealth obligations, or if it or any of its subcontractors are suspended or debarred by the Commonwealth, the federal government, or any other state or governmental entity. Such notification shall be made within 15 days of the date of suspension or debarment.

   d. The failure of the contractor to notify the contracting agency of its suspension or debarment by the Commonwealth, any other state, or the federal government shall constitute an event of default of the contract with the Commonwealth.

   e. The contractor agrees to reimburse the Commonwealth for the reasonable costs of investigation incurred by the Office of State Inspector General for investigations of the contractor's compliance with the terms of this or any other agreement between the contractor and the Commonwealth, which results in the suspension or debarment of the contractor. Such costs shall include, but shall not be limited to, salaries of investigators, including overtime; travel and lodging expenses; and expert witness and documentary fees. The contractor shall not be responsible for investigative costs for investigations that do not result in the contractor's suspension or debarment.

   f. The contractor may obtain a current list of suspended and debarred Commonwealth contractors by either searching the Internet at http://www.dgsweb.state.pa.us/debarmentlist/NonArchiveByCompany.asp?p=
   or contacting the:

   Department of General Services
   Office of Chief Counsel
   603 North Office Building
   Harrisburg, PA 17125
   Telephone No: (717) 783-6472
   FAX No: (717) 787-9138

IF THE CONTRACTOR INTENDS TO USE ANY SUBCONTRACTORS, LIST THEIR NAMES(S), ADDRESS(ES), AND FEDERAL IDENTIFICATION OR SOCIAL SECURITY NUMBER(S) IN THE SPACE BELOW.

2. **Certification Regarding Application/Proposal/Bid Validity**

   This application/proposal/bid shall be valid for a period of 120 days following the time and date designated for bid opening of applications/proposals/bids received in response to this Request for Application/Request for Proposals/Invitation for Bid # RFA#10-07-07 .

BY SIGNING BELOW, THE APPLICANT, BY ITS AUTHORIZED SIGNATORY, IS BINDING ITSELF TO THE ABOVE TWO CERTIFICATIONS.

SIGNATURE OF AUTHORIZED CERTIFYING OFFICIAL	TITLE
APPLICANT ORGANIZATION	ADDRESS OF ORGANIZATION
DATE SUBMITTED	CONTRACTOR'S FEDERAL I.D. OR S.S. NUMBER

RFA#10-07-07
Attachment VI

501(c)(3) Form

See Part One, General Information; Section C, Application Instructions and Required Format; Subsection 2d for instructions.

Work Statement

See Part One, General Information; Section C, Application Instructions and Required Format, Subsection 2e, Work Statement, for complete instructions.

ADDITIONAL APPENDICES

See Part One, General Information; Section C, Application Instructions and Required Format; Subsection 2e i (9) for instructions for Tier 1 and Subsection 2e ii (10) for instructions for Tier 2.

BUDGET TEMPLATE

See Part One, General Information; Section C, Application Instructions and Required Format; Subsection 2e i (10) for instructions for Tier 1 and Subsection 2e ii (11) for instructions for Tier 2.

Use the downloadable budget format attached to this RFA to present your budget request. INSTRUCTIONS REGARDING COMPLETION OF THE BUDGET CAN BE FOUND IN THE LAST WORKSHEET OF THE DOWNLOADABLE EXCEL BUDGET FILE.

BUDGET JUSTIFICATION

See Part One, General Information; Section C, Application Instructions and Required Format; Subsection 2e i (11) for instructions for Tier 1 and Subsections 2e ii (12) for instructions for Tier 2.

W-9 Form

Provide a copy of the completed Internal Revenue Service form W-9. The W-9 form and instructions for completing the form are available at the website http://www.irs.gov.

RFA # 10-07-07

PAYMENT PROVISIONS

The Department agrees to pay the Contractor for services rendered pursuant to this Contract as follows:

A. Subject to the availability of state and federal funds and the other terms and conditions of this Contract, the Department will reimburse Contractor in accordance with Appendix C, and any subsequent amendments thereto, for the costs incurred in providing the services described in this Contract.

B. Payment to the Contractor shall be made in accordance with the Budget set forth in Appendix C, and any subsequent amendments thereto, as follows:

1. The Department shall have the right to disapprove any expenditure made by the Contractor that is not in accordance with the terms of this Contract and adjust any payment to the Contractor accordingly.

2. Payments will be made monthly upon submission of an itemized invoice for services rendered pursuant to this Contract using the invoice format in Attachment 1 to this Appendix.

3. An original invoice shall be sent by the Contractor directly to the address as listed in Attachment 1 to this Appendix. Documentation supporting that expenditures were made in accordance with the Contract budget shall be sent by the Contractor to the Project Officer.

4. The Contractor has the option to reallocate funds between and within budget categories, subject to the following criteria:

   a. Reallocation of funds between budget categories by the Contractor shall not occur more than once each half of the state fiscal year and the cumulative reallocation of funds between budget categories shall not exceed 10 percent of the amount budgeted for the category to which the funds are being transferred or from which the funds are being transferred during the state fiscal year. The Contractor shall promptly notify the Department in writing of such transfers. Reallocation of funds between budget categories exceeding 10 percent, requires prior written approval by the Department. Reallocation (budget revision) requests shall be submitted to the Project Officer of the Department of Health no later than April 15 of each state fiscal year.

   b. Contractor may not reallocate funds to, or move funds within, the Personnel Services Category of the Budget (Appendix C), and any subsequent amendments thereto, to increase staff personnel or fringe benefit line items except that in the event the Contractor is subject to a collective bargaining agreement or other union agreement and, during the term of this Contract, salaries, hourly wages, or fringe benefits under this Contract are increased because of a renegotiation of that collective bargaining agreement or other union agreement. Contractor may reallocate funds to cover such increase. In such case, the Contractor must obtain the Department's prior written approval for such reallocation. Contractor shall submit to the Department written documentation of the new collective bargaining or other union agreement, which necessitates such reallocation. In addition, this paragraph is not intended to restrict any employee from receiving an increase in salary based on the employer's fee schedule for the job classification. However, all increases are subject to the availability of funds awarded under this Contract. The Commonwealth is not obligated to increase the amount of award.

5. Unless otherwise specified elsewhere in this Contract, the following shall apply. Contractor shall submit monthly invoices within 30 days from the last day of the month within which the work is performed. The final invoice shall be submitted within 45 days of the Contract's termination date. The Department will neither honor nor be liable for invoices not submitted in compliance with the time requirements in this paragraph unless the Department agrees to an extension of these requirements in writing. The Contractor shall be reimbursed only for services acceptable to the Department.

6. The Department, at its option, may withhold the last 20 percent of reimbursement due under this Contract, until the Project Officer has determined that all work and services required under this Contract have been performed or delivered in a manner acceptable to the Department.

7. The Commonwealth will make payments through the Automated Clearing House (ACH) Network. The Pennsylvania Electronic Payment Program (PEPP) establishes the Automated Clearing House Network as the preferred method of payment in lieu of issuing checks. The PEPP enrollment form may be obtained at: www.vendorregistration.state.pa.us/cvmu/paper/Forms/ACH-EFTenrollmentform.pdf and can be completed online, as applicable.

   a. Within 10 days of award of the Contract or Purchase Order, the Contractor must submit or must have submitted its ACH information within its user profile in the Commonwealth's procurement system (SRM). At the time of submitting ACH information, the Contractor will also be able to enroll to receive remittances via electronic addenda. Within 10 days of award of the Grant Agreement, the Contractor must submit or must have already submitted its ACH information and electronic addenda information, if desired, to the Commonwealth's Payable Service Center, Vendor Data Management Unit at 717-214-0140 (FAX) or by mail to the Office of Comptroller Operations, Bureau of Payable Services, Payable Service Center, Vendor Data Management Unit, 555 Walnut Street – 9th Floor, Harrisburg, PA 17101.

   b. The Contractor must submit a unique invoice number with each invoice submitted. The unique invoice number will be listed on the Commonwealth of Pennsylvania's ACH remittance advice to enable the Contractor to properly apply the state agency's payment to the invoice submitted.

   c. It is the responsibility of the Contractor to ensure that the ACH information contained in SRM (for Contracts or Purchase Orders) or in the Commonwealth's Central Vendor Master File (for Grant Agreements) is accurate and complete. Failure to maintain accurate and complete information may result in delays in payments.

   d. In the event this language conflicts with language contained elsewhere in this agreement, the language contained herein shall control.

RFA# 10-07-07 PROGRAM SPECIFIC PROVISIONS

Equipment. Notwithstanding section 34 (Disposition of Equipment) (Standard General Terms and Conditions), equipment purchased through Community Primary Care Challenge Grant funds may remain the property of the Community Primary Care Challenge Grant recipient as long as it continues to be used for the original intent and purpose stated in the approved application.

Appendix C

OVERALL BUDGET SUMMARY

(Insert Vendor Name)
RFA 10-07-07
July 1, 2012 - June 30, 2014

CATEGORIES	Total	Amendment (If Applicable)	New Total DOH Funds	Matching Funds	Full Project Costs
I. PERSONNEL SERVICES	-	-	-	-	-
II. CONSULTANT SERVICES	-	-	-	-	-
III. SUBCONTRACT SERVICES	-	-	-	-	-
IV. PATIENT SERVICES	-	-	-	-	-
V. EQUIPMENT	-	-	-	-	-
VI. SUPPLIES	-	-	-	-	-
VII. TRAVEL	-	-	-	-	-
VIII. OTHER COSTS	-	-	-	-	-
TOTAL	-	-	-	-	-

Composition of Matching Funds (If Applicable):	
Total	0.00

Appendix C

BUDGET SUMMARY

(Insert Vendor Name)
RFA 10-07-07
July 1, 2012 - June 30, 2013

CATEGORIES	Total	Amendment Type & Number	New Total DOH Funds	Matching Funds	Full Project Costs
I. PERSONNEL SERVICES	-	-	-	-	-
II. CONSULTANT SERVICES	-	-	-	-	-
III. SUBCONTRACT SERVICES	-	-	-	-	-
IV. PATIENT SERVICES	-	-	-	-	-
V. EQUIPMENT	-	-	-	-	-
VI. SUPPLIES	-	-	-	-	-
VII. TRAVEL	-	-	-	-	-
VIII. OTHER COSTS	-	-	-	-	-
TOTAL	-	-	-	-	-

Composition of Matching Funds (if Applicable):	
Total	0.00

Appendix C
(Insert Vendor Name)
RFA 10-07-07
July 1, 2012 - June 30, 2013

Categories			Original Budget (Enter Funding Source)	Amendment Type & Number (Enter Funding Source)	Matching Funds	Full Project Costs
I. PERSONNEL SERVICES						
A. Staff Personnel	Hourly Rate	Number of Hours				
					-	-
					-	-
					-	-
					-	-
					-	-
					-	-
					-	-
					-	-
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					-	-
		Sub-Total	-	-	-	-

Appendix C
(Insert Vendor Name)
RFA 10-07-07
July 1, 2012 - June 30, 2013

Categories			Original Budget (Enter Funding Source)	Amendment Type & Number (Enter Funding Source)	Matching Funds	Full Project Costs
B. Fringe Benefits						
	Salary	Rate				
	-				-	-
	-				-	-
	-				-	-
	-				-	-
	-				-	-
	-				-	-
	-				-	-
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	-				-	-
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	-				-	-
	-				-	-
	-				-	-
	-				-	-
Specify the benefits included in this rate:					-	-
					-	-
					-	-
					-	-
					-	-
					-	-
					-	-
					-	-
					-	-
Sub-Total			-	-	-	-
Total			-	-	-	-

Consultants

Appendix C
(Insert Vendor Name)
RFA 10-07-07
July 1, 2012 - June 30, 2013

Categories			Original Budget (Enter Funding Source)	Amendment Type & Number (Enter Funding Source)	Matching Funds	Full Project Costs
II. CONSULTANT SERVICES						
Consultants	Hourly Rate	Number of Hours				
					-	-
					-	-
					-	-
					-	-
					-	-
					-	-
					-	-
					-	-
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					-	-
					-	-
					-	-
					-	-
					-	-
					-	-
		Total	-	-	-	-
III. SUBCONTRACT SERVICES						
						-
						-
						-
						-
						-
						-
						-
						-
						-
						-
						-
						-
						-
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						-
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						-
						-
						-
						-
						-
		Total	-	-	-	-

Appendix C
(Insert Vendor Name)
RFA 10-07-07
July 1, 2012 - June 30, 2013

Categories	Original Budget (Enter Funding Source)	Amendment Type & Number (Enter Funding Source)	Matching Funds	Full Project Costs
IV. PATIENT SERVICES				
				-
				-
				-
				-
				-
				-
				-
				-
				-
				-
				-
				-
Total	-	-	-	-

	Quantity	Unit Cost				
V. EQUIPMENT						
					-	-
					-	-
					-	-
					-	-
					-	-
					-	-
					-	-
					-	-
					-	-
					-	-
					-	-
Total			-	-	-	-

VI. SUPPLIES				
				-
				-
				-
				-
				-
				-
				-
				-
				-
				-
				-
				-
				-
Total	-	-	-	-

Appendix C
(Insert Vendor Name)
RFA 10-07-07
July 1, 2012 - June 30, 2013

Categories	Original Budget (Enter Funding Source)	Amendment Type & Number (Enter Funding Source)	Matching Funds	Full Project Costs
VII. TRAVEL				
				-
				-
				-
				-
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				-
				-
				-
				-
				-
				-
				-
				-
				-
				-
Total	-	-	-	-
VIII. OTHER COSTS				
				-
				-
				-
				-
				-
				-
				-
				-
				-
				-
				-
				-
				-
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				-
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				-
				-
				-
				-
				-
Total	-	-	-	-
TOTAL	-	-	-	-

Appendix C
BUDGET SUMMARY

(Insert Vendor Name)
RFA 10-07-07
July 1, 2013 - June 30, 2014

CATEGORIES	Total	Amendment Type & Number	New Total DOH Funds	Matching Funds	Full Project Costs
I. PERSONNEL SERVICES	-	-	-	-	-
II. CONSULTANT SERVICES	-	-	-	-	-
III. SUBCONTRACT SERVICES	-	-	-	-	-
IV. PATIENT SERVICES	-	-	-	-	-
V. EQUIPMENT	-	-	-	-	-
VI. SUPPLIES	-	-	-	-	-
VII. TRAVEL	-	-	-	-	-
VIII. OTHER COSTS	-	-	-	-	-
TOTAL	-	-	-	-	-

Composition of Matching Funds (If Applicable):	
Total	0.00

Appendix C
(Insert Vendor Name)
RFA 10-07-07
July 1, 2013 - June 30, 2014

Categories			Original Budget (Enter Funding Source)	Amendment Type & Number (Enter Funding Source)	Matching Funds	Full Project Costs
I. PERSONNEL SERVICES						
A. Staff Personnel	Hourly Rate	Number of Hours				
					-	-
					-	-
					-	-
					-	-
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		Sub-Total	-	-	-	-

Appendix C
(Insert Vendor Name)
RFA 10-07-07
July 1, 2013 - June 30, 2014

Categories	Salary	Rate	Original Budget (Enter Funding Source)	Amendment Type & Number (Enter Funding Source)	Matching Funds	Full Project Costs
B. Fringe Benefits						
	Salary	Rate				
	-				-	-
	-				-	-
	-				-	-
	-				-	-
	-				-	-
	-				-	-
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	-				-	-
	-				-	-
	-				-	-
	-				-	-
Specify the benefits included in this rate:					-	-
					-	-
					-	-
					-	-
					-	-
					-	-
					-	-
					-	-
					-	-
Sub-Total			-	-	-	-
Total			-	-	-	-

Consultants

Appendix C
(Insert Vendor Name)
RFA 10-07-07
July 1, 2013 - June 30, 2014

Categories	Original Budget (Enter Funding Source)	Amendment Type & Number (Enter Funding Source)	Matching Funds	Full Project Costs
II. CONSULTANT SERVICES				
Consultants (Hourly Rate / Number of Hours)				
			-	-
			-	-
			-	-
			-	-
			-	-
			-	-
			-	-
			-	-
			-	-
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			-	-
			-	-
			-	-
			-	-
			-	-
			-	-
			-	-
			-	-
Total	-	-	-	-
III. SUBCONTRACT SERVICES				
				-
				-
				-
				-
				-
				-
				-
				-
				-
				-
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				-
Total	-	-	-	-

Appendix C
(Insert Vendor Name)
RFA 10-07-07
July 1, 2013 - June 30, 2014

Categories	Original Budget (Enter Funding Source)	Amendment Type & Number (Enter Funding Source)	Matching Funds	Full Project Costs
IV. PATIENT SERVICES				
				-
				-
				-
				-
				-
				-
				-
				-
				-
				-
				-
				-
				-
Total	-	-	-	-

	Quantity	Unit Cost				
V. EQUIPMENT						
					-	-
					-	-
					-	-
					-	-
					-	-
					-	-
					-	-
					-	-
					-	-
					-	-
					-	-
Total			-	-	-	-

VI. SUPPLIES				
				-
				-
				-
				-
				-
				-
				-
				-
				-
				-
				-
				-
Total	-	-	-	-

Appendix C
(Insert Vendor Name)
RFA 10-07-07
July 1, 2013 - June 30, 2014

Categories	Original Budget (Enter Funding Source)	Amendment Type & Number (Enter Funding Source)	Matching Funds	Full Project Costs
VII. TRAVEL				
				-
				-
				-
				-
				-
				-
				-
				-
				-
				-
				-
				-
				-
				-
				-
				-
				-
Total	-	-	-	-
VIII. OTHER COSTS				
				-
				-
				-
				-
				-
				-
				-
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				-
Total	-	-	-	-
TOTAL	-	-	-	-

Budget Instructions

General Instructions

- Please copy this file to your hard drive before making any edits. **Do not make any changes to this template.**
- Complete only highlighted areas. All other areas are formula driven and are template protected. Data should only be entered on the "Budget Details" tab.
- **Rows should not be deleted** (even if a particular category is not being used). If additional rows are needed, please contact the Division of Contracts to unprotect this template.
- Additional columns are available (and currently "hidden") for either multiple funding sources or amendments. If additional columns are needed, please contact the Division of Contracts to unprotect this template.
- A column is available for "Matching Funds".
- Tabs are provided to input data for up to 5 separate budget years. For agreements with multiple years, fill in the budget details for each applicable year. **For the original base document, the Budget Details, accompanying Budget Summary and Summary-Overall should be printed for submission.**
- **This template should be used for completing original budgets and amendments that involve matching requirements.** When preparing an amendment, start with the original budget information already completed and add the amendment changes within the budget category, directly below the original information. Please indicate the Amendment Type and Number in the appropriate column heading and update the Appendix C reference to indicate the amendment number. **For amendments the Budget Details and accommpanying Budget Summary should be printed for submission.**

Budget Details - Personnel Services

- Complete all highlighted areas.
- List all personnel to be funded, the hourly rate and number of hours. This calculation will automatically appear under Full Project Costs.
- Complete the costs to DOH Funds, as applicable. The balance will automatically reflect under Matching Funds.
- Once all personnel costs are completed under Staff Personnel, each staff identified and their full project costs will also automatically appear under Fringe Benefits. Complete the benefit rate for each staff identified. The Full Project Costs will automatically calculate.
- Complete the costs to DOH Funds, as applicable. The balance will automatically reflect under Matching Funds.
- Identify the fringe rate and specific benefits included in the rate.

Budget Details - Consultants Services

- List consultants to be funded, the hourly rate and number of hours. This calculation will automatically appear under Full Project Costs.
- Complete the costs to DOH Funds, as applicable. The balance will automatically reflect under Matching Funds.

Budget Details - SubContract Services

- Identify services or subcontractors.
- Complete costs associated to DOH Funds and Matching Funds. The Full Project Costs will automatically calculate.

Budget Details - Patient Services

- Identify services.
- Complete costs associated to DOH Funds and Matching Funds. The Full Project Costs will automatically calculate.

Budget Details - Equipment

- Identify equipment, the quantity and unit cost. (Use this category for equipment that is $5,000/unit or greater.) This calculation will automatically appear under Full Project Costs.
- Complete the costs to DOH Funds, as applicable. The balance will automatically reflect under Matching Funds.

Budget Details - Supplies

- Identify supplies (in general terms).
- Complete costs associated to DOH Funds and Matching Funds. The Full Project Costs will automatically calculate.

Budget Details - Travel

- Identify travel. Ensure costs are at approved rates as identified in the incorporated document for Commonwealth Travel and Subsistence Rates
- Complete costs associated to DOH Funds and Matching Funds. The Full Project Costs will automatically calculate.

Budget Details - Other Costs

- Identify other costs. (Indirect costs, if applicable, should be reflected under this category.)
- Complete costs associated to DOH Funds and Matching Funds. The Full Project Costs will automatically calculate.

Budget Details - Total

- Totals calculate automatically.

Summary

- All areas are formula driven and password protected. The only entry required on this page is to identify "matching fund sources".

Summary - Overall

- Most areas are formula driven and password protected. Data entry is only required to reflect the total project period and to idenfiy "matching fund sources".