

2014/2015 Rural Health Systems Program Application

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INSTRUCTIONS

Instructions for completion of this application are contained in the body of the application. For submission information and additional instructions, please refer to the Instructions portion of this site. This site contains essential information regarding technical assistance. Thank you for your interest in the Rural Health Systems Program.

In order to facilitate the completion of this application, it has been made available in fill in PDF format.

Rural Health Systems Program

2014/2015 APPLICATION

A. GENERAL INFORMATION AND IDENTIFICATION OF APPLICANT

1. Applicant/Lead Agency:

2. Applicants Year End:

3. Applicant/Lead Agency's Mailing Address:

Phone: _____

Fax: _____

4. Applicant/Lead Agency:

(Current Type of Audit completed: Financial, Yellowbook, A-133, etc.)

5. Applicant/Lead Agency's Contact Person(s):

Name: _____

Title: _____

Phone: _____

Fax: _____

Email: _____

6. Date of Application: _____

7. Application Revised Date(s): _____
(Use only if you are required to submit a revised application, please provide the date(s) of revision)

5. Applicant/Lead Agency's County and/or service area:

7. Is the Applicant/Lead Agency located in a MUA or HPSA? Yes No

If no, has the Applicant/Lead Agency received a waiver of the MUA or HPSA requirement? Yes No

8. a. Legal Status of Applicant/Lead Agency:

(Please provide legal status: non-profit corporation, partnership, state, county or local governmental entity created by statute. For-profit corporations are not eligible for funding, unless critical access hospital.)

b. If corporation, please provide State of Incorporation:

c. If governmental corporation or entity, please explain how created and/or the statutory authority (i.e., West Virginia Code section or legislation) that created your agency, department or entity:

(Please note: If you are a governmental entity, you may be exempt from W. Va. Code § 12-4-14)

d. FEIN No: _____

9. List Current Officers of the Corporation or Entity (Names and Full Titles):

(Please provide names of current officers who have the authority to execute and sign the Grant Agreement and/or Loan Agreement, Note and other legally binding Grant/Loan documents)

PLEASE ATTACH CORPORATE OR BOARD RESOLUTION AUTHORIZING ENTRY INTO THE GRANT AGREEMENT.

Name Full Title

Name Full Title

Name Full Title

10. Current on Workers' Compensation?

Yes No

11. Current on state taxes?

Yes No

12. Current on financial disclosure set forth in 65 C.S.R. 13 (financial disclosure required to be submitted to the WV Health Care Authority)?

Yes No

13. Current on financial reporting to the WV Health Care Authority for any grant reporting requirements, including but not limited to the submission of a quarterly report (if required), a final report or an audit?

Yes No

14. This Application is for a Grant Loan *(please check one)*.

15. Total Amount of Grant /Loan Request: _____

16. Brief Summary of Project: *(Not more than two (2) lines)*

[Section C - Statement of Work - This is the area in which the grant project will be detailed]

17. Brief description of how the community would benefit from the project if approved:

18. Project Time-Frame: (3,6,9 or 12 months)

[See the award cycle. For Spring grant applications, the grant start date will be July 1, 2013. For Fall grant applications, the grant start date will be January 1, 2013]

Start Date _____ Ending Date _____

19. Payment Methodology: (The grantee will be required to submit a request for payment on a reimbursement basis - invoice form)

Please select your preferred invoice format: Monthly _____ Quarterly _____

If a schedule of payments is needed in lieu of reimbursement, please justify:

19. Collaborating Agencies and/or Organizations:

(Please list health care providers, support/ancillary service providers and community support service providers who have agreed to collaborate and cooperate with the project outlined in this application.)

_____	_____
_____	_____
_____	_____
_____	_____

20. Non-collaborating agencies and organizations in the service area:

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Crisis application, no collaboration required.

21. Funding Category: *(Please check one)*

Collaboration (Definition/Examples): a comprehensive process that includes providers who jointly and cooperatively plan, develop and implement integrated health care delivery systems. A collaboration application might include a rural hospital, local health department, and primary care center proposing the creation of a new organization which would integrate the primary care services of the organizations. **Matching funds of one to one (1-1) are required for all collaborative grant requests.**

EHR Project

Crisis (Definition/Examples): health care entities facing closure which will impact on the delivery of essential health care services to people of an area. Entity(s) is seeking funding in order to make a quick transition including right sizing and realignment of services.

22. Did you receive technical assistance in order to complete this application?

Yes No

If so, from whom: _____

B. DESCRIPTION OF PROBLEM TO BE ADDRESSED

1. Population of community/service area and unique characteristics that contribute to the difficulty in obtaining health care.

2. Service sites of other significant health care providers **and other organizations providing similar services in the county and/or service area:** *(describe in the space below)*

Name	<u>Type of Service</u> <i>(briefly describe)</i>	<u>Site Location</u> <i>(county and city)</i>
------	--	---

_____	_____	_____
_____	_____	_____
_____	_____	_____

3. Organizations providing similar services in service area.

4. If applying for a Crisis Grant provide a description of essential health services being threatened if the applicant does not receive funding.

5. If applying for a grant or loan seeking funding to perform a capital repair, please describe why the repair is exigent, the extent to which other funding sources were unavailable or insufficient to cover the entire cost of the capital repair, and in the event that the capital repair exceeds the limits of this program, how the remaining balance will be funded.

6. Description of Problem: In providing details of the problem you are proposing to solve, please include socioeconomic and demographic issues that will justify this request as well as any physical documentation such as a map of the service area.

Attach an additional sheet if necessary.

C. **STATEMENT OF WORK**

insurance, private pay, grants, etc). **If the applicant is seeking a Crisis Grant please provide detailed evidence of financial crisis.** (e.g., current balance sheet, financial report, extraordinary costs, etc.).

E. PLANS TO SUSTAIN

Describe how this project will continue after the grant funds are expended.

F. EVIDENCE OF COLLABORATION

If you have submitted a collaborative application, complete the following: identifying the health care providers, support/ancillary service providers, community support service providers and other affected parties who have agreed to collaborate and cooperate with the project. Attach evidence of collaboration: local news articles, minutes from planning sessions held, and participation agreements from each of the collaborators. *(Collaborative Applications submitted must have all signatures of collaborators. Failure to obtain all signatures prior to submitting, your application may be grounds for rejecting the application and may affect the applicant's Priority regarding funding)*

Crisis application, no collaboration required

Signature of Participating Partner: _____

Printed Name: _____ Date: _____

Title _____

Name of Agency or Service _____

Signature of Participating Partner: _____

Printed Name: _____ Date: _____

Title _____

Name of Agency or Service _____

Signature of Participating Partner: _____

Printed Name: _____ Date: _____

Title _____

Name of Agency or Service _____

Signature of Participating Partner: _____

Printed Name: _____ Date: _____

Title _____

Name of Agency or Service _____

G. BUDGET

1. Instructions

Use the budget forms attached. (See, Appendix A & B). Your budget may consist of personnel, or non-personnel expenses, or both. **Funding for personnel costs is limited to a short-term basis. Thus, personnel costs of an on-going nature such as salaries and fringe benefits will not be considered allowable.** Purchase of equipment and upgrading will be considered as allowable expense if related to the provision of core and system support services.

For each budget category, please attach a narrative budget justification that describes the purpose for each item of expense included in the budget. **The total amount of the budget must equal the requested amount. If the budget information submitted has a total amount in excess of the requested amount, your application may be returned for correction.**

2. RHSP Proposed Budget Form - Appendix A

3. Matching Funds - Appendix B
For collaborative application only

H. **CERTIFICATION**

I certify that all representations made in this application are true and correct to the best of my knowledge. In the event that I later learn that any representation made in this application is false or incorrect, I will inform the West Virginia Health Care Authority, in writing, of such falsehood or incorrect information.

Name of Applicant/Lead Agency

Applicant's Signature

Printed Name

Title

Date

THIS APPLICATION WAS PREPARED BY:

Printed Name

Preparer's Signature

APPENDIX A

West Virginia Health Care Authority
 2014/2015 Rural Health Systems Program
 Proposed Budget

Proposed Grant Projected Start and End Date:

(Should be 3, 6, 9 or 12 months)

Line Item Description	Misc.	Sub Total	Total
Personnel Services			
(List Name, Position, Amount)			
1.			
2.			
3.			
4.			
Total Personnel Services			
Fringe Benefits			
(List Name, Position, Amount)			
1.			
2.			
3.			
4.			
Total Fringe Benefits			
Equipment and Other Capital Expenditures			
(Itemize each item)			
1.			
2.			
3.			
4.			
Total Equipment and Other Capital Expenditures			

Materials and Supplies			
(Itemize by type)			
1.			
2.			
3.			
4.			
Total Materials and Supplies			
Professional Services Cost or Contracts			
(Itemize by Position/Number of Hours/Hourly Cost)	HRS		
1.			
2.			
3.			
4.			
Total Professional Services Cost			
Other			
(List by Category and Explain:)			
1.			
2.			
3.			
4.			
Total Other			
Total Grant Budget			

The Applicant will also be required to provide a board resolution or other authority giving approval to enter into the Grant Agreement and/or Loan Agreement.

APPENDIX B
Matching Funds Disclosure
(For Collaborative Applications Only)

If one to one match will be done through cash, please complete the following chart:

Amt. of Money	Source of Funds	Activity for which funds will be expended

If one to one match will be done through in kind contribution, please complete one of the following charts:

In-kind Personal Services

Title/job description of job duties	Annual Salary or Rate	Percentage FTE	Number of MOS/HRS	Total Expense

In-kind - Other (Specify)

Amt. of Money	Source of Funds	Description of In-kind Item(s)

Total Matching Funds \$ _____