

# 2010 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

## 2010 APPLICATION

A. GENERAL INFORMATION AND IDENTIFICATION OF APPLICANT

L Applicant/Lead Agency:

\_\_\_\_\_

2. Applicant/Lead Agency's Mailing Address:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Phone: \_\_\_\_\_

Fax: \_\_\_\_\_

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

Name: \_\_\_\_\_

Title: \_\_\_\_\_

Phone: \_\_\_\_\_

Fax: \_\_\_\_\_

Email: \_\_\_\_\_

4. Date of Application: \_\_\_\_\_

5. Application Revised Date(s): \_\_\_\_\_

*(Use only if you are required to submit a revised application, please provide the date(s) of revision)*

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

\_\_\_\_\_

7. Is the Applicant/Lead Agency located in a MUA or HPSA?

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

14. Total Amount of Grant/Loan Request: \_\_\_\_\_

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

\_\_\_\_\_  
\_\_\_\_\_

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

\_\_\_\_\_  
\_\_\_\_\_

17. Project Time-Frame:

Start Date \_\_\_\_\_ Ending Date \_\_\_\_\_

18. 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.)*

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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

\_\_\_\_\_

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Crisis application, no collaboration required.

20. 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.**

**Priority Area** *(Please check one)*

- Oral Health;
- Health Information Technology/Electronic Health Records;
- Provider and Operational Performance Improvement; and
- Emergency Medical Services.
- Other: \_\_\_\_\_

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.

21. 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>
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_____	_____	_____
_____	_____	_____

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. GOALS AND OBJECTIVES/ WORK PLAN AND TIME FRAMES**

Please describe the major focus/goals and objectives of this project in broad statements on the following page. These statements should outline the strategy to be used to accomplish the goals. The objectives should describe how the goal will be accomplished through the implementation of specific activities. These specific activities should be measurable. Assign time frames to each goal, objective and activity. Please identify the person or persons responsible and the parties who will be involved in each activity.

GOAL, OBJECTIVE AND/OR ACTIVITY	ANTICIPATED OUTCOME	TIME FRAME	RESPONSIBLE PERSON/S	*NO. OF MOS./HRS	COST

List number of months (MOS) for salaried personnel; for consultants, list number of hours (HRS).

**D. IMPLEMENTATION**

Describe the management structure, financial systems, and facilities that are essential to this project.

1. Describe the organizational structure and lines of authority - an organizational chart may be attached.

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2. Describe the current financial and fiscal status of the organization. The applicant should list all sources of operating revenues and funding sources. (e.g., Medicaid, Medicare, private 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.).

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**E. PLANS TO SUSTAIN**

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

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**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 \_\_\_\_\_

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 & Q. 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.** Please provide specific and detailed descriptions and justification for all budget items. Common items of allowable expense are staff, travel, telephone, printed literature, and use of computer equipment, consultant, accounting and legal fees. Office space and equipment, oversight and secretarial support are to be considered in-kind support. 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 item, a narrative budget justification must be written that describes the need for each item of expense included in the budget. **The total amount of the budget must equal the requested amount.** If your total request exceeds the requested amount, please reduce your budget to indicate a line item budget reflecting a total expenditure of the requested amount. If the budget information submitted has a total amount in excess of the requested amount, your application may be rejected.

**All budget items for professional services (i.e., health care consultants, computer, data or other consultants, accountants, lawyers) should contain a breakdown, including the following: hourly rates for the professional, time allotted by professional for each task and a summary of work or services to be provided. The applicant should obtain a written estimate from the professional prior to filing the application which describes the work to be performed, the hourly rate and an estimate of the time required to perform the specific project, analysis, services or activity.**

**It is recommended that the applicant solicit competitive bids and/or obtain quotes from vendors and professionals for significant budget items that are non-personnel related (e.g., computer equipment or other equipment, printed literature or professional consulting/contracting services). Applicants that demonstrate fiscal responsibility by obtaining competitive bids and supplying written verification for budget expenditure items with their application will reduce the level of scrutiny and examination performed by the Management Team in reviewing applications and will likely expedite the grant process.**

**All budget items for travel, seminars, meetings or conferences should contain a description of the program to be attended or sponsored, including the date and location and a breakdown of the expected travel expenditures (i.e., mileage, travel expenses, food, lodging, etc.). Receipts should be maintained for all such budget items.**

Grantees shall be required under the grant/loan agreements to provide verifiable and quantifiable support (e.g., written invoices, invoices of services provided by professionals, summary of travel expenses with receipts) for any budget expenditures.

2. Personnel Expenses - Appendix A
3. Non-Personnel Expenses - Appendix B
4. Matching Funds - Appendix C  
*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.

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**Name of Applicant/Lead Agency**

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**Applicant's Signature**

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**Printed Name**

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**Title**

---

**Date**

**THIS APPLICATION WAS PREPARED BY:**

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**Printed Name**

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**Preparer's Signature**





APPENDIX C  
Matching Funds Disclosure

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 \$ \_\_\_\_\_