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| **Section** | **Rural Health Centers Program****Capital Project SFY 2018 - 2019** |
| **General Information**  | **RFA Title:** Rural Health Centers Capital Support**Funding Agency Name:** North Carolina Office of Rural Health (ORH)**Funding Agency Address:** 311 Ashe Avenue, Raleigh, NC 27606**Funding Agency Contacts/Inquiry Information:** Andrea Murphy, 919 527-6448, andrea.murphy@dhhs.nc.gov; Robert Coble, 919 527-6474, robert.coble@dhhs.nc.gov; or Tammy Norville, 919-527-6476, tammy.norville1@dhhs.nc.gov 1. **Capital Project Grant-**Award issue date**:** 7/1/2018

**Capital Project Grant Application Closing Date and Submission Instructions:** Grant applications must be received by March 29, 2019. Only electronic copies will be accepted.All electronic applications and questions regarding the application should be sent to your ORH assigned field support staff. Incomplete applications and applications not completed in accordance with the instructions provided below will not be reviewed.  |
| **RFA Description****Eligibility** **Application Instructions** | The purpose of grants awarded under this program is to support state-designated rural health centers. The Office of Rural Health (ORH) assists underserved communities and populations with developing innovative strategies for improving access, quality, and cost-effectiveness of health care. Distribution of primary care providers in North Carolina has historically been skewed toward cities and larger towns. Rural residents, who often face transportation issues, find accessing primary care services difficult. Through the establishment of rural health centers, ORH enables local communities to provide access to their underserved populations who would otherwise be unable to receive needed primary care services due to geographic, economic, or other barriers. Thus, rural health centers have become an integral part of the health care safety net for North Carolina’s rural and underserved residents.Through this Capital Project award, the rural health center will continue to develop and implement projects intended to increase quality-driven, cost-effective care to meet the transitions mandated through Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) legislation and other industry trends. These funds may be used for a variety of projects including information technology components as deemed appropriate by ORH. In addition, these funds may include planned and unplanned structural improvements, upkeep, etc. of the facility/physical plant. ***If the proposed capital project may result in an insurance claim or involves information technology, please contact your assigned ORH field staff prior to completing this application packet***. ***The maximum total grant award is dependent upon demonstrated need at the rural health center and the availability of funding.*** This is a project-based grant opportunity. All funding must be expended by May 31, 2019.To be eligible to apply for these funds, your organization must be deemed a 501(c) 3 State-Designated Rural Health Center by ORH. The maximum total grant award is dependent upon demonstrated need at the rural health center and is contingent upon funding availability. Grant funds must be used at physical locations where primary medical care is provided and may not be used for vehicles or to pay down loans.Please read the following instructions and requirements carefully. Applications that do not adhere to all instructions and requirements will be ineligible. You must submit your application through the online survey tool found here: <https://ncruralhealth.az1.qualtrics.com/jfe/form/SV_0Cz7YfputVDBa8B>**Application Deadline:** Applications must be received prior to March 30, 2019.Applicants may apply for multiple funding options within the same application. Applicants should work through their assigned ORH field support staff prior to seeking additional funding and prior to submitting grant applications for multiple funding options. The maximum total grant award is dependent upon demonstrated need at the rural health center. Grant funds must be used at physical locations where primary medical care is provided and may not be used for vehicles or to pay down loans.**Funding Cycle:** Awards are granted between July 1, 2018 and prior to March 29, 2019. All grantees must fully expend grant funds prior to May 31, 2019. All invoices for completed and projected work must be submitted to ORH for reimbursement no later than May 31, 2019. If projections are included in the final invoice, the grantee must attest that all work will be completed by the end of the grant cycle.**Scoring Criteria**

|  |  |
| --- | --- |
| Scope of Work | 50 Points |
| Evaluation and Baseline Data | 20 Points |
| Budget and Budget Narrative | 30 Points |
| **Total Points Awarded** | **100 Points** |

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| **Application** | See documents below |

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**ORGANIZATIONAL INFORMATION & SIGNATURE SHEET**

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

Organization EIN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mailing Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Organization Fiscal Year: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Organization Type (check one)

🞎 Rural Health Clinic (95-210) 🞎 State-Designated Rural Health Center

🞎 Other (specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary County served (where the grant will be utilized): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other Counties served (if applicable): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Grant Request: Total $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |
| --- |
| **Summary of Request** – *Provide a brief one or two sentence description of your request*. |

Contact Person: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

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

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

Grant Application Submitted By:

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

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**Organizational Profile**

Number of Service Delivery Sites (locations): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Total FTEs (full time equivalent) of Clinical (non-volunteer) Staff Employed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (please refer to Appendix A for instructions on calculating number of FTEs)

**Clinical Staff Profile**

|  |  |
| --- | --- |
|  | # of FTEs Employed |
| Physician |  |
| Nurse Practitioner |  |
| Physician Assistant |  |
| Certified Nurse Midwife |  |
| Registered Nurse (RN) |  |
| Licensed Practical Nurse (LPN) |  |
| Medical Assistant (CMA, COA, etc.) |  |
| Licensed Clinical Social Worker or Psychologist |  |

**Patient Mix**

Report the number of patients seen during your most recently completed fiscal year. \*Many RHC’s fiscal years runs from July 1st to June 30th, but yours may not-please ensure for accuracy. For example, if your fiscal year runs from July 1 to June 30, the most recently completed fiscal year would be July 1, 2016 to June 30, 2017.

|  |  |
| --- | --- |
| Insurance Type | # of Unduplicated Patients |
| None/Uninsured Patients (include MAP) |  |
| Medicaid  |  |
| Children’s Health Insurance Program (CHIP) |  |
| Medicare (include duals in this count) |  |
| Other public insurance (e.g. Tricare) |  |
| Privately Insurance (e.g. BCBS) |  |
| Other (define) |  |
| Total |  |

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**Summary of Evaluation Criteria & Baseline Data**

**SECTION I: Patient Insurance Status:** Enter the number of unduplicated patients by category, who will be served by the proposed project or during the project period. Enter a baseline value as of July 1, 2018 in Column A; a target for the total number of patients who will be served by May 31, 2019 in Column B; and the net additional patients seen in Column C for each insurance status.

|  |  |  |  |
| --- | --- | --- | --- |
|  | Column ABaselineas of07/01/2018 | Column BTotal Servedas of05/31/2019 | Column CNet Additional PatientsCol B minus Col A |
| None/Uninsured Patients (include MAP) |  |  |  |
| Medicaid  |  |  |  |
| Children’s Health Insurance Program (CHIP) |  |  |  |
| Medicare (including duals) |  |  |  |
| Other public insurance (e.g. Tricare) |  |  |  |
| Privately Insurance (e.g. BCBS) |  |  |  |
| 7.Total Unduplicated Patients (sum of Lines 1-6) |  |  |  |

**Section II: Evaluation Criteria**

Complete the mandatory performance measures required for all applicants. These measures will be reported quarterly. Add additional measures to the table as needed working with the assigned Rural Health field support staff.

*For each measure you will need to include the following information:*

* **Data Source:** where will you obtain the information you report for your performance measures?
* **Collection Process and Calculation:** what method will you use to collect the information?
* **Collection Frequency:** how often will you collect the information?
* **Data Limitations**: what may prevent you from obtaining data for your performance measures?

*A* ***minimum of two*** *capital project-specific performance measures must be developed and submitted on this Performance Measures Table. The performance measures must be specific to the capital project described in the application.*

|  |  |  |
| --- | --- | --- |
| **EVALUATION CRITERIA** | **BASELINE VALUES/MEASURES****as of *\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_*** | **TARGET TO BE REACHED BY*****5/31/2019*** |
| **1.Demand**Total number of unduplicated patients served by the rural health center.Data Source:Collection Process and Calculation:Collection Frequency:Data Limitations: |  |  |
| **2. Outcome/Output/Efficiency/Quality (Choose)**  Data Source:Collection Process and Calculation:Collection Frequency:Data Limitations: |  | .  |
| **3.**Data Source:Collection Process and Calculation:Collection Frequency:Data Limitations: |  |  |

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**Scope of Work**

**Background**

*Detail who will be involved in the development, implementation, and execution of this capital project. Provide background of the applying organization and provide relevance of the background to the request for capital funding.*

Insert Text

**Purpose (20 point max)**

*Detail specifics of the capital project and anticipated outcome(s). Outcome specific details should include the effect of the capital project on a least one of the following categories:*

1. *Patient and/or staff comfort and safety*
2. *Quality of services provided*
3. *Efficiency of services provided*
4. *Compliance with current state and/or federal regulations*
5. *Health Information Technology*

*In addition, detail the location(s) where tasks/goals of the capital project will be met.*

Insert Text

**Performance Requirements (10 point max)**

*Detail the timeline for specific tasks/goals to be completed during the capital project period ending May 31, 2019. Additionally, provide information about the following:*

1. *Detail how the capital project activities previously outlined in the “Purpose” section above will be accomplished. This section should be an in-depth description of the process that will be used to complete the capital project within the grant period.*
2. *Describe how progress toward meeting the outlined performance measures will be tracked. Include details of process, tools used, funding sources and any other pertinent information.*

Insert Text

**Program Success (20 point max)**

*Detail the expected gain for the applicant through this capital project. Will the result of this capital project effect the long-term sustainability of the applicant? If yes, detail the anticipated effect. If no, provide a detailed explanation.*

Insert Text

**Appendix A: Table for proper conversion of hours to Full Time Equivalent (FTE)**

|  |  |  |
| --- | --- | --- |
| **# of FTEs** | **Conversion** | **Logic when staff sustained from grant >1.00 FTE****Add 1.00 to fraction of part time.****Example: if there is a part time staff working 10 hours a week in addition to one full time, that converts to** **1.00+.25=1.25 FTE****Hint: for staff working odd number of hours (e.g., 3 hours per week) round up to next level or, in this case, to** **4 hours=.10FTE.**  |
| 2 hours/week | .05 FTE |
| 4 hours/week | .10 FTE |
| 6 hours/week | .15 FTE |
| 8 hours/week | .20 FTE |
| 10 hours/week | .25 FTE |
| 12 weeks/week | .30 FTE |
| 14 hours/week | .35 FTE |
| 16 hours/week | .40 FTE |
| 18 hours/week | .45 FTE |
| 20 hours/week | .50 FTE |
| 22 weeks/week | .55 FTE |
| 24 hours/week | .60 FTE |
| 26 hours/week | .65 FTE |
| 28 hours/week | .70 FTE |
| 30 hours/week | .75 FTE |
| 32 hours/week | .80 FTE |
| 34 hours/week | .85 FTE |
| 36 hours/week | .90 FTE |
| 38 hours/week | .95 FTE |
| 40 hours/week | 1.00 FTE |