Arkansas Department of Health

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Governor Sara Huckabee Sanders

Renee Mallory, RN, BSN, Secretary of Health

Jennifer Dillaha, MD, Director

DH-24-0022 R
Notice Of Funds Availability
APPLICATION PACKET
FY25 Charitable Clinics

Purpose of Sub-Grant: **Purpose of Sub-Grant:**

The Arkansas Department of Health (ADH) issues this Notice of Funds Availability (NOFA) on behalf of Arkansas Charitable Clinics Grant Program to obtain applications for funding to assist Charitable Clinics in providing basic primary care, dental, optometry, pharmacy and/or behavioral health services for free or at low cost to those persons unable to pay for medical care.

APPLICATION SIGNATURE PAGE

Type or print the following information.

APPLICANT'S INFORMATION						
Company (as listed with IRS) with dba if applicable						
Federal Tax-ID#		**AASIS Vendor Number (if known)**				
Is your Company 501(c) 3 Nonprofit?	☐**Yes** ☐**No**	**If, yes, your IRS designation letter must be submitted**				
Your Agency Fiscal Year Dates:						
Address:				**P.O. Box**		
City:		**State:**		**Zip Code:**		
Business Designation:	☐**Individual**	☐**Sole Proprietorship**			☐**Public Service Corp**	
	☐**Partnership**	☐**Corporation**			☐ **Nonprofit** ☐**Intergovernmental**	
Minority and Women-Owned Designation: *	☐**Not Applicable** ☐**African American**	☐**American Indian** ☐**Hispanic American**	☐**Asian American** ☐**Pacific Islander American**		☐**Service-Disabled Veteran** ☐**Women-Owned**	
	AR Certification #: _____	*** See *Minority and Women-Owned Business Policy***				

APPLICANT CONTACT INFORMATION *Provide contact information to be used for bid solicitation related matters.*			
Contact Person:		**Title:**	
Phone:		**Alternate Phone:**	
Email:			
Alternate Email:			

ILLEGAL IMMIGRANT CONFIRMATION

By signing and submitting a response to this solicitation, the applicant agrees and certifies that they do not employ or contract with illegal immigrants. If selected, the recipient certifies that they will not employ or contract with illegal immigrants during the aggregate term of a contract.

ISRAEL BOYCOTT RESTRICTION CONFIRMATION

By signing and submitting a response to this solicitation, the applicant agrees and certifies that they do not boycott Israel, and if selected, will not boycott Israel during the aggregate term of the contract.

Geographical Coverage Area: Indicate geographical coverage area as either statewide or by individual counties, alphabetically.

_____

_____

An official authorized to bind the prospective recipient to a resultant contract shall sign below.

By signing and submitting a response to this Request for Application (RFA), the applicant agrees to comply with all requirements, and that any exception that conflicts with a requirement of this RFA will cause the application to be disqualified.

Authorized Signature: _____ Title: _____

Printed/Typed Name: _____ Date: _____

PROPOSED SUBCONTRACTORS FORM

- ***Do not*** *include additional information relating to subcontractors on this form or as an attachment to this form.*

PROSPECTIVE CONTRACTOR PROPOSES TO USE THE FOLLOWING SUBCONTRACTOR(S) TO PROVIDE SERVICES.

Type or print the following information

Subcontractor's Company Name	Street Address	City, State, ZIP

☐ **PROSPECTIVE CONTRACTOR DOES NOT PROPOSE TO USE SUBCONTRACTORS TO PERFORM SERVICES.**

ADDITIONAL INFORMATION

Arkansas Charitable Clinics Grant Program Guidelines
Sample Budget Spreadsheet and Explanation of Match

A budget that lists the total grant amount requested through the application year and breaks out how support to the program will be utilized must be provided. A sample spreadsheet has been provided as well as budget form. The budget form is divided into two separate columns of Grant Funds and In-Kind.

In-Kind may be used for the purchase of goods or services that are considered an inappropriate use of State funds, (e.g., Salaries, travel for out-of-state training, seminars, conferences, training related to certification or licensure of program personnel, etc.)

NOTE: A required 25% ($11,250.00) funding match requirement must be met by in-kind match, i.e., volunteer hours, depreciation, rent, etc. In other words, the value of any real property (depreciation), equipment, goods or services that is contributed by a third party could be counted towards the match requirement. Federal, county, foundation, private contributions as well as any other in-kind resources may be used as in-kind match. In-kind matching funds may be used toward expenditures of clinic services and operations. Grant funds must be used toward purchases outlined in the grant agreement

The grant award is made directly to the successful applicant. No reimbursement will be made for any expenses that do not include proof of payment. No reimbursement will be made for the purchase of equipment or services made prior to the grant award. No state grant funds shall be used to provide goods or services to out-of-state residents. The Arkansas Department of Health will have the final decision on allowable costs.

Salaries are limited to clinical/patient care staff and non-clinical patient care related staff. Salaries for administrators, billing staff, fiscal staff or maintenance staff will not be allowed. Funds may be used for CONTRACTED SERVICES.

Grant awards are subject to review by the Arkansas State Legislature. If your project involves an out-of-state provider of services, it should be noted that this may involve additional Legislative review.

SAMPLE BUDGET

ITEM/SERVICE TO BE PURCHASED	GRANT FUNDS	IN-KIND	ROW TOTAL
Salaries			
Fringe			
Contract Labor			
Medications			
Medical equipment			
Medical Supplies			
Office Supplies			
Lab testing			
COLUMN TOTAL			

Arkansas Charitable Clinics Grant Program Guidelines
Proposal Narrative – Description of Purpose

Please provide the following information in this order. Do not use more than five pages for all categories, exclusive of attachments.

I. Project Name - List (If applicable)

II. Project Summary - Provide a brief description of the proposed project including a summary of the clinic's history, mission, and description of current programs, activities, strengths/accomplishments and challenges faced by the clinic. Include how the need was determined.

Arkansas Charitable Clinics Grant Program Guidelines
Proposal Narrative – Description of Purpose

Please provide the following information in this order. Do not use more than five pages for all categories, exclusive

III. Target Area – List target population, constituents and all counties served in alphabetical order.

IV. Goals and Objectives - State the key objectives of your grant proposal and provide a description of the measurable activities through which you will accomplish each objective. List specific time frames and responsible parties for completion of objectives. Explain how the proposed activities will impact the designated community or population.

Arkansas Charitable Clinics Grant Program Guidelines
Proposal Narrative – Description of Purpose

Please provide the following information in this order. Do not use more than five pages for all categories, exclusive of attachments.

V. Project Management - Provide a description of the management structure, financial systems, and facilities that are essential to the management of the project. Also provide a brief history of your successes and experience in managing grant funds.

Arkansas Charitable Clinics Grant Program Guidelines
Proposal Narrative – Description of Purpose

Please provide the following information in this order. Do not use more than five pages for all categories, exclusive of attachments.

VI. Evaluation - Explain how you will measure success in achieving your goals and objectives. How will your results be used, disseminated, or publicized?

Arkansas Charitable Clinics Grant Program Guidelines
Proposal Overview

Clinic Overview

1. Please provide the following details about your clinic:

Legal Name of Clinic: _____

Address: _____

Name of Clinic: _____

Clinic Address: _____

Name of Executive Director: _____

Name of President of Board: _____

Total number of Board Members: _____

Federal ID number: _____

Grant Requestor Contact Name and Title: _____

Phone: _____ Fax: _____

Email: _____ Web Address: _____

2. IRS 501(c) 3 nonprofit? _____
   A copy of designation letter from IRS must be provided.

3. End of year income (clinic): _____ End of year expenses (clinic): _____

4. Total annual operating budget (clinic): _____ Dates of fiscal year: _____

5. List the amounts and sources of your four largest sources of income.

Income Source	Income Amount

Arkansas Charitable Clinics Grant Program Guidelines
Description of Clinic Operations

1. Describe the staffing within your clinic. Specify the **total** number of volunteer staff and hours currently providing services through your clinic.

Staff	Volunteer Staff	Volunteer Hours Last Fiscal Year	Volunteer Hours Fiscal Year to Date
Physicians			
Dentists			
Nurse Practitioners			
Pharmacists			
Behavioral Health Professionals			
RNs			
LPNs			
Physician Assistants			
Dental Assistants			
Administrative (intake, scheduling, clerical, etc.)			
Optometry Services			
Other (please specify)			

Specify the **total** number of paid/contracted staff currently providing services through your clinic.

Staff	Employed/Contracted Last Fiscal Year	Employed/Contracted Fiscal Year to Date
Physicians		
Dentists		
Nurse Practitioners		
Pharmacists		
Behavioral Health Professionals		
RNs		
LPNs		
Physician Assistants		
Dental Assistants		
Administrative (intake, scheduling, clerical, etc.)		
Optometry Services		
Other (please specify)		

2. List all current services and programs provided by your clinic, as well as any key affiliations with other hospitals or health care providers:

Services Provided Onsite:

☐ Primary Care
☐ Dental Care
☐ Patient education
☐ Other (please specify all)
☐ Social Work
☐ Pharmacy
☐ Optometry Services
☐ Behavioral Health

Programs:	
Key Affiliations:	

3. Please specify your clinical hours of operation.
   **If clinical hours vary by program, please specify the clinical hours provided by each program.*

4. Are there any eligibility requirements a patient must meet in order to receive care at your clinic? If yes, please attach requirements.

5. Does your clinic help clients apply for government or private programs? If yes, please list.

6. How does your clinic handle client referrals? Attach a copy of your current referral policy if applicable.

Arkansas Charitable Clinics Grant Program Guidelines
Patient Data – Direct Care Services

Please use the grid below to summarize your clinic's patient data for *your last fiscal year* and *the current fiscal year to date.* This will capture the impact that your clinic has made and enable us to measure future improvements made by your team.

Total Patients Served (unduplicated)	**Last Fiscal Year**	**Last Fiscal Year % of Patients Medicaid Billed**	**Current Fiscal Year to Date**	**Current Fiscal year To Date % of Patients Medicaid Billed**
Primary Medical Care Services				
Dental Services				
Pharmacy Services				
Behavioral Health Services				
Patient Education Services				
Optometry Services				
Social Work Services				
Other (please specify)				
Total Visits/Encounters**	0	0	0	0

***Total visits/encounters include the number of services each patient receives. If a patient receives primary care, dental and education service, the patient would be counted for each service received. If this same patient returns at a later date, he/she is not counted as an additional patient in the total patients served number, but each service he/she receives is an additional service that should be counted as a visit/encounter.*

Arkansas Charitable Clinics Grant Program Guidelines
Certification of Eligibility
(Please Check All That Apply)

☐ The clinic is a volunteer-based, safety-net health care organization that provides a range of medical, dental, pharmacy optometry and/or behavioral health services to the economically disadvantaged individuals that are predominantly uninsured.

☐ The clinic is a 501(c)3 tax-exempt organization or operates as a program component or affiliate of a 501(c)3 tax-exempt organization. A charitable clinic may charge a nominal administrative fee to patients. A charitable clinic may bill Medicaid, providing essential services of primary care, dental, optometry, pharmacy and/or behavioral health, are delivered regardless of the patient's ability to pay.

☐ The clinic is a member of the Arkansas Association of Charitable Clinics.

☐ The clinic is a member of National Association of Free Clinics.

☐ The clinic is in good standing with ADH and fully operational

☐ The clinic is located within Arkansas and provides health care services to the uninsured.

_____ _____
Authorized Representative Signature Date

_____
Authorized Representative Printed Name and Title

Arkansas Charitable Clinics Grant Program Guidelines
List of Required Supporting Documents

Please include the following information with the completed application in the order below.

I. Organizational Information

1. An organizational chart (if applicable) and a one-paragraph description of key staff.

II. Financial Information

1. The source(s) of the In-Kind must be verified and documented by a letter from the Executive Director or Board Chairman/President (1 page). This grant year, matching funds may be verified from July 1, 2023, through June 30, 2024.
2. Itemized budget spreadsheet showing planned grant fund In-Kind expenditures. Budget form is provided. (1 page).
3. A justification for all requested budget expenditures (1–2 pages).
4. A completed W-9 for the applicant clinic (1 page).
5. Annual operating budget and actual income and expenses for most recently completed fiscal year **AND** for current year-to-date (1–2 pages).
6. Clinics most recent AUDITED financial statement (if organization's budget is greater than $500,000) or IRS Form 990 (if required by Federal tax law). If neither document is available, include unaudited financial statements (no page limit).
7. A sustainability plan describing how the project will continue after funds are expended (1 page).
8. A copy of the organization's 501(c)3 designation letter from the IRS.

III. Forms (Complete and Sign as Required)

1. Proposal Overview
2. Description of Clinic Operations (2 pages)
3. Patient Data – Direct Care Services
4. Certification of Eligibility

IV. Other Supporting Materials (Optional)

1. Letters of agreement from any collaborating or affiliated agencies, if applicable.