



**North Carolina Department of Health and Human Services
Office of Rural Health and Community Care**

2009 Mail Service Center • Raleigh, North Carolina 27699-2009

Tel: 919-733-2040 • Fax: 919-733.8300

Beverly Eaves Perdue, Governor
Lanier M. Cansler, Secretary

John Price, Director

**FY 2010 Community Health Center Grants
NOTIFICATION OF MEDICAL ACCESS PLAN (MAP) GRANTS**

The FY 2010 state budget passed by the General Assembly contained recurring funding for the Community Health Center Grant Program. The purpose of grants awarded under this program is to increase access to primary medical care for uninsured and medically indigent patients in the state. These monies may be used to expand the Office of Rural Health and Community Care's Medical Access Plan (MAP). The MAP Program provides grant funding tied to the direct provision of indigent care by a non-profit primary care medical provider. The companion document, *Medical Access Plan (MAP) Reference Manual*, provides a thorough description of the MAP Program. **Please review this document closely if you are interested in applying.**

You are eligible to apply for a MAP grant if you meet **ALL** of the following criteria:

- Non-profit;
- Provide comprehensive primary care services;
- Do not currently receive state or federal funding for indigent care for the delivery site for which you are requesting MAP funding; and
- Accept Medicaid and Medicare and bill patients and insurance companies for services provided.

To confirm that you are eligible to apply for a MAP grant, please contact Parcheul Harris at the Office of Rural Health and Community Care BEFORE you submit an application. Ms. Harris can be reached at 919-733-2040 or by email at parcheul.harris@dhhs.nc.gov.

The maximum grant amount is \$25,000 for the six month period January – June 2010. If the General Assembly continues funding the Community Health Center Grant Program, the intent is to allow recipients of MAP grants to apply for Year 2 and Year 3 funding with funding decisions based on progress made in meeting evaluation objectives. Year 2 and 3 grants would be for twelve months each (July-June) with a maximum grant award of \$50,000 per year. Any funding beyond Year 3 would require submission of a new grant application and competition in the larger grant pool.

It is anticipated that notification of grant awards will be made no later than December 21, 2009. Grants will be awarded based on a competitive application and review process. Grant applications will be scored according to the following criteria:

Description of population and community need	15 points
Estimate of numbers of patients who will qualify and apply for the MAP program	15 points
Availability of other indigent care resources	30 points
Collaboration and coordination with other safety net providers	15 points
After-hours patient care	05 points
Project evaluation measures	10 points
MAP budget worksheet	10 points

To apply, please complete the following application and **submit one original and four copies** (five grant applications total), along with one copy of your most recent audit and IRS letter verifying your tax exempt status, to Dr. Andrea Radford at the Office of Rural Health and Community Care (contact information below). **All applications must be either postmarked by Tuesday, November 17, 2009 OR received by 5:00 pm Friday, November 20, 2009. Electronic copies (email or fax) will not be accepted.**

Applications received after the deadline will not be reviewed and will be returned. All applications should be in 12 point font with 1 inch margins. Subheadings should be used to identify each section of the grant. Pages should be numbered sequentially and include the applicant's name on each page.

Applications should not exceed the page limits stated in the application (excluding letters of support).

Please review the application instructions closely prior to submitting your grant request.

After verifying your eligibility to apply for the MAP grant with Parcheul Harris, questions regarding the grant application may be directed to Dr. Andrea Radford by email at andrea.radford@dhhs.nc.gov or a voicemail message may be left at 919-966-7922.

Applications sent by mail should be sent to:

Dr. Andrea Radford
NC Office of Rural Health and Community Care
2009 Mail Service Center
Raleigh, NC 27699-2009

Note: Do NOT send overnight packages to the Mail Service Center address; use the address below.

Applications sent by FedEx or other overnight delivery services should be shipped to:

Dr. Andrea Radford
NC Office of Rural Health and Community Care
311 Ashe Avenue
Raleigh, NC 27606
919-733-2040

FY 2010 Community Health Center Grants

MAP Grant

INSTRUCTIONS

- Complete the Organizational Information & Signature Sheet. This should be the first page of your grant application.
- Complete the Summary of Evaluation Criteria & Baseline Data Sheet. This should be the second page of your grant application. **Applications that do not include a completed Summary of Evaluation Criteria & Baseline Data Sheet will not be reviewed and will not be considered for funding.**
- Letters of support should be provided in an appendix and copies included with each copy of the grant application. A maximum of 5 (five) letters of support should be submitted. Letters of support do not count towards the application page limit. If letters of support are not provided 0 (zero) points will be awarded for the collaboration section. **Letters of support should NOT be sent directly to the Office of Rural Health and Community Care but must be included with your grant application.** Letters of support not included with your grant application will not be considered during the review process.
- All applications should be in 12 point font with 1 inch margins. Subheadings should be used to identify each section of the grant. Pages should be numbered sequentially and include the applicant's name on each page. Applications should not exceed the stated page limits excluding letters of support.
- Individual copies of the application should be either stapled or binder clipped. Do not enclose the applications in notebooks, folders, plastic sheeting, or any other type of binding.
- Your application packet should include the following:
 - One original and four copies of your grant application (total of five applications submitted). The original application must include a signature on the Organizational Information & Signature Sheet.
 - One copy of your IRS tax-exempt letter – do not send multiple copies.
 - One copy of your most recent audit – do not send multiple copies.
- Applications sent by mail should be sent to:
Dr. Andrea Radford
NC Office of Rural Health and Community Care
2009 Mail Service Center
Raleigh, NC 27699-2009
Note: Do NOT send overnight packages to the Mail Service Center address, use the contact information below.
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- **Applications must be either postmarked by Tuesday, November 17, 2009 OR received no later than 5:00 pm on Friday, November 20, 2009.** Electronic (email and fax) copies will not be accepted.
- For questions about the application contact Dr. Andrea Radford by email at andrea.radford@dhhs.nc.gov or you may leave a voicemail message at 919-966-7922.

FY 2010 Community Health Center Grants
ORGANIZATIONAL INFORMATION & SIGNATURE SHEET

Organization Name: _____

Organization EIN: _____

Mailing Address: _____

Primary County (where the capital grant will be utilized): _____

Other Counties Served (if applicable): _____

Rural / Urban Designation (see Appendix II: Rural/Urban Determination Worksheet located at the end of the RFA)

Rural Urban

Organization Type (check one)

- FQHC Free Clinic AHEC Program
 Health Department Hospital Rural Health Clinic
 Other (specify) _____

Organization Fiscal Year: _____

Contact Person: _____

Email Address: _____

Phone Number: _____

Grant Request: Total cannot exceed \$25,000 \$ _____

Grant Application Submitted By:

Signature: _____ Date: _____

Name: _____ Title: _____

Organization Name: _____

FY 2010 Community Health Center Grants
SUMMARY OF EVALUATION CRITERIA & BASELINE DATA

Instructions: This form must be completed and submitted with your grant application to be considered for community health grant funding. **IF THIS FORM IS NOT COMPLETED YOUR REQUEST WILL NOT BE CONSIDERED FOR FUNDING.**

Patients Served by Project

Report the current number of unduplicated patients who will be served by MAP through June 30, 2010. These are the number of unduplicated patients who will be enrolled in the MAP and have at least one visit by June 30th. Because MAP is a new program the baseline value is 0 (zero). For assistance in estimating the number of unduplicated patients based on visit data see Appendix I: Estimating Unduplicated Patients.

	Baseline as of 01/01/2010	Target to be Served by 06/30/2010
Total Unduplicated MAP Patients	0	

Evaluation Criteria

Summarize the evaluation criteria from your application in the table below. You need to complete both this table and the evaluation section in the grant application.

Evaluation Criteria	Baseline Values/Measures as of 01/01/2010	Target to Be Reached by 06/30/2010
<i>Example:</i> To enroll 150 patients in MAP by 06/30/10	<i>0 enrollees as of 01/01/10</i>	<i>150 enrollees</i>
1.		
2.		
3.		
4		

FY 2010 Community Health Center Grants
MEDICAL ACCESS PLAN GRANTS

This application should not exceed 8 (eight) pages, excluding letters of support.

I Overview of Organization (1-2 paragraphs)

Provide a brief description of your organization.

II Community Need (1 page) 15 points

Describe the population served by your organization and their healthcare needs. Include information on the incidence of poverty in the targeted community, the number of uninsured, and other demographic data wherever possible. Provide citations/reference sources for all community demographic and health-status data.

III Eligible Patients (1-2 paragraphs) 15 points

Based on the MAP eligibility requirements (see the *Medical Access Plan (MAP) Reference Manual*), estimate the number of eligible patients in your service area and estimate the number of patients who will enroll for the MAP program by June 30, 2010.

IV Indigent Care Resources (1 page) 30 points

Describe the health care resources currently available in your community for indigent care.

V Collaboration (1 page) 15 points

Describe how you collaborate with other safety net providers in your community, including your local community hospital. A maximum of 5 letters of support should be included and should reference how the author's organization collaborates with your organization. If no letters of support are included 0 points will be awarded for this section.

VI After-Hours Patient Care (1-2 paragraphs) 05 points

Describe how you will ensure appropriate after-hours coverage and care for MAP patients.

VII Project Evaluation (1 page) 10 points

Describe how you will evaluate your project. The evaluation must include measurable criteria. Each criterion must include a baseline value and a target value to be reached by June 30, 2010.

VIII Project Budget (1 page) 10 points

Complete the MAP budget worksheet. If the MAP budget worksheet is not utilized 0 (zero) points will be awarded for this section.

MAP Budget Worksheet

Time Period January 1, 2010 through June 30, 2010

MAP Rate \$72.00 per visit

A	B	C	D	E	F	G
	# Visits	Total MAP Amount Col B x \$72	Patient Copay	Copoly Collection Rate	Total Copays Col B x Col D x Col E	MAP Grant Amount Col C – Col F
MAP 5			\$5	%		
MAP 10			\$10	%		
MAP 15			\$15	%		
MAP 20			\$20	%		
Total						

Cannot exceed \$25,000

Appendix I
ESTIMATING THE NUMBER OF UNDUPLICATED USERS

If your current patient management/IT package does not allow you to collect data on the number of unduplicated patients you serve during a specified time period you can make an estimate based on current patient encounter data.

Step 1: From a listing of your current/active patients select 30 names at random.

Step 2: For each of the 30 patients selected review their account or chart and count the number of visits he or she has had in the last 12 months.

Step 3: Add up the total number of visits for all 30 patients. Divide this total number of visits by 30. This is your visit rate per patient.

Step 4: To complete Section I of the Summary of Evaluation Criteria & Baseline Data worksheet, estimate the number of baseline visits and the target number of visits for each patient type.

Step 5: For each patient type divide both the baseline and target visit numbers by the visit rate per patient (from Step 3) to calculate the estimated number of users.

Step 6: Enter the estimated numbers of users in Section I of the Summary of Evaluation Criteria & Baseline Data worksheet.

The following worksheet can be used to complete the four steps outlined above. This worksheet is for your internal use only and should not be submitted with your grant application.

**Do NOT submit the Unduplicated Patients Worksheet with
your grant application.**

UNDUPLICATED PATIENTS WORKSHEET

Patient Identifier	Patient Visits
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	
9.	
10.	
11.	
12.	
13.	
14.	
15.	
16.	
17.	
18.	
19.	
20.	
21.	
22.	
23.	
24.	
25.	
26.	
27.	
28.	
29.	
30.	
Total Number of Patient Visits Sum of Lines 1-30	
Divide Total Number of Patient Visits by Total Number of Patients	÷ 30
(A) Visit Rate per Patient	

Unduplicated Patients Worksheet - Continued

Baseline number of uninsured visits _____

Divide by **(A)** Visit Rate per Patient \div _____

Estimate of Baseline Uninsured Unduplicated Patients: _____

Target number of uninsured visits _____

Divide by **(A)** Visit Rate per Patient \div _____

Estimate of Target Value Uninsured Unduplicated Patients: _____

Baseline number of Medicaid/Health Choice visits _____

Divide by **(A)** Visit Rate per Patient \div _____

Estimate of Baseline Medicaid/Health Choice Unduplicated Patients: _____

Target number of Medicaid/Health Choice visits _____

Divided by **(A)** Visit Rate per Patient \div _____

Estimate of Target Medicaid/Health Choice Unduplicated Patients: _____

Baseline number of Other Patient visits _____

Divide by **(A)** Visit Rate per Patient \div _____

Estimate of Baseline Medicaid/Health Choice Unduplicated Patients: _____

Target number of Other Patient visits _____

Divided by **(A)** Visit Rate per Patient \div _____

Estimate of Target Medicaid/Health Choice Unduplicated Patients: _____

Appendix II: Rural/Urban Determination Worksheet

Follow the steps below to determine if your proposed project or capital request is considered urban or rural based. Mark the appropriate box on the Information Sheet.

Step 1: Identify the county in which the service will be provided or the capital grant utilized.

Step 2: If the county identified in Step 1 is listed in *Table A: Nonmetropolitan Counties* this is a rural-based project. Mark the box labeled Rural on the Information Sheet. If the county is not listed in Table A continue to Step 3.

Step 3: If the county identified in Step 1 is NOT listed in Table A, then identify the zip code for where the service will be provided or the capital grant utilized.

Step 4: If the zip code identified in Step 3 is listed in *Table B: Rural Urban Commuting Area 4.0 and Greater* this is a rural-based project. Mark the box labeled Rural on the Information Sheet.

Step 5: If the zip code identified in Step 3 is NOT listed in Table B this is an urban-based project. Mark the box labeled Urban on the Information Sheet.

Table A: Nonmetropolitan Counties

Alleghany	Cleveland	Hyde	Moore	Stanly
Ashe	Columbus	Iredell	Northampton	Surry
Avery	Craven	Jackson	Pamlico	Swain
Beaufort	Dare	Jones	Pasquotank	Transylvania
Bertie	Davidson	Lee	Perquimans	Tyrrell
Bladen	Duplin	Lenoir	Polk	Vance
Camden	Gates	Lincoln	Richmond	Warren
Carteret	Graham	Macon	Robeson	Washington
Caswell	Granville	Martin	Rowan	Watauga
Cherokee	Halifax	McDowell	Rutherford	Wilkes
Chowan	Harnett	Mitchell	Sampson	Wilson
Clay	Hertford	Montgomery	Scotland	Yancey

Table B: Rural Urban Commuting Area (RUCA) 4.0 and Greater (columns read down)

27011	27317	27577	27865	27937	28020	28319	28382	28472	28579	28656	28725
27013	27320	27582	27866	27938	28021	28320	28383	28501	28580	28657	28733
27014	27321	27584	27867	27939	28024	28327	28384	28502	28581	28659	28734
27017	27322	27586	27869	27941	28033	28328	28385	28503	28582	28660	28736
27020	27323	27589	27870	27942	28039	28329	28387	28504	28583	28662	28737
27024	27325	27593	27872	27943	28040	28330	28388	28508	28584	28663	28740
27027	27326	27594	27874	27944	28041	28332	28392	28509	28585	28664	28741
27028	27330	27805	27875	27946	28042	28334	28393	28510	28586	28665	28743
27030	27331	27806	27876	27947	28043	28335	28394	28511	28587	28668	28744
27031	27332	27807	27877	27948	28071	28337	28396	28512	28589	28669	28746
27042	27341	27808	27880	27949	28072	28338	28398	28515	28594	28670	28747
27046	27343	27810	27881	27953	28074	28339	28399	28516	28604	28672	28749
27048	27344	27813	27883	27954	28076	28340	28420	28518	28605	28674	28750
27049	27351	27814	27885	27957	28089	28341	28423	28519	28606	28675	28752
27054	27355	27817	27886	27959	28090	28342	28424	28520	28607	28676	28755
27055	27356	27818	27887	27960	28091	28343	28430	28521	28608	28677	28756
27203	27371	27819	27889	27962	28092	28344	28431	28522	28615	28678	28761
27204	27374	27820	27890	27964	28093	28345	28432	28523	28616	28679	28762
27205	27375	27821	27892	27965	28102	28347	28433	28524	28617	28683	28763
27207	27376	27822	27893	27966	28109	28349	28434	28525	28618	28684	28765
27208	27379	27824	27894	27967	28114	28350	28438	28526	28621	28685	28766
27209	27505	27825	27895	27968	28119	28351	28439	28527	28622	28687	28768
27212	27506	27826	27896	27969	28125	28352	28441	28528	28623	28688	28771
27213	27507	27831	27897	27970	28127	28353	28442	28529	28624	28689	28772
27229	27524	27832	27906	27972	28128	28355	28444	28531	28625	28691	28773
27230	27536	27839	27907	27973	28136	28358	28446	28532	28626	28692	28774
27237	27537	27840	27909	27974	28137	28359	28447	28533	28627	28693	28775
27242	27542	27841	27910	27976	28138	28360	28448	28537	28629	28694	28777
27247	27544	27842	27915	27978	28139	28362	28450	28551	28631	28697	28779
27248	27546	27843	27916	27979	28144	28363	28452	28552	28634	28698	28781
27252	27549	27845	27919	27980	28145	28364	28453	28553	28635	28699	28782
27256	27551	27846	27920	27981	28146	28366	28455	28556	28636	28702	28783
27259	27552	27847	27921	27982	28147	28367	28458	28557	28640	28705	28788
27281	27553	27849	27922	27983	28150	28368	28459	28560	28641	28707	28789
27288	27555	27850	27923	27985	28151	28369	28461	28561	28642	28708	28901
27289	27556	27851	27924	27986	28152	28370	28462	28562	28643	28712	28902
27292	27563	27852	27925	28001	28159	28372	28463	28563	28644	28713	28903
27293	27565	27853	27926	28002	28160	28373	28464	28564	28646	28714	28904
27294	27568	27854	27927	28007	28166	28374	28465	28570	28647	28717	28905
27295	27569	27855	27928	28009	28167	28375	28466	28571	28649	28718	28906
27298	27570	27857	27930	28010	28169	28377	28467	28572	28651	28719	28909
27299	27573	27860	27932	28017	28170	28378	28468	28573	28652	28720	
27306	27574	27862	27935	28018	28315	28379	28469	28575	28653	28722	
27316	27576	27864	27936	28019	28318	28380	28470	28577	28654	28723	