Rural Health Systems Program
Application

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APPENDICES:

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.

Prior to any award being granted, the Applicant must be in compliance with the following:

1) **Be a state registered vendor;**
2) **Registered with the State of West Virginia Secretary of State's office; and,**
3) **Neither on hold or debarred in OASIS due to worker's compensation default or other state program, not debarred from DHHR grants or the Legislative website (SAGA).**

Thank you for your interest in the Rural Health Systems Program.

Rural Health Systems Program

APPLICATION

A. GENERAL INFORMATION AND IDENTIFICATION OF APPLICANT

1. Applicant's Name and Mailing Address:

   _____

   _____

   _____

   _____

2. Applicant's FEIN: _____

3. Applicant's Legal Status (check one): ❑ County/State ❑ Not for Profit

4. Describe organizational structure or attach organization chart:

   _____

   _____

   _____

5. Contact Person (name, title, telephone number(s)and email address):

   _____

   _____

   _____

   _____

6. Date of Application: _____

7. Date of Application Revision, if applicable: _____

8. Type of Application (check one): ❑ Crisis ❑ Collaboration

9. Service Area: _____

   _____

   _____

10. Is the Applicant located in a MUA or HPSA? ❑ Yes ❑ No

If no, has a waiver been received from OCHSP? ❑ Yes ❑ No

11. Is the Applicant compliant with all HCA financial disclosure and filing requirements, if applicable? ❑ Yes ❑ No

12. 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

13. Brief Summary of Project: (not more than two (2) lines)

[Section B (Statement of Work) – This is the area in which the grant project will be detailed]

_____

_____

B. STATEMENT OF WORK

14. Provide a detailed description of project/work (include dates, deliverables, time frames, describe how the community will benefit from project and specific demographic issues. If this is a crisis grant, explain essential health services being threatened if funding is not approved and why funding is exigent). **DO NOT INCLUDE Protected Health Information or Personally Identifiable Information.**

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15. 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, 2017]

Start Date _____ Ending Date _____

16. 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 (prepayment) is needed in lieu of reimbursement, please justify:

_____

_____

_____

C. SUSTAINABILITY

17. Describe how the project will continue after the grant funds are expended. Additionally, if the grant is insufficient to cover the entire cost of the proposed project, please detail how the remaining balance will be funded.

_____

_____

_____

_____

****FOR CRISIS GRANTS ONLY, PLEASE SKIP TO SECTION G (BUDGET)****

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:

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

D. EVIDENCE OF COLLABORATION

If you have submitted a collaborative application, complete the following: identify 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 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).*

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 _____

E. 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)

F. 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

_____

Date

APPENDIX A

West Virginia Health Care Authority
Rural Health Systems Program
Proposed Budget

Proposed Grant Projected Start and End Dates:
(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)	Qty		
1.			
2.			
3.			
4.			
Total Equipment and Other Capital Expenditures			
Materials and Supplies			

(Itemize by type)	Qty		
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 is 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 $_____