Sarah Huckabee Sanders
GOVERNOR

Renee Mallory, RN, BSN
SECRETARY OF HEALTH

Jennifer Dillaha, MD
DIRECTOR

# *APPLICATION PACKET*
# *DH 26-0013*
# *FY2027 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 the Arkansas Charitable Clinics Grant Program to obtain applications for funding to assist Charitable Clinics in providing basic primary care, dental, behavioral health counseling services, and/or optical care 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:** | | **Your Agency UEI Number:** | | | | |
| **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<br>*Provide contact information to be used for bid solicitation related matters.* | | | |
|---|---|---|---|
| **Contact Person:** | | **Title:** | |
| **Phone:** | | **Alternate Phone:** | |
| **Email:** | | | |
| **Alternate Email:** | | | |

**REQUIRED CERTIFICATIONS**

By signing and submitting a response to this Solicitation, Prospective Contractor represents, warrants, and certifies that they are not a Scrutinized Company, and they do not currently and shall not for the aggregate term of a resultant contract:

- Boycott Israel.
- Knowingly employ or contract with illegal immigrants.
- Boycott Energy, Fossil Fuel, Firearms, or Ammunition Industries.
- Employ a Scrutinized Company as a contractor.

Prospective Contractor further represents, warrants, and certifies that it shall not become a Scrutinized Company during the aggregate term of a contract resulting from this Solicitation.

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: _____

*Use Ink Only.*

Printed/Typed Name:_____ Date: _____

# PROPOSED SUBCONTRACTORS FORM

- ***Choose one of the following:***

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

*Type or Print the following information*

| Subcontractor's Name | Street Address, City, State, Zip Code | Sub-contractor's National Provider Identifier (NPI) Number, if applicable | Detail Listing of services to be provided |
|---|---|---|---|
| | | | |
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☐ **PROSPECTIVE CONTRACTOR DOES NOT PROPOSE TO USE SUBCONTRACTORS TO PERFORM SERVICES.**

# ADDITIONAL INFORMATION

**Arkansas Charitable Clinics Grant Program Guidelines**
**Budget Spreadsheet and Example of Match Requirement**

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 a 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. salary, travel for out-of-state training, seminars, conferences, training related to certification or licensure of program personnel, etc.)

***NOTE:*** The table below is provided as a ***sample*** spreadsheet that represents a 75% to 25% Grant/In-Kind. In-Kind is the amount of actual In-Kind Matching to the charitable clinic that is or will be completed for this project. In-Kind Match, such as volunteer hours, federal/county/private/foundation funding received, or expenditures of clinic services and/or operations is what you will list in this column.

**Funds may be used for CONTRACTED SERVICES**.
Contracted services requirement below:
No more than 30% of total award ($42,000 = $12,600 maximum) can be used for Contracted Administrative Staff and/or Providers.

## SAMPLE BUDGET

***Note: Applicant is required to utilize the Budget Provided in Attachment One to this application packet.***

| **ITEM/SERVICE TO BE PURCHASED** | GRANT FUNDS (75%) | MATCH/IN-KIND (25%) | ROW TOTAL (100%) |
|---|---|---|---|
| Dental Supplies | $5,625.00 | $1,400.00 | $7,025.00 |
| Diabetic Testing Equipment | $1,000.00 | $0 | $1,000.00 |
| Diabetic Testing Supplies | $2,886.00 | $700.00 | $3,586.00 |
| Medications | $4,313.00 | $1500.00 | $5,813.00 |
| X-Ray Equipment / Maintenance | $ 450.00 | | $ 450.00 |
| Contracted Services, Administrative/contracted provider (30% max) | $12,600.00 | | $12,600.00 |
| Volunteer Hours | | $3,118.00 | $3118.00 |
| **COLUMN TOTAL** | $26,874.00 | $6,718.00 | $33,592.00 |

**BUDGET NARRATIVE (please describe what will be purchased and quantity):**

- **Dental Supplies: Brief description of supplies**
- **Diabetic testing equipment/supplies: Brief description of supplies/equipment to include quantity and who will be receiving equipment/supplies – clinic, patient, or both?**
- **Medication: Summary of type of medication and assistance**
- **X-ray Equipment / Maintenance: Summary of the equipment and/or description of maintenance**
- **Utilities:** If you are requesting reimbursement for charitable clinic utilities, please list which utilities and the amount you are requesting.
- **Medical Supplies:** Please identify what supplies you will be purchasing, such as sharps containers, Band-Aids, cotton swabs, gloves, masks, etc.
- **Office Supplies/Equipment:** Please identify what supplies/equipment you are requesting.

***Expenses not allowed in the Charitable Clinic budget:***

- *Salary/Fringe/Insurance*
- *Rent*
- *Insurance – Building and/or Malpractice*
- *Licenses*
- *Lawncare*
- *Signage*
- *Vehicle purchases, maintenance, fuel*
- *Security*
- *Construction*

## Proposal Narrative – Description of Purpose

**I. Charitable Clinic Name and date established:**

**II. Project Summary** - Provide a brief description of the proposed project including a summary of the clinic's description of all current programs/services provided to patients. Please Include how the patient population was determined.

*If you are funded as a FY2025 ADH Arkansas Charitable Clinic with **NO CHANGES** to:*

- *III. Target Area*
- *IV. Goals and Objectives*
- *V. Charitable Clinic Management*
- *VI. Evaluation*

*You may notate under each "No Change" and move to the next page.*

*If you were **NOT** funded in FY2025, please continue filling out each area below:*

**III. Target Area –** List the patient population and all counties served in alphabetical order that includes total population reach. Please explain how you determined the population selected.

**IV. Goals and Objectives** - State the overall goals, with objectives and detailed activities of your grant proposal and provide a description of the measurable activities through which you will accomplish each. List specific time frames and responsible parties for the completion of each. Explain how the proposed activities will impact the chosen population.

*Example:*
*Goal One: Provide 100 Glucose Monitor Kits to 100 patients by May 1, 2026.*
*Objective One: Log all glucose monitor kits dispersed to patients*
*Activity One: Create a spreadsheet/database to track*
*Objective One: Educate patients on proper use of glucose monitor*
*Activity One: Provide information to patient on when to use glucose monitor, how to log sugar counts and how to request more test strips before patient leaves the clinic with monitor kit.*
*Objective Two: Ensure patient signs off on document stating they received glucose monitor kit*
*Activity One: Add signed document to patient record*

**V. Charitable Clinic Management** - Provide a description of the charitable clinic's management structure, financial systems in place, and facilities that are essential to the management of the project.

**VI. Evaluation** - Explain how you will measure achievement of goals, objectives, and activities.

1. Describe the staffing within your clinic

| ***Staff*** | ***# Volunteer Staff*** | ***# Paid Staff/Contractor(s)*** |
|---|---|---|
| Physicians | | |
| Dentists | | |
| Nurse Practitioners | | |
| Pharmacists | | |
| Behavioral Health Counselors | | |
| RNs | | |
| LPNs | | |
| Physician Assistants | | |
| Dental Assistants | | |
| Administrative (intake, scheduling, clerical, etc.) | | |
| Optometry Services | | |

2. Does your clinic currently utilize an electronic medical record (EMR) system? If yes, describe the system used. If no, please list how you maintain patient records.

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

**Services Provided Onsite: Choose all that apply**

| | |
|---|---|
| Primary Care | Optometry Services |
| Dental Care | Pharmacy Services |
| Behavioral Health Counseling | Maternal Health |

| | |
|---|---|
| **Key Affiliations/Partnerships:** | |

4. Please specify your **charitable clinic hours** per week/month **ONLY**.
**If charitable clinic hours vary by program, please specify the clinical hours provided by each program. (i.e. dental, primary, etc.)*

5. What are the eligibility requirements a patient must meet to receive care in your clinic?
Please list/attach the requirements and other supporting documents, such as an application form.

6. Does your charitable clinic refer patients to ADH Local Health Units for services? If so, which services are the most common?

**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 (FY24)** | **Current Fiscal Year (FY25)** |
|---|---|---|
| **Total Visits** | | |
| Primary Medical Care | | |
| Dental Care | | |
| Pharmacy Services | | |
| Behavioral Health Counseling | | |
| Optometry Services | | |
| Medical, Dental, Optical Referrals | | |
| **Totals:** | | |

***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 later, he/she is not counted as an additional patient in the total patients served number.*

**Arkansas Charitable Clinics Grant Program Guidelines**
**Certification of Eligibility,**
**All requirements must be met at the time of application**

## *Please initial each line below.*

____ The clinic is a volunteer-based, safety-net health-care organization located in Arkansas that provides a range of medical, dental, pharmacy, behavioral health counseling services, and/or optical care 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 care, optometry care, behavioral health counseling, and/or pharmacy services are delivered regardless of the patient's ability to pay.

____ The clinic is in good standing with ADH and fully operational at the time of this application.

____ The clinic provides medical diagnosis and treatment of complaints by a licensed provider.

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

____ The clinic is on the Arkansas Volunteer Health Care Act Registry

____ The clinic does not receive public or private reimbursement from third-party payer sources (Other than Medicaid).

_____ _____
Authorized Representative Signature Date

_____ _____
Authorized Representative Printed Name and Title Date

**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 and a one-paragraph description of key staff members.

**II. Financial Information**

1. Matching funds will be verified from July 1, 2026, through June 30, 2027.
2. Itemized budget spreadsheet showing planned grant fund expenditures as well as In-Kind expenditures. Budget form is provided. (1- 2 pages).
3. A completed W-9 for the applicant clinic (1 page).
4. Annual operating budget and actual income and expenses for most recently completed fiscal year **AND** for current year-to-date (1–2 pages).
5. 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).
6. A copy of the organization's current 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. Annual Budget request form, narrative included
5. Certification of Eligibility