Sarah Huckabee Sanders
GOVERNOR

Renee Mallory, RN, BSN
SECRETARY OF HEALTH

Jennifer Dillaha, MD
DIRECTOR

APPLICATION PACKET
DH-25-0013
FY2026 Charitable Clinics

Application Due Date
April 18, 2025
NLT 4:30pm CT

APPLICATION REVIEW PROCESS & PROCEDURE

ADH will collect applications via email and award up to twenty (20) qualified applicants. The order of receipt of applications will be identified by the State's email system.

ADH will review each Application Packet to verify requirements. Applications that do not meet requirements will not be considered.

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 *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

- ***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 Name	Street Address, City, State, Zip Code	Sub-contractor's National Provider Identifier (NPI) Number	Detail Listing of services to be provided

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

SECTION 1
ADDITIONAL INFORMATION

Arkansas Charitable Clinics Grant Program Guidelines
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 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 done 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.

The way these funds are distributed within the table should not be taken as indicative of how your spreadsheet should be broken out for expenses. This table will assist with explaining how Grant and In-Kind funds will be utilized and will be used for clarification of your Budget Narrative.

Funds may be used for CONTRACTED SERVICES. Contracted services are for licensed medical professionals, the total amount may not exceed 10% of total award. *For example, if you are requesting $20,000 total for your charitable clinic, the contracted services total amount may not exceed $2,000.*

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

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	$1,875.00	7,500.00
Diabetic Testing Equipment	$1,000.00	0	$1,000.00
Diabetic Testing Supplies	$2,886.00	$964.00	$3,850.00
Medications	4,313.00	$1437.00	$5,750.00
X-Ray Equipment / Maintenance	$450.00		$450.00
Contracted Services (10% max)	No greater than $4,200.00	$750.00	$4,950.00
Utilities		$1,000.00	$1,000.00
Medical Supplies			
Office Supplies/Equipment			
Other			
COLUMN TOTAL	$18,474.00	$6,026.00	$24,500.00

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, the calculations should be based on the hours of the charitable clinic, not the hours of the overall clinic.

> **Example:**
> The health clinic hours of operation:
> Monday – Friday 8:00 am – 4:00 pm (8hrs /day = 40 hrs. per week
> The Charitable Clinic hours of operation: Wednesdays 4:30 pm – 8:00 pm (3.5hrs/day) and Saturdays 7:00 am – 1:00pm (6 hrs. day) = 9.5 hrs. per week
>
> Monthly total: 198 total hours of operations / 38 of those hours are for Charitable Clinic appointments, so you will be reimbursed for 19% of your utilities from the AR Charitable Clinic Grant Program.

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.

Other: You must be detailed in what you are requesting for this category.

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

- *Salary/Fringe/Insurance*
- *Rent*
- *Insurance*
- *Licenses*
- *Lawncare*
- *Signage*
- *Vehicle purchases, maintenance, fuel*
- *Security*
- *Construction*

SECTION 2
Arkansas Charitable Clinics Grant Program Guidelines
Proposal Narrative – Description of Purpose

Please provide the following detailed information in this order.

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 and barriers encountered by the clinic. Please Include how the patient population was determined.

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.

SECTION 3
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 all amounts and sources of your clinic's sources of income.

Income Source	Income Amount

6. List your regular clinic hours and charitable clinic hours of operation

SECTION 4
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 Counselors			
RNs			
LPNs			
Physician Assistants			
Dental Assistants			
Administrative (intake, scheduling, clerical, etc.)			
Optometry Services			

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

Staff	***Employed/Contracted Last Fiscal Year (FY24)***	***Employed/Contracted Fiscal Year to Date (FY25)***
Physicians		
Dentists		
Nurse Practitioners		
Pharmacists		
Behavioral Health Professionals		
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 describe in detail how you maintain patient records.

3. 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
Behavioral Health Counseling
Optometry Services
Pharmacy Services

Programs Provided:	
Key Affiliations/Partnerships:	

4. Please specify your ***regular clinical hours*** of operation **and** your **charitable clinic hours** per week.
   **If clinical hours vary by program, please specify the clinical hours provided by each program.*

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

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

SECTION 5
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)**	**Last Fiscal Year % of Patients Medicaid Billed**	**Current Fiscal Year (FY25)**	**Current Fiscal year-to-Date % of Patients Medicaid Billed**
Total Visits				
Primary Medical Care				
Dental Care				
Pharmacy Services				
Behavioral Health Counseling				
Optometry Services				
Medical, Dental, Optical Referrals				

***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.*

Patient Data Narrative (must provide the following for Fiscal Year 25 (July 1, 2024 – June 30, 2025):

Primary Medical Care Services: (please summarize the types of medical care provided, i.e. physical exams, x-rays, immunizations, maternal health, etc.)

Dental Care Services: (please summarize the type of dental care provided, i.e. fillings, caps, crowns, x-rays, etc.)

Pharmacy Services: (please summarize the services provided, $0 cost medications to XX# of clients, etc.)

Behavioral Health Counseling Services: (please summarize the type of services, i.e. therapy, etc.)

Optometry Services: (please summarize the type of services, i.e. eye exams, glass frames, lenses, etc.)

Medical, Dental, Optical Care Referrals: (please summarize the type of referrals made and to whom)

SECTION 6
Arkansas Charitable Clinics Grant Program Guidelines
Certification of Eligibility

Please initial each applicable 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 a member of the Arkansas Association of Charitable Clinics.

____ The clinic does not receive public or private reimbursement from third-party payer sources.

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

_____ _____
Authorized Representative Signature Date

_____ _____
Authorized Representative Printed Name and Title Date

SECTION 7
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. 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, 2025, through June 30, 2026.
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 this funding is exhaused (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.

Budget Template

CHARITABLE CLINIC NAME

DATE: Project Title:

Budget Narrative **July 1, 2025 – 6/30/2026**

Contractual: $0.00

Contractual services are for licensed medical professionals, the total amount may not exceed 10% of the total award. *For example, if you are requesting $20,000 total for your charitable clinic, the contracted services total amount may not exceed $2,000.*

Justification:

Please list the contractor's name and National Provider Identifier (NPI) Number and what work will be performed. Weekly/Monthly, etc.

Medical Supplies/Equipment: $0.00

Item/Service to be purchased	Quantity	GRANT FUNDS (75%)	MATCH/IN-KIND (25%)	ROW TOTAL (100%)
Contour Next One Blood Glucose Monitoring System @ $21/ea.	100	$2,100.00	0	$2,100.00
TOTAL		$2,100.00	$0.00	$2,100.00

Please list line items and/or services you are proposing to purchase with projected quantity.

JUSTIFICATION:

Blood Glucose Monitoring System: (Charitable Clinic Name) will disperse 100 Contour Next One Blood Glucose Monitoring Systems to 100 patients by 6/30/2026.

DATE: Project Title:

Utilities:

Item/Service to be purchased	Regular Hours of Clinic	Charitable Hours of Clinic	% of the total to be requested per month	Total for 12 mos.

If you are requesting reimbursement for charitable clinic utilities, the calculations should be based on the hours of the charitable clinic, not the hours of the overall clinic.

Example:

The health clinic hours of operation:
Monday – Friday 8:00 am – 4:00 pm (8hrs /day = 40 hrs. per week
The Charitable Clinic hours of operation: Wednesdays 4:30 pm – 8:00 pm (3.5hrs/day) and Saturdays 7:00 am – 1:00pm (6 hrs. day) = 9.5 hrs. per week
Monthly total: 198 total hours of operations / 38 of those hours are for Charitable Clinic appointments, so you will be reimbursed for 19% of your utilities from the AR Charitable Clinic Grant Program.

Office Supplies/Office Equipment: $0.00

Item/Service to be purchased	Quantity	GRANT FUNDS (75%)	MATCH/IN-KIND (25%)	ROW TOTAL (100%)
TOTAL				

JUSTIFICATION:

Please identify what supplies/equipment you are requesting.

Total Requested Amount: $0.00

DEPARTMENT OF TRANSFORMATION AND SHARED SERVICES
OFFICE OF STATE PROCUREMENT

COMBINED CERTIFICATIONS FOR CONTRACTING WITH THE STATE OF ARKANSAS

Pursuant to Arkansas law, a vendor must certify as specified below and as designated by the applicable laws.

1. **Israel Boycott Restriction:** For contracts valued at $1,000 or greater.
   A public entity shall not contract with a person or company (the "Contractor") unless the Contractor certifies in writing that the Contractor is not currently engaged in a boycott of Israel. If at any time after signing this certification the Contractor decides to boycott Israel, the Contractor must notify the contracting public entity in writing. *See* Arkansas Code Annotated § 25-1-503.

2. **Illegal Immigrant Restriction:** For contracts valued at $25,000 or greater.
   No state agency may contract for services with a Contractor who knowingly employs or contracts with an illegal immigrant. The Contractor shall certify that it does not knowingly employ, or contract with, illegal immigrants. *See* Arkansas Code Annotated § 19-11-105.

3. **Energy, Fossil Fuel, Firearms, and Ammunition Industries Boycott Restriction:** For contracts valued at $75,000 or greater.
   A public entity shall not contract unless the contract includes a written certification that the Contractor is not currently engaged in and agrees not to engage in, a boycott of an Energy, Fossil Fuel, Firearms, or Ammunition Industry for the duration of the contract. *See* Arkansas Code Annotated § 25-1-1102.

4. **Scrutinized Company Restriction:** Required with bid or proposal submission.
   A state agency shall not contract with a Scrutinized Company or a company that employs a Scrutinized Company as a subcontractor. A Scrutinized Company is a company owned in whole or with a majority ownership by the government of the People's Republic of China. A state agency shall require a company that submits a bid or proposal for a contract to certify that it is not a Scrutinized Company and does not employ a Scrutinized Company as a subcontractor. *See* Arkansas Code Annotated § 25-1-1203.

By signing this form, the Contractor agrees and certifies they are not a Scrutinized Company and they do not currently and shall not for the aggregate term 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 subcontractor.

Contract Number: _____ Description: _____

Agency Name: _____

Vendor Number: _____ Vendor Name: _____

_____ _____
Vendor Signature Date

CONTRACT AND GRANT DISCLOSURE AND CERTIFICATION FORM

Failure to complete all of the following information may result in a delay in obtaining a contract, lease, purchase agreement, or grant award with any Arkansas State Agency.

SUBCONTRACTOR: **SUBCONTRACTOR NAME:**

☐ **Yes** ☐ **No**

TAXPAYER ID NAME:

IS THIS FOR:

☐ **Goods?** ☐ **Services?** ☐ **Bot ?**

YOUR LAST NAME: **FIRST NAME:** **M.I.:**

ADDRESS:

CITY: **STATE:** **ZIP CODE:** **COUNTRY:**

AS A CONDITION OF OBTAINING, EXTENDING, AMENDING, OR RENEWING A CONTRACT, LEASE, PURCHASE AGREEMENT, OR GRANT AWARD WITH ANY ARKANSAS STATE AGENCY, THE FOLLOWING INFORMATION MUST BE DISCLOSED:

FOR INDIVIDUALS*

Indicate below if: you, your spouse or the brother, sister, parent, or child of you or your spouse *is* a current or former: member of the General Assembly, Constitutional Officer, State Board or Commission Member, or State Employee:

Position Held	Mark (√)		Name of Position of Job Held [senator, representative, name of board/ commission, data entry, etc.]	For How Long?		What is the person(s) name and how are they related to you? [i.e., Jane Q. Public, spouse, John Q. Public, Jr., child, etc.]	
	Current	Former		From MM/YY	To MM/YY	Person's Name(s)	Relation
General Assembly							
Constitutional Officer							
State Board or Commission Member							
State Employee							

☐ **None of the above applies**

FOR AN ENTITY (BUSINESS)*

Indicate below if any of the following persons, current or former, hold any position of control or hold any ownership interest of 10% or greater in the entity: member of the General Assembly, Constitutional Officer, State Board or Commission Member, State Employee, or the spouse, brother, sister, parent, or child of a member of the General Assembly, Constitutional Officer, State Board or Commission Member, or State Employee. Position of control means the power to direct the purchasing policies or influence the management of the entity.

Position Held	Mark (√)		Name of Position of Job Held [senator, representative, name of board/commission, data entry, etc.]	For How Long?		What is the person(s) name and what is his/her % of ownership interest and/or what is his/her position of control?		
	Current	Former		From MM/YY	To MM/YY	Person's Name(s)	Ownership Interest (%)	Position of Control
General Assembly								
Constitutional Officer								
State Board or Commission Member								
State Employee								

☐ **None of the above applies**

Contract and Grant Disclosure and Certification Form

Failure to make any disclosure required by Governor's Executive Order 98-04, or any violation of any rule, regulation, or policy adopted pursuant to that Order, shall be a material breach of the terms of this contract. Any contractor, whether an individual or entity, who fails to make the required disclosure or who violates any rule, regulation, or policy shall be subject to all legal remedies available to the agency.

As an additional condition of obtaining, extending, amending, or renewing a contract with a *state agency* I agree as follows:

1. Prior to entering into any agreement with any subcontractor, prior or subsequent to the contract date, I will require the subcontractor to complete a **CONTRACT AND GRANT DISCLOSURE AND CERTIFICATION FORM**. Subcontractor shall mean any person or entity with whom I enter an agreement whereby I assign or otherwise delegate to the person or entity, for consideration, all, or any part, of the performance required of me under the terms of my contract with the state agency.

2. I will include the following language as a part of any agreement with a subcontractor:

   Failure to make any disclosure required by Governor's Executive Order 98-04, or any violation of any rule, regulation, or policy adopted pursuant to that Order, shall be a material breach of the terms of this subcontract. The party who fails to make the required disclosure or who violates any rule, regulation, or policy shall be subject to all legal remedies available to the contractor.

3. No later than ten (10) days after entering into any agreement with a subcontractor, whether prior or subsequent to the contract date, I will mail a copy of the **CONTRACT AND GRANT DISCLOSURE AND CERTIFICATION FORM** completed by the subcontractor and a statement containing the dollar amount of the subcontract to the state agency.

I certify under penalty of perjury, to the best of my knowledge and belief, all of the above information is true and correct and that I agree to the subcontractor disclosure conditions stated herein.

Signature_____ Title_____ Date_____

Vendor Contact Person_____ Title_____ Phone No._____

Agency use only

Agency Number_____ Agency Name_____ Agency Contact Person_____ Contact Phone No._____ Contract or Grant No._____

Reset Form Print Form