

# Wyoming Primary Care Support Grant Program

*Application Package*



Wyoming  
Department  
of Health

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**Commit to your health.**

Public Health Division  
Office of Rural Health  
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## **PURPOSE OF THE WYOMING PRIMARY CARE SUPPORT GRANT PROGRAM**

The purpose of the Wyoming Primary Care Support Grant Program is to provide grants to Community Health Centers and Rural Health Clinics for capital construction and start-up costs, as follows:

1. As one-time start-up costs of a new Community Health Center or Rural Health Clinic; or
2. To allow existing Community Health Centers or Rural Health Clinics to:
  - a. Expand the population served; or
  - b. Initiate new services; or
  - c. Facilitate compliance with quality criteria.
3. Grants cannot be used for operational expenses.

## **PROGRAM RULES AND REGULATIONS**

Full details on the requirements of the Wyoming Primary Care Support Grant Program can be found in the Rules and Regulations for the Wyoming Primary Care Support Grant Program. The document can be found online at <http://www.health.wyo.gov/rfhd/rural/PCSP.html>.

## **ELIGIBILITY**

The following are general eligibility requirements. For additional information on the definitions and eligibility of each clinic type or full details on other eligibility requirements, please review the Program Rules and Regulations.

### **1. Community Health Centers**

- a. New Community Health Centers which will apply for a “New Access Point” grant to receive Public Health Service Act Section 330 (PHS 330) funding as a federally qualified Community Health Center.
- b. Existing Community Health Centers.
- c. Existing Federally Qualified Health Center Look-Alikes (FQHC-LAs).
- d. Eligible Community Health Centers do not include other types of Federally Qualified Health Centers (FQHCs) including, but not limited to, migrant and homeless clinics.

### **2. Rural Health Clinics**

- a. New Rural Health Clinics which will apply to the Centers for Medicare and Medicaid Services (CMS) to receive designation as a Rural Health Clinic.
- b. Existing Rural Health Clinics.

**3. Clinics Awarded in 2013.** Clinics which received an award under the Program in 2013 are eligible to apply; however, new applicants will have higher priority and current project and award status will be considered during the selection process.

**4. Additional Eligibility Requirements.** All applicants must have the following in order to be eligible to apply for a grant under this Program:

- a. An electronic health record, or inclusion of an electronic health record in the applied for project, that has been certified under the Certified IT Product List (CHPL). The CHPL is available at <http://onc-chpl.force.com/ehrcert>.
- b. Approval to apply for a grant under the Program from the Board of County Commissioners of the applicable county which is no more than six (6) months old at the time of the application.

## APPLICATION REQUIREMENTS AND CHECKLIST

Application documents must be typed and submitted in the following format and order. Handwritten applications and those missing the following required elements will not be accepted and will be returned to the applicant as ineligible. Required fillable PDF forms for use in the application are available in the Forms Section of this document and by clicking the hyperlink in the document name.

- 1. Application Cover Sheet.** Complete the [Application Cover Sheet](#).
- 2. Board of County Commissioners Approval.** Complete the [Board Approval Cover Sheet](#), and attach an official copy of the meeting minutes obtained from the County Clerk or a signed letter from the Board of County Commissioners of the applicable county proving board approval was granted to apply for a grant under this Program.
- 3. Local Matching Funds.** Complete the [Matching Funds Cover Sheet](#) and attach documentary evidence of local matching funds in an amount no less than twenty-five percent (25%) of the total funding request.
  - a.** Local matching funds may be in cash, in-kind, or both, and must be shown in the form of a contract, promissory note or other legally binding written agreement. An appraisal of goods and services must be included for in-kind local matching funds.
- 4. Proof of Clinic Status.** Complete the [Clinic Status Cover Sheet](#) and attach:
  - a.** Documentary evidence of existing federally qualified Community Health Center, Federally Qualified Health Center Look-Alike, or Rural Health Clinic status; **OR**
  - b.** A description of the current progress towards federally qualified Community Health Center or Rural Health Clinic status, a timeline identifying milestones necessary in obtaining the status, and plan of action should the pursuit be unsuccessful. Maximum one (1) page in length.
- 5. Project Narrative.** Complete the [Project Narrative Cover Sheet](#) and attach a Project Narrative which:
  - a.** Describes the scope of the project;
  - b.** How the project is supported by the financial plan; and
  - c.** Demonstrates how the project will benefit the community or the patient population served (if applicable).
  - d.** Project Narrative is limited to two (2) pages in length.
- 6. Operation Plan.** Complete the [Operation Plan Cover Sheet](#) and attach an Operation Plan. The Operation Plan is limited to three (3) pages in length (not including attachments) and must describe how the clinic is expected to function after completion of the project and should include:
  - a.** How the clinic plans to integrate healthcare services within the entire service community to promote accessibility and quality of care. *Recommended attachments:* MOU/As with other healthcare providers/agencies, hospitals, and other entities in the service area deemed appropriate by the applicant;
  - b.** How the clinic may reduce Emergency Room or similar type care usage. *Recommended attachments:* MOU/As with other hospitals and other entities in the service area deemed appropriate by the applicant;
  - c.** How the clinic will provide services to individuals regardless of their ability to pay and provide care to Medicare, Medicaid, and CHIP eligible patients.

- Recommended attachments:* charity care policy, sliding fee scale and other documentation deemed appropriate by the applicant;
- d. How the new operation plan meets the goals and objectives of the project applied for under this Program;
  - e. New staffing plan and hours of operation;
  - f. The areas (towns and/or communities) the clinic will be serving upon completion of the project as well as the anticipated number of uninsured to be served; and
  - g. Other important aspects of the operation.
  - h. Any attachments to the Operation Plan (MOU/As, etc.) must incorporate the [Attachment Cover Sheet](#).
7. **Quality, Performance, and Reporting Narrative.** Complete the [Quality, Performance, and Reporting Cover Sheet](#) and attach the Quality, Performance, and Reporting Narrative. The narrative is limited to two (2) pages and must:
- a. Identify three (3) quality indicators of the applicant's choice;
  - b. Identify a list of key performance indicators for the project, as defined in the Program Rules and Regulations; and
  - c. Describe how the applicant will meet reporting requirements to remain in compliance with the Program during the entire three (3) year grant term.
8. **Financial Plan.** The Financial Plan is not a narrative but consists of the following three (3) required forms:
- a. [Financial Plan Attachment 1A](#) provides a breakdown of the costs of the proposed project.
  - b. [Financial Plan Attachment 1B](#) is a cover sheet for the Project Bid selected by the applicant. Please include both the cover sheet and the selected Project Bid as the complete Financial Plan Attachment 1B.
  - c. [Financial Plan Attachment 2](#) shows the demand for services by population and the resulting income generated.
9. **Additional Attachments.** Attachments in addition to the Financial Plan attachments are expected. Include copies of all MOU/As, contracts, and other documents that support aspects of the project, financial plan, or operation plan.
- a. Each additional attachment must contain a cover sheet identifying the attachment by number. For example, the first attachment to the Operation Plan will have a cover sheet titled "Operation Plan Attachment 1" with a descriptive title on the second line such as "MOU with Local Hospital." Please complete the [Attachment Cover Sheet](#) for this purpose.

## APPLICATION ACCEPTANCE DATES AND SUBMISSION

Applications will be accepted May 1, 2015 through close of business (5:00 PM MST) August 31, 2015. Submit completed application via regular mail or parcel post, including two (2) complete photo copies, to:

Office of Rural Health  
Wyoming Department of Health  
6101 Yellowstone Road, Suite 420  
Cheyenne, WY 82002 (regular mail) or 82009 (UPS, FedEx, etc.)

## **TECHNICAL ASSISTANCE AND RESOURCES**

The Wyoming Department of Health contact for the Program is Keri Wagner, Office of Rural Health, Public Health Division, 6101 Yellowstone Rd. Ste. 420, Cheyenne, WY 82002, (307) 777-6512, [keri.wagner@wyo.gov](mailto:keri.wagner@wyo.gov). Additional information, assistance, and resources may be available from the Wyoming Primary Care Association, (307) 632-5743, [www.wypca.org](http://www.wypca.org).

Census information and community specific information can be found online at the following:

1. <http://eativ.state.wy.us>
2. [http://eativ.state.wy.us/demog\\_data/pop2010/Profile/2010Profiles\\_WY.html](http://eativ.state.wy.us/demog_data/pop2010/Profile/2010Profiles_WY.html).

## **FUNDING**

The 2015 General Session of the Wyoming Legislature appropriated an additional \$200,000 for awards. The maximum allowable grant to any one (1) Community Health Center or Rural Health Clinic under this Program is \$1 million; however available funding limits the maximum award to \$200,000 for this application period. All awards must include local matching funds in an amount no less than twenty-five percent (25%) of the grant award amount.

## **FORMS**

The fillable PDF forms and cover sheets which are required in the application are available on the following pages and by clicking on the hyperlink in each document name.

[Application Cover Sheet](#) (fillable)

[Board Approval Cover Sheet](#)

[Matching Funds Cover Sheet](#)

[Clinic Status Cover Sheet](#)

[Project Narrative Cover Sheet](#)

[Operation Plan Cover Sheet](#)

[Quality, Performance, and Reporting Cover Sheet](#)

[Financial Plan Attachment 1A](#) (fillable)

[Financial Plan Attachment 1B](#)

[Financial Plan Attachment 2](#) (fillable)

[Attachment Cover Sheet](#) (fillable)

**Application Cover Sheet**

Please provide the following information, handwritten forms will not be accepted.

Legal name of applicant: \_\_\_\_\_

Name(s) and contact information of responsible person(s) (CEO, BOD, Owner, etc). A minimum of two must be provided.

\_\_\_\_\_ Phone:\_\_\_\_\_ E-mail:\_\_\_\_\_

\_\_\_\_\_ Phone:\_\_\_\_\_ E-mail:\_\_\_\_\_

\_\_\_\_\_ Phone:\_\_\_\_\_ E-mail:\_\_\_\_\_

\_\_\_\_\_ Phone:\_\_\_\_\_ E-mail:\_\_\_\_\_

Name of main contact person from list above: \_\_\_\_\_

Current or planned physical address of clinic:

Mailing address:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Nearest primary care access point other than the applicant (using mapquest.com):

Clinic name: \_\_\_\_\_ Distance: \_\_\_\_\_ miles

Name of community: \_\_\_\_\_

Date of Board of County Commissioners approval of application: \_\_\_\_\_

Does the applicant have a certified electronic health record currently in use (yes/no)? \_\_\_\_\_

What is the purpose of the project? Indicate at least one of the following:

\_\_\_ Expand the population served                      \_\_\_ Initiate new service(s)

\_\_\_ Improve compliance with quality criteria            \_\_\_ Initial start-up costs

Grant amount requested: \$ \_\_\_\_\_

Local matching funds available: \$ \_\_\_\_\_

Total Cost of project involved in this grant application: \$ \_\_\_\_\_

Board of County Commissioners Approval

## Matching Funds

Clinic Status

Clinic Status

## Project Narrative

# Operation Plan

## Quality, Performance, and Reporting Narrative

## Financial Plan Attachment 1A

<b>EXPENSES</b>	
Project cost not including construction:	\$
Construction (to final product):	\$
Total Equipment (itemize on Page 2):	\$
Supplies (tongue depressors, lab supplies, etc.):	\$
Total salaries/benefits of new employees (itemize each new employee on Page 3):	\$
Mortgage/lease/rent:	\$
New utility expenses (phone, electric, heating/cooling):	\$
Other (itemize on Page 4):	\$
<b>TOTAL EXPENSES</b>	\$







**Financial Plan Attachment 1B**  
**Selected Project Bid**

## Financial Plan Attachment 2

To determine the number of appointments required to meet the demand of a given population, the Office of Rural Health requires applicants to use the Rural Health Works model. The Rural Health Works model was developed by Oklahoma State University ([www.ruralhealthworks.org](http://www.ruralhealthworks.org)) and uses the age and gender of the population to determine primary care medical appointment demand. Census data can be obtained from the Wyoming Department of Administration and Information, Economic Analysis Division at: (<http://eadiv.state.wy.us>). Census information specific to communities can be obtained at the following web address: [http://eadiv.state.wy.us/demog\\_data/pop2010/Profile/2010Profiles\\_WY.html](http://eadiv.state.wy.us/demog_data/pop2010/Profile/2010Profiles_WY.html). Use the below demand table to determine the demand of your community. Use the income table to determine your projected income. Both tables are required.

**Demand Table**

1	2	3	4	5	6	7	8
Age Group	2010 Male Population	Multiplier (Do not change multipliers)	Male visits* (multiply Column 2 by Column 3)	2010 Female Population	Multiplier (Do not change multipliers)	Female visits* (multiply Column 5 by Column 6)	Total Visits* (add columns 7 and 4)
Under 15		2.4			2.3		
15-24		1.2			2.3		
25-44		1.6			3.1		
45-64		3.0			4.1		
65-74		5.4			6.1		
75+		6.7			6.4		
<b>TOTAL</b>		N/A			N/A		

**Income Table**

Insurance Type	Number of Visits	Reimbursement per Visit	Total
Medicare		\$	\$
Medicaid/KidCare		\$	\$
Uninsured/Self-pay		\$	\$
Private Insurance		\$	\$
Other income (itemized below)		\$	\$
		\$	\$
		\$	\$
		\$	\$
		\$	\$
		\$	\$
		\$	\$
		\$	\$
		\$	\$
<b>TOTAL</b>		N/A	\$

\* The number of visits in the Income Table should not exceed the number of visits in the Demand Table. The total in the bottom right box of the Income Table should equal or exceed the Expense Table total in Financial Plan Attachment 1A, minus project, equipment, and construction. If these conditions are not met, it will indicate an ineffective operation or financial plan.

Attachment

Attachment