**Department of State Health Services**

FORM A: FACE PAGE

This form requests basic information about the Applicant and project, including the signature of the authorized representative. The face page is the cover page of the Application and must be completed in its entirety.

|  |
| --- |
| **APPLICANT INFORMATION** |
| **1) LEGAL BUSINESS NAME:** |  |
| **2) MAILING Address** **Information** (include mailing address, street, city, county, state and 9-digit zip code): | **Check if address change** | [ ]  |
|  |                 |
| **3) PAYEE Name and Mailing Address, including 9-digit zip code** (if different from above): | **Check if address change** | [ ]  |
|  |                      |
| **4)** | **UEID Number required if receiving federal funds:**        |
| **5) Federal Tax ID No.** (9-digit), **State of Texas Comptroller Vendor ID Number** (14-digit) or **Social Security Number** (9-digit):  |       |
| **\*The Applicant acknowledges, understands and agrees that the Applicant's choice to use a social security number as the vendor identification number for the contract, may result in the social security number being made public via state open records requests.** |
| **6) TYPE OF ENTITY** (check all that apply): |
|  | [ ]  | City | [ ]  | Nonprofit Organization**\*** | [ ]  | Individual |
|  | [ ]  | County | [ ]  | For Profit Organization**\*** | [ ]  | Federally Qualified Health Centers |
|  | [ ]  | Other Political Subdivision | [ ]  | HUB Certified | [ ]  | State Controlled Institution of Higher Learning |
|  | [ ]  | State Agency | [ ]  | Community-Based Organization | [ ]  | Hospital |
|  | [ ]  | Indian Tribe | [ ]  | Minority Organization | [ ]  | Private |  |
|  |  |  | [ ]  | Faith Based (Nonprofit Org) | [ ]  | Other (specify): |       |  |
| **\***If incorporated, provide 10-digit charter number assigned by Secretary of State: |       |  |
| **7) PROPOSED BUDGET PERIOD:** | **Submission Date:**  |       | **End Date:** |       |
| **8) COUNTIES SERVED BY PROJECT:**  |  |
|  |       |
| **9) AMOUNT OF FUNDING REQUESTED:**  |       | **11) PROJECT CONTACT PERSON** |
| **10) PROJECTED EXPENDITURES**  |  |  |  | Name:Phone:Fax:Email:  |                           |
| Does Applicant’s projected federal expenditures exceed $500,000, or its projected state expenditures exceed $500,000, for Applicant’s current fiscal year (excluding amount requested in line 9 above)? \*\* Yes [ ]  No [ ] *\*\*Projected expenditures should include anticipated expenditures under all federal grants including “pass through” federal funds from all state agencies, or all anticipated expenditures under state grants, as applicable.* |  |  |  |
|  |  |  |  |
|  | **12) FINANCIAL OFFICER** |
|  |  | Name:Phone:Fax:Email: |                           |
| The facts affirmed by me in this application are truthful and I warrant the Applicant is in compliance with the assurances and certifications contained in **APPENDIX A: General Affirmations.** I understand the truthfulness of the facts affirmed herein and the continuing compliance with these requirements are conditions precedent to the award of a contract. This document has been duly authorized by the governing body of the Applicant and I (the person signing below) am authorized to represent the Applicant. |
| **13) AUTHORIZED REPRESENTATIVE** | **Check if change** [ ]  | **14) SIGNATURE OF AUTHORIZED REPRESENTATIVE** |
|  | Name:Title:Phone:Fax:Email: |                           |  |
|  |  |  | **15) DATE** |
|  |  |  |  |       |

FORM B: Open Enrollment Application Checklist

Department of State Health Services

Open Enrollment Application OE No. HHS0014148

**Each Open Enrollment Application Must Contain the Following Completed Items (As Indicated):**

|  |
| --- |
| **Documentation Required for Category 1 Applicants- Current FQHCs and FQHC Look-alike****Documentation Required for Submission** All documentation listed must be returned for a complete Application. Provide the documentation in the same sequence as outlined below by using the Item number(s) and title(s) as necessary.  |
| 1. **Exhibit A - HHS Solicitation Affirmations Version 2.4**

Must be completed and signed **Important Note: Applications received without the signed Exhibit A will be disqualified.**  |
| 1. **Exhibit B - HHS Uniform Terms and Conditions – Vendor, Version 3.4**

For reference only |
| 1. **Exhibit C - Federal Assurances, Non-Construction**

Must be completed and signed if not doing construction or renovations |
| 1. **Exhibit D – Federal Assurances, Construction**

Must be completed and signed if doing construction or renovations |
| 1. **Exhibit E - Certification Regarding Lobbying** Must be completed and signed
 |
| 1. **Exhibit F - Fiscal Federal Funding Accountability and Transparency Act (FFATA) Certification**

Must be completed and signed |
| 1. **Form A - Face Page**

 Must be completed and signed |
| 1. **Form B - Open Enrollment (OE) Application Checklist**

Must be included |
| 1. **Form C - Contact Person Information Form**

 Must be completed |
| 1. **Form D - Vendor Information Form**

 Must be completed and signed |
| 1. **Form E - Organizational Category Form**

 Must be completed by selecting applicable category and providing all requested documentation. |
| 1. **Form F - FQHC Look-alike Application Attestation**

 Must be completed and signed |
| 1. **Form G - Attestation of Primary Care Clinical Hours**

 Must be completed and signed |
| 1. **Form H - Landlord Consent for Construction on Leased Spaces**

 Must be completed as applicable for planned construction projects in leased spaces. |
| 1. **Form I - FQHC New Access Business Plan Template**

 Must be completed as applicable |
| 1. **Form J - Workplan Template: FQHC Incubator Program-New Health Center Location**

Must be completed as applicable |
| 1. **Form K - FQHC Budget Template**

 Must be completed and signed |
| 1. **Notice of Criminal Activity – Reference Section 8.6**

Provide confirmation that the Applicant, any person with ownership or controlling interest in the Applicant, its agent, employee, subcontractor, or volunteer who will be providing the required services:1. have not engaged in any activity that does or could constitute a criminal offense equal to or greater than a Class A misdemeanor or grounds for disciplinary action by a state or federal regulatory authority; and
2. have not been placed on community supervision, received deferred adjudication, or been indicted for or convicted of a criminal offense relating to involvement in any financial matter, federal or state program, or sex crime.
 |
| 1. **Notice of Insolvency or Indebtedness – Reference Section 8.7**

Provide with the Application detailed written descriptions of any insolvency, incapacity, and outstanding unpaid obligations of Applicant owed to the Internal Revenue Service (IRS) or the State of Texas, or any agency or political subdivision of the State of Texas. |
| 1. **Public Information Act Copy of Application, if applicable – Reference Section 11.1**
 |
| **The following appendices are not required to be submitted as part of the Application and are included for informational purposes only. Appendices will be used when submitting deliverables.** |
| 1. **Appendix A - Enrichment Activities**
 |
| 1. **Appendix B - Staffing List**
 |
| 1. **Appendix C - Capital Improvement Activities**
 |
| 1. **Appendix D - Progress Statement**
 |
| 1. **Appendix E - Budget Sheet**

 Must be completed as applicable |
| 1. **Appendix F - Final Impact Report**
 |

|  |
| --- |
| **Documentation Required for Category 2 Applicants - Non-Profit Health Centers****Documentation Required for Submission** All documentation listed must be returned for a complete Application. Provide the documentation in the same sequence as outlined below by using the Item number(s) and title(s) as necessary.  |
| 1. **Exhibit A – HHS Solicitation Affirmations Version 2.4**

Must be completed and signed **Important Note: Applications received without the signed Exhibit A will be disqualified.**  |
| 1. **Exhibit B –** **HHS Uniform Terms and Conditions – Vendor, Version 3.4**

For reference only |
| 1. **Exhibit B-1 - HHS Uniform Terms and Conditions – Governmental Entity, Version 3.3**

For reference only |
| 1. **Exhibit C – Federal Assurances, Non-Construction**

Must be completed and signed if not doing construction or renovations |
| 1. **Exhibit D – Federal Assurances, Construction**

Must be completed and signed if doing construction or renovations |
| 1. **Exhibit E – Certification Regarding Lobbying** Must be completed and signed
 |
| 1. **Exhibit F – Fiscal Federal Funding Accountability and Transparency Act (FFATA) Certification**

Must be completed and signed |
| 1. **Form A - Face Page**

Must be completed and signed |
| 1. **Form B - Open Enrollment (OE) Application Checklist**

Must be included |
| 1. **Form C - Contact Person Information Form**

Must be completed |
| 1. **Form D - Vendor Information Form**

Must be completed and signed |
| 1. **Form E - Organizational Category Form**

Must be completed by selecting applicable category and providing all requested information. |
| 1. **Form F - FQHC Look-alike Application Attestation**

Must be completed and signed |
| 1. **Form G - Attestation of Primary Care Clinical Hours**

Must be completed and signed |
| 1. **Form H - Landlord Consent for Construction on Leased Spaces**

Must be completed as applicable for planned construction projects in leased spaces.  |
| 1. **Form I - FQHC New Access Business Plan Template**

Must be completed as applicable |
| 1. **Form J - Workplan Template: FQHC Incubator Program - New Health Center Location**

Must be completed as applicable |
| 1. **Form K - FQHC Budget Template**

Must be completed and signed |
| 1. **Notice of Criminal Activity – Reference Section 8.6**

Provide confirmation that the Applicant, any person with ownership or controlling interest in the Applicant, its agent, employee, subcontractor, or volunteer who will be providing the required services:a. have not engaged in any activity that does or could constitute a criminal offense equal to or greater than a Class A misdemeanor or grounds for disciplinary action by a state or federal regulatory authority; andb. have not been placed on community supervision, received deferred adjudication, or been indicted for or convicted of a criminal offense relating to involvement in any financial matter, federal or state program, or sex crime. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_1. **Notice of Insolvency or Indebtedness – Reference Section 8.7**

Provide with the Application detailed written descriptions of any insolvency, incapacity, and outstanding unpaid obligations of Applicant owed to the Internal Revenue Service (IRS) or the State of Texas, or any agency or political subdivision of the State of Texas. |
| 1. **Public Information Act Copy of Application, if applicable - Reference Section 11.1**
 |
| **The following appendices are not required to be submitted as part of the Application and are included for informational purposes only. Appendices will be used when submitting monthly reports and final reports as well as documenting deliverables in return for payment.** |
| 1. **Appendix A - Enrichment Activities**
 |
| 1. **Appendix B - Staffing List**
 |
| 1. **Appendix C - Capital Improvement Activities**
 |
| 1. **Appendix D - Progress Statement**
 |
| 1. **Appendix E - Budget Sheet**

Must be completed as applicable |
| 1. **Appendix F - Final Impact Report**
 |

FORM C: Contact Person Information Form

Department of State Health Services

Open Enrollment Application OE No. HHS0014148

|  |  |
| --- | --- |
| Legal Business Name: |       |

This form provides information about the appropriate contacts in the Applicant’s organization in addition to those on the FACE PAGE. If any of the following information changes during the term of the Contract, please send written notification to the Contract Manager at FQHCIncubator.Contracts@dshs.texas.gov**.**

|  |
| --- |
|  |
| **Contact:** |       |  | **Mailing Address (incl. street, city, county, state, & zip):** |
| **Title:** |       |  |       |  |
| **Phone:** |       | Ext. |  |       |  |
| **Fax:** |       |  |       |  |
| **E-mail:** |       |  |       |  |
|  |
|  |
| **Contact:** |       |  | **Mailing Address (incl. street, city, county, state, & zip):** |
| **Title:** |       |  |       |  |
| **Phone:** |       | Ext. |  |       |  |
| **Fax:** |       |  |       |  |
| **E-mail:** |       |  |       |  |
|  |
|  |
| **Contact:** |       |  | **Mailing Address (incl. street, city, county, state, & zip):** |
| **Title:** |       |  |       |  |
| **Phone:** |       | Ext. |  |       |  |
| **Fax:** |       |  |       |  |
| **E-mail:** |       |  |       |  |
|  |
|  |
| **Contact:** |       |  | **Mailing Address (incl. street, city, county, state, & zip):** |
| **Title:** |       |  |       |  |
| **Phone:** |       | Ext. |  |       |  |
| **Fax:** |       |  |       |  |
| **E-mail:** |       |  |       |  |
|  |
|  |
| **Contact**: |       |  | **Mailing Address (incl. street, city, county, state, & zip):** |
| **Title:** |       |  |       |  |
| **Phone:** |       | Ext. |  |       |  |
| **Fax:** |       |  |       |  |
| **E-mail:** |       |  |       |  |
|  |
|  |

Form D: Vendor Information Form

Department of State Health Services

Open Enrollment Application OE No. HHS0014148

|  |
| --- |
| VENDOR INFORMATION  |
| 1a. **Legal name** **of Other Party (OP)** as it appears on documentation from IRS, Comptroller, or Secretary of State. This is the name that will appear on the contract document either as “Contractor” or by name. If using an assumed name, please attach documentation from Office of the Secretary of State or County Attorney.      |
| 1b**. OP Address** (Include Street and Mailing Addresses, City, County, State and 9-digit Zip Code):      |
| 1c. **PAYEE Name and Mailing Address and 9-digit Zip Code** (as it should appear on financial instruments and remittances):      |
| 1d. **Federal Employer Identification No.** [FEIN] (9 digit), name and Social Security Number (SSN), if individual, or State of Texas Comptroller Vendor Identification No. (14 digit).      **NOTE: Use of SSN may result in it becoming part of documents that are subject to the Public Information Act. DSHS will not redact SSN when releasing information to the public.** |
| 1e**. Mail code**, if known (3 digits):       |
| 1f. **DUNS Number** (9 digits - required for subrecipient contractors):      For instructions to obtain a DUNS refer to FFATA Guidance at <http://www.dshs.state.tx.us/grants/gen-prov.shtm> |
| 2. **TYPE OF ENTITY** (enter appropriate letter in box):     Is your entity certified as a HUB?    Yes    No A. City or County (Governmental Entity) E. Texas Non-profit Corporation\* I. Sole Proprietor M. Out-of-State Corp B. State Agency F. Texas For Profit Corporation\* J. Individual N. Other \*\*\* C. State Institution of Higher Learning G. Professional Association\* K. Partnership\*\* D. Other Political Subdivision H. Regular Association L. Limited Partnership\*\*\*Please provide 10-digit charter or file number assigned by the Secretary of State:      \*\* Please provide the name and SSN or FEIN of each partner:      \*\*\*If “Other”, specify:       |
| 3a. **Legal name of person or entity** authorized to contract with Department of State Health Services.      |
| 3b. Typed **Name & Title of Person** *Authorized to Sign Contracts*:      | 3b. Telephone      |
| 3c. Typed **Name & Title** of Contact Person (Contract Documents and Correspondence)      | 3c. Telephone      |
| 3d. **Contact Person’s E-mail Address**       |
| 4a. **Signature of person** *Authorized to Sign Contracts* :      | 4b. Date      |

Form E: Organizational Category Form

Department of State Health Services

Open Enrollment Application OE No. HHS0014148

|  |  |
| --- | --- |
| Legal Business Name: |        |

**Instructions: First, select if you are a Category 1 Applicant or a Category 2 Applicant.**

[ ]  **(1.)** Existing FQHC or FQHC Look-alike.

**OR**

**[ ]  (2.)** Other Eligible Organizations: A non-profit organization or governmental entity that is not a FQHC or FQHC Look-alike but meets the below requirements is eligible to apply for a Contract.

**For Category 1 Applicants, please submit the following required documents along with Form E: Organizational Category Form:**

Applicant must provide as part of its Application the following information:

* 1. Copy of your most recent HRSA Notice of Award (NoA) or copy of your HRSA FQHC Look-alike designation letter.
	2. If any conditions exist on the NoA or the Look-alike designation letter, include documentation that indicates work has been completed or is on-going to remove the conditions.
	3. A map of the proposed service area for your proposed new site utilizing the HRSA Uniform Data System (UDS) mapper tool: <https://data.hrsa.gov/tools/data-reporting>.
	4. A business plan that includes a market analysis and financial sustainability plan for the proposed new clinical site.
		+ Applicants with an existing business plan that meets all the criteria outlined in **Form I: FQHC New Access Business Plan Template** can submit their existing business plan with their Application to meet this requirement. They must ensure that their business plan is comprehensive, detailing a market analysis, and a financial sustainability plan for the proposed new clinical site.
		+ Applicants who do not have an existing business plan must develop a business plan that includes a market analysis and financial sustainability plan for the proposed new clinical site. Applicant must submit **Form I: FQHC New Access Business Plan Template** to meet this requirement.

**For Category 2 Applicants, please submit the following required documents along with Form E: Organizational Category Form:**

Applicant must provide as part of its Application the following information:

1. The physical address of the location where health care services are provided.
2. Written proof of its status as a domestic private non-profit entity or a governmental entity located within the State of Texas.
3. An attestation that your site will apply within the Contract term for FQHC Look-alike Status or other available Health Resources and Services Administration (HRSA) health center funding (such as New Access Point funding)using **Form F: FQHC Look-alike Application Attestation Form.**
4. Confirmation that the Applicant is currently open and able to provide Primary Care Services to people in a MUA or for a MUP for at least one full day (at a minimum of 8 hours) per week. Applicant must sign and submit **Form G: Attestation of Primary Care Clinical Hours**, to confirm that the Applicant meets this requirement.
5. Copies of Bylaws, Mission Statement, and Board of Directors Membership Roster, and a current Organizational Chart (as applicable).
6. A map of the proposed service area for their health center utilizing the HRSA Uniform Data System (UDS) mapper tool: <https://data.hrsa.gov/tools/data-reporting>.
7. If the specified MUA or MUP in the Applicant’s service area is currently being served by another FQHC or FQHC Look-alike, or is located within five (5) miles from another FQHC or FQHC Look-alike (which can be determined utilizing the HRSA Uniform Data System (UDS) mapper tool: <https://data.hrsa.gov/tools/data-reporting>), then Applicant must submit either:
	* A letter of support from each FQHC or FQHC Look-alike that is located in the same service area or within five (5) miles of the proposed clinical site for the Application; **OR**
	* A letter of explanation as to the unmet needs in the community your health center serves, why your health center will uniquely be able to meet the unmet needs in the community, explanation of why the letter/s of support were not able to be obtained, and the plan for collaboration with the FQHC or FQHC Look-alikes that are located in the same service area or within five (5) miles of the proposed clinical site for the Application.
8. A business plan that includes a market analysis and financial sustainability plan for the proposed new clinical site.
	1. Applicants with an existing business plan that meets all the criteria outlined in **Form I: FQHC New Access Business Plan Template** can submit their existing business plan with their application to meet this requirement. They must ensure that their business plan is comprehensive, detailing a market analysis, and a financial sustainability plan for the proposed new clinical site.
	2. Applicants who do not have an existing business plan must develop a business plan that includes a market analysis and financial sustainability plan for the proposed new clinical site. Applicant must submit **Form I: FQHC New Access Business Plan Template** to meet this requirement.
9. Two (2) Letters of Support from Community Partners that you have engaged previously who are in support of your application to become a FQHC Look-alike. Letters of support must include information on the relationship between your organizations including the length of time you have been working together and a brief summary of ongoing and future collaborations.

**Form F: FQHC Look-alike Application Attestation**

Department of State Health Services

Open Enrollment Application OE No. HHS0014148

Organization Name:

Organization Address:

Contact Person:

Contact Email:

Contact Phone Number:

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, the undersigned, being the [Title] of [Organization Name], hereby attest to the following:

Acknowledgment: I understand that Federally Qualified Health Center (FQHC) Look-alike Status is a designation provided by the U.S. Department of Health & Human Services (HHS) that allows qualified centers to receive certain federal benefits.

Commitment and Timelines: I affirm that [Organization Name] is committed to applying for FQHC Look-alike Status or other available Health Resources and Services Administration (HRSA) health center funding (such as New Access Point funding) and confirm that we will initiate and complete the application process within the Contract term specified in our agreement with [Contracting Entity].

Requirements: I acknowledge that [Organization Name] is responsible for meeting all requirements, both organizational and clinical, as specified by the U.S. Department of Health & Human Services for obtaining FQHC Look-alike Status.

Documentation: I confirm that [Organization Name] will maintain all necessary documentation to demonstrate compliance with relevant federal regulations and guidelines.

Authenticity: I affirm that all information provided is true to the best of my knowledge and belief.

Authorized Representative Signature

|  |  |  |  |
| --- | --- | --- | --- |
| Printed Name:  |  | Signature: |  |

**Form G: Attestation of Primary Care Clinical Hours**

Department of State Health Services

Open Enrollment Application OE No. HHS0014148

This form is to confirm that this Applicant is open and able to provide Primary Care Services in a Medically Underserved Area (MUA) or to a Medically Underserved Population (MUP) for a least one full day per week. For the purposes of this form, Primary Care Services are defined by the primary health services listed in Section 330(b)(1) of the Public Health Service Act, per the Health Center Program Compliance Manual published by HRSA. Health centers must be providing “Countable visits” per the HRSA definition to meet this requirement. Please see Section 3 of the Open Enrollment document “Definitions and Acronyms Section” for more information.

I attest that our non-profit health care organization is currently open and able to provide at a minimum one full day per week of Primary Care Services at the following location (please list address):

Health Care Providers Signature (only one signature is required, but if there are multiple providers that together provide the one full day per week, please have each provider sign with the number of hours they individually provide).

|  |  |  |  |
| --- | --- | --- | --- |
| Printed Name:  |  | Signature: |  |
| Applicable Texas License #  |   | # of Primary care hours per week:  |   |
|    |   |   |   |
| Printed Name:   |   | Signature:  |   |
| Applicable Texas License #  |   | # of Primary care hours per week:  |   |
|    |   |   |   |
| Printed Name:   |   | Signature:  |   |
| Applicable Texas License #  |   | # of Primary care hours per week:  |   |

Authorized Representative Signature

|  |  |  |  |
| --- | --- | --- | --- |
| Printed Name:  |  | Signature: |  |

**Form H: Landlord Consent for Construction on Leased Spaces**

Department of State Health Services

Open Enrollment Application OE No. HHS0014148

      is/are the owner(s) of the property located at      . The property is currently leased by      .       currently has/will have a lease agreement with      , for the period of       years that will expire on      .

      is/are in full agreement of the proposed improvements to the aforementioned leased property as part of the Texas Department of Health Services (DSHS)       funding opportunity, and grant permission to       to undertake proposed improvements.

      agrees to either modify the existing lease, or include in the new lease, the following restrictive terms, which will be signed by both       and      :

1. The recipient agrees not to sublease, assign, or otherwise transfer the property, or use the property for a non- FQHC Incubator Funding -related purpose(s) without the written approval from DSHS (at any time during the term of the lease/agreement, whether or not FQHC Incubator Funding support has ended).
2. The property owner will inform DSHS of any default by the recipient under the lease/agreement.
3. DSHS shall have 60 days from the date of receipt of the property owner’s notice of default in which to attempt to eliminate the default, and that the property owner will delay exercising remedies until the end of the 60-day period.
4. DSHS may intervene to ensure that the default is eliminated by the recipient or another recipient named by DSHS.
5. The property owner shall accept payment of money or performance of any other obligation by the DSHS’ designee, for the recipient, as if such payment of money or performance had been made by the recipient.
6. In the event that the recipient defaults, the Contract is terminated, or the recipient vacates the property before the end of the lease term, DSHS shall have the right to designate a replacement for the recipient for the balance of the lease term, subject to approval by the property owner, which will not be withheld except for good reason.

      also acknowledge that there will be a Federal interest in the property as a result of the proposed improvements and that       agrees to file a Notice of Federal Interest prior to work commencing, if required by DSHS.

|  |  |
| --- | --- |
| Landlord/Corporation Signature:  |  |
|  |  |  |
| Typed Name:  |  |
|  |  |  |
| Title:  |  |
|  |  |  |
| Date:  |  |

**Form I: FQHC New Access Point Business Plan Template**

Department of State Health Services

Open Enrollment Application OE No. HHS0014148

1. **Executive Summary***: A snapshot of your Health Center as a whole. It provides a reader with a quick overview of the Health Center's most essential aspects, its mission, and its objectives. Ideally, this should be concise enough to be read in a couple of minutes but thorough enough to provide a clear picture of the Health Center.*
	1. Write your Health Center name and location.
	2. Please provide the mission and vision for the requested project, specifically focusing on core purpose of the project.
	3. Define your objectives: Outline clear, quantifiable goals. Articulate a compelling depiction of the project’s aspirational goals and the envisaged impact it aims to impart in the context of the Health Center.
2. **Company Description***: An in-depth look at the Health Center’s foundation and structure. It describes what the Health Center does, its history, vision and mission, the markets it serves, and the unique advantages it offers in providing health care to the population served.*
3. Describe your Health Center's history: When it started, the inspiration behind it, milestones achieved.
4. Identify the problem your Health Center solves.
5. Elaborate on your target market: Who are your primary patients?
6. Describe the services that you offer to patients at your site/s.
7. List the partners, or alliances that support your Health Center.
8. **Market Analysis**: *A comprehensive review of the market the Health Center is situated in. This section evaluates the current market conditions, segments, trends, growth potential, and identifies the company's main competitors. It demonstrates knowledge of the market and backs up any strategies the Health Center plans to adopt*.
	1. Research your market: Size, growth rate, trends.
	2. Segment your target market: Demographics, health care utilization trends, describe the previously unmet health care need.
	3. Profile your competitors: Identify their strengths, weaknesses, market share, and strategies.
	4. Determine barriers to entry: Evaluate what might prevent your center from entering the MUA/MUP.
9. **Strategy and Implementation:** *An outline of how the company plans to achieve its objectives. This section discusses marketing and sales strategies, including promotional efforts and a detailed operational plan.*
	1. Describe your patient outreach strategy: How will you attract and retain patients?
	2. List major milestones: Highlight significant future events like service expansions.
	3. Outline your day-to-day operational plan: such as staffing, scheduling, supplier agreements, or any important aspects of your operations.
10. **Organizational Structure**: *A description and visualization (often using an org chart) of the company's structure. This covers key team members, their roles, and how they interact. It might also provide biographies of key team members to showcase their relevant experience and skills.*
11. Include an organizational chart.
12. Detail key team members: Include brief bios highlighting their relevant experience and roles.
13. Define hiring needs: Identify gaps in your team and the roles you need to fill.
14. **Financial Plan**: *A projection of the company's financial future. This section includes startup or capital requirements (if applicable), projected profit and loss statements, cash flow forecasts, balance sheets, and break-even analyses. These figures provide a sense of the Health Center's viability and financial stability.*
15. List startup/capital requirements: If you're just starting, how much will you need and for what?
16. Project profit and loss: Forecast your revenue, costs, and projected profits for the next 1-5 years.
17. Prepare a cash flow statement: Forecast your monthly cash inflow and outflows.
18. Develop a balance sheet: This captures your company's financial position at a particular moment in time.
19. Conduct a break-even analysis: Determine when your Health Center will start to make a profit.
20. **SWOT Analysis**: An *evaluation of the Health Center's Strengths, Weaknesses, Opportunities, and Threats. This section is a strategic tool that can help the Health Center understand its position in the market and potential areas of growth or concern.*
21. List your Strengths: Core competencies, competitive advantages.
22. Identify Weaknesses: Areas of improvement, vulnerabilities.
23. Pinpoint Opportunities: Unexplored markets, potential partnerships.
24. Recognize Threats: Changing market trends, competitive pressures, operational risks.
25. **Risk and Strategy**: *An exploration of potential challenges the Health Center may face and strategies to mitigate them. This section shows preparedness and strategic thinking, offering solutions and contingencies for foreseeable problems.*
26. Enumerate potential risks: Every venture has risks—identify them.
27. Propose mitigation strategies: For each risk, how do you plan to handle or avoid it?

**Form J: Workplan Template: Federally Qualified Health Center Incubator Program**

**New Health Center Location**

Department of State Health Services

Open Enrollment Application OE No. HHS0014148

**Organization Name:**

**Date of Application:**

**Application Category:** Choose 1 or 2.

**INSTRUCTIONS**: Please use this workplan template to describe in detail how you plan to use the FQHC Incubator Funds New Health Center Location funding to propose a new clinical site for your FQHC or FQHC look-alike or, if you are an organization that is not currently an FQHC or FQHC Look-alike, how you will use the funding to strengthen your Application to become a new FQHC Look-alike (FQHC LAL). Please answer each question completely using the form below.

1. **Health Center Address:**
2. **MUA/MUP Served:**
3. **Please provide a brief description of the proposed Service Area for your health center (no more than 300 words). Please include the counties which will be impacted by your proposed location**:

1. **Funding Types**

**Instructions:**  Please indicate in the space provided the amount you are requesting for each Funding Opportunity. The total of the three categories should equal $1 Million dollars. If you do not wish to receive funding for that Funding Opportunity, please include N/A in the appropriate field.

1. **Technical Assistance & Development Enrichment Amount**: $

Provide a summary of you will utilize the funding in this category. Examples of potential activities that funding can be used for including (but are not limited to) conferences, trainings, workshops, professional organization memberships, consultant costs, professional legal consultation, recruitment fees, or other costs related to assistance in management or operations of the site. Costs related to onboarding new staff members that are not equipment, such as EMR licenses, should be included in this category. Describe how these activities will assist in opening a new clinical site or enhance your future FQHC or FQHC LAL Application. As a reminder, **Signing Bonuses are not an allowable cost.** (Insert additional rows as needed).

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Activity**  | **Description**  | **Date**  | **Staff Member(s) & Role(s)**  | **Estimated Cost**  |
| *(e.g., Conference attendance)*  | *(Describe activity)*  | *(Est. date)*  | *(Name & Role)*  |   |
| *(e.g., Workshop)*  | *(Describe activity)*  | *(Est. date)*  | *(Name & Role)*  |   |
|   |   |   |   |   |
|   |   |   |   |   |
|   |   |   |   |   |
|   |   |   |   |   |
|   |   |   | *\*Grand Total*  |   |

***\* This amount should match line A, Technical & Development Enrichment Amount***

***Please ensure this table matches your Form K: Budget Template.***

1. **Staffing Funding Amount**: $

Provide a list of the proposed staff that you will hire using FQHC Incubator Program Funding. As a reminder, FQHC Incubator funding cannot be used to pay existing staff, unless those employees are being promoted into a new position with different job duties or if they are moving from part-time to full-time work (for example, an employee currently working for 20 hours per week and increasing to 40 hours per week). Relocation expenses, sign-on bonuses, and incentives are not an allowable cost. (Insert additional rows as needed).

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Position**  | **Estimated Start Date**  | **New or Expanded**  | **Annual Salary/Fringe**  | **Percent of Annual Salary/Benefits Supported by FQHC Funds**  |
|   |   |   |   |   |
|   |   |   |   |   |
|   |   |   |   |   |
|   |   |   |   |   |
|   |   |   | *\*Grand Total*  |   |

***\* This amount should match line B, Staffing Funding Amount***

***Please ensure this table matches your Form K: Budget Template.***

1. **Capital Funding Amount:**
2. **Subcategory Totals**:
3. **Equipment Purchase $**
4. **Construction Related Costs $**
5. **Construction $**

Provide a summary of you will utilize the funding in this category. If construction is planned, please provide describe the scope of work and the site of work (leased space versus owned). In, addition, if you intend to use leased space for construction, it is imperative that you submit Form H: Landlord Letter of Consent. If this funding will be used for equipment or other purchases, please describe the purchases required.

Examples of potential activities that are eligible for funding include (but are not limited to) construction costs (including labor and materials), construction related costs (such as architect fees, engineering fees, permits), and equipment (for example, medical equipment, furnishings, IT equipment). *Costs related to onboarding new staff members that are not equipment, such as EMR licenses, should be included in the Technical Assistance/Development category.*

**\*\*Please note, if your project has been awarded funding (or is awarded funding during the Contract term) that requires Davis-Bacon time reporting for labor costs, labor will NOT be a reimbursable cost under this OE.** Other construction related costs will still be reimbursable using FQHC Incubator funding.

***Please ensure this description below matches your Form K: FQHC Budget Template.***

**Description:**

1. **Sustainability Plan**

Provide a plan outlining the strategies and measures your center intends to implement to maintain financial viability and continue offering services to your target population once FQHC Incubator Funding is exhausted. If you plan to hire staff using FQHC Incubator funding, please ensure you describe clearly how staff salaries will be maintained after the contract is completed.

1. **Additional Sources of Funding**

Please list any additional sources of funding you will plan to use to open the proposed new clinical site (Category 1 Applicants) or support the application to for your site to become an FQHC Look-alike (Category 2 Applicants). **\*\*Please note, if your project includes construction and has been awarded funding (or is awarded funding during the Contract term) that requires Davis-Bacon time reporting for labor costs, labor will NOT be a reimbursable cost under this Open Enrollment.**