

**FEDERALLY QUALIFIED HEALTH CENTER (FQHC) UNCOMPENSATED CARE FUND APPLICATION**

**STATE FISCAL YEAR 2018**

**OKLAHOMA STATE DEPARTMENT OF HEALTH UNCOMPENSATED CARE FUNDING**

**IS SUBJECT TO AVAILABILITY**

**POINT OF CONTACT: JAMES ROSE**

**OFFICE OF PRIMARY CARE AND RURAL HEALTH DEVELOPMENT**

**CENTER FOR HEALTH INNOVATION AND EFFECTIVENESS**

**OKLAHOMA STATE DEPARTMENT OF HEALTH**

**1000 NE 10TH STREET, ROOM 915**

**OKLAHOMA CITY, OKLAHOMA 73117-1299**

**OKLAHOMA STATE DEPARTMENT OF HEALTH UNCOMPENSATED CARE FUND**

**ASSISTANCE TO FEDERALLY QUALIFIED HEALTH CENTERS (FQHC) APPLICATION**

**SUBMISSION GUIDELINES**

**COMPLETED APPLICATIONS MUST BE RECEIVED BY 5:00 PM CST, THURSDAY, AUGUST 31, 2017.**

**Applications must be submitted via email at** **FQHC@health.ok.gov****.**

**If the application is incomplete or non-responsive to submission requirements, it will not be entered into the recipient pool for uncompensated care costs assistance in SFY 2018.**

The applicant will be notified the application did not meet submission requirements.

Timely and complete submissions are the responsibility of the applicant(s).

 **ALL LATE APPLICATIONS WILL BE CONSIDERED NON-RESPONSIVE TO SUBMISSION REQUIREMENTS.**

**FQHC Administrative Contact**

Contract Monitor

James Rose

Statistical Research Specialist III

Office of Primary Care and Rural Health Development

Center for Health Innovation and Effectiveness

Oklahoma State Department of Health

1000 NE 10th Street. Room 915 I Oklahoma City, OK 73117

Phone: 405.271.9444 ext. 52541

JamesR@health.ok.gov

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| **OKLAHOMA STATE DEPARTMENT OF HEALTH** **APPLICATION CHECKLIST****Submit all documents on the checklist, and return this completed form with the application.** Mailing Address MAY NOT be a post office box. |
| **Applicant Organization:** |
| **Contact Name:** |
| **Address:** |
| **City:** | **State:** | **Zip Code:** |
| **Phone:** | **Email:** |
| The following documents must be submitted with your application. A copy of this completed application checklist will be returned to you to confirm that your application for assistance through the Oklahoma Uncompensated Care Fund has been received by the OSDH.Completed Application (Forms A – G) with signed Application ChecklistSigned Contract between OSDH and Applicant (includes Business Associate Agreement and Non-Collusion Certification) Current federal HRSA Notice of Grant Award, including HRSA-approved budget Uniform Data System Report for period of January 1, 2016 through December 31, 2016, to include Patient Data by Zip Code 330 Health Center Cluster Grant application submitted to HRSA (most recent)IRS 990 for 2016 Tax Year (or most recent)Independent Audit (most recent, as required by and submitted to HRSA)Current board-adopted sliding fee schedule for uninsured patients Current Billing and Collections policies and procedures, if available Governing Board Composition (use Form F template)Certificate of Liability Insurance / Workers’ Compensation Coverage / FTCA Coverage (Deeming Letter)  **The undersigned, authorized agent for the above-named Applicant, by signing below attests that all documents requested**  **above have been submitted per the application guidelines.****Authorized Agent Name**   **Authorized Agent Signature Date**  |
|  **FOR INTERNAL USE ONLY:** **Administrative Review Completed Application Complete** **Application Incomplete or Non-Responsive**   **James Rose, Contract Monitor Date**  **Adrienne Rollins, Interim Director Date** |

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Oklahoma State Department of Health

FORM A

 **State Fiscal Year 2018 Uncompensated Care Fund Application**

This form requests basic information about the applicant. The Form A page is the cover page of the application and must be completed in its entirety. If any of the following information changes during the term of the contract, applicant MUST send written notification to the assigned Contract Monitor at the OSDH email address FQHC@health.ok.gov.

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| **FEDERALLY QUALIFIED HEALTH CENTER INFORMATION** |
| **LEGAL NAME OF FQHC:**       |
| **MAILING ADDRESS INFORMATION** (include mailing address, street, city, state, and zip code):      |
| **CONTRACTOR NAME AND MAILING ADDRESS** (if different from above): |
| **PROPOSED BUDGET PERIOD: Start date 07/01/2017 End Date 06/30/2018** |
| **DESCRIPTION OF FQHC SERVICE AREA BY COUNTY:**       |
| **TOTAL NUMBER OF UNINSURED PATIENTS SERVED IN SFY 2017:**      Percent of primary care patients that utilized the sliding fee schedule:      Percent of mental/behavioral health patients that utilized the sliding fee schedule:      Percent of dental patients that utilized the sliding fee schedule:       |
| **PROJECTED NUMBER OF UNINSURED PATIENTS IN SFY 2017:**       |

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|  |
| **Executive Director:** |       |  | **Mailing Address (incl. street, city, state, & zip code):** |
| **Title/Credentials:** |       |  |       |  |
| **Phone:** |       | Ext.  |  |       |  |
| **Email:** |       |  |       |  |
|  |
|  |
| **Primary FQHC Contact:** |       |  | **Mailing Address (incl. street, city, state, & zip code):** |
| **Title/Credentials:** |       |  |       |  |
| **Phone:** |       | Ext. |  |       |  |
| **Email:** |       |  |       |  |
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| **Medical Director:** |       |  | **Mailing Address (incl. street, city, state, & zip code):** |
| **Title/Credentials:** |       |  |       |  |
| **Phone:** |       | Ext. |  |       |  |
| **Email:** |       |  |       |  |
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FORM B: PROJECTED COSTS OF UNINSURED ENCOUNTERS

**Applicant/FQHC:**

**Instructions:***Using the information below,**calculate the total projected cost of providing primary, dental, and behavioral health services to uninsured patients, and complete the table below.*

Box A: The applicant must project a reasonable estimate of the combined total number of uninsured billable encounters the applicant will provide services to at all of their FQHC site(s) in SFY 2018.

Box B. Calculate the costs according to the current prospective payment system (PPS) rate assigned to the applicant by the Oklahoma Health Care Authority for billable encounters.

Box C. Enter the total number of uninsured billable encounters and multiply by the PPS rate per encounter to determine the total dollar amount. Enter in the table below.

**Total Number of** **Uninsured Encounters/ PPS Rate per Encounter/ Total Amount**

|  |  |  |
| --- | --- | --- |
| **A.** **Total #** **Uninsured, Billable Encounters** | **B.** **PPS Rate Per** **Billable Encounter** | **C.** **# Encounters X PPS Rate****=****Total Amount** |
|       | $      | $      |

**NOTE:** *Legislatively appropriated uncompensated care funds are to be used solely for the reimbursement of uncompensated care costs associated with the delivery of primary health care to uninsured patients without creditable coverage.*

The term creditable coverage means coverage of an individual under any of the following:

(i) A group health plan as defined in § 146.145(a).

(ii) Health insurance coverage as defined in § 144.103 of this chapter.

(iii) Part A or B of Title XVIII of the Social Security Act (Medicare).

(iv) Title XIX of the Social Security Act (Medicaid), other than coverage consisting solely of benefits under section 1928 of the Social Security Act (the program for distribution of pediatric vaccines).

(v) Title 10 U.S.C. Chapter 55 (medical and dental care for members and certain former members of the uniformed services, and for their dependents; for purposes of Title 10 U.S.C. Chapter 55, uniformed services means the armed forces and the Commissioned Corps of the National Oceanic and Atmospheric Administration and of the Public Health Service).

(vi) A medical care program of the Indian Health Service or of a tribal organization.

(vii) A State health benefits risk pool.

(viii) A health plan offered under Title 5 U.S.C. Chapter 89 (the Federal Employees Health Benefits Program).

(ix) A public health plan.

(x) A health benefit plan under section 5(e) of the Peace Corps Act (22 U.S.C. 2504(e)).

(xi) Title XXI of the Social Security Act (State Children's Health Insurance Program).

Creditable coverage does not include coverage of solely excepted benefits (described in CFR Title 45 § 146.145). The following benefits are excepted in all circumstances—

(i) Coverage only for accident (including accidental death and dismemberment);

(ii) Disability income coverage;

(iii) Liability insurance, including general liability insurance and automobile liability insurance;

(iv) Coverage issued as a supplement to liability insurance;

(v) Workers' compensation or similar coverage;

(vi) Automobile medical payment insurance;

(vii) Credit-only insurance (for example, mortgage insurance); and

(viii) Coverage for on-site medical clinics.

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FORM C: FQHC SECONDARY SITE

***Instructions: Complete a separate form for each clinic site, numbered consecutively (see FQHC Secondary Site Form Instructions).***

|  |
| --- |
| **Legal Name of Applicant/FQHC:       Site #    of**  |

|  |
| --- |
| **FQHC Site Name to Appear on OSDH Website:** |
| **Service Area (counties to be served by this site):** |
| **FQHC Site Contact Person:**  |
| **Number of Patients Served at this Site in SFY 2017:**  |
| **Location of Site:       Street Address:**  |
| **City:       County:       Zip Code:**  |
| **Phone: (   )   -     Fax: (   )   -** |
| **Is this Site a Subcontractor Site? [ ]  Yes [ ]  No** |
| **Email:**      **Website:**         |

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FORM D: FQHC SECONDARY SITE

***Instructions: Complete a separate form for each clinic site, numbered consecutively (see FQHC Secondary Site Form Instructions).***

|  |  |  |  |
| --- | --- | --- | --- |
| **DAY** | **HOURS OF OPERATION** | **SERVICES PROVIDED / CLINIC TYPE** | **# MONTHLY CLINICS** |
|  | **From** | **To** |  |  |
| **MONDAY** | **Morning** |   :   |   :   |       |      |
| **Afternoon** |   :   |   :   |       |  |
| **Evening (After 5 PM)** |   :   |   :   |       |  |
| **TUESDAY** | **Morning** |   :   |   :   |       |      |
| **Afternoon** |   :   |   :   |       |  |
| **Evening (After 5 PM)** |   :   |   :   |       |  |
| **WEDNESDAY** | **Morning** |   :   |   :   |       |      |
| **Afternoon** |   :   |   :   |       |  |
| **Evening (After 5 PM)** |   :   |   :   |       |  |
| **THURSDAY** | **Morning** |   :   |   :   |       |      |
| **Afternoon** |   :   |   :   |       |  |
| **Evening (After 5 PM)** |   :   |   :   |       |  |
| **FRIDAY** | **Morning** |   :   |   :   |       |      |
| **Afternoon** |   :   |   :   |       |  |
| **Evening (After 5 PM)** |   :   |   :   |       |  |
| **SATURDAY** | **Morning** |   :   |   :   |       |      |
| **Afternoon** |   :   |   :   |       |  |
| **Evening (After 5 PM)** |   :   |   :   |       |  |
| **SUNDAY** | **Morning** |   :   |   :   |       |      |
| **Afternoon** |   :   |   :   |       |  |
| **Evening (After 5 PM)** |   :   |   :   |       |  |
| **TOTAL HOURS/MONTH** |      | **TOTAL # CLINICS PER MONTH** |     Page 6 of 10 |

FQHC SECONDARY SITE FORM INSTRUCTIONS

**Instructions: Complete a separate FQHC site form for each existing or proposed site for which SFY 2018 Uncompensated Care Funds are requested and number sites consecutively. Information provided on site forms will be used to update OSDH websites and public databases; therefore, each site form must contain current and accurate information.**

|  |  |
| --- | --- |
| Legal Name of Applicant | Applicant’s legal name. |
| FQHC Site # \_\_\_ of \_\_\_ | Example: FQHC Site #1 of 5 for the first site out of five sites, FQHC Site #2 of 5 for the second site of five, etc. |
| FQHC Site Name to Appear on OSDH Website  | Name of the site as it will appear on the OSDH website. (The name should be recognizable to clients.) |
| Service Area | List counties served by that specific clinic site. |
| FQHC Site Contact Person | Name of contact person for that site. |
| Phone | Phone number for the site. |
| Number of Patients Served at this Site in SFY 2017 | List the approximate number of patients that received primary care services at this satellite site in SFY 2017.  |
| Location of Site | FQHC location (e.g., Medical Center/Medical Plaza/etc.) |
| Street Address/ City/Zip  | Physical address of site. Do not enter a P.O. Box. |
| Subcontractor Site | For each site, indicate whether that particular site is subcontracted by the applicant to another entity for the provision of services.  |
| Hours of Operation | List the operating hours of each site for each day of the week broken into morning (ex., 8:00 a.m. – Noon), afternoon (ex. 12:01 p.m. – 5:00 p.m.), and evening hours (ex., 5:01 p.m. – 8:00 p.m.). Indicate days of the week when the clinic is closed (ex. Tuesday – closed). |
| Services Provided/Clinic Type | List the type of services provided or type of clinic for each day of the week (ex. Monday = child health clinic, Wednesday = dental clinic, etc.) |
| # Monthly Clinics | List the total number of clinics each month by the day of the week (ex. Monday = 4 clinics per month; Tuesday = 0 clinics per month, etc.) |
| Total Hours/Month | List the total number of hours of operation per month for each clinic site (ex. Clinic Site 1 = 128 hours per month; Clinic Site 2 = 160 hours per month, etc.) |
| Total # Clinics Per Month | List the total number of clinics held per month per clinic site (ex., Clinic Site 1 = 16, Clinic Site 2 = 20, etc.) |

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| FORM E: FQHC FUNDING SOURCES |  |   |   |   |   |  |  |
| Mark an X in the applicable column(s) for each SFY 2018 funding source, and provide the award amount.  |   |   |  |  |  |  |  |
|  |  | Source | Application Pending | Currently Receive | Do Not Receive | Total Amount Awarded | Coverage Period |
|  |  | BPHC Grant - Community Health Center |   |   |   |   |  |
|  |  | BPHC Grant - Migrant Health Center |   |   |   |   |  |
|  |  | BPHC Grant - Health Care for the Homeless |   |   |   |   |  |
|  |  | ARRA Increased Demand for Services Grant |   |   |   |   |  |
|  |  Foundation/Private Grants\* |   |   |   |   |  |
|  |  Other |  |  |  |  |  |

\*Please indicate below the portion or percentage of total Foundation/Private Grants that is dedicated or contributed towards the delivery of primary care services to uninsured patients.

Please note below any other projected funding for the mitigation of uncompensated care costs.

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FORM F: **Quality Performance Measure Requirements Per OSDH Contract**

 **Mandatory Quality Performance Measure**

|  |  |
| --- | --- |
| **X** | The Contractor is **required** to initiate efforts to ensure that by the end of State Fiscal Year 2018, 75% of patients aged 18 years and older are screened for tobacco use one or more times within 24 months AND receive cessation counseling intervention if identified as a tobacco user. |

1. **Please mark an X in the box next to two of the seven measures that your FQHC will incorporate into their strategic plan.**

|  |  |
| --- | --- |
|  | By the end of Calendar Year 2018, develop a baseline for the percentage of women 21–64 years of age who were screened for cervical cancer (NQF 32/CMS124) using either of the following criteria: - Women age 21–64 who had cervical cytology performed every 3 years. - Women age 30–64 who had cervical cytology/human papillomavirus (HPV) co-testing performed every 5 years. |
|  | By the end of Calendar Year 2018, develop a baseline for the percentage of patients 50–75 years of age who had appropriate screening for colorectal cancer (NQF 34/CMS 130). |
|  | By the end of Calendar Year 2018, develop a baseline for the percentage of patients 18 to 85 years of age who had a diagnosis of hypertension and whose blood pressure (BP) was adequately controlled (<140/90) during the measurement year (NQF 18/CMS 165). |
|  | By the end of Calendar Year 2018, develop a baseline for the percentage of patients 18-75 years of age with diabetes (type 1 and type 2) whose most recent HbA1c level during the measurement year was greater than 9.0% (poor control) or was missing a result, or if an HbA1c test was not done during the measurement year (NQF 59/CMS 122). |
|  | By the end of Calendar Year 2018, develop a baseline for the percentage of patients aged 12 years and older screened for clinical depression using an age appropriate standardized tool AND follow-up plan documented (NQF 418/CMS 2). |
|  | By the end of Calendar Year 2018, develop a baseline for the percentage of patients 3-17 years of age who had an outpatient visit with a primary care physician (PCP) or an OB/GYN and who had evidence of the following during the measurement year: Body mass index (BMI) percentile documentation, counseling for nutrition, counseling for physical activity. Because BMI norms for youth vary with age and gender, this measure evaluates whether BMI percentile is assessed rather than an absolute BMI value (NQF 24/CMS 155). |
|  | By the end of Calendar Year 2018, percentage of patients aged 18 years and older with a documented BMI during the current encounter or during the previous six months AND when the BMI is outside of normal parameters, a follow-up plan is documented during the encounter or during the previous six months of the encounter. Normal Parameters: Age 65 years and older BMI > or = 23 and < 30 Age 18-64 years BMI > or = 18.5 and < 25 (NQF 421/CMS 69). |

1. **Please mark an X in the box next to one of the following two surveys the contractor must participate in:**

|  |  |
| --- | --- |
|  | American Association of Diabetes Educators (AADE)-accredited programs during the contract period. |
|  | American Diabetes Association (ADA)-recognized Diabetes Self-Management Education programs during the contract period. |

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 FORM G: **GOVERNING BOARD COMPOSITION**

|  |  |  |  |
| --- | --- | --- | --- |
|  **Name** |  **Board Office/Position** |  **Board Term Expiration** **MO/YY** | **Years of Continuous**  **Board Service** |
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