

CALIFORNIA HEALTH FACILITIES FINANCING AUTHORITY

John Chiang, Chairman
CA State Treasurer

Lifeline Grant Program Application Form

GRANT FUNDS
FOR CALIFORNIA'S
HEALTH FACILITIES

915 Capitol Mall, Suite 435
Sacramento, California 95814
Phone: (916) 653-2799
Fax: (916) 654-5362

General Instructions

Applications submitted via mail or in person:

Applicant must submit an original and two copies of the completed application. Completed applications can be submitted to the California Health Facilities Financing Authority (the "Authority") either by mail or in person to:

California Health Facilities Financing Authority
915 Capitol Mall, Suite 435
Sacramento, California 95814
Attn: Operations Manager

OR

Applications submitted via email:

Applicant must submit one ~~By email as a~~ Portable Document Format (PDF) attachment to chffa@treasurer.ca.gov.

Applications ~~must be received~~ will be due the first business day of each month, with the following exceptions:

- For October, Applications are due on October 7.
- Applications are not accepted in November, no later than 5:00 p.m. (Pacific Time)
~~on the deadline posted by the Authority on its website.~~

Applications shall be reviewed and evaluated within 60 days from receipt by Authority Staff according to the evaluation criteria described in Section 7219 of Title 4 of the California Code of Regulations.

Each eligible Health Facility applying for Grant funds shall submit a separate Application.

The Health Facility must provide documentation with this Application that substantiates the Federal Trigger as defined in Section 7213, subdivision (j) of Title 4 of the California Code of Regulations and indicates that the Federal Trigger has occurred prior to the submission of the Application for Grant funds. The Federal Trigger cannot be earlier than July 10, 2017.

The Health Facility must also provide documentation showing the effect of the Federal Trigger on the Health Facility, which could include, but is not limited to, internal operating budgets, patient utilization statistics, and internal memos.

Please note:

- *Incomplete or illegible applications will not be accepted for consideration and will be returned to the Applicant.* ~~or reviewed.~~
- *The Authority is not responsible for email transmittal delays or failures of any kind.*
- *On the answers under Evaluation Criteria, font size must not be smaller than 10pt.*
- ~~*To be considered for a grant, supporting documentation is required under Evaluation Criteria, Section B: Use of Grant Funds, Question 2, Sub Questions a-d, in order to substantiate the impact of the reduction or elimination of federal government assistance.*~~

LIFELINE GRANT PROGRAM APPLICATION FORM

ELIGIBILITY

SECTION A

The Health Facility shall meet one of the following requirements. Please confirm eligibility by checking one that applies to your Facility:

- ☐ A tax-exempt nonprofit corporation, licensed to operate the Health Facility by the State of California, and an annual gross revenue not exceed ten million dollars (\$10,000,000).
- ☐ A tax-exempt nonprofit corporation, licensed to operate the Health Facility by the State of California, which is located in a Rural Medical Service Study Area, as defined in Section 7213 subdivision (w) of the regulations.
- ☐ A clinic operated by a district hospital or health care district.

SECTION B

The Health Facility must meet all of the following conditions.* Please confirm eligibility by checking all that apply:

- ☐ The Health Facility must provide a minimum of two (2) of the five (5) Medical Health Services as defined for purposes of this program.
- ☐ 50% or more of the persons served must be equal to or below 200% of the Federal Poverty Level.
- ☐ The Health Facility serves persons identified as the vulnerable populations which includes the indigent, underinsured, uninsured, underserved, and undocumented immigrant populations.

***Notwithstanding the above requirements, a Health Facility located in a Rural Medical Service Study Area shall meet the requirements of Section 7214, subdivision (c) of Title 4, California Code of Regulations.**



**If one or more of these requirements cannot be met,
the Health Facility is not eligible to participate in this Grant program.**



CERTIFICATION

The Executive Director of the Health Facility, Board Chairperson, or other individual with the authority to commit the Health Facility to contract must complete the following certification:

I certify that to the best of my knowledge, the information contained in this Application and the accompanying supplemental materials is true and accurate. I understand that misrepresentation may result in the cancellation of the Grant and other actions which the Authority is authorized to take.

By (Print Name)

Signature

Title

Date

APPLICANT INFORMATION			
Health Facility Name			
Parent Health Facility Name <i>[If different from above]</i>			
Street Address		City, State & Zip	
County	Federal Tax I.D. Number	Contact Person / Title	
Telephone Number		E-mail Address	

FEDERAL TRIGGER INFORMATION
FEDERAL TRIGGER EXPERIENCED: <i>[Please explain the Federal Trigger below]</i>

GRANT INFORMATION
AMOUNT REQUESTED: <i>[Max. \$250,000 per Health Facility]</i> <i>Request cannot exceed the federal government assistance reduction or elimination.</i> \$

ELIGIBLE AND INELIGIBLE USE OF GRANT FUNDS
<p>Eligible use of Grant funds: is is</p> <p>“Working capital” for core operating support.</p> <p><i>In the CHFFA Act, Government Code Section 15432, subdivision (h), “working capital” means moneys to be used by, or on behalf of, a participating health institution to pay or prepay maintenance or operation expenses or any other costs that would be treated as an expense item, under generally accepted accounting principles, in connection with the ownership or operation of a health facility, including, but not limited to, reserves for maintenance or operation expenses, interest for not to exceed one year on any loan for working capital made pursuant to this part, and reserves for debt service with respect to, and any costs necessary or incidental to, that financing.</i></p> <p>Ineligible use of Grant funds:</p> <ul style="list-style-type: none"> • <u>To pay the costs associated with inflation of programs and/or services.</u> • <u>To provide any services or programs unrelated to those services or programs provided prior to the reduction or elimination of the federal government assistance.</u> • <u>For any service, program or expenditure beyond what was specified in the Application.</u>
USE OF GRANT FUNDS: <i>[Please describe what the Grant funds will be used for according to eligible uses.]</i>

HEALTH FACILITY TYPE

Check the one that applies (if applicable).

- ☐ Federally Qualified Health Center
☐ Federally Qualified Health Center Look-Alike

SERVICE AREA

Check the one that applies (if applicable).

- ☐ Rural Medical Service Study Area
☐ Frontier Medical Service Study Area

POPULATION SERVED

Check all that apply.

Percent of Total
Population Served

- | | |
|---|---------|
| <input type="checkbox"/> Indigent Populations | _____ % |
| <input type="checkbox"/> Underinsured Populations | _____ % |
| <input type="checkbox"/> Uninsured Populations | _____ % |
| <input type="checkbox"/> Underserved Populations | _____ % |
| <input type="checkbox"/> Undocumented Immigrant Populations | _____ % |

SERVICES PROVIDED

Check all that apply. To be eligible, the Health Facility must currently provide a minimum of two (2) of the five (5) Medical Health Services listed below:

Percentage of Patients
Accessing the Service

- | | |
|--|---------|
| <input type="checkbox"/> Reproductive Services | _____ % |
| <input type="checkbox"/> Family Planning | _____ % |
| <input type="checkbox"/> Sexual Health Services | _____ % |
| <input type="checkbox"/> Geriatric Services | _____ % |
| <input type="checkbox"/> Chronic Disease Prevention, Diagnosis and Treatment | _____ % |

Distance of closest Health Facility providing like services _____ miles

EVALUATION CRITERIA

(NO MORE THAN ~~TWO~~ ONE (21) SINGLE SIDED PAGES FOR SECTION A; FONT SIZE NO SMALLER THAN 10PT)

A. HEALTH FACILITY PROFILE

1. Describe your Health Facility and its operation as it currently exists. Description must include, at a minimum, the geographical area served, the vulnerable populations served, services provided, day-to-day operations including hours/days of operation, staff qualifications and number of staff, how long the Health Facility has been in operations, and sources of current revenue. **(Required, zero points)**

B. USE OF GRANT FUNDS

(NO MORE THAN A TOTAL OF THREE (3) SINGLE SIDED PAGES FOR SECTION B; FONT SIZE NO SMALLER THAN 10PT)

Applications shall be scored on the following question addressing all four (4) criteria below (50 points possible):

2. Describe the effects to your Health Facility and its operation as a result of any federal government reduction or elimination of funds that impact any reimbursement or eligibility for participation in any federal program or initiative. Describe how the Grant funds will be used to maintain the operation of the Health Facility and a projection of how long the Grant funds will sustain the Health Facility. **Describe each of the items below as it relates to the reduction or elimination of federal government assistance and how the Grant funds will be utilized to positively impact the effects of a federal government reduction or elimination of funds.**
Example: Effects may include, but are not limited to, a reduction in operations, staff, and vulnerable population(s) served. (50 points)

- a. **Financial Impact.** Provide specifics; i.e., the current amount of federal government assistance received, the amount of reduction or elimination, and the percent of the revenue and expenses this reduction or elimination represents to the total operating budget. *(substantiate with supporting documentation)*
Describe the effects to your Facility and its operation as a result of any federal government reduction or elimination of funds that impact any reimbursement or eligibility for participation in any federal program or initiative.

Describe how the Grant funds will be used to maintain the operation of the Facility and a projection of how long the Grant funds will sustain the Facility.

Describe the financial impact as it relates to the reduction or elimination of federal government assistance and how the Grant funds will be utilized to positively impact the effects of a federal government reduction or elimination of funds.

- b. **Services Provided.** May include elimination of one or more of the Medical Health Services as specified in Section 7213 subdivision (u) of the regulations. *(substantiate with supporting documentation)*
Describe the effects to your Facility and its operation as a result of any federal government reduction or elimination of funds that impact any reimbursement or eligibility for participation in any federal program or initiative.

Describe how the Grant funds will be used to maintain the operation of the Facility and a projection of how long the Grant funds will sustain the Facility.

Describe services provided as it relates to the reduction or elimination of federal government assistance and how the Grant funds will be utilized to positively impact the effects of a federal government reduction or elimination of funds.

- c. **Vulnerable Populations Served.** If the federal government reduction or elimination affects the populations defined as vulnerable, specify the vulnerable population(s) affected; i.e., the specific effects to that population, percentage of Health Facility patients impacted, and the impact on the community. ~~(substantiate with supporting documentation)~~
Describe the effects to your Facility and its operation as a result of any federal government reduction or elimination of funds that impact any reimbursement or eligibility for participation in any federal program or initiative.

Describe how the Grant funds will be used to maintain the operation of the Facility and a projection of how long the Grant funds will sustain the Facility.

Describe vulnerable populations served as it relates to the reduction or elimination of federal government assistance and how the Grant funds will be utilized to positively impact the effects of a federal government reduction or elimination of funds.

- d. **Day-to-Day Operations.** If the federal government reduction or elimination affects the day-to-day operations, specify that effect; i.e., number of staff impacted (may include staff layoffs, classification and duties of impacted staff; salary/hourly rate cuts) and decrease in days and hours of Health Facility operation. ~~(substantiate with supporting documentation)~~
Describe the effects to your Facility and its operation as a result of any federal government reduction or elimination of funds that impact any reimbursement or eligibility for participation in any federal program or initiative.

Describe how the Grant funds will be used to maintain the operation of the Facility and a projection of how long the Grant funds will sustain the Facility.

Describe day-to-day operations as it relates to the reduction or elimination of federal government assistance and how the Grant funds will be utilized to positively impact the effects of a federal government reduction or elimination of funds.

Legal Status Questionnaire

Applicant Name:

1. Financial Viability

Disclose any legal or regulatory action or investigation that may have a material impact on the financial viability of the project or the applicant. The disclosure should be limited to actions or investigations in which the applicant or the applicant's parent, subsidiary, or affiliate involved in the management, operation, or development of the project has been named a party.

Response:

2. Fraud, Corruption, or Serious Harm

Disclose any legal or regulatory action or investigation involving fraud or corruption, or health and safety where there are allegations of serious harm to employees, the public, or the environment. The disclosure should be limited to actions or investigations in which the applicant or the applicant's current board member (except for volunteer board members of non-profit entities), partner, limited liability corporation member, senior officer, or senior management personnel has been named a defendant within the past ten years.

Response:

Disclosures should include civil or criminal cases filed in state or federal court; civil or criminal investigations by local, state, or federal law enforcement authorities; and enforcement proceedings or investigations by local, state or federal regulatory agencies. The information provided must include relevant dates, the nature of the allegation(s), charges, complaint or filing, and the outcome.

Religious Affiliation Due Diligence:

Note: Evidence (e.g., written admission policy, patient/resident application form, written hiring policies, codes of conduct, website information, statistical information, etc.) of each stated fact should be included in this tab.

QUESTIONS	ANSWER (Yes or No) Please provide explanations as requested – Attach additional pages as needed
Admission Policies	
<ul style="list-style-type: none"> Does the facility admit patients or residents of all religions and faiths? 	<input type="checkbox"/> Yes <input type="checkbox"/> No (please explain)
<ul style="list-style-type: none"> Are patients/residents ever turned away because of their religious affiliation? 	<input type="checkbox"/> Yes (please explain) <input type="checkbox"/> No
<ul style="list-style-type: none"> Does the facility grant any preference, priority or special treatment with respect to admission, treatment, payment, etc., based on religion or faith? 	<input type="checkbox"/> Yes (please explain) <input type="checkbox"/> No
<ul style="list-style-type: none"> Does the facility focus on the needs of, market to, or target, a particular religious population? 	<input type="checkbox"/> Yes (please explain) <input type="checkbox"/> No
<ul style="list-style-type: none"> Does the facility discourage individuals from seeking admission to the facility on the basis of religion? 	<input type="checkbox"/> Yes (please explain) <input type="checkbox"/> No
<ul style="list-style-type: none"> Is it the facility's mission to serve patients/residents of a particular religion? 	<input type="checkbox"/> Yes (please explain) <input type="checkbox"/> No
<ul style="list-style-type: none"> What percentage of the patients/residents admitted and treated at the facility are of the same religious denomination as the facility's religious affiliation? 	
Hiring and Employment Practices	
<ul style="list-style-type: none"> Does the facility hire employees and medical staff that are of all religions and faiths? 	<input type="checkbox"/> Yes <input type="checkbox"/> No (please explain)
<ul style="list-style-type: none"> In hiring employees and medical staff, does the facility give preference to applicants of a particular religion? 	<input type="checkbox"/> Yes (please explain) <input type="checkbox"/> No

Religious Affiliation Due Diligence (Continued):

Note: Evidence (e.g., written admission policy, patient/resident application form, written hiring policies, codes of conduct, website information, statistical information, etc.) of each stated fact should be included in this tab.

QUESTIONS	ANSWER (Yes or No) Please provide explanations as requested – Attach additional pages as needed
<ul style="list-style-type: none">What percentage of the facility's staff (professional and non-professional) is of the same religious denomination as the facility's religious affiliation?	
<ul style="list-style-type: none">Does the facility place any religious-based restrictions on how medical staff performs its duties or what medical procedures can be performed?	<input type="checkbox"/> Yes (please explain) <input type="checkbox"/> No
<ul style="list-style-type: none">Are employees or medical staff required to sign or abide by a statement of faith or religious beliefs or similar document?	<input type="checkbox"/> Yes (please explain) <input type="checkbox"/> No
To what degree does the health care facility enjoy institutional harmony apart from the affiliated church or religion?	
<ul style="list-style-type: none">Is the facility sponsored by a church or religion?	<input type="checkbox"/> Yes (please explain) <input type="checkbox"/> No
<ul style="list-style-type: none">Must members of the governing board of the facility be members of a particular religion or church? Does the church elect the board members?	<input type="checkbox"/> Yes (please explain) <input type="checkbox"/> No
<ul style="list-style-type: none">Does the church dictate how the health care facility allocates its resources?	<input type="checkbox"/> Yes (please explain) <input type="checkbox"/> No
<ul style="list-style-type: none">Does the church approve the facility's financial transactions?	<input type="checkbox"/> Yes (please explain) <input type="checkbox"/> No
Will loan proceeds be used to finance any building or facility that will be used for religious worship?	<input type="checkbox"/> Yes (please explain) <input type="checkbox"/> No

Provide the following as attachments:

Attachment A – Financial Information

- Provide a copy of your most current audited financial statement.
This information will be used to verify that the Health Facility's annual gross revenue does not exceed ten million dollars (\$10,000,000), with exception to Health Facilities located in a Rural Medical Service Study Area, where this requirement does not apply.

Note: the most current audited financial statement must be within six months of the most current fiscal year end.

“Audited Financial Statements” means an examination and report of an independent accounting firm on the financial activities of a public agency or private nonprofit corporation.

Note: audited financials must be free of going concern language.

“Going Concern” means an opinion of an independent accounting firm auditor that there is substantial doubt regarding the entity's ability to continue into the future, generally defined as the following year.

Attachment B – Background

- Provide a copy of your Health Facility's mission and history (i.e. brochure, website literature).

Attachment C – Management/Facility Information

- Provide a copy of the State of California operating license for the Health Facility.
- Provide copies of Health Facility's certified Articles of Incorporation and Bylaws, and any Amendments.

Checklist - Grant Application

Please use this checklist to determine if the application is complete. ***(Incomplete or illegible applications will not be considered and will be returned to the Applicant).***

Eligibility & Certification

(Page 1) ☐ - Complete Sections A & B re: eligibility and sign the certification section

Applicant, Federal Trigger & Grant Information

(Page 2) ☐ - Complete Applicant Information

☐ - Complete Federal Trigger Information

☐ - Complete Grant Information

Health Facility Type & Service Area

(Page 23) ☐ - Complete Health Facility Type *(if applicable)*

☐ - Complete Service Area *(if applicable)*

Population Served & Services Provided

(Page 3) ☐ - Complete Population Served Information

☐ - Complete Services Provided

Evaluation Criteria

(Page 34) ☐ - Complete Health Facility Profile, question 1*

(Page 45) ☐ - Complete Use of Grant Funds, question 2a *(Financial Impact)***

☐ - Complete Use of Grant Funds, question 2b *(Services Provided)***

(Page 56) ☐ - Complete Use of Grant Funds, question 2c *(Vulnerable Populations Served)***

☐ - Complete Use of Grant Funds, question 2d *(Day-to-Day Operations)***

Legal Status Questionnaire

(Page 67) ☐ - Complete Legal Status Questionnaire (with an explanation for all “yes” answers)

Religious Affiliation Due Diligence

(Page 7-8-9) ☐ - Complete Religious Affiliation Due Diligence

Attachment A – Financial Information

☐ - Provide a copy of most current audited financial statement

Attachment B – Background

☐ - Provide Health Facility’s background information

Attachment C – Management/Health Facility Information

☐ - Provided operating license for the Health Facility ~~receiving~~ requesting funding

☐ - Provided copies of certified Articles of Incorporation, Bylaws, and any Amendments

***NO MORE THAN ONE (1) SINGLE SIDED PAGE FOR QUESTION 1, FONT SIZE NO SMALLER THAN 10PT.**

****NO MORE THAN A TOTAL OF THREE (3) SINGLE SIDED PAGES FOR QUESTIONS 2A-2D, FONT SIZE NO SMALLER THAN 10PT.**