CALIFORNIA HEALTH FACILITIES FINANCING AUTHORITY
(CHFFA)
&
CALIFORNIA DEPARTMENT OF HEALTH CARE ACCESS AND INFORMATION
(HCAI)

DISTRESSED HOSPITAL LOAN PROGRAM APPLICATION TECHNICAL ASSISTANCE WEBINAR

JUNE 23, 2023

CHFFA
Welcome and Introductions

EXECUTIVE DIRECTOR

CAROLYN ABOUBECHARA

DEPUTY EXECUTIVE DIRECTOR

BIANCA SMITH

OPERATIONS MANAGER

ROSALIND BREWER

PROGRAM MANAGER

MATT FRANCIS

LOAN OFFICERS

CHRIS HEALY and ERICA RODRIGUEZ

HCAI
Welcome and Introductions

OFFICE OF HEALTH FACILITY LOAN INSURANCE

DEPUTY DIRECTOR

J.P. MARION

SUPERVISING ACCOUNT MANAGERS

DEAN O'BRIEN

CONSUELO HERNANDEZ

ACCOUNT MANAGERS

LAUREN HADLEY

DENNIS LO

ARNE BRACCHI

TOM WENAS

AGENDA FOR TODAY

- BACKGROUND & LOAN TERMS
- APPLICATION
- METHODOLOGY
- LOAN CLOSING PROCESS
- TIMELINE
- QUESTIONS

BACKGROUND & LOAN TERMS

Provides loans to not-for-profit and public hospitals in significant financial distress or to governmental entities representing a closed hospital to prevent closure or facilitate reopening of a closed hospital (cannot belong to an integrated health care system with more than two separately licensed hospital facilities)

- HCAI and CHFFA partnering to administer the program
- $150 million one-time funding available*
- Interested hospitals will need to apply through CHFFA

Loan terms:

a) 0% Interest
b) 72-month term, with an 18-month deferment period before repayment
c) 20% Medi-Cal checkwrite payments to secure loan repayment

*Any remaining funds after the first funding round shall be available in subsequent funding rounds, and a notice of subsequent funding rounds will be posted on CHFFA's website

APPLICATION

- General Information and Instructions
- Section One: Summary Information
- Section Two: Financial Standing
- Section Three: Community Need/Benefit Statement
- Section Four: Payor Mix & Utilization Tables
- Section Five: Legal Status Questionnaire
- Supplemental Attachments A & B – Financial Information and Management/Organization Information
- Attachment C – Turnaround Plan
- Application Certification
- Application Checklist
- Exhibits A-C – Applicant's Board Resolution, Fi$Cal Form, STD 204 Form
- Application Review

GENERAL INFORMATION AND INSTRUCTIONS

- Deadline for a complete first funding round application submission:

  5:00pm Pacific Time (PT) on July 31, 2023.

- Optional: Preliminary review by HCAI to determine the hospital's eligibility prior to the hospital spending resources on developing a Turnaround Plan, deadline to submit application with all items except the Turnaround Plan by no later than 5:00pm (PT) on June 30, 2023.

- Available on CHFFA's website: https://www.treasurer.ca.gov/chffa/programs/dhlp.asp

- Download application, fill it out in PDF format, and submit your completed application by email as a PDF attachment to chffa@treasurer.ca.gov.

- Attach additional pages to the application to respond to any of the questions.

- Please Note: CHFFA is not responsible for email transmittal delays or failures of any kind.

GENERAL INFORMATION AND INSTRUCTIONS (CONTINUED)

- HCAI will review loan applications as they are received.
- Hospitals in danger of closure prior to the first funding round deadline, submit applications early.
    - HCAI may take necessary actions to issue a small bridge loan to assist the hospital until the funding round is closed and final loan determinations are made.

<u>Loan Terms and Conditions:</u>

- Execute a Loan and Security Agreement and a Promissory Note.
    - The Loan and Security Agreement will include ongoing compliance requirements, such as quarterly and annual submission of financial statements, budgets, Turnaround Plan progress reports, utilization statistics, and various financial ratios.

<u>Security:</u>

- CHFFA will receive the right to intercept 20% of all Medi-Cal checkwrite payments from the Applicant in the event that the Applicant misses a payment or does not pay off its loan within 72 months, until the loan amount has been satisfied.

SECTION ONE: SUMMARY INFORMATION

SECTION ONE: SUMMARY INFORMATION

APPLICANT INFORMATION:		
Legal Name (Include DBA Name)		
Street Address	Federal Tax I.D. Number	
City, State & Zip	Contact Person / Title	
County	Telephone Number	Email Address
Type of Entity (as defined in Health and Safety Code section 129381): ☐ Not-for profit Hospital ☐ Public Hospital		
NOTE: Not-for-profit and public hospitals that belong to integrated health care systems with more than two separately licensed hospital facilities are ineligible under Health and Safety Code section 129383, subdivision (e).		
LOAN INFORMATION:		
Amount Requested: $		
Provide a high-level explanation of how loan proceeds will be used for the purposes of preventing the closure, or facilitating the reopening, of the hospital, summarizing any preliminary projections and strategies for regaining financial viability (this should not be the full Turnaround Plan):		

SECTION TWO: FINANCIAL STANDING

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1. **Financial Ratios:** Calculate the hospital's financial ratios, including:

   a) Days Cash on Hand:
   Days Cash on Hand = unrestricted cash and cash equivalents ÷ [(operating expenses – non-cash charges) ÷ 365 days]

   b) Current Ratio:
   Current Ratio = (Current Assets ÷ Current Liabilities)

   c) Operating Margin:

   Operating Margin = (Net Income ÷ Total Revenue)

   d) Net Cash Runway:

   Net Cash Runway = Cash Balance ÷ Monthly Average Operating Loss (excluding depreciation and non-cash expenses)

   e) Debt Service Coverage (Net):
   Debt Service Coverage Ratio = Net Income Available for Debt Service* ÷ Actual Annual Debt Service

   * Net Income Available for Debt Service = Excess of Revenue Over Expenses + Depreciation Expense + Amortization Expense + Interest Expense + Non-Cash Charges – Restricted Donations – Extraordinary/Non-Recurring Charge – Non-Cash Revenues – Unrealized Gain (Loss) on Investments

2. Describe any material changes in revenue, expenses, assets, and liabilities over the last full audited fiscal year and fiscal year-to-date.

3. Describe any attempts that the hospital has made to secure lines of credit or other working capital. Describe the outcome of those attempts and if the attempts were successful, unsuccessful, or not economically viable.

4. Is the hospital in technical or payment default with any long-term debt covenants? Please include whether the lender is implementing remedies of default actions.

5. Has the hospital already pledged Medi-Cal revenues to any lender or creditor, which would result in the Medi-Cal revenue collateral for the Distressed Hospital Loan Program to be subordinate to the existing loan or lien? If so, provide the name of the lender or creditor and the purpose of the loan or lien.

SECTION THREE: COMMUNITY NEED/BENEFIT STATEMENT

SECTION THREE: COMMUNITY NEED/BENEFIT STATEMENT

1. Describe how the closure of the hospital would impact the health care needs of the community or of underserved populations. Attach additional pages if needed.

2. What is the access to care impact for the provider network and service offerings in the community if the hospital were to close? Also describe the distance (in miles) to the nearest hospital and outpatient services, as well as the name of the nearest hospital and outpatient services and the types of services that they offer.

3. Is your hospital located in one of the following Medical Service Study Area designations? (Verify location designation)

   a. Medically Underserved Area (MUA) Yes__ No__
   b. Medically Underserved Population (MUP) Yes__ No__

SECTION FOUR:
PAYOR MIX & UTILIZATION TABLES

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1. For the two most recently completed fiscal years, provide the percentage of each revenue source (Medi-Cal, Medicare, private insurance, etc.).

Revenue Source	% of Total Revenue For *Fiscal Year* 20	20
Medi-Cal (including Managed Medi-Cal)		
Medicare (including Managed Medicare)		
Commercial (private insurance)		
Self-pay		
Charity & Unreimbursed Care		
Total:	**100%**	**100%**

2. For the last five fiscal years and year-to-date, provide the following:

	2018	2019	2020	2021	2022	2023 YTD
Average Daily Census						

	2018	2019	2020	2021	2022	2023 YTD
Inpatient Visits						
Outpatient Visits (Hosp)						
Outpatient Visits (Clinic)						
Emergency Visits						

SECTION FIVE: LEGAL STATUS QUESTIONNAIRE

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1. Financial Viability

   Disclose material information relating to any legal or regulatory proceeding or investigation in which the applicant/borrower/project sponsor is or has been a party and which might have a material impact on the financial viability of the project or the applicant/borrower/project sponsor. Such disclosures should include any parent, subsidiary, or affiliate of the applicant/borrower/project sponsor that is involved in the management, operation, or development of the project.

   Response:

2. Fraud, Corruption, or Serious Harm

   Disclose any civil, criminal, or regulatory action in which the applicant/borrower/project sponsor, or any current board members (not including volunteer board members of non-profit entities), partners, limited liability corporation members, senior officers, or senior management personnel has been named a defendant in such action in the past ten years involving fraud or corruption, matters related to employment conditions (including, but not limited to wage claims, discrimination, or harassment), or matters involving health and safety where there are allegations of serious harm to employees, the public or the environment.

   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.

SUPPLEMENTAL ATTACHMENTS A & B

Provide the following supplemental attachments:

Attachments A – Financial Information

1. Provide a copy of audited financial statements for the most recent fiscal year.
2. Provide a copy of internally prepared year-to-date unaudited financial statements for the current year.
3. Complete and provide the Fi$Cal Form (for government agencies, Exhibit B) or STD 204 (for not-for-profit hospitals, Exhibit C)

Attachments B – Management/Organization Information

1. Provide the most recent board meeting minutes/packet.
2. Provide the current operating license for the hospital.
3. Provide the organization's articles of incorporation/bylaws, if applicable.
4. Provide the most recent and complete IRS Form 990.
5. If applicable, complete and provide a copy of the applicant's board resolution approving/ratifying the submission of the application and authorizing the execution of loan documents and additional indebtedness (Exhibit A).

   Note: This resolution may be completed and submitted at the time of or after application submittal, but it is required for loan disbursement.

ATTACHMENT C – TURNAROUND PLAN

Attachment C - Turnaround Plan[1]

An applicant may submit its application without a Turnaround Plan; however, prior to consideration for loan approval, the applicant must provide a Turnaround Plan, which must include projections detailing the uses of the proposed loan and strategies proposed by the hospital's governing body to regain financial viability to continue to operate. Turnaround Plan must include:

a) A 24-month cash-flow projection of current financial situation.

b) Narrative describing actions being taken or to be taken by leadership including whether to cut or eliminate any services.

c) A 24-month cash-flow projection of future financial situation that incorporates the actions taken by leadership and identifies how the loan proceeds will be utilized and repaid after the 18-month grace period.

d) A description of how actions will affect various revenue and expense line items.

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[1] Prior to dedicating financial and labor resources to create a Turnaround Plan, applicants are encouraged to submit all application questions and data submittal items without the Turnaround Plan for a preliminary review by HCAI's staff. Please see General Information and Instructions for deadlines.

APPLICATION CERTIFICATION

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An individual with the authority to bind the applicant to an agreement with the State of California, if a loan under the Distressed Hospital Loan Program is approved for the applicant, 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 submitted by the applicant for a loan under the Distressed Hospital Loan Program are true and accurate. I understand that if the applicant is approved for a loan under the Distressed Hospital Loan Program, the applicant will be required to enter into a Loan and Security Agreement with the State of California and execute a Promissory Note, as well as provide any additional information or documentation that may be required for loan disbursement. I further understand that misrepresentation or inaccurate information or documentation provided by the applicant may result in the cancellation of the loan, if approved, and that the State of California is authorized to take any additional actions as may be provided under the laws of the State of California.

_____	_____
By (Print Name)	Signature
_____	_____
Title	Date

APPLICATION CHECKLIST

Checklist – Distressed Hospital Loan Program Application

Please use this checklist to determine if the application is complete.

Section One: Summary Information
(Page 2) ☐ - Completed Applicant Information & Loan Information sections.

Section Two: Financial Standing
(Page 3) ☐ - Provided Financial Ratio calculations.
☐ - Provided and completed a management report of any material changes in revenue, expenses, assets, and liabilities over the last full audited fiscal year and fiscal year-to-date.
☐ - Provided description of attempts to secure lines of credit or other working capital.
☐ - Described if the hospital was in technical or payment default.
☐ - Described if the hospital has already pledged Medi-Cal revenues.

Section Three: Community Need/Benefit Statement
(Page 4) ☐ - Described how the closure of the hospital would impact or has impacted the health care needs of the community or of underserved populations.
☐ - Described the access to health care impact for the provider network and service offerings in the community if the hospital were to close and to the nearest hospital.
☐ - Completed Medical Service Study Area designations.

Section Four: Payor Mix & Utilization Tables
(Page 4) ☐ - Completed Payor Mix Table.
☐ - Completed Utilization Table.

Section Five: Legal Status Questionnaire
(Page 5) ☐ - Completed Legal Status Questionnaire (with an explanation for all "yes" answers).

Attachments A – Financial Information
☐ - Provided a copy of audited financial statements for the most recent fiscal year.
☐ - Provided a copy of internally prepared year-to-date unaudited financial statements for the current year.
☐ - Provided a completed copy of the Fi$Cal Form (Exhibit B) **or** Form STD 204 (Exhibit C).

Attachments B – Management/Organization Information
☐ - Provided the most recent board meeting minutes/packet.
☐ - Provided the current operating license for the hospital.
☐ - Provided the articles of incorporation/bylaws, if applicable.
☐ - Provided the most recent and complete IRS Form 990.
☐ - Provided copy of applicant's board resolution (Exhibit A), if applicable. **Note:** This resolution may be completed and submitted at the time of or after application submittal, but it is required for loan disbursement.

Attachment C – Turnaround Plan
☐ - Provided a complete Turnaround Plan.

Application Certification
☐ - Executed Application Certification.

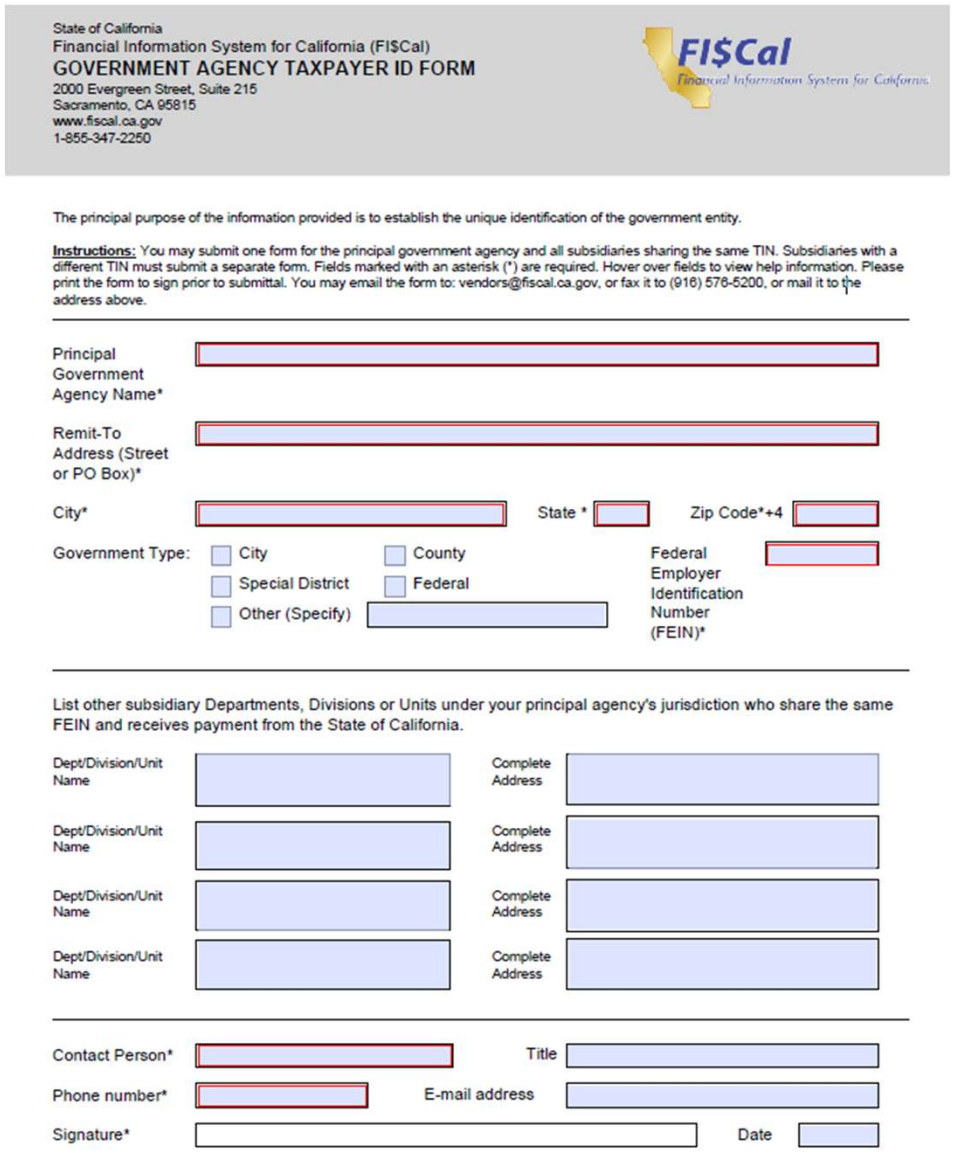
Exhibit A – Applicant's Board Resolution

SAMPLE

Exhibit A – Applicant's Board Resolution

RESOLUTION NO. xx-xx
RESOLUTION OF {**BORROWER NAME**} AUTHORIZING EXECUTION AND DELIVERY OF A PROMISSORY NOTE, LOAN AND SECURITY AGREEMENT, AND CERTAIN ACTIONS IN CONNECTION THEREWITH FOR A LOAN UNDER THE DISTRESSED HOSPITAL LOAN PROGRAM

Exhibit B – Fi$Cal Form



State of California
Financial Information System for California (FI$Cal)
GOVERNMENT AGENCY TAXPAYER ID FORM
2000 Evergreen Street, Suite 215
Sacramento, CA 95815
www.fiscal.ca.gov
1-855-347-2250

FI$Cal Financial Information System for California

The principal purpose of the information provided is to establish the unique identification of the government entity.

Instructions: You may submit one form for the principal government agency and all subsidiaries sharing the same TIN. Subsidiaries with a different TIN must submit a separate form. Fields marked with an asterisk (*) are required. Hover over fields to view help information. Please print the form to sign prior to submittal. You may email the form to: vendors@fiscal.ca.gov, or fax it to (916) 576-5200, or mail it to the address above.

Principal Government Agency Name*

Remit-To Address (Street or PO Box)*

City* State * Zip Code*+4

Government Type: ☐ City ☐ County ☐ Special District ☐ Federal ☐ Other (Specify)

Federal Employer Identification Number (FEIN)*

List other subsidiary Departments, Divisions or Units under your principal agency's jurisdiction who share the same FEIN and receives payment from the State of California.

Dept/Division/Unit Name	Complete Address
Dept/Division/Unit Name	Complete Address
Dept/Division/Unit Name	Complete Address
Dept/Division/Unit Name	Complete Address

Contact Person* Title

Phone number* E-mail address

Signature* Date

Exhibit C – Form STD 204

STATE OF CALIFORNIA – DEPARTMENT OF FINANCE

PAYEE DATA RECORD

(Required when receiving payment from the State of California in lieu of IRS W-9 or W-7)

STD 204 (Rev. 03/2021)

Section 1 – Payee Information

NAME (This is required. Do not leave this line blank. Must match the payee's federal tax return)

BUSINESS NAME, DBA NAME or DISREGARDED SINGLE MEMBER LLC NAME (If different from above)

MAILING ADDRESS (number, street, apt. or suite no.) (See instructions on Page 2)

CITY, STATE, ZIP CODE	E-MAIL ADDRESS

Section 2 – Entity Type

Check one (1) box only that matches the entity type of the Payee listed in Section 1 above. (See instructions on page 2)

- ☐ **SOLE PROPRIETOR / INDIVIDUAL**
- ☐ **SINGLE MEMBER LLC** *Disregarded Entity owned by an individual*
- ☐ **PARTNERSHIP**
- ☐ **ESTATE OR TRUST**

CORPORATION (see instructions on page 2)

- ☐ **MEDICAL** *(e.g., dentistry, chiropractic, etc.)*
- ☐ **LEGAL** *(e.g., attorney services)*
- ☐ **EXEMPT** *(e.g., nonprofit)*
- ☐ **ALL OTHERS**

Section 3 – Tax Identification Number

Enter your Tax Identification Number (TIN) in the appropriate box. The TIN must **match** the name given in Section 1 of this form. Do not provide more than one (1) TIN. The TIN is a 9-digit number. **Note:** Payment will not be processed without a TIN.

- For **Individuals**, enter SSN.
- If you are a **Resident Alien**, and you do not have and are not eligible to get an SSN, enter your ITIN.
- Grantor Trusts (such as a Revocable Living Trust while the grantors are alive) may not have a separate FEIN. Those trusts must enter the individual grantor's SSN.
- For **Sole Proprietor or Single Member LLC (disregarded entity), in which the sole member is an individual**, enter SSN (ITIN if applicable) or FEIN (FTB prefers SSN).
- For **Single Member LLC (disregarded entity), in which the sole member is a business entity**, enter the owner entity's FEIN. Do not use the disregarded entity's FEIN.
- For all other entities including LLC that is taxed as a corporation or partnership, estates/trusts (with FEINs), enter the entity's FEIN.

Social Security Number (SSN) or Individual Tax Identification Number (ITIN)

___ ___ ___ - ___ ___ - ___ ___ ___ ___

OR

Federal Employer Identification Number (FEIN)

___ ___ - ___ ___ ___ ___ ___ ___ ___

Section 4 – Payee Residency Status (See instructions)

- ☐ **CALIFORNIA RESIDENT** – Qualified to do business in California or maintains a permanent place of business in California.
- ☐ **CALIFORNIA NONRESIDENT** – Payments to nonresidents for services may be subject to state income tax withholding.
  - ☐ No services performed in California
  - ☐ Copy of Franchise Tax Board waiver of state withholding is attached.

Section 5 – Certification

I hereby certify under penalty of perjury that the information provided on this document is true and correct. Should my residency status change, I will promptly notify the state agency below.

NAME OF AUTHORIZED PAYEE REPRESENTATIVE	TITLE	E-MAIL ADDRESS

SIGNATURE	DATE	TELEPHONE *(include area code)*

Section 6 – Paying State Agency

Please return completed form to:

STATE AGENCY/DEPARTMENT OFFICE	UNIT/SECTION	
MAILING ADDRESS	**FAX**	**TELEPHONE** *(include area code)*

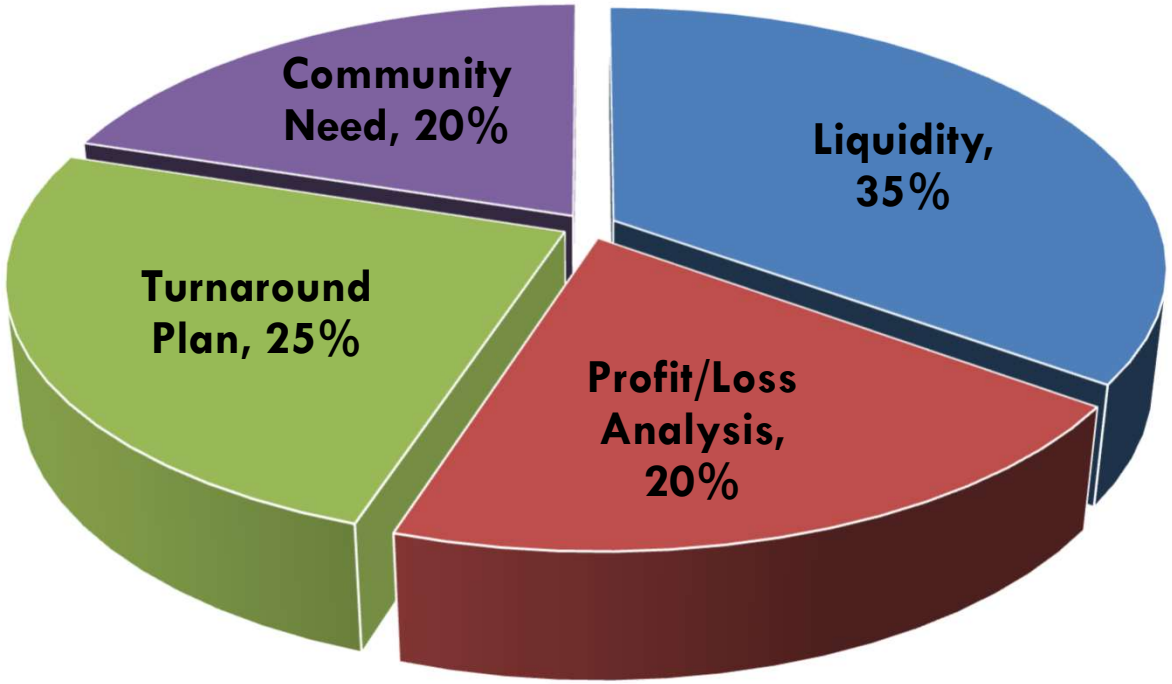
CITY	STATE	ZIP CODE	E-MAIL ADDRESS

APPLICATION REVIEW

- CHFFA will receive and share the submitted applications with HCAI, who will then determine whether the applications are complete.
- HCAI will review and evaluate the applications to determine the applicant's eligibility, whether the submitted applications and plans are viable, and if there is reasonable likelihood that the applicant will be able to regain financial viability and continue to operate as a hospital.
- HCAI will then determine loan amount awards to eligible applicants and send CHFFA a determination letter to issue the loans.

METHODOLOGY

Criteria Weighting



EVALUATION METHODOLOGY

Criteria #1 - Liquidity		
Sub-Criteria	Summary	Weight
1.1: Days Cash on Hand	Applicants currently experiencing lower levels of cash will receive higher consideration	20%
1.2: Current Ratio	Lower Current Ratio will receive higher consideration	10%
1.3: Access to Working Capital	Applicants with no access to other forms of working capital will receive full credit in this area	5%
	Criteria #1 – Liquidity, Total Weight	35%

EVALUATION METHODOLOGY

Criteria #2 – Profit/Loss Analysis		
Sub-Criteria	Summary	Weight
2.1: Operating Margin	Applicants with operating losses in their last fiscal year end and current year-to-date periods will receive higher consideration.	5%
2.2: Impact of Operating Losses on Liquidity – "Cash Runway"	Applicants that will run out of working capital sooner will receive higher consideration	15%
	Criteria #2 – Profit/Loss Analysis, Total Weight	20%

EVALUATION METHODOLOGY

Criteria #3 – Turnaround Plan		
Sub-Criteria	Summary	Weight
3.1: Turnaround Plan	Turnaround plans will be evaluated for an applicant's ability to return to financial viability considering factors such as revenue enhancement initiatives, cost cutting measures, service line closures, affiliation, sale, or partnership opportunities and the likelihood that these factors will occur.	25%
	Criteria #3 – Turnaround Plan, Total Weight	25%

EVALUATION METHODOLOGY

Criteria #4 – Community Need		
Sub-Criteria	Summary	Weight
4.1: Distance to Nearest Alternative Hospital	Analyze if there are alternative hospitals within 15 miles or 30-minute drive.	5%
4.2: Payor Mix	Applicants that have a higher payor mix of Medi-Cal, Medicare, Indigent and Charity Care will receive more consideration.	5%
4.3: Utilization Analysis	Average utilization amongst hospitals in the applicant's service area will be reviewed and applicants that have higher than their group average occupancy will receive more consideration.	5%
4.4: Service Area Designation	The applicant is located in a designated Medically Underserved Area or Medically Underserved Population, or both.	5%
	Criteria #4 – Community Need, Total Weight	20%

LOAN CLOSING PROCESS

- HCAI Determination Letters
- CHFFA Letters to Approved Borrowers
- Loan and Security Agreement Covenants
- Medi-Cal Intercept Form
- Loan Funds Disbursement Request
- Disbursement of funds

HCAI Determination Letters

HCAI will send a Determination Letter to CHFFA of all hospitals that were determined eligible, as well as the loan amount awarded from the Distressed Hospital Loan Program Fund to the hospitals.

CHFFA LETTERS TO APPROVED BORROWERS

CHFFA will then notify eligible hospitals that they have been approved by HCAI for an interest-free cashflow loan by sending a letter to the contact from the hospital, as listed in the application.

The letter will include the loan terms and be accompanied by a set of loan documents. Loan funding is contingent upon the execution of **ALL** closing documents (as hardcopy or as DocuSign) as follows:

1. Loan and Security Agreement
2. Promissory Note
3. Medi-Cal Intercept Form
4. Loan Funds Disbursement Request Form

Please note: if Applicant's Borrower's resolution was not submitted at time of application, it is required prior to sending out letter and loan documents.

LOAN AND SECURITY AGREEMENT COVENANTS

Throughout duration of the loan, Borrower covenants that:

Borrower shall provide periodic reports and financial information to CHFFA and HCAI in the manner set forth below:

- Audited annual consolidated financial statements (120 days after FYE)
- Unaudited quarterly financial statements (45 days after FQE)
- Borrower's board-approved annual budget (30 days after FYE)
- A report from the Borrower of any progress made in relation to the Turnaround Plan (45 days after FQE)
- A report detailing the Borrower's utilization statistics (120 days after FYE)
- Financial ratios (120 days after FYE & 45 days after FQE):
    - Days Cash on Hand, Current Ratio, Operating Margin, Net Cash Runway, Debt Service Coverage Ratio

MEDI-CAL INTERCEPT FORM

Medi-Cal Intercept Form (Exhibit A of Loan and Security Agreement)

- Borrower must execute a Medi-Cal Intercept Form, authorizing the Department of Health Care Services (DHCS) to redirect Borrower's Medi-Cal checkwrite payments to CHFFA if the Borrower fails to pay.

- Borrower must agree to assign the Collateral, not to exceed 20% of its respective Medi-Cal checkwrite payments, to CHFFA until CHFFA notifies DHCS that the loan is made current or has been satisfied.

LOAN FUNDS DISBURSEMENT REQUEST

Loan Funds Disbursement Request Form (Exhibit B of Loan and Security Agreement)

- Borrower must execute a Loan Funds Disbursement Request Form.
- Borrower must select whether to receive funds by bank wire or a paper warrant.
  - Note: the disbursement of funds should take approximately one to two weeks if you opt to receive funds via wire or two to three weeks for a paper warrant.
- A wire will be made to the account provided in the form, or a check will be mailed to the contact person provided in the form.

DISBURSEMENT OF FUNDS

- Once all completed and executed loan closing documents are received from the Borrower, CHFFA will review them for completion.
- CHFFA's Executive Director or the Deputy Executive Director will sign the documents, and a request will be sent for loan disbursement.
- After the loan is disbursed, Borrowers will have an 18-month deferment period beginning the date that the loan documents are executed by CHFFA.
- On an annual basis, CHFFA will send the Borrower monthly debt service payment invoices for each given year.
- Monthly invoices may be paid via paper check to CHFFA or using CHFFA's Electronic Payment Service at http://www.govone.com/PAYCAL/CHFFA.
    - Borrowers may use the one-time payment option located on the top of the page or become an enrolled user, which provides features such as scheduling future payments, and viewing payment history (made through the system).

TIMELINE

First Funding Round Event:	Due Date:
Optional: Preliminary Review of Application Deadline	June 30, 2023
Application Submission **with** Turnaround Plan Deadline	**July 31, 2023**
Application Review and Scoring	August 2023
Loan Award Determination Letters to CHFFA	August 2023
Loan Documents Distributed	September 2023
Loans Funded	September 2023

Questions?

CONTACT INFORMATION

Phone	(916) 653-2799
Email	CHFFA@TREASURER.CA.GOV

Phone	(916) 319-8800
Email	DHLP@HCAI.CA.GOV