



**REQUESTS FOR PROPOSALS**  
**for**  
**SCHOOL-BASED AND SCHOOL-LINKED**  
**CHILD AND ADOLESCENT HEALTH CENTERS**

**Issued By:**  
**Michigan Department of Education**

**Issued: August 29, 2014**  
**Required Intent to Apply Form Due: September 15, 2014**  
**Proposals Due: October 3, 2014**

**MICHIGAN DEPARTMENT OF EDUCATION**  
**August 2014**

**ANNOUNCEMENT FOR REQUESTS FOR PROPOSALS FOR SCHOOL-BASED AND  
SCHOOL-LINKED CHILD AND ADOLESCENT HEALTH CENTER FUNDING**

**This packet includes:**

- Grant Announcement
- Part I: General Information
- Part II: Additional Information
- Part III: Review Process and Information
- Part IV: Application Information for Clinical and Alternative Clinical School-Based and School-Linked Child and Adolescent Health Center Grants
- Attachments

**NATURE OF ACTION REQUESTED:   X   VOLUNTARY**

The Michigan Departments of Education and Community Health are pleased to announce the availability of **\$2.7 million** in funds for School-Based and School-Linked Child and Adolescent Health Centers (CAHC) to fund grants to local communities to support NEW clinical and alternative clinical CAHCs in October 2014. The grants will be awarded through a competitive process to eligible applicants.

The grant application for School-Based and School-Linked Child and Adolescent Health Centers, including all required forms, is available on the CAHC website ([www.michigan.gov/cahc](http://www.michigan.gov/cahc)). **Completed applications must arrive to the Michigan Department of Education on or before Friday, October 3, 2014.**

**To be eligible to apply for funding, an Intent to Apply form must be submitted to the Michigan Department of Education for each application by September 15, 2014. If an Intent to Apply form is not received by that time, the application will not be accepted.**

**An ORIGINAL and FOUR (4) copies (for a total of five) of the completed application must be submitted by the deadline. No electronic copies will be accepted.** The application and a *Frequently Asked Questions* webpage will be available August 29 to October 3, 2014, for public use throughout the application-writing period at [www.michigan.gov/cahc](http://www.michigan.gov/cahc). **Questions will not be accepted after October 3, 2014.** The application, related forms and frequently asked questions can be found at that site. Any questions regarding the application **must** be submitted to Keri DeRose, CAHC Program Consultant, at [derosek@michigan.gov](mailto:derosek@michigan.gov). Questions will be responded to and posted solely using this webpage. The questions and responses will be available for public access within two business days of receipt of the original question. It is up to each applicant to regularly check the *FAQ* webpage.

**The website is the only opportunity that grantees will have to ask questions regarding the proposals.**

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**MICHIGAN DEPARTMENT OF EDUCATION**  
**August 2014**

**APPLICATION FOR SCHOOL-BASED AND SCHOOL-LINKED  
CHILD AND ADOLESCENT HEALTH CENTER FUNDING**

**PART I: GENERAL INFORMATION**

**INTRODUCTION**

The Michigan Departments of Education and Community Health are pleased to announce the availability of \$2.7 million in funds for the Child and Adolescent Health Center (CAHC) Program, to fund grants to local communities to support NEW clinical and alternative clinical CAHCs. Section 31a, Subsection 6 of the State School Aid Act of 2010-2011 (*Attachment A*) provides state funding for the Child and Adolescent Health Center Program. Federal Medicaid Outreach dollars are leveraged with this state funding.

School-based and school-linked health center services have been provided in Michigan since the 1980s. State funding for such services began in 1987 through the Michigan Department of Public Health (now the Michigan Department of Community Health) and focused exclusively on the adolescent population. Leveraged federal funding in 2004 allowed for the expansion of clinical services to the elementary age population (youth 5-10). The CAHC program is jointly managed by the Michigan Department of Community Health (MDCH) and Michigan Department of Education (MDE).

**With this RFP, the Departments are seeking applications for:**

1. School-Based and/or School-Linked Clinical Child and Adolescent Health Centers.
2. School-Based and/or School-Linked Alternative Clinical Child and Adolescent Health Centers.

For the purpose of this application guidance, **school-based health centers** are primary care centers that are LOCATED ON SCHOOL PROPERTY. Centers operating on school property must follow School Code regulations. **School-linked health centers** are primary care centers that have strong ties to surrounding schools or school districts but are NOT LOCATED ON SCHOOL PROPERTY. Both clinical and alternative clinical centers can be either school-based or school-linked.

Many children and adolescents in Michigan communities confront serious health concerns: unintentional injuries; child abuse and other interpersonal violence; alcohol, tobacco and other drug use; overweight and unhealthy food choices; early pregnancy and childbearing; family conflict; depression and teen suicide. These problems have a direct, negative impact on school attendance, academic achievement and school completion.

Many children and adolescents in Michigan lack adequate access to the health services needed to prevent and intervene in these health problems. Increasingly, families cannot afford time away from school and work to seek needed health services. Many live in areas with limited healthcare

providers and lack health insurance, money, transportation, and knowledge of how to use local health care systems. A major emphasis of this program is to ensure that eligible children and adolescents within or linked to targeted schools are insured and have access to a range of preventative, support, referral, and coordination services.

The period of adolescent growth and development is filled with risks and opportunities. These years mark the formation of health behavior patterns that have lifelong ramifications. Most young people, ages 10-21, growing up in the United States have the potential of maturing into responsible, healthy adults. However, certain groups of young people are limited because of their health status, the economic condition of their families/communities, and their involvement in many high-risk behaviors, which include: school drop-out; use of alcohol, tobacco or other drugs; unsafe driving; early and/or unprotected sexual activity; fathering a child or becoming pregnant; poor nutrition; lack of exercise; and involvement in violent behavior. Adolescence is a time of change physically, emotionally and cognitively. While risk-taking behaviors are normal in the movement through this life cycle, adult and health-related intervention is often necessary to assure that these youth emerge safe and healthy. In the United States, the adolescent population is the least likely age group to receive needed and appropriate health care services. Adolescent-specific school-based and school-linked health center models are designed to address this unmet need and provide services unique to the adolescent population in a “teen friendly” environment.

MDE and MDCH believe that “healthy kids learn better.” Moving primary care services into or close to schools with significant numbers of uninsured and underinsured children and families that have problems accessing adequate health services gives children and adolescents access to care in an environment that is tailored to their unique needs and is conveniently located. Through the establishment of this program, interventions can be provided to those age 5-21 with the aim of achieving the best possible physical, intellectual, and emotional health status. Funding of these programs and ensuring on-going support for program growth that meets the needs of the community and the target population requires collaboration with the state, local community organizations, youth, parents, and schools.

MDCH and MDE embrace the CAHC models as an effective means for increasing access to primary health care for children and teens in underserved communities. There is a growing body of evidence that access to primary health care in schools can improve both health status and learning readiness.

Services offered by Clinical and Alternative Clinical Health Centers must include at a minimum: (1) comprehensive primary medical care including preventative services, (2) chronic disease management, (3) Medicaid outreach and enrollment, (4) access to Medicaid preventative services, (5) early intervention and other support services including psychosocial services, (6) health education and promotion, and (7) referral services.

For a list of key terms and definitions for this competitive process, please refer to *Attachment B*.

## **GRANT PURPOSE**

A major role of the CAHC program is to provide a safe and caring place for children and adolescents to learn positive health behaviors, prevent diseases, and receive needed medical care and support, thereby resulting in healthy youth who are ready and able to learn and become educated, productive adults. CAHCs assist eligible children and youth with enrollment in Medicaid and provide access to Medicaid preventative services.

CAHCs are required to collaborate with Medicaid Health Plans as necessary to ensure that children and youth are receiving needed health services. It is crucial to have community acceptance and support for these child and adolescent health service models.

**These grant application instructions are provided to interested and eligible parties to enable them to prepare and submit competitive proposals for the following:**

1. **Clinical Child and Adolescent Health Center Grants**– designed to provide primary care (including well care and diagnosis and treatment for both acute and chronic illness), psychosocial and health promotion/disease prevention services, Medicaid outreach activities and access to Medicaid preventative services in a “consumer” friendly manner and atmosphere to eligible children and youth. Clinical centers are required to be open a minimum of 30 hours, five days a week and serve a minimum of 500 unduplicated youth for adolescent sites and 350 unduplicated children for elementary sites. Funding may not be used to provide clinical services to adults over 21 years of age.
2. **Alternative Clinical Health Center Grants** – designed to provide primary care (including well care and diagnosis and treatment for both acute and chronic illness), psychosocial and health promotion/disease prevention services, Medicaid outreach activities, and access to Medicaid preventative services in a “consumer” friendly manner and atmosphere to eligible children and youth. Alternative Clinical Health Centers (ACHC) differ from Clinical centers only in the number of hours they are required to be open and the number of youth required to be reached. ACHCs are required to be open a minimum of 24 hours, three consistent days per week and serve a minimum of 200 unduplicated youth. Funding may not be used to provide clinical services to adults over 21 years of age.

**Agencies applying for Clinical or Alternative Clinical sites MUST start their planning process October 1, 2014, or upon grant notification. Previously funded fiduciaries must be fully operational, including the ability to meet the State’s minimum program requirements, by April 1, 2015. Newly funded fiduciaries must have basic clinical services in place by April 1, 2015, and be fully operational, including the ability to meet minimum program requirements, by October 1, 2015.**

## **ELIGIBLE APPLICANTS**

Eligible applicants include public and non-profit entities (e.g., local health departments, community health centers, Community Mental Health agencies, Federally Qualified Health Centers, non-profit hospitals/health systems, school districts and other health care or social service organizations qualified to provide school-based or school-linked health care services).

Documentation of incorporation as a non-profit agency or other legal status or evidence of application must be included with this application. Applicants **must demonstrate** collaboration between the local school district, health care providers, and sponsoring agencies in the proposal.

**APPLICANTS MUST SUBMIT AN INTENT TO APPLY FORM BY SEPTEMBER 15, 2014. IF AN INTENT TO APPLY FORM IS NOT RECEIVED, THE APPLICATION WILL NOT BE ACCEPTED.** See the attached Intent to Apply Form (*Attachment C*).

### **ASSURANCES**

To be eligible for funding, all applicants must check written assurance that abortion services, counseling, and referrals for abortion services will not be provided as part of the services offered on the application coversheet. For programs providing services on school property, checked written assurance is required that family planning drugs and/or devices will not be prescribed, dispensed, or otherwise distributed on school property as mandated in the Michigan School Code on the application coversheet. Proposals must check a statement of assurance of compliance with all federal and state laws and regulations prohibiting discrimination and with all requirements and regulations of MDE and MDCH on the coversheet. **These assurances must be checked on the application coversheet.**

### **TARGET POPULATIONS TO BE SERVED**

This request seeks proposals for the delivery of health services to those aged 5-21 in geographic areas where it can be documented that health care services that are accessible and acceptable to children and youth require enhancement or do not currently exist. The infants and young children of the adolescent target population may also be served where appropriate.

### **FUNDING LIMIT AND DURATION OF FUNDING**

This grant will provide base funding for Clinical Health Centers and Alternative Clinical Health Centers starting October 1, 2014, through September 30, 2019, based on availability of funding. Up to 13 grants will be awarded funding through this competitive process. Funding recommendations for Child and Adolescent Health Centers suggest for program sustainability that a formula exist with equal partnership between state, school, and local community. *The intent of this RFP is to provide base funding support to operate Child and Adolescent Health Centers.*

Base grants (Clinical, Alternative Clinical Programs) will vary due to unique differences in program operations; e.g., cost-based reimbursements and types of services provided.

#### **Clinical Child and Adolescent Health Centers**

- School-Based Health Centers, which are located on school property, will receive base funding of **\$195,000** per year.
- Community-Based or School-Linked centers will receive base funding of **\$250,000** per year.
- Federally Qualified Health Centers (FQHC) that are Community-Based/School-Linked or School-Based will be eligible for the **\$195,000** base funding allocation due to their unique ability to secure full cost-based reimbursement for services.

### Alternative Clinical Health Centers

- Alternative Clinical School-Based Health Centers, which are located on school property, will receive base funding of **\$135,000** per year including those that are sponsored by FQHC.
- Community-Based or School-Linked Alternative Clinical Centers will receive base funding of **\$190,000** per year.
- FQHC that are School-Linked Alternative Clinical Centers will be eligible for **\$165,000** base funding allocation due to their unique ability to secure full cost-based reimbursement for services.

Type of Center	School-based	School-linked
Clinical	\$195,000	\$250,000
FQHC Clinical	\$195,000	\$195,000
Alternative Clinical	\$135,000	\$190,000
FQHC Alternative Clinical	\$135,000	\$165,000

Awards will begin October 1, 2014, and end September 30, 2019, based on the availability of funding.

Annual non-competitive applications will be due for all funded grantees in future years through September 30, 2019. Awards are contingent upon the availability of funds as well as the performance of the grantee in previous years. MDCH and MDE reserve the right to terminate any contract due to failure to meet established minimum program and reporting requirements and/or failure to meet annual negotiated performance numbers.

**A local match of 30 percent of the amount requested is required.** Any match provided by a collaborative partner must be documented in writing by that organization and included as part of this proposal. **If one organization is applying for more than one grant in different geographic locations or more than one model of funding, separate applications and budgets must be submitted. Neither MDCH nor MDE are liable for any costs incurred by applicants prior to the execution of a contract.**

### REJECTION OF PROPOSALS

MDE and MDCH reserve the right to reject any and all proposals received as a result of this announcement and will do so if the proposal does not adhere to funding specifications, preparation instructions, or if an Intent to Apply Form was not submitted.

### INTENT TO APPLY FORM

All applicants are required to **submit the attached Intent to Apply Form** (*Attachment C*) for **EACH** application. The form must be received by 5:00 p.m. on September 15, 2014. The form must be submitted via fax (517-373-1233) or by e-mail to [koyalchickk@michigan.gov](mailto:koyalchickk@michigan.gov).

A confirmation fax will be sent once the Intent to Apply Form is received. If confirmation is not received by September 19, 2014, please contact **Kim Koyalchick** at **517-241-4284**.

## **CLOSING DATE AND DELIVERY ADDRESS**

Proposals are due on or before 5:00 p.m. on Monday, October 3, 2014. If a proposal arrives after this due date or is submitted by fax or e-mail, it will not be considered or reviewed. Proposals submitted, but not in accordance with the proposal preparation instructions below, will not be accepted and will be returned to the applicant *without review*.

**The ORIGINAL proposal, bearing ORIGINAL signatures and FOUR (4) COPIES** (for a total of five) of the completed proposal must be documented by delivery agent for delivery on or before **Friday, October 3, 2014**. Proposals should be mailed via U.S. mail, United Parcel Service, Federal Express or other similar courier in sufficient time as to arrive on or before the due date.

### **Proposals should be mailed to the attention of:**

Kim Kovalchick  
Michigan Department of Education  
Coordinated School Health and Safety Programs  
P.O. Box 30008  
608 W. Allegan Street  
Lansing, MI 48909

**Complete Attachment D: Application Coversheet, Checklist and Fax Back Form and include it as the cover page of your proposal.** This will be faxed back to you within three business days from the date of arrival at MDE. If you do not receive this confirmation notice by fax within three days of arrival at MDE, contact Kim Kovalchick, Coordinated School Health and Safety Programs, at **517-241-4284**.

### **Acceptable Packaging and Mailing Procedures**

- The postmark or other mailing validation must be documented by delivery agent for delivery **on or before October 3, 2014**. The original proposal and all required copies should be enclosed in a sealed envelope within the mailing packet. If the applicant used a delivery service, the dated receipt for delivery service must be available to validate the **October 3, 2014**, postmark requirement.
- When the proposal is received, the Application Checklist and Fax Back Form on the front of the application package will be signed by the appropriate personnel and then faxed to the applicant to verify receipt of proposal and participation in the grant process. **The applicant is responsible for contacting Kim Kovalchick at (517) 241-4284 or [kovalchickk@michigan.gov](mailto:kovalchickk@michigan.gov) by October 3, 2014, if the applicant does not receive a faxed copy of the signed form.**
- In case of late delivery of the proposal, verification of appropriate delivery efforts will be required to participate in this grant process.

## **Review Process**

The Departments will appoint an objective review committee to review and prioritize proposals for funding. Notification of award or rejection is expected by October 31, 2014.

## **PROPOSAL PREPARATION, PAGE LIMIT, AND FONT SIZE**

Proposals should be prepared simply and economically, providing a concise description of the requirements of the proposal with a narrative **no longer than 30 pages** in length for Clinical and Alternative Clinical. Proposals should be typed with a font no smaller than Times New Roman 12 point font, double-spaced, single-sided, and using standard one-inch margins. Applicants must number all pages sequentially, including attachments.

**Proposals should not be stapled together but rather sent unbound.** Individual binder clips should be used to bind each copy of the proposal(s). Special bindings and binders should not be used. Required forms and support documents (title page, table of contents, certifications and assurances, list of advisory council members, copies of policies and procedures, interagency agreements, budget forms, budget narrative, work plan, and letters of commitment/support and need) are not counted in the narrative page limit. Supplementary materials will not be reviewed and will be discarded.

## **ACKNOWLEDGEMENT**

All publications, including reports, films, brochures, and/or any project materials developed with funding from this program, must contain the following statement: **“These materials were developed with state funds allocated by the Michigan Department of Education and Michigan Department of Community Health.”**

## **AMERICANS WITH DISABILITIES ACT**

MDE and MDCH are committed to providing equal access to all persons in admission to or operation of its programs or services. Individuals with disabilities needing accommodations for effective participation in this program are invited to contact either of the two State Departments for assistance.

## **AVAILABILITY OF APPLICATION**

The application packet is available from the Child and Adolescent Health Center website at [www.michigan.gov/cahc](http://www.michigan.gov/cahc).

## **WHERE TO OBTAIN ASSISTANCE**

MDCH and MDE issues the instructions contained in these materials, and are the sole points of contact in the State for this program.

A *Frequently Asked Questions* webpage will be available for public use August 29 to October 3, 2014, at [www.michigan.gov/cahc](http://www.michigan.gov/cahc). The application, related forms, and frequently asked questions can be found at this site. Any questions regarding the application **must** be submitted to Keri DeRose, Child and Adolescent Health Center Program Consultant, at [derosek@michigan.gov](mailto:derosek@michigan.gov). Questions will be responded to and posted solely using this webpage.

The questions and responses will be available for public access within two business days of receipt of the original question. It is up to each applicant to regularly check the *FAQ* webpage. **The website is the only opportunity that grantees will have to ask questions regarding the proposals.**

## **PART II: ADDITIONAL INFORMATION**

### **FUNDING PROCESS**

The Departments will make the Clinical and Alternative Clinical grants available through a competitive process for fiscal year (FY) 2015 (October 1, 2014-September 30, 2015). Applicants receiving FY 2015 funding will be invited to apply for continuation funds to operate the CAHC throughout the entire funding cycle (ending September 30, 2019) only after demonstrating satisfactory progress achieving performance measures. Progress will be measured through both performance measure reports and financial reports.

### **PAYMENT SCHEDULE**

Michigan Primary Care Association (MPCA) will issue contracts to all grantees. Grantees will receive quarterly payments from MPCA. Expenditures must be reported quarterly and year-end in accordance with the terms and conditions of this agreement and outlined in the CAHC contract issued by MPCA.

### **FINANCIAL REPORTING**

Quarterly and year-end expenditure reports will be required annually of all grant recipients. The final expenditure report is due within 30 days of the end of each of the project years (i.e., the first year of funding the final report will be due by October 30, 2016). All financial reporting requirements are detailed in required documents and forms found at [www.michigan.gov/cahc](http://www.michigan.gov/cahc).

### **PERFORMANCE REPORTING AND MONITORING RESPONSIBILITIES**

After grants are awarded, the grantee will carry out the proposed programming under the general direction of MDCH and MDE. Program oversight, including technical assistance and consultation, will be provided by MDCH. For Clinical and Alternative Clinical Programs, the services and activities described in the Minimum Program Requirements (*Attachment E*) must be addressed in the proposal and implemented throughout the funding cycle.

Quarterly and year-end reports will be required of all grant recipients including data and billing collection, financial reporting, and program objective outcomes. The reports are subject to be used by both MDE and MDCH to assist in evaluating the effectiveness of programs funded under the State grants program and to report to the legislature.

### **TECHNOLOGY REQUIREMENTS**

Each funded applicant is **required** to have an accessible electronic mail account (email) to facilitate ongoing communication between MDE, MDCH and grantees. All funded grantees will be added to the State-funded list serve, which is the primary vehicle for communication between the State Departments and grantees.

Clinical and Alternative Clinical applicants must have the necessary technology and equipment to support billing and reimbursement from third-party payers. Minimum Program Requirements (*Attachment E*) for both elementary and adolescent health centers describe the billing and reimbursement requirements for all grantees.

### **TECHNICAL ASSISTANCE AND TRAINING**

MDCH has a team of consultants to provide technical assistance to successful grantees. Anticipate monthly meetings with an assigned MDCH consultant. Within the first two to three years, each grantee will have a comprehensive site review scheduled to ensure that all minimum program requirements are being met and to provide technical assistance and follow-up as needed. After this initial site review, subsequent reviews will occur at least once every five years or more frequently if necessary.

In addition, the CAHC program provides training opportunities for program staff throughout the year. The annual coordinator meeting, typically held in the fall, is a required training for all grantees. Additional trainings may be required during the planning process. Staff are highly encouraged to attend other CAHC sponsored trainings.

## **PART III: REVIEW PROCESS AND INFORMATION**

### **PROPOSAL REVIEW PROCESS AND APPROVAL**

All proposals will be reviewed jointly by MDCH and MDE and evaluated using a peer review system. Proposals must address all of the identified criteria and contain all requested information in the format laid out in this guidance. Rubrics will be used as a rating instrument in the review process. The rubric can be obtained at [www.michigan.gov/cahc](http://www.michigan.gov/cahc). Award selections will be based on merit and quality as determined by points awarded from the Review Criteria Section and all relevant information. Each applicant can request feedback including specific strengths, weaknesses, and recommendations based on their proposal. Successful applicants must respond to any conditions of funding within 30 days of receiving written notice of award. All funding will be subject to approval by the State Superintendent at the Michigan Department of Education and Director of the Michigan Department of Community Health.

### **ADDITIONAL REVIEW FACTORS**

In addition to the review criteria in Part IV and Part V, MDE and MDCH may apply other factors in making funding decisions, such as: (1) geographical distribution, (2) gaps in services, (3) duplication of effort, (4) duplication of funding, (5) agency capacity, (6) evidence that an applicant has performed satisfactorily on previous state grants, and (7) other factors relevant to addressing changing needs and populations.

### **GRANT REVIEWERS**

MDE and MDCH will designate a panel of peer reviewers with extensive knowledge of the Child and Adolescent Health Center Program Requirements. This review panel will receive training prior to reviewing proposals and will use a consensus process to enhance reviewer reliability of the final score. **Persons involved in the development of a proposal, associated with an**

**organization or district submitting a proposal, or having any other real or perceived conflict of interest may not serve as reviewers.**

## **APPLICATION INSTRUCTIONS**

Application information, instructions, and review criteria for **Clinical and Alternative Clinical Child and Adolescent Health Center Grants** are detailed in **Part IV** of this application guidance.

**If one organization is applying for more than one grant in different geographic locations or more than one model of funding, separate applications and budgets must be submitted.**

## **PART IV: APPLICATION INFORMATION FOR CLINICAL AND ALTERNATIVE CLINICAL SCHOOL-BASED AND SCHOOL-LINKED CHILD AND ADOLESCENT HEALTH CENTER GRANTS**

### **REVIEW CRITERIA**

All applicants will be evaluated on the basis of the criteria described in this section. Narrative sections of the applications should address each criterion. Applications are not to include pamphlets, handbooks, reports, brochures, news articles, folders, binders, dividers, etc. **Three hundred and thirty (330)** is the maximum score that can be obtained for this application, and the value assigned for each section is indicated. Proposals exceeding a 30 page written narrative will not be accepted. Required forms and support documents (title page, table of contents, certifications and assurances, list of advisory council members, budget forms, budget narrative, work plan, interagency agreement with school, and letters of commitment and need) are not counted in the narrative page limit.

### **PART A – APPLICATION COVER SHEET/APPLICATION (Page 1 of the Application, Required coversheet found in Attachment D)**

Using the required application coversheet (*Attachment D*), the agency or organization submitting the application, as well as the direct contact person for this program, must be fully identified. All boxes are to be accurately completed. The application requires an original signature from the person with binding authority from the applicant agency. *Rubber stamps and copies are unacceptable.*

**1. Funding Strategy.** Identify the type of program the applicant proposes:

#### **Clinical Child and Adolescent Health Center Model:**

School-Based Health Center Model - \$195,000

School-Linked Health Center Model - \$250,000

Federally Qualified Health Center (School-Based or School-Linked) - \$195,000

**Clinical CAHCs must reach a minimum of 500 unduplicated children or youth annually for adolescent (10-21 years old) sites and 350 for elementary (5-10 years old) sites.**

Applicants must also identify the total number of children and/or youth in the service area including school enrollment numbers for school-based sites. This information will be used to

determine a **minimum** number of users to be served by each applicant. This number will vary depending on the grantee and the unique geographic characteristics of the service area.

**Alternative Clinical Child and Adolescent Health Center:**

School-Based Alternative Health Center Model - \$135,000

School-Linked Alternative Health Center Model - \$190,000

Federally Qualified Alternative Health Center School-Based - \$165,000

Federally Qualified Alternative Health Center School-Linked - \$190,000

**Alternative Clinical CAHCs must reach a minimum of 200 unduplicated children or youth annually.** Applicants must also identify the total number of children and/or youth in the service area including school enrollment numbers for school-based sites. This information will be used to determine a **minimum** number of users to be served by each applicant. This number will vary depending on the grantee and the unique geographic characteristics of the service area.

2. **Service Area.** Identify the service/target area the requested funds will service (school district, county, city, metropolitan area, etc.).
3. **Target Population.** Identify the age group of the target population that will be served by the proposed project. **Please identify the primary age group that will be served.**

Children ages 5-10 (Elementary Age Population)

Youth ages 10-21 (Middle and High School Age Population and Young Adults)

Applicants are strongly encouraged to **choose one** of the age groups listed above. Please note that if the majority of clients served fit in one of the two age groups, please only check the age group that encompasses the majority of the population that will be accessing this center. If both populations are proposed to be served equally, the applicant must provide a detailed description of how they will ensure that the teen population will view this clinic as accessible and acceptable. *The applicant must describe in the narrative how serving young children will not pose a barrier to the teen population accessing this center.* Please note that there are separate Minimum Program Requirements (MPRs) for clinical centers serving those age 5-10 versus centers serving those age 10-21. School-Linked Health Centers are adolescent models, serving only youth 10-21 years of age. If the grantee plans on serving **both** age groups, they must adhere to **both** MPRs, which are included in *Attachment E*.

If the adolescent (age 10-21) population is being served, the applicant **must provide** a teen-friendly clinic atmosphere that is both acceptable and accessible to this population.

**State funding for CAHCs CANNOT be used to serve the adult population.**

**PART B - ASSURANCES**

To be eligible for funding, all applicants must check written assurance that abortion services, counseling, and referrals for abortion services will not be provided as part of the services offered on the application coversheet. For programs providing services on school property, checked assurance will be required that family planning drugs and/or devices will not be prescribed,

dispensed, or otherwise distributed on school property as mandated in the Michigan School Code on the coversheet. Proposals must check a statement of assurance of compliance with all federal and state laws and regulations prohibiting discrimination and with all requirements and regulations of the Michigan Department of Education and Michigan Department of Community Health on the coversheet. **These assurances must be included in the application coversheet.**

**PART C – GRANT PROGRAM DETAILS (330 POINTS)**

**1. Table of Contents.** Provide a table of contents with corresponding page numbers on each page of the application. Attachments should be paginated and listed in the table of contents.

**2. Project Abstract/Summary (10 points).** Provide **no more than a two-page, single-spaced** summary of the proposal. Explain briefly:

- A. Organization’s history of administering programming for which this application requests funds.
- B. Statement of need for the proposed program, the target area and population the program will serve, and the estimated number of unduplicated children and/or youth expected to be reached in the first year of funding.
- C. A summary of the major program goals and expected outcomes.
- D. A brief description of the proposed programming including a description of where services will be provided (include a brief description of the clinic space).
- E. Total amount of local resources which will be applied to the project and how they will be used (30% local match requirement).
- F. Highlight key people who will be involved with the project.

**3. Assessment of Need (60 points).** The proposal must include documentation from multiple sources on the lack of accessible and child or youth-acceptable services in the geographic area proposed to be served. The need/demand for services must be well-documented.

- A. Provide descriptive and demographic information of the service area including:
  - 1) Service area geographical description.
  - 2) Other agencies providing similar services as those proposed.
  - 3) Data on estimated need/demand for the proposed services.
  - 4) Description of other unusual factors affecting the need for the proposed services.
- B. Describe the characteristics of the target population including:
  - 1) Size of the target population.
  - 2) Age of the target population (applicants are strongly encouraged to select either the age 5-10 or the age 10-21 population; if both populations will be equally served, please provide a detailed explanation for how teen-friendly services will be provided that are both accessible and acceptable to the 10-21 age group).

- 3) Economic status of the target population (at a minimum, include number of children or youth in the target population that receive free or reduced price school lunch).
  - 4) Gender and race/ethnicity of the target population.
- C. Identify and include the results of a health survey that has been conducted in the previous three years to assess the target population's health needs and which identify health status and level of risk-taking behaviors among the target population.
- D. Current letters of need documenting the lack of services must be obtained from at least three of the following agencies: community mental health, local office of substance abuse services, federally qualified health centers (FQHCs), local Department of Human Services (DHS), local hospital, Mayor's office, local health department board of health, school district superintendent or school board, intermediate school district, and/or local public health department.
- 4. Sponsoring Agency Experience (30 points).** Briefly describe the agency's historical commitment to initiatives similar to the proposed program as well as its support for health services for the adolescent population (if adolescents are proposed to be served) or young children (if the 5-10 year age group is to be served). Include a description of services provided by the applicant organization, which are similar to or which complement the proposed services. Provide evidence of the applicant organization's ability to accomplish the proposed plan and manage a grant program of similar size and complexity. Finally, briefly summarize the applicant's present or past experience mobilizing, establishing and maintaining a community-based, broadly representative local advisory committee with a health-related mission.
- 5. Community Collaboration/Support (30 points).** The proposal should demonstrate the support of other related service providers and the general community. Provide a description of the available community resources, which will help sustain the proposed program (both hard match and/or in-kind services).

Provide a listing of collaborative and referral arrangements which will be utilized for the proposed programming. The listing should include, at a minimum, other programs that provide similar or related services to the target population and how the proposed program will interact with (i.e., refer to and/or accept referrals from) these organizations but not duplicate efforts.

- 6a. Community Advisory Committee Structure, Membership, and Activity (20 points).** Describe the extent to which key local partners are involved, or proposed to be involved, in the Community Advisory Committee (CAC) have experience working together to improve the health of children and youth in the proposed area of need. Describe previous, existing or intended collaborative planning processes in the community that could be linked and coordinated with this effort.

At a minimum, the following partners should be involved in the planning efforts that will need to occur over the first six months of the grant, including:

- Administrators and staff from the school building in which services are proposed, if planning a *school-based* Child and Adolescent Health Center.
- School health representatives such as the health education teacher, school nurse, school social worker, psychologist, counselor and/or special education teacher.
- Medical service providers from the proposed provider agency.
- Parents of school aged children or adolescents.
- Youth from the target population (if an adolescent site is being proposed).
- Local Health Department.

**Consider including these additional representatives on your CAC:** superintendent, school board members, building principals, school health coordinator, sex education supervisor, dental providers, faith-based organizations, Parent/Teacher Association or Organization (PTA/PTO), other youth-serving agencies, and local community health, mental health, substance abuse, and community collaborative bodies.

Provide an initial roster of proposed or existing CAC members as an attachment.

Outline the plan to recruit and maintain diverse members that are representative of the racial, ethnic, economic, and philosophical diversity of the target area.

Describe the proposed structure of the committee including membership, leadership, activities, procedures for developing/approving policy and frequency of meetings. See #13 in the Minimum Program Requirements (*Attachment E*) for both Elementary and Adolescent Clinical and Alternative Health Centers for specific regulations regarding the composition of the membership, frequency of meetings, and policy requirements. Address each of these elements in this section.

If policies and procedures on the following topics already exist, include them as attachments to the proposal:

- Parental consent.
- Requests for medical records and release of information that include the role of the non-custodial parent and parents with joint custody.
- Confidential services [e.g., services that minors can consent to by federal and/or state law (*adolescent centers only*)].
- Disclosure by clients or evidence of child physical or sexual abuse and/or neglect.

**6b. Youth and Parent Involvement (5 points).** If providing services to the adolescent population, describe how youth input will occur. For elementary centers, describe how the health needs of children in the service area will be integrated into the center's service delivery plan and describe how parents will be involved at the center.

**7. Organizational Structure (25 points).** Describe the administrative and organizational structure within which the program and the advisory committee will function. Submit an organizational chart depicting the program, including the advisory committee, the fiduciary agency, program coordinator, Medical Director, proposed subcontractors (if applicable), and all related program personnel, as an attachment.

Describe the number of staff who will provide the proposed services including a description of the skills/qualifications necessary. In the attachments, include job descriptions or vitae (if available) of the personnel who will play key roles in the administration of the project and the delivery of services. See *Attachment E--Minimum Program Requirements* for a description of required providers and clinical hours of operation (MPR #8, #9 and #10 for Adolescent Health Centers and MPR #7, #8, #9 and #10 for Elementary Centers). Provide a description of how program coordination will occur, including any full-time equivalents (FTEs) dedicated to overseeing and coordinating administrative functions. Briefly describe the staff development opportunities that will be made available to the staff or required of them.

- 8. Planning Timeline (50 points).** Each grantee will have six months to convene their partners and undergo the necessary planning to start a CAHC with either limited or full services operational by April 1, 2015. For the planning period, each grantee will have six required objectives, which are detailed below. Applicants are encouraged to add additional objectives that are tailored to the community and reflect the community's progress in the planning period.

Required objectives include:

- Objective 1: By October 30, 2014, a Community Advisory Committee (CAC) will be formed or designated.
- Objective 2: By November 30, 2014, the location of the CAHC will be finalized, with a detailed plan and timeline for construction and renovation, including anticipated costs, along with a financial plan with sources secured for construction.
- Objective 3: By December 30, 2014, a comprehensive service delivery plan that is responsive to both the minimum program requirements and the health needs of the target population will be developed and approved by the CAC.
- Objective 4: By December 30, 2014, a finalized staffing plan with a timeline for hiring new staff will be submitted.
- Objective 5: By February 28, 2015, sample policies and procedures for administration and clinic operations will be submitted.
- Objective 6: By March 30, 2015, a 6-month Goal Attainment Scaling (GAS) work plan detailing the clinical services offered at the CAHC for the period of April 1 through September 30, 2015, will be submitted.

Each applicant should complete the Planning Phase Timeline/Activities Table (*Attachment F*). Use one table for each objective as an attachment to their application. For each planning objective, add specific activities needed to meet the required objective along with the person/position responsible for the task and specific time frames.

- 9. Service Plan Narrative (45 points).** Services proposed to be provided should be fully and clearly described in this section. *The services as described in this proposal must be operational and accessible to the described target population by April 1, 2015, for previously funded fiduciaries. Newly funded fiduciaries must provide some clinical services by April 1, 2015, and fully operational by October 1, 2015.*

- A. Provide a description of the proposed services that will be provided at the center. Carefully review the Minimum Program Requirements included in *Attachment E*. It is imperative that the required services in MPR #1 and #2 for both adolescent and elementary CAHCs are specifically addressed.
- B. Describe the case finding system that will be used to identify and recruit clients.
- C. Describe the referral process that will be used for services not provided by the health center, including follow-up procedures.
- D. Describe the proposed hours of operation and arrangements for 24/7 after-hours coverage. Clinical services must be provided to the population served through the center for a minimum of 30 hours per week for full clinical and 24 hours per week for alternative clinical. Mental health services must be provided to the population served through the center for a minimum of 20 hours per week for full clinical and 12 hours per week for alternative clinical. *Services must be provided year round, including times when school is not in session.*
- E. Indicate the number of unduplicated children and/or youth proposed to be served in the course of the fiscal year. **A minimum of 500 unduplicated users must be proposed and served for Adolescent Clinical Centers, a minimum of 350 unduplicated users must be proposed and served for Elementary Clinical Centers, and a minimum of 200 unduplicated users must be proposed and served for Alternative Clinical Centers.** Please note that a minimum number of users will be negotiated with MDCH for FY 2015 and subsequent years for each grantee and will take into account a number of factors including the proposed number of users included in the work plan, size of service area, and historical utilization numbers.
- F. Describe where and how services will be provided. If the selected site is a location other than on school property, justify the accessibility of the site for the target population. If the selected site is on school property, a signed letter of commitment for the CAHC from the (1) school building administration and (2) local school district must be included with the proposal. Commitment letters must demonstrate assurance that agencies will collaborate to determine the final location of the health center, administration of a health survey to enrolled students in the school, parental consent policy and services rendered in the health center program. If awarded, a formal written approval by the school administration and the local school board will have to be submitted for those items within the first year of the grant.
- G. Describe the proposed location within the school building or location within the community that is being considered for the CAHC. Include any renovation or construction that is needed to ensure this space is fully operational with a minimum of two private exam rooms, lab space, waiting room, private office and accessible bathroom. Please note that grant funds cannot be used for construction or architectural costs.

**10. Medicaid Outreach Plan (10 points).** Due to funding guidelines, each agency must provide Medicaid Outreach activities to eligible children and youth in their service area throughout the grant period. A preliminary six-month plan with proposed activities should be described. For a list of eligible activities, refer to MSA 04-13, which is included in *Attachment G*.

**11. Financial Plan (25 points).** The financial plan should be sufficient to achieve the proposed project, but not be excessive. **A minimum local match of 30% of the amount requested is required.** The match can be reached either through cash contributions (hard match) or in-kind resources such as donated space or time (soft-match). The financial plan should also address the following:

- A. Briefly describe all funding sources that will help support the center, the amount of support, and clearly identify the distribution of these funds.
- B. Confirm that this funding must not be used to supplant current funding supporting clinic services.
- C. Describe the billing system that will be used to recover appropriate revenues from third-party payers and provide assurances that revenue collected will be utilized for center operations. (See *Attachment E--Minimum Program Requirements for CAHCs*, which states that services cannot be denied because of inability to pay.)
- D. Describe how the billing and fee collection processes protect client confidentiality.

## **PART D: BUDGET**

1. **Budget Forms (10 points):** Prepare a line-item budget for the period of October 1, 2014, through September 30, 2015, on the **Budget Summary** and **Cost Detail Forms** for the amount requested (*forms and instructions can be found at [www.michigan.gov/cahc](http://www.michigan.gov/cahc)*). All in-kind resources and hard match must also be included on the budget. **The budget and budget narrative should clearly delineate specific staff and staff costs, percentage of fringe benefits, travel and purchases supported with state dollars.**
2. **Budget Narrative (10 points):** Budget narratives must provide detailed descriptions of planned expenditures, including justification and rationale. All budget line items must be described in the budget narrative (*Guidelines for the Budget Narrative are found in Attachment H*).

If your agency is currently funded to provide services similar or related to those proposed in this application, provide a list of the funding source(s), amount of award, contract period, and services supported.

# **ATTACHMENT A**

## **STATE SCHOOL AID ACT**

**SECTION 31a, SUBSECTION 6  
OF THE  
STATE SCHOOL AID ACT**

(6) From the funds allocated under subsection (1), there is allocated for 2014-2015 an amount not to exceed \$3,557,300.00 to support child and adolescent health centers. These grants shall be awarded for 5 consecutive years beginning with 2003-2004 in a form and manner approved jointly by the department and the department of community health. Each grant recipient shall remain in compliance with the terms of the grant award or shall forfeit the grant award for the duration of the 5-year period after the noncompliance. To continue to receive funding for a child and adolescent health center under this section a grant recipient shall ensure that the child and adolescent health center has an advisory committee and that at least one-third of the members of the advisory committee are parents or legal guardians of school-aged children. A child and adolescent health center program shall recognize the role of a child's parents or legal guardian in the physical and emotional well-being of the child. Funding under this subsection shall be used to support child and adolescent health center services provided to children up to age 21. If any funds allocated under this subsection are not used for the purposes of this subsection for the fiscal year in which they are allocated, those unused funds shall be used that fiscal year to avoid or minimize any proration that would otherwise be required under subsection (14) for that fiscal year.

388.1631a amended effective October 1, 2014

# **ATTACHMENT B**

## **KEY TERMS AND DEFINITIONS**

## **Key Terms and Definitions for Child and Adolescent Health Center Competitive Process**

**CLINICAL SCHOOL-BASED HEALTH CENTER (SBHC)** is defined as a health center located in a school or on school grounds that provides on-site comprehensive primary and preventative health services, including referrals, tracking and follow-up, throughout the year with signed agreements with the host school and/or local school district. The SBHC is expected to operate at least 30 hours, five days per week at a single location and provide 24-hour backup coverage to all students and users enrolled in the SBHC. The 30 hours of clinic services must be provided by a certified Nurse Practitioner (PNP, FNP, SNP), Physician Assistant, or a Physician. The health center must be staffed with a minimum of a .50 FTE (20 hours) licensed Masters level mental health provider (i.e., counselor or Social Worker). Appropriate supervision must be available. School-Based Health Centers can be located in elementary, middle, high, or alternative schools and must follow School Code Regulations.

**CLINICAL SCHOOL-LINKED HEALTH CENTER (SLHC)** is defined as a health center NOT LOCATED ON SCHOOL PROPERTY that provides on-site comprehensive primary and preventative health services, including referrals, tracking and follow-up, throughout the year to adolescents and young adults. A school-linked health center is located in the community at an accessible location and has strong ties to area schools. The primary population of adolescents should come from the local schools. A school-linked health center is expected to operate at least 30 hours, five days per week at a single location in an adolescents-only environment and provide 24-hour backup coverage to all adolescents, young adults, and users enrolled in the center. The 30 hours of clinic services must be provided by a certified Nurse Practitioner (PNP, SNP, FNP), Physician Assistant, or a Physician. The health center must be staffed with a minimum of a .50 FTE (20 hours) licensed Masters level mental health provider (i.e., counselor or Social Worker). Appropriate supervision must be available. A school-linked health center does not have to follow School Code Regulations. School-linked health centers provide services to youth ages 10-21 and the young children of the adolescent population.

**ALTERNATIVE CLINICAL SCHOOL-BASED HEALTH CENTER (ACSBHC)** is defined as a health center located in a school or on school grounds that provides on-site comprehensive primary and preventative health services, including referrals, tracking and follow-up, throughout the year with signed agreements with the host school and/or local school district. The ACSBHC is expected to operate at a single location at least 24 hours per week (a minimum of three days per week with consistent days each week) and provide 24-hour backup coverage to all students and users enrolled in the ACHC. The 24 hours of clinic services must be provided by a certified Nurse Practitioner (PNP, FNP, SNP), Physician Assistant, or a Physician. Alternative clinical centers must be staffed with a minimum of a .30 FTE (12 hours) licensed Masters level mental health provider (i.e., counselor or Social Worker). Appropriate supervision must be available. The ACSBHC can be located in elementary, middle, high, or alternative schools and must follow School Code Regulations.

**ALTERNATIVE CLINICAL SCHOOL-LINKED HEALTH CENTER (ACSLHC)** is defined as a health center NOT LOCATED ON SCHOOL PROPERTY that provides on-site comprehensive primary and preventative health services, including referrals, tracking and follow-up, throughout the year to adolescents and young adults. A school-linked health center is located in the community at an accessible location and has strong ties to area schools. The primary population of adolescents should come from the local schools. A school-linked alternative clinical health center is expected to operate at a single location at least 24 hours per week (a minimum of three days per week with consistent days each week) and provide 24-hour backup coverage to all students and users enrolled in the ACSLHC. The 24 hours of clinic services must be provided by a certified Nurse Practitioner (PNP, FNP, SNP), Physician Assistant, or a Physician. Alternative clinical centers must be staffed with a minimum of a .30 FTE (12 hours) licensed Masters level mental health provider (i.e., counselor or Social Worker). Appropriate supervision must be available.

**SERVICE AREA** is defined as a geographic area with precise boundaries (e.g., school district, county). The size of the service area should be appropriate to provide services in a timely fashion.

**TARGET POPULATION** is defined as a subset of the entire service area population (e.g., school building, city, or other). For the purpose of this program, the eligible target population is 5-21 years of age (up to age 26 for Special Education students) and the young children of the adolescent population. The description of the target population should include the major health problems of that population and should serve as the basis for the center's service delivery plan.

**ATTACHMENT C**  
**INTENT TO APPLY FORM**  
(Template can be found at [www.michigan.gov/cahc](http://www.michigan.gov/cahc))

**SCHOOL-BASED AND SCHOOL-LINKED  
CHILD AND ADOLESCENT HEALTH CENTER PROGRAM RFP  
INTENT TO APPLY FORM**

*\*\*NOTE: A separate intent to apply form must be completed for EACH proposed health center \*\**

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Agency

---

Address

---

City

State

Zip Code

---

Phone

Fax

---

Contact Person

Title

---

Email

**Type of Agency:** (check only one)

Community Based 501(c)(3) \_\_\_\_\_

Federally Qualified Health Center \_\_\_\_\_

Tribal Council \_\_\_\_\_

Local Health Department \_\_\_\_\_

School or School District \_\_\_\_\_

Hospital or Healthcare System \_\_\_\_\_

**Service area** - please identify the proposed location for services (including school building, district, city, and county).

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**Proposed funding model (check one):**

\_\_\_ Clinical School-Based

\_\_\_ Clinical School-Linked

\_\_\_ Alternative Clinical School-Based

\_\_\_ Alternative Clinical School-Linked

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Signature of Authorized Representative

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Date

---

Print Name and Title

**Please fax or email to:**

**Kim Kovalchick**  
**Coordinated School Health and Safety Programs**  
**Michigan Department of Education**  
[kovalchick@michigan.gov](mailto:kovalchick@michigan.gov)  
**(517) 373-1233 (fax)**

**ATTACHMENT D**  
**APPLICATION COVERSHEET,**  
**CHECKLIST AND FAX BACK FORM**  
(Template can be found at [www.michigan.gov/cahc](http://www.michigan.gov/cahc))

## APPLICATION COVERSHEET

Applicant agency name:	Applicant agency address:
Contact Person (name, email, phone):	
Authorized agency signatory name and title:	
Authorized agency signature:	

Type of CAHC: <input type="checkbox"/> Clinical <input type="checkbox"/> Alternative Clinical	Target Population (Main Focus): <input type="checkbox"/> Children (ages 5-10) <input type="checkbox"/> Adolescents (ages 10-21)
Target Service Area (school, community, etc.):	
Amount of Funds Requested:	

**Assurances**

<input type="checkbox"/> Abortion services, counseling and referrals for abortion services will not be provided as part of the services offered.
<input type="checkbox"/> Services will comply with all federal and state laws and regulations prohibiting discrimination and with all requirements and regulations of MDE and MDCH.
<input type="checkbox"/> Family planning drugs and/or devices will not be prescribed, dispensed or otherwise distributed (if located on school property).
<input type="checkbox"/> All CAHC Minimum Program Requirements will be met through the CAHC proposal.
Authorized agency signature: _____ Date: _____

**APPLICATION CHECKLIST AND FAX BACK FORM  
FOR  
SCHOOL-BASED AND SCHOOL-LINKED  
CHILD AND ADOLESCENT HEALTH CENTERS**

**Sponsoring Agency:** \_\_\_\_\_

**Clinic Name:** \_\_\_\_\_

**Contact Name:** \_\_\_\_\_ **Fax:** \_\_\_\_\_

- Is the Fax Back Form Confirmation of Receipt completed?
- Is the Application Cover Page completed ***and*** signed by the authorized signatory?
- Does the cover letter include the appropriate assurances regarding family planning devices and abortion counseling/services/referral ***and*** contain original signatures?
- Is the narrative double-spaced and typed in a font no smaller than Times New Roman 12 point?
- Is the narrative complete?
- Does the planning timeline follow the required format and objectives?
- Are all budget pages complete and accurate?
- Is the Budget Summary signed by the authorized signatory?
- Have you included at least three Letters of Need from suggested local agencies?
- Have you included a membership list of the proposed Community Advisory Committee?
- Have you included an organizational chart?
- If the center is located on school property, have you included commitment letters from the school building administration and local school district for collaboration on determining location of the health center, administration of a health survey to students enrolled in the school, parental consent policy, and services rendered in the health center program?
- Have you included 1 original and 4 ***complete*** copies of the application?

-----  
***MDE Use Only:***

Receive Date: \_\_\_\_\_

Authorization: \_\_\_\_\_

**ATTACHMENT E**  
**MINIMUM PROGRAM REQUIREMENTS**  
**FOR CLINICAL AND ALTERNATIVE**  
**CLINICAL CAHCs**

# **MINIMUM PROGRAM REQUIREMENTS FOR CHILD AND ADOLESCENT HEALTH CENTERS ADOLESCENT SITES CLINICAL AND ALTERNATIVE CLINICAL MODELS**

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## **ELEMENT DEFINITION:**

Services provided through the school-based and school-linked Child and Adolescent Health Center Program are designed specifically for adolescents 10 through 21 years of age and are aimed at achieving the best possible physical, intellectual, and emotional health status. Included in this element are adolescent health centers designed to provide comprehensive primary care, psychosocial and mental health services, health promotion/disease prevention, and outreach services. The infants and young children of the target age group can be served through this program.

## **MINIMUM PROGRAM REQUIREMENTS:**

### Services

1. The health center shall provide a range of health and support services based on a needs assessment of the target population/community and approved by the community advisory committee. The services shall be of high quality, accessible, and acceptable to youth in the target population. The use of age appropriate prevention guidelines and screening tools must be utilized.
  - a) Clinical services shall include, at a minimum: primary care, including health care maintenance, immunization assessment and administration using the MCIR, care of acute and chronic illness; confidential services including STD diagnosis and treatment and HIV counseling and testing as allowed by state and/or federal law; health education and risk reduction counseling; and referral for other services not available at the health center. (See Attachment 1 for services detail.)
  - b) Mental health services must be provided at all adolescent Child and Adolescent Health Centers.
  - c) Each health center shall implement two evidence-based programs and/or clinical interventions in at least one of the approved focus areas as determined through needs assessment data (See Attachment 2 for approved focus areas).
2. Clinical services provided, including mental health services, shall meet the recognized, current standards of practice for care and treatment of adolescents and their children.
3. The health center shall not provide abortion counseling, services, or make referrals for abortion services.
4. The health center, if on school property, shall not prescribe, dispense, or otherwise distribute family planning drugs and/or devices.

5. The health center shall provide Medicaid outreach services to eligible youth and families and shall adhere to Child and Adolescent Health Centers and Programs outreach activities as outlined in MSA 04-13.

Administrative

6. If the health center is located on school property, or in a building where K-12 education is provided, there shall be a current interagency agreement defining roles and responsibilities between the sponsoring agency and the local school district. Written approval by the school administration and local school board exists for the following:
  - a) Location of the health center.
  - b) Administration of a needs assessment process, which includes at a minimum a risk behavior survey, to determine priority health services.
  - c) Parental consent policy.
  - d) Services rendered in the health center.
7. The health center shall be located in a school building or an easily accessible alternate location.
8. The health center shall be open during hours accessible to its target population, and provisions must be in place for the same services to be delivered during times when school is not in session. Not in session refers to times of the year when schools are closed for extended periods such as holidays, spring breaks, and summer vacation. These provisions shall be posted and explained to clients.

Clinical Centers: The health center shall provide clinical services a minimum of five days per week. Total primary care provider clinical time shall be at least 30 hours per week. Mental health provider time must be a minimum of 20 hours per week. Hours of operation must be posted in areas frequented by the target population.

Alternative Clinical Centers: The health center shall provide clinical services a minimum of three consistent days per week. Total primary care provider clinical time shall be at least 24 hours per week. Mental health provider time must be a minimum of 12 hours per week. Hours of operation must be posted in areas frequented by the target population.

The health center shall have a written plan for after-hours and weekend care, which shall be posted in the health center including external doors, and explained to clients. An after-hours answering service and/or answering machine with instructions on accessing after-hours care is required.

9. The health center shall have a licensed physician as a medical director who supervises the medical services provided and who approves clinical policies, procedures, and protocols.

10. The health center staff shall operate within their scope of practice as determined by certification and applicable agency policies:
  - a) The center shall be staffed by a certified nurse practitioner (FNP, PNP, or SNP), licensed physician, or a licensed physician assistant working under the supervision of a physician. Nurse practitioners must be certified or eligible for certification in Michigan; accredited by an appropriate national certification association or board; and have a current, signed collaborative practice agreement, and prescriptive authority agreement with the medical director or designee. Physicians and physician assistants must be licensed to practice in Michigan.
  - b) The health center must be staffed with a minimum of a .50 FTE licensed Masters level mental health provider (i.e. counselor or Social Worker). Alternative clinical centers must be staffed with a minimum of a .30 FTE licensed Masters level mental health provider. Appropriate supervision must be available.
11. The health center must establish a procedure that does not violate confidentiality for communicating with the identified Primary Care Provider (PCP), based on criteria established by the provider and the Medical Director.
12. The health center shall implement a continuous quality improvement plan. Components of the plan shall include, at a minimum:
  - a) Practice and record review shall be conducted at least twice annually by an appropriate peer and/or other staff of the sponsoring agency, to determine that conformity exists with current standards of health care. A system shall also be in place to implement corrective actions when deficiencies are noted. A CQI Coordinator shall be identified. CQI meetings, that include staff of all disciplines working in the health center, shall be held at least quarterly. These meetings shall include discussion of reviews, client satisfaction survey, and any identified clinical issues.
  - b) Completing, updating, or having access to an adolescent health needs assessment process including at a minimum risk behavior survey conducted within the last three years to determine the health needs of the target population.
  - c) Conducting a client satisfaction survey at a minimum annually.
13. A local community advisory committee shall be established and operated as follows:
  - a) A minimum of two meetings per year.
  - b) The committee must be representative of the community and include a broad range of stakeholders such as school staff.
  - c) One-third of committee members must be parents of school-aged children/youth.
  - d) Health care providers shall not represent more than 50% of the committee.
  - e) The committee must approve the following policies and the health center must develop applicable procedures:
    1. Parental consent policy.
    2. Requests for medical records and release of information that include the role of the non-custodial parent and parents with joint custody.
    3. Confidential services as allowed by state and/or federal law.
    4. Disclosure by clients or evidence of child physical or sexual abuse, and/or neglect.

- f) Youth input to the committee shall be maintained through either membership on the established advisory committee; a youth advisory committee; or through other formalized mechanisms of youth involvement and input.
- 14. The health center shall have space and equipment adequate for private physical examinations, private counseling, reception, laboratory services, secured storage for supplies and equipment, and secure paper and/or electronic client records. The physical facility must be barrier-free, clean, and safe.
- 15. The health center staff shall follow all Occupational Safety and Health Act guidelines to ensure protection of health center personnel and the public.
- 16. The health center shall conform to the regulations determined by the Department of Health and Human Services for laboratory standards.

Billing and Fee Collection

- 17. The health center shall establish and implement a sliding fee scale, which is not a barrier to health care for adolescents. Adolescents must not be denied services because of inability to pay. CAHC state funding must be used to offset any outstanding balances (including copays) to avoid collection notices and/or referrals to collection agencies for payment.
- 18. The health center shall establish and implement a process for billing Medicaid, Medicaid Health Plans, and other third party payers.
- 19. The billing and fee collection processes do not breach the confidentiality of the client.
- 20. Revenue generated from the health center must be used to support health center operations and programming.

**REV for 10/2014**

## **MINIMUM PROGRAM REQUIREMENTS FOR CHILD AND ADOLESCENT HEALTH CENTERS ELEMENTARY SITES**

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### **ELEMENT DEFINITION:**

Services provided through Child and Adolescent Health Centers are designed specifically for elementary school-aged children ages 5-10 aimed at achieving the best possible physical, intellectual, and emotional status. Included in this element are elementary, school-based health centers designed to provide comprehensive primary care, psychosocial and mental health services, health promotion/disease prevention, and outreach services.

### **MINIMUM PROGRAM REQUIREMENTS:**

#### Services

1. The health center shall provide a range of health and support services, based on a needs assessment of the community/target population and approved by the community advisory committee, that are of high quality, accessible, and acceptable to the target population. The use of age appropriate prevention guidelines and screening tools must be utilized.
  - a) Clinical services shall include, at a minimum: primary care, including health care maintenance (well care), EPSDT screening, immunization assessment and administration using the MCIR, care of acute and chronic illness; health education and risk reduction counseling; dental services or referral and referral for other services not available at the health center. (See Attachment 1 for services detail.)
  - b) Mental health services must be provided at all elementary Child and Adolescent Health Centers.
  - c) Each health center shall implement two evidence-based programs and/or clinical interventions in at least one of the approved focus areas as determined through needs assessment data (See Attachment 2 for approved focus areas).
2. Clinical services, including mental health services, shall meet the recognized, current standards of practice for care and treatment of elementary school-aged children (ages 5-10).
3. The health center shall not provide abortion counseling, services, or make referrals for abortion services.
4. The health center shall not prescribe, dispense, or otherwise distribute family planning drugs and/or devices.
5. The health center shall provide Medicaid outreach services to eligible children and families and shall adhere to Child and Adolescent Health Centers and Programs outreach activities as outlined in MSA 04-13.

## Administrative

6. There shall be a current interagency agreement defining roles and responsibilities between the sponsoring agency and the local school district. Written approval by the school administration and local school board exists for the following:
  - a) Location of the health center in the school.
  - b) Administration of a needs assessment process to determine priority health services.
  - c) Parental consent policy.
  - d) Services rendered in the health center.
  - e) Policy and procedure on how children will access the center during school hours.
7. The health center shall be open during hours accessible to its target population, and provisions must be in place for the same services to be delivered during times when school is not in session. Not in session refers to times of the year when schools are closed for extended periods such as holidays, spring breaks, and summer vacation. These provisions shall be posted and explained to clients.

Clinical Centers: The health center shall provide clinical services a minimum of five days per week. Total primary care provider clinical time shall be at least 30 hours per week. Mental health provider time must be a minimum of 20 hours per week. Hours of operation must be posted in areas frequented by the target population.

Alternative Clinical Centers: The health center shall provide clinical services a minimum of three consistent days per week. Total primary care provider clinical time shall be at least 24 hours per week. Mental health provider time must be a minimum of 12 hours per week. Hours of operation must be posted in areas frequented by the target population.

The health center must have a written plan for after-hours and weekend care, which shall be posted and explained to clients. An after-hours answering service and/or answering machine with instructions on accessing after-hours care is required.

8. The health center shall have a licensed physician as a medical director who supervises the medical services provided and who approves clinical policies, procedures, and protocols. The medical director will designate prescriptive authority to the mid-level provider.
9. The health center staff shall operate within their scope of practice as determined by certification and/or agency policies. The center shall be staffed by a certified nurse practitioner (FNP, PNP, or SNP), licensed physician, or a licensed physician assistant working under the supervision of a physician. Nurse practitioners must be certified or eligible for certification in Michigan; accredited by an appropriate national certification association or board; and have a current, signed collaborative practice agreement and prescriptive authority agreement with the medical director or designee. Physicians and physician assistants must be licensed to practice in Michigan.
10. The health center must be staffed with a minimum of a .50 FTE licensed Masters level mental health provider (i.e. counselor or Social Worker) for full clinical centers. For

Alternative clinical centers must be staffed with a minimum of a .30 FTE licensed Masters level mental health provider. Appropriate supervision must be available.

11. The health center must establish a procedure that does not violate confidentiality for communicating with the identified Primary Care Provider (PCP), based on criteria established by the provider and the Medical Director.
12. The health center shall implement a continuous quality improvement plan. Components of the plan shall include at a minimum:
  - a) Practice and record review shall be conducted at least twice annually by an appropriate peer and/or other staff of the sponsoring agency, to determine that conformity exists with current standards of health care. A system shall also be in place to implement corrective actions when deficiencies are noted. A CQI Coordinator shall be identified. CQI meetings, that include staff of all disciplines working in the health center, shall be held at least quarterly. These meetings shall include discussion of reviews, client satisfaction survey and any identified clinical issues.
  - b) Completing, updating, or having access to a health needs assessment process including at a minimum risk behavior survey conducted within the last three years to determine the health needs of the target population.
  - c) Conducting a client satisfaction survey at a minimum annually.
13. A local community advisory committee shall be established and operated as follows:
  - a) A minimum of two meetings per year.
  - b) The committee must be representative of the community and must be comprised of at least 50% members of the community.
  - c) Health care providers shall not represent more than 50% of the committee.
  - d) One-third of committee members must be parents of school-aged children.
  - e) School staff must be represented on the committee, including at least one of the following: school nurse (if applicable), administrative positions, teachers, specialty school program staff, or student support team members.
  - f) The advisory committee must approve the following policies and the elementary school health center must develop applicable procedures for:
    1. Parental consent.
    2. Requests for medical records and release of information that include the role of the non-custodial parent and parents with joint custody.
    3. Confidential services as allowed by state and/or federal law.
    4. Disclosure by clients or evidence of child physical or sexual abuse, and/or neglect.
14. The health center shall have space and equipment adequate for private physical examinations, private counseling, reception, laboratory services, secured storage for supplies and equipment, and secure paper and/or electronic client records. The physical facility must be barrier-free, clean, and safe.
15. The health center health center staff shall follow all Occupational Safety and Health Act guidelines to ensure protection of health center personnel and the public.

16. The health center shall conform to the regulations determined by the Department of Health and Human Services for laboratory standards.

Billing and Fee Collection

17. The health center shall establish and implement a sliding fee scale, which is not a barrier to health care for children. Children must not be denied services because of inability to pay. CAHC state funding must be used to offset any outstanding balances (including copays) to avoid collection notices and/or referrals to collection agencies for payment.
18. The health center shall establish and implement a process for billing Medicaid, Medicaid Health Plans and other third-party payers.
19. The billing and fee collection processes must not breach the confidentiality of the client.
20. Revenue generated from the health center must be used to support health center operations and programming.

**REV for 10/2014**

# **CHILD AND ADOLESCENT HEALTH CENTERS CLINICAL AND ALTERNATIVE CLINICAL MODELS**

## **Attachment 1: Services Detail**

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**The following health services are required (\*or recommended) as part of the Child and Adolescent Health Center service delivery plan:**

### PRIMARY CARE SERVICES

- Well child care
- EPSDT screenings and exams
- Comprehensive physical exams
- Risk assessment/other screening
- Laboratory services
  1. CLIA Waived testing
  2. Specimen collection for outside lab testing
- Vision screening
- Hearing screening
- \*Other diagnostic/screening
  1. Spirometry
  2. Pulse oximetry
  3. Tympanometry
  4. Office microscopy

### MENTAL HEALTH SERVICES

- Mental Health services provided by a Masters level mental health provider.

### ILLNESS/INJURY CARE

- Minor injury assessment/treatment and follow-up.
- Acute illness assessment/treatment and follow-up and/or referral.

### CHRONIC CONDITIONS CARE

- Includes assessment, diagnosis and treatment of a new condition.
- Maintenance of existing conditions based on need, collaborations with PCP/specialist or client/parental request.
- Chronic conditions may include: asthma, diabetes, sickle cell, hypertension, obesity, metabolic syndrome, depression, allergy, skin conditions, or other specific to a population.

### IMMUNIZATIONS

- Screening and assessment utilizing the MCIR and other data.
- Complete range of immunizations for the target population utilizing Vaccine for Children and private stock.
- Administration of immunizations.
- Appropriate protocols, equipment, medication to handle vaccine reactions.

## HEALTH EDUCATION

### STI & HIV EDUCATION, COUNSELING, and VOLUNTARY TESTING (Adolescent Centers Only)

- Education appropriate for age, other demographics of the target population, and needs assessment data.
- Risk assessment, historical and physical assessment data informs individualized care.
- A certified HIV counselor/tester is on site.
- Testing for and treatment of STI and testing and referral for HIV treatment is on site.

### “CONFIDENTIAL SERVICES” AS DEFINED BY MICHIGAN AND/OR FEDERAL LAW (Adolescent Centers Only)

- Confidential services are those services that may be obtained by minors without parental consent.
- Confidential services include: mental health counseling, pregnancy testing and services, STI/HIV testing and treatment, substance abuse counseling and treatment, family planning (excluding contraceptive prescription/distribution on school property).

## REFERRAL

- PCP, specialists, psychiatrists, dental, community agencies, etc.

### REQUIRED FOR ELEMENTARY CENTERS ONLY

- Dental services or referral for dental care.

## **CHILD AND ADOLESCENT HEALTH CENTERS**

### **Attachment 2: Focus Areas**

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Each year, health centers should review their needs assessment data to determine priority health issues that are of such significance to their target population to warrant an enhanced “focus” for the upcoming year. Each center is required to implement at least two evidence based programs or clinical interventions to begin to address the needs within the selected focus area(s).

#### **FOCUS AREAS**

- ALCOHOL/TOBACCO/OTHER DRUG PREVENTION
- CHRONIC DISEASE MANAGEMENT
- HIV/AIDS/STI PREVENTION
- NUTRITION AND PHYSICAL ACTIVITY
- PREGNANCY PREVENTION

Focus areas are meant to provide services above and beyond what would typically be provided in comprehensive primary care. It is expected that each of these focus areas will be a part of comprehensive primary care already, but those selected for the focus area requirement should be significantly beyond typical care. Strategies should be intensive, evidence-based, and include appropriate evaluation methods to assess impact and progress on meeting focus areas.

# **ATTACHMENT F PLANNING PHASE TIMELINE/ACTIVITIES TABLE**

(Templates can be found at [www.michigan.gov/cahc](http://www.michigan.gov/cahc))

<b>OBJECTIVE # _____:</b>		
<b>ACTIVITIES/INTERVENTIONS</b>	<b>PERSON RESPONSIBLE</b>	<b>TIMEFRAME</b>
List your planning activities for the timeframe of October 1, 2014- April 1, 2015 for each objective.	Clearly identify the position(s) responsible for carrying out each proposed activity or intervention.  Please provide <i>titles/positions</i> and <i>not names</i> of individuals.	Provide the projected dates for <i>implementing</i> each activity.

# **ATTACHMENT G**

## **MEDICAID BULLETIN**



# Bulletin

Michigan Department of Community Health

**Distribution:** Medicaid Health Plans 04-08  
Local Health Departments 04-05  
Federally Qualified Health Centers 04-01

**Issued:** August 24, 2004

**Subject:** Outreach Activities

**Effective:** October 1, 2004

**Programs Affected:** Medicaid

Child & Adolescent Health Centers and Programs (CAHCPs), under agreement with the Michigan Department of Community Health, will begin performing Medicaid outreach activities on behalf of the Medicaid Health Plans (MHPs) effective October 1, 2004. CAHCPs were formerly known as school-based, school-linked health centers and the Michigan Model program. This bulletin describes the categories of outreach services that the CAHCPs are expected to perform under the agreement. All outreach activities must be specific to the Medicaid program.

CAHCPs are expected to perform outreach activities to potential and current Medicaid beneficiaries in the following categories:

### **Medicaid Outreach and Public Awareness**

Activities that are to be performed include those associated with informing eligible or potentially eligible individuals about Medicaid covered benefits and how to access them. This includes providing information about Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services or making referral for such services. This category of outreach also includes coordinating and presenting information about Medicaid through media resources, health fairs and other community forums.

### **Facilitating Medicaid Eligibility Determination**

Activities in this category of Medicaid outreach are related to assisting potential Medicaid eligible individuals in applying for Medicaid benefits. This includes explaining eligibility rules and assisting with the completion of the Medicaid application. It also includes referring individuals to the Michigan Family Independence Agency to make application for benefits.

### **Program Planning, Policy Development and Interagency Coordination Related to Medical Services**

Under this category of outreach activities, the CAHCPs must work collaboratively with other community agencies to assure the delivery of Medicaid-covered services. This includes tracking requests for referrals and coordinating services with the Medicaid Health Plans. Activities that include development of health programs and services targeted to the Medicaid population fall into this category.

**Referral, Coordination, and Monitoring of Medicaid Services**

Outreach activities in this category include development of program resources for program- specific services at CAHCPs. Coordination of programs and services at the school and/or community levels and monitoring delivery of Medicaid services within the school and/or community are included. CAHCPs may provide information such as that for EPSDT services or making referrals for family planning services.

**Medicaid-Specific Training on Outreach Eligibility and Services**

Activities that fall into this category of outreach are those that focus on coordinating, conducting, or participating in training and seminars to instruct patients, school personnel, health center staff and community members about the Medicaid program and benefits and how to assist families in accessing Medicaid services. Outreach-related activities include training that enhances early identification, screening and referral of children and adolescents for EPSDT services or behavioral health needs. This category includes development and presentation of training modules regarding Medicaid eligibility and benefits to health center and school health staff and other stakeholders, such as parents and guardians.

**Related Documents**

The Department will work with the MHPs and the Michigan Primary Care Association (representing the CAHCPs) to develop agreements through which these outreach activities will be coordinated.

**Public Comment**

Public comment on this bulletin will be accepted and considered for future policy revisions. Comments may be submitted to MDCH Program Policy Division, PO Box 30479, Lansing, MI, 48909-7979.

**Manual Maintenance**

Retain this bulletin for future reference.

**Questions**

Any questions regarding this bulletin should be directed to Provider Support, P.O. Box 30731, Lansing, Michigan 48909-8231, or e-mail at [ProviderSupport@michigan.gov](mailto:ProviderSupport@michigan.gov). When you submit an e-mail, be sure to include your name, affiliation, and phone number so you may be contacted if necessary. Providers may phone toll-free 1-800-292-2550.

**Approval**

Paul Reinhart, Director  
Medical Services Administration

# **ATTACHMENT H**

## **BUDGET NARRATIVE INSTRUCTIONS**

## Budget Narrative Instructions

All proposals must include a budget narrative and a line-item budget for the project for the time frame October 1, 2014-September 30, 2015.

This attachment details information required in the budget narrative. In the budget narrative, applicants are expected to justify the total cost of the program and to list other sources of funding that contribute to the CAHC program.

**Budget Justification.** The budget justification must provide detailed descriptions of planned expenditures, including justification and rationale. All budget line-items must be described in the budget narrative.

- *Salaries and Wages (personnel)* - For each staff position associated with the program, provide the name, title, annual salary, and percent of a full time equivalent (FTE) dedicated to the program. Describe the role of each staff person in achieving proposed program objectives. Salaries and wages for program supervision are allowable costs, proportionate to the time allocated to the proposed program.
- *Taxes and Fringe Benefits* - Indicate, by percentage of total salary, payroll, and fringe rate (e.g., FICA, retirement, medical, etc.).
- *Travel* - Describe who is traveling and for what purpose. Include reimbursement rates for mileage, lodging and meals. Indicate how many miles, overnights, etc. will be supported annually. **Travel of consultants should not be included in this category but rather under the category of Other - Consultant Fees.** International travel cannot be supported with funding awarded under this RFP. Out of state travel must be reasonable and necessary to the achievement of proposed goals and objectives. Staff travel for training and skills enhancement should be included here and justified.
- *Supplies and Materials* - Describe the types and amount of supplies and materials that will be purchased. Include justification for level of support requested for items and how it relates to the proposed program. Items requested may include but are not limited to: postage, office supplies, screening devices, prevention materials, training supplies, and audio/visual equipment (under \$5,000).
- *Contractual* - Describe all subcontracts with other agencies. Include the purpose of the contract, method of selection, and amount of the sub-contract. **Contracts with individuals** should be included in the *Other category as Consultant Fees*.
- *Equipment* - This category includes stationary and moveable equipment to be used in carrying out the objectives of the program. **Equipment items costing less than five thousand dollars (\$5,000) each are to be included in the Supplies and Materials category.**

- *Other Expenses* - This category includes all other allowable costs. Common expenditures in this category include the following, though your budget may include additional items.
  - Consultant Services* - Provide the name (if known), hourly rate, scope of service, and method of selection for each consultant to be supported. The expertise and credentials of consultants should be described. Provide rationale for use of consultant for specified services. Travel and other costs of these consultants are to be included in this category and justified.
  - Space* - Include items such as rent and utilities in this category. Each of these costs must be described. The description must address the cost per month and indicate the method of calculating the cost. Cost for acquisition and/or construction of property are not allowable costs under this RFP.
  - Communications* - Describe monthly costs associated with the following:
    - phone (average cost per month, proportionate to proposed program)
    - fax (average cost per month, proportionate to proposed program)
    - internet access/email service (average cost per month, proportionate to proposed program)
    - teleconferencing (number of sessions, average cost per use)
  - Printing and Copying* - Describe costs associated with reproduction of educational and promotional materials (manuals, course hand-outs, pamphlets, posters, etc.). Do not include copying costs associated with routine office activities.
  - Indirect Costs* - Indirect costs are not allowed under this grant.**
  - Architectural Costs* – Architectural and building costs are not allowed.**
  - Capital Costs* – Capital costs are not allowed.**

**Other Funding Sources.** If the applicant receives other funding to conduct services which are linked to the proposed program, they are to supply the following information for each source.

- Source of funding
- Project period
- Annual amount of award
- Target population
- Brief description of intervention (2-3 sentences)

If applicant does not receive any other support for proposed service, indicate that this section is not applicable.