



Oklahoma State
Department of Health
Creating a State of Health

**FEDERALLY QUALIFIED HEALTH CENTER (FQHC)
UNCOMPENSATED CARE FUND APPLICATION
STATE FISCAL YEAR 2015**

**OKLAHOMA STATE DEPARTMENT OF HEALTH UNCOMPENSATED CARE FUNDING
IS SUBJECT TO AVAILABILITY**

**POINT OF CONTACT: JOHN GILES, DIRECTOR
CENTER FOR HEALTH INNOVATION AND EFFECTIVENESS
OKLAHOMA STATE DEPARTMENT OF HEALTH
1000 NE 10TH STREET
OKLAHOMA CITY, OKLAHOMA 73117-1299**

Uncompensated Care Fund Application

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Oklahoma State
Department of Health

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**Center for
Health
Innovation &
Effectiveness**

**OKLAHOMA STATE DEPARTMENT OF HEALTH, UNCOMPENSATED CARE FUND
ASSISTANCE TO FEDERALLY QUALIFIED HEALTH CENTERS (FQHC) APPLICATION**

SUBMISSION GUIDELINES

COMPLETED APPLICATIONS MUST BE RECEIVED BY 5:00 PM CST, FRIDAY, AUGUST 29, 2014.

Submission requires remittance of one (1) original and one (1) copy of this Application. Applications may be delivered via USPS, Fed Ex, UPS etc., hand delivered or couriered.

IF THE APPLICATION IS INCOMPLETE OR NON-RESPONSIVE TO SUBMISSION REQUIREMENTS, IT WILL NOT BE ENTERED INTO THE RECIPIENT POOL FOR UNCOMPENSATED CARE COSTS ASSISTANCE IN SFY 2015.

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

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

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

Mailing Address for Application Delivery:

Contract Monitor

John Giles, MPA
Director, Center for Health Innovation and Effectiveness
Oklahoma State Department of Health
1000 NE 10th Street
Oklahoma City, Oklahoma 73117-1299
FQHC@health.ok.gov

Administrative Contact

Valorie Owens, MSW
Project Manager, Center for Health Innovation and Effectiveness
Oklahoma State Department of Health
1000 NE 10th Street, Oklahoma City, OK 73117-1299
405-271-9444, ext. 56734
FQHC@health.ok.gov

OKLAHOMA STATE DEPARTMENT OF HEALTH

APPLICATION CHECKLIST

Submit all documents on the checklist, and return this completed form with the application.

Mailing Address MAY NOT be a post office box.

Applicant Organization:

Contact Name:

Address:

City:

State:

Zip Code:

Phone: () -

E-mail:

The following documents must be submitted with your application. A copy of this completed application checklist will be returned to you to confirm that your application for assistance through the Oklahoma Uncompensated Care Fund has been received by the OSDH.

- Completed Application (Forms A – F) with signed Application Checklist
Signed Contract between OSDH and Applicant (includes Business Associate Agreement & Non-Collusion Certification)
Current federal HRSA Notice of Grant Award, including HRSA-approved budget
Uniform Data System Report for period of January 1, 2013 through December 31, 2013
330 Health Center Cluster Grant application submitted to HRSA (most recent)
IRS 990 for 2013 Tax Year (or most recent)
Independent Audit (most recent, as required by and submitted to HRSA)
Current board-adopted sliding fee schedule for uninsured patients
Current Billing and Collections policies and procedures, if available
Certificate of Liability Insurance/Workers' Compensation Coverage/ FTCA Coverage (Deeming Letter)

The undersigned, authorized agent for the above-named Applicant, by signing below attests that all documents requested above have been submitted per the application guidelines.

Authorized Agent Name

Authorized Agent Signature

Date

FOR INTERNAL USE ONLY:

Administrative Review Completed Application Complete Application Incomplete or Non-Responsive

John Giles, Contract Monitor Signature

Date

Valorie Owens, Administrative Signature

Date



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FORM A
State Fiscal Year 2015 Uncompensated Care Fund Application

This form requests basic information about the applicant. If any of the following information changes during the term of the contract, applicant MUST send written notification to the assigned Contract Monitor at the OSDH mailing address.

FEDERALLY QUALIFIED HEALTH CENTER INFORMATION

LEGAL NAME OF FQHC:

MAILING ADDRESS INFORMATION (include mailing address, street, city, state and zip code):

CONTRACTOR Name and Mailing Address (if different from above):

PROPOSED BUDGET PERIOD: Start date **07/01/2014** End Date **06/30/2015**

DESCRIPTION OF FQHC SERVICE AREA (If possible, please include a map of the service area approved and on file with the Bureau of Primary Health Care):

TOTAL NUMBER OF UNINSURED PATIENTS SERVED IN SFY 2014:

PROJECTED NUMBER OF UNINSURED PATIENTS IN SFY 2015:

Executive Director:

Mailing Address (incl. street, city, state, & zip):

Title/Credentials:

Phone:

Ext.

Fax:

E-mail:

Primary FQHC Contact:

Mailing Address (incl. street, city, state, & zip):

Title/Credentials:

Phone:

Ext.

Fax:

E-mail:

Medical Director:

Mailing Address (incl. street, city, state, & zip):

Title/Credentials:

Phone:

Ext.

Fax:

E-mail:

FORM B: PROJECTED COSTS OF UNINSURED ENCOUNTERS

Applicant/FQHC: _____

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

Box A: The applicant must project a reasonable estimate of the combined total number of unduplicated uninsured billable encounters the applicant will provide services to at all of their FQHC site(s) in SFY 2015.

Box B. Enter the current prospective payment system (PPS) rate per encounter assigned to the applicant by the Oklahoma Health Care Authority for billable encounters.

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

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

A. Total # Unduplicated Uninsured, Billable Encounters (for all sites)	B. PPS Rate Per Billable Encounter	C. # Encounters X PPS Rate = Total Amount
	\$	\$

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

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

- (i) A group health plan as defined in § 146.145(a);
- (ii) Health insurance coverage as defined in § 144.103 of this chapter;
- (iii) Part A or B of Title XVIII of the Social Security Act (Medicare);
- (iv) Title XIX of the Social Security Act (Medicaid), other than coverage consisting solely of benefits under section 1928 of the Social Security Act (the program for distribution of pediatric vaccines);
- (v) Title 10 U.S.C. Chapter 55 (medical and dental care for members and certain former members of the uniformed services, and for their dependents; for purposes of Title 10 U.S.C. Chapter 55, uniformed services means the armed forces and the Commissioned Corps of the National Oceanic and Atmospheric Administration and of the Public Health Service);
- (vi) A medical care program of the Indian Health Service or of a tribal organization;
- (vii) A State health benefits risk pool;
- (viii) A health plan offered under Title 5 U.S.C. Chapter 89 (the Federal Employees Health Benefits Program);
- (ix) A public health plan;
- (x) A health benefit plan under section 5(e) of the Peace Corps Act (22 U.S.C. 2504(e)); and
- (xi) Title XXI of the Social Security Act (State Children's Health Insurance Program).

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

- (i) Coverage only for accident (including accidental death and dismemberment);
- (ii) Disability income coverage;
- (iii) Liability insurance, including general liability insurance and automobile liability insurance;
- (iv) Coverage issued as a supplement to liability insurance;
- (v) Workers' compensation or similar coverage;
- (vi) Automobile medical payment insurance;
- (vii) Credit-only insurance (for example, mortgage insurance); and
- (viii) Coverage for on-site medical clinics.

FORM C: FQHC SECONDARY SITE

Instructions: Complete a separate form for each clinic site, numbered consecutively (see Instructions for completing FQHC Secondary Site Forms on page 9 of this application).

Legal Name of Applicant/FQHC:		Site #	of
FQHC Site Name to Appear on OSDH Website:			
Service Area (counties to be served by this site):			
FQHC Site Contact Person:			
Location of Site:			
Street Address:			
City:	State:	Zip Code:	HSR:
Phone: () -	Fax: () -		
Is this Site a Subcontractor Site? <input type="checkbox"/> Yes <input type="checkbox"/> No			
E-mail:		Website:	

FORM D: FQHC SECONDARY SITE

Instructions: Complete a separate form for each clinic site, numbered consecutively (see Instructions for completing FQHC Secondary Site Forms on page 9 of this application.)

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

FQHC SECONDARY SITE FORM INSTRUCTIONS

Instructions: Complete separate FQHC site forms for each existing or proposed site for which SFY 2015 Uncompensated Care Funds are requested and number sites consecutively. Information provided on site forms will be used to update OSDH websites and public databases; therefore, each site form must contain current and accurate information.

FIELD NAME	INFORMATION REQUIRED
Legal Name of Applicant	FQHC's legal name.
FQHC Site # ___ of ___	Example: FQHC Site #1 of 5 for the first site out of five sites, FQHC Site #2 of 5 for the second site of five, etc.
FQHC Site Name to Appear on OSDH Website	Name of the site as it will appear on the OSDH website. (The name should be recognizable to clients.)
Service Area	List counties <u>served by that specific clinic site.</u>
FQHC Site Contact Person	Name of contact person for that site.
Phone	Phone number for the site.
Location of Site	FQHC location (e.g., Medical Center, Medical Plaza, etc.)
Street Address/ City/Zip	Physical address of site. (Do Not enter a P.O. Box.)
HSR	Health Service Region where site is located.
Subcontractor Site	For each site, indicate whether that particular site is subcontracted by the applicant to another entity for the provision of services.
Hours of Operation	List the operating hours of each site for each day of the week broken into morning (Ex: 8:00 a.m. – Noon), afternoon (Ex: 12:01 p.m. – 5:00 p.m.), and evening hours (Ex: 5:01 p.m. – 8:00 p.m.). Indicate days of the week when the clinic is closed (Ex: Tuesday – closed).
Services Provided/Clinic Type	List the type of services provided or type of clinic for each day of the week (Ex: Monday = child health clinic, Wednesday = dental clinic, etc.)
# Monthly Clinics	List the total number of clinics each month by the day of the week (Ex: Monday = 4 clinics per month; Tuesday = 0 clinics per month, etc.)
Total Hours/Month	List the total number of hours of operation per month for that clinic site (Ex: 128 hours per month)
Total # Clinics Per Month	List the total number of clinics held per month for that clinic site (Ex: 16 clinics)

FORM E: FQHC Funding Sources

Mark an X in the applicable column(s) for each SFY 2015 funding source and provide award amount.

Source	Application Pending	Currently Receive	Do Not Receive	Total Amount Awarded	Coverage Period (mm/yy - mm/yy)
BPHC Grant - Community Health Center					
BPHC Grant - Migrant Health Center					
BPHC Grant - Health Care for the Homeless					
ARRA Increased Demand for Services Grant					
Foundation/Private Grants*					

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

2. Please note below any other projected funding for the mitigation of uncompensated care costs for SFY 2015:

