



STATE OF MARYLAND

Community Health Resources Commission

4201 Patterson Avenue, Room 400 • Baltimore, Maryland 21215

Martin O'Malley, Governor – Anthony G. Brown, Lt. Governor – John A. Hurson, Chair
Grace S. Zaczek, Executive Director

**Aligning Community Health Resources:
Improving Access to Care for Marylanders**

Request for Proposals

May 4, 2009

Overview

The Community Health Care Access and Safety Net Act of 2005 authorized the creation of the Maryland Community Health Resources Commission. Governor Martin O'Malley appointed the current Commissioners in May, 2007. Through grants, community assessments, and technical assistance, the Commission works to increase access to care for low-income families and under- and uninsured individuals. The Commission helps communities develop more coordinated, integrated systems of community-based care, redirect non-emergency care from hospital emergency rooms to other providers in the community, and assist individuals in establishing a medical home. The cornerstones of these efforts are community-based health care centers and programs, referred to in the legislation as "community health resources."

Aligning Community Health Resources: Improving Access to Care for Marylanders is the grants program of the Maryland Community Health Resources Commission. The program awards grants to community health resources serving Marylanders in Maryland. In this offering, the Commission will consider projects in one priority area. The Commission has received a limited amount of additional funding for Fiscal Year 2010, and wants to support community health resources in beginning services to Maryland residents as soon as possible. The Commission intends to have proposals selected for award and grant agreements signed by June 30, 2009. To accomplish this goal, the Commission has devised a compressed timeline for the application and grant award process as described below in "How to Apply," and "Proposal Guidelines."

The Commission's priority area for Fiscal Year 2010 is reducing infant mortality, pre-term births and low birth weight babies through pre-natal initiatives. Proposals should be designed to clearly address these outcomes. Strategies could include creating or expanding clinical pre-natal services of an obstetrician, or a primary care provider, nurse practitioner or physician's assistant who focuses on pre-natal, postpartum and newborn care. The project should offer case management and a significant program of education for families about proper pre-natal and newborn and infant care. The project must include services to determine mothers' and newborns' eligibility for financial assistance programs such as Medicaid and to enroll them in those programs. The project must establish a primary care medical home for patients, either within the applicant organization or by case-managed referral to a primary care provider that accepts the patient's healthcare coverage or for uninsured patients offers a sliding fee scale. The applicant organization must document that the patient is enrolled with and actually receiving care with the primary care provider.

The Commission will consider proposals for projects of 30 or 36 months' duration for up to \$500,000 for new services or for up to \$300,000 for expansion grants. Forty percent of the total award will be available in Fiscal Year 2010, forty percent will be available in Fiscal Year 2011, and twenty percent will be available in Fiscal Year 2012. Funds in each fiscal year are contingent on the General Assembly appropriating sufficient funds for the Commission, or funds otherwise being made available in that fiscal year.

The FY 2010 Grant process for this round is being significantly streamlined in terms of the Process. Letters of Intent submitted by May 11 will be reviewed by the Commission and the Commission will select potential applicants who will be invited to make a complete application.



Which Community Health Resources May Apply for these Grants?”

In this grantmaking round, the Commission will consider proposals from any Community Health Resource eligible under the Commission’s regulations at COMAR 10.45.05. A Community Health Resource must submit a proposal as outlined under “How to Apply” below.

- A Letter of Intent for the proposed project must be submitted by May 11, 2009.

What is a Community Health Resource?

An organization can demonstrate that it is a community health resource in any of three ways:

➔ **As a Designated Community Health Resource.** The legislation and the Commission designated as community health resources the fourteen organization types listed below. All of these are eligible to apply for and receive grants from the Commission.

- Federally qualified health centers (FQHCs) and FQHC “look-alikes”
- Community health centers
- Migrant health centers
- Health care programs for the homeless
- Primary care programs for public housing projects
- Local nonprofit and community-owned health care programs
- School-based health centers
- Teaching clinics
- Wellmobiles
- Community health center-controlled operating networks
- Historic Maryland primary care providers
- Outpatient mental health clinics
- Local health departments
- Substance abuse treatment providers

Organizations not designated above may also qualify as a community health resource. To do so, organizations must demonstrate that they meet the Commission’s criteria for either a Primary Health Care Services Community Health Resource or an Access Services Community Health Resource.

➔ **As a Primary Health Care Services Community Health Resource.** Organizations must demonstrate that they:

- Provide primary health care services
- Offer those services on a sliding scale fee schedule
- Serve individuals residing in Maryland.

➔ **As an Access Services Community Health Resource.** Organizations must demonstrate that they:

- Assist individuals in gaining access to reduced price clinical health care services
- Offer their services on a sliding scale fee schedule
- Serve individuals residing in Maryland.



Sliding Scale Fee Schedule Requirements

Organizations seeking to demonstrate that they are a Primary Health Care Services Community Health Resource or an Access Services Community Health Resource must offer a sliding scale fee schedule consistent with the following guidelines established by the Commission. An applicant organization's sliding scale fee schedule must provide discounts to individuals with a family income at or below 200 percent of the federal poverty level, with no more than a nominal charge for individuals with a family income at or below 100 percent of the federal poverty level. No additional fees may be charged, such as an enrollment fee. The availability of discounted fees must be publicly displayed, and discounted services must be available to all who meet the eligibility criteria. The organization must review documentation on income from applicants. An organization that provides discounted or free care to all individuals who seek service, or to those with family income at or below 200 percent of the federal poverty level, complies with this requirement.

The Grants Program

Aligning Community Health Resources: Improving Access to Care for Marylanders seeks to award grants to community health resources in Maryland in one priority area.

Strategies to Reduce Infant Mortality, Pre-Term Births, Low-Birth Weight Babies and Teenage Pregnancy through Pre-natal Initiatives

- Awards will be for 30 or 36 months and for up to \$500,000 for new services and up to \$300,000 for expansion of existing services that clearly address outcomes of reducing infant mortality, pre-term births, low-birth weight babies, and teenage pregnancy.

According to the Babies Born Healthy Initiative of the DHMH Center for Maternal and Child Health, the percent of women receiving prenatal care in the first trimester of pregnancy has been dropping since 2000, reaching a low of 79.5% in 2007. Among white women in the state, 82% received early prenatal care, compared with 73.5% of Black women and only 63% of Hispanic women. African-American infants continue to be at greater risk, with a disparity of nearly to 2:1 in prematurity rates, and over 2:1 in infant death rates. Between 2006 and 2007 the disparity in infant deaths increased to 3:1. Preterm births have increased by 6% since 2000.

The Initiative reports that in 2005, 12.7% of all births in the United States were premature. In Maryland in 2005, the rate of prematurity was slightly higher than the national average, with 13.3% of all babies born prematurely. Almost 10,000 babies are born prematurely in Maryland every year.

The Annie E. Casey Foundation's *2008 Kids Count Data Book* states that Maryland is the wealthiest state in the nation, but the health of its infants is poor. The report goes on to say that Maryland ranks 39th out of the 50 states for low-birthweight births and 31st for infant mortality. About 7,000 Maryland babies are born too small each year. In 2007, 9.1% of births were low-birthweight according to the DHMH *Vital Statistics Administration 2007 Final Report*.



According to a study by the Maryland Advocates for Children and Youth, “the nine percent of Maryland births below normal birthweight . . . account for over half of the spending on births. A study by the Maryland Advocates for Children and Youth is the first examination of Maryland’s poor birth outcomes in the context of their fiscal cost to the State. Very low birthweight babies remain in the hospital for 15 times longer than normal weight babies. They also cost 36 times more.” In 2007, charges for VLBW and LBW babies were \$166.6 million, compared to \$146.0 million for the other 91 percent of babies, according to the study.

A November, 2006 report from the National Campaign to Prevent Teen Pregnancy shows that teen childbearing (teens 19 and younger) in Maryland cost taxpayers (federal, state, and local) at least \$195 million in 2004. Of the total 2004 teen childbearing costs in Maryland, 34% were federal costs and 66% were state and local costs.

Most of the costs of teen childbearing are associated with negative consequences for the *children* of teen mothers. In Maryland, in 2004, annual taxpayer costs associated with children born to teen mothers included: \$44 million for public health care (Medicaid and SCHIP); \$43 million for child welfare; \$46 million for incarceration; and \$48 million in lost tax revenue due to decreased earnings and spending. The costs of childbearing are greatest for younger teens. In Maryland, the average annual cost associated with a child born to a mother 17 and younger is \$5,150. Between 1991 and 2004 there have been more than 101,400 teen births in Maryland, costing taxpayers a total of \$3.4 billion over that period.

Strategies to address infant mortality, pre-term births, low-birth weight babies and teenage pregnancy could include providing clinical services of an obstetrician, a primary care physician, a nurse practitioner, or a physician’s assistant to manage pre-natal care, a nurse or health educator to teach patients self-care during pregnancy and new-born development and care, and outreach to the community on the need for and benefits of pre-natal care, and teenage pregnancy prevention. Services in a comprehensive pre-natal program should meet the particular needs of an organization’s patient population, must include services to determine mothers’ and newborns’ eligibility for financial assistance programs such as Medicaid and to enroll them in those programs. The project should offer case management, and where needed, language interpretation. Projects to address teenage pregnancy can focus on the special pre-natal care needs of teenagers who are pregnant, and strategies to prevent teenage pregnancy.

Selection Criteria

Applicants may submit proposals for projects to reduce infant mortality, pre-term births, low birthweight babies, and teenage pregnancy as described above. The Commission will use the following criteria to assess and select proposals for funding:

Prospects for Success: The proposed project directly addresses the priority area of this Request for Proposals. The goals and objectives of the project are clear, feasible, measurable, and achievable. The work plan and budget are reasonable. The team assembled possesses the skills, competencies, commitment, and sufficient capacity to carry out the proposed work and has a supportive organizational and community environment. The Commission’s priorities for awarding grant funds include establishing a “medical home” for families and children, and



providing evening and weekend hours in new projects, and increased evening and weekend hours in expansion of existing projects.

Potential Impact: The project is likely to lead to improved access to care for the target population and improved health (and birth) outcomes. The project has potential for expansion or replication within the community, in neighboring areas, or more broadly across the state.

Community Need: The target population is clearly identified and geographically defined, the number of individuals targeted is reliably quantified, and the needs of this population are adequately documented through qualitative and quantitative data, such as demographics, rates of insurance coverage, and service utilization statistics. The organization's baseline number of the target population currently served is clearly stated. The applicant demonstrates a deep understanding of the community to be served.

Sustainability: The project is likely to continue to provide benefits to the target population and the community at large beyond the duration of the proposed grant. Proposals must identify likely sources of future revenue or funding sufficient to sustain the project activities after the grant funds end. The Commission will give strong preference to those projects that can demonstrate funding from internal sources or community matching support, including "in kind" support. The Letter of Intent can describe the applicant's plans for securing the external match. Full applications must include specific progress towards obtaining the match, and plans for having acquired firm commitments for the full match by the time the project starts.

Preference will be given to those projects that can demonstrate community-wide, local support: at least 15% of the budget should come from funding commitments (cash or signed pledges) restricted to this project from other community partners such as chambers of commerce, hospitals, medical organizations, community organizations, individual donors, foundations, and corporations to ensure the sustainability of the project. (Funding commitments are to be fully paid within the inclusive dates of the grant award). If the project's community support is not yet in place, then the applicant should provide information that details the plan for generating such support. Five percent of the community match can be in-kind as tangible assets, such as furniture or computers, not staff time.

Preferences will be given to those Community Health Resources that can make at least an additional 5% financial commitment to this project from their own internal funds (operating funds or reserves). The five percent of the match can be in-kind as tangible assets, such as furniture or computers, not staff time. Indirect costs are limited to 10% of the total grant.

The local community contribution of 15 percent is intended to encourage applicants to raise public and private funds in their local communities to ensure sustainability of Commission funded initiatives. Letters of commitment for challenge funding or of intent to consider funding should be submitted as part of the full proposal. The source of the internal match can be funds which the applicant has, as long as those funds are for activities related to the proposed project.

Participation of Stakeholders and Partners: The project has enlisted as key participants relevant stakeholders and partners from the community and appropriate agencies and



organizations. These collaborators will be actively engaged as demonstrated by participation in the planning and implementation process, dedicated staff and other resources allocated to the project, contributions of facilities and equipment, and/or provision of free or discounted health care services. Letters of commitment from collaborators are required, and must be included in the proposal but letters alone may not be sufficient for demonstrating active engagement. The letters of commitment from outside organizations must clearly state what they will contribute to the project, and how they will participate in the project.

Data Collection: The project team has the ability to measure and report progress in achieving project goals and objectives through quantitative measures, such as the number, demographics, characteristics, and service utilization of the target population, both at baseline and as the project proceeds. The project team must also have the ability to comply with the evaluation and monitoring requirements of this grants program.

Organizational Commitment: The applicant organization is committed to improving access to care for the target population and can demonstrate that the proposed project will significantly contribute to this goal.

Financial Viability and Accountability: The applicant organization is in sound financial standing, has adequate financial management systems, and is capable of managing grant funds.

Provision of Sliding Scale Fee Schedule Services: The extent to which the applicant organization demonstrates use of a sliding scale fee schedule to increase access to care for low-income uninsured and under-insured individuals in Maryland.

The Commission will also consider the statutory priorities specified in Health General §19-2201(g). These are provided in the Appendix.

Evaluation and Monitoring

Grantees will be required to submit periodic progress reports and expenditure reports, as well as deliverables produced under the grant. To facilitate project monitoring, clearly defined data elements will be required from all grantees on a regular basis so that project accomplishments can be monitored, compared, and compiled.

The project team may be asked to attend meetings, participate in site visits, and give reports on progress and accomplishments to the Commission, its staff and advisors, and other grantees. At the conclusion of the project, the grantee will be required to provide a written report on the project.

As a condition of receiving grant funds, grantees must agree to participate in an evaluation of the grants program. This includes assisting with any data collection and information gathering required, such as participation in surveys, site visits, meetings, and interviews with the evaluators.



Use of Grant Funds

Grant funds may be used for project staff salaries and fringe benefits, consultant fees, data collection and analysis, project-related travel, conference calls and meetings, and office supplies and expenses. Grant funds may also be expended for a limited amount of essential equipment and minor infrastructure improvements required by the project. Grantees may subcontract with other organizations as appropriate to accomplish the purposes of the project.

Grant funds may not be used for major equipment or new construction projects, to support clinical trials, or for lobbying or political activity. Grant funds may be used for those renovations necessary to carry out the proposed project.

If the services in an applicant's proposal will be delivered by a contractor agency, not directly by the applicant, the applicant may not take a fee for passing through the funds to the contractor agency.

Awards

The Commission anticipates awarding grants in the one priority area. The funds will be disbursed over three Fiscal Years beginning in Fiscal Year 2010. Forty percent of the total award will be available in Fiscal Year 2010, forty percent will be available in Fiscal Year 2011, and twenty percent will be available in Fiscal Year 2012. Funds in each fiscal year are contingent on the General Assembly appropriating sufficient funds, or funds otherwise being made available in that fiscal year.

As part of the grant application review process, the Commission may request that an applicant organization provide additional information or revise its application as a condition of approving an award. Awards will be made by the Commission. The Commission will consider geographic diversity within the state of Maryland in making awards.

How to Apply

The Commission is refining its grant project selection process. The Letter of Intent has been expanded, and the full proposal for those applicants invited to submit one, has been reduced to accommodate a faster timeline for grant award decisions. For this round of grant making, applicants will submit a Letter of Intent as described below. The Commission will review the letters and select from them a number of applicants who will be invited to submit a full proposal as described below. Applicants submitting a full proposal will present their projects at the Commission's June 18, 2009 meeting. Based on the full proposals and presentations, the Commission will select projects for grant awards.

Step 1: Letter of Intent

Applicants must submit one original and seven copies of a Letter of Intent for the proposal to be considered. Letters of Intent must be received by 5:00 p.m. EDT on May 11, 2009 at the Commission's offices by hand delivery, U.S. Postal Service, or private courier.

The Letter of Intent should also be sent by 5:00 PM EDT on May 11, 2009 via e-mail to: mdchrc@dhmh.state.md.us The letter should not exceed four single-spaced pages in length.



The Letter of Intent should include:

- Name and location of the applicant organization.
- The project's title.
- The amount of funds being requested and the project's estimated duration.
- Whether this is a new project or an expansion of existing services and expected outcomes of the project.
- The services the project will provide and the site(s) where the services will be delivered.
- A precise, clear description of the target population
- A concise description of the population the organization serves and the project's target population with relevant data and information to support the need for the project.
- A brief description of the applicant organization.
- A one page budget for the total project with major line items. Categories of personnel or types of professional contracts in the project should be listed.
- A list of other organizations participating in the project and a brief statement of their role in or contribution to the project
- A short description of how the project activities will be sustained when the grant funding ends.
- Name, title, address, telephone number, and e-mail for the organization's chief executive officer, the proposed project director, and a contact person for the project.
- If this is the first time your organization is applying for Commission funds, you must include with the Letter of Intent documentation that clearly demonstrates your organization meets the definition of a "Community Health Resource." This documentation is not included in the four page limit for the letter of Intent. Further documentation of the applicant organization's financial viability and board structure will be requested if the applicant is invited to submit a full application.

Hard copy Letters of Intent should be sent to:

Grace S. Zaczek
Executive Director
Maryland Community Health Resources Commission
4201 Patterson Avenue, Room 400
Baltimore, MD 21215

Step 2: The Proposal

Applicants invited to submit a full proposal should prepare proposals following the "Proposal Guidelines" in this Request for Proposals.

Step 3: Submission of Proposals

Grant proposals are due at the Commission's offices by 5:00 p.m. EDT on May 26, 2009 by hand delivery, U.S. Postal Service, or private courier. Applications must include:

1. **Transmittal letter:** This letter from the applicant organization's chief executive officer should specify the title of the proposal, the applicant organization, and the project director and state that the applicant organization understands that submission of a proposal constitutes acceptance of the terms of the grants program.



2. **Grant Application Cover Sheet:** This form is posted at <http://dhmh.state.md.us/mchrc/>. The form should be completed and signed by the project director(s) and either the chief executive officer or the individual responsible for conducting the affairs of the applicant and legally authorized to execute contracts on behalf of the applicant organization.
3. **Contractual Obligations, Assurances, and Certifications:** A form for this agreement is available at <http://dhmh.state.md.us/mchrc/>. The agreement should be completed and signed by either the chief executive officer or the individual responsible for conducting the affairs of the applicant and authorized to execute contracts on behalf of the applicant organization.
4. **Proposal:** See “Proposal Guidelines” in the Request for Proposals.

By the deadline for receipt of applications (May 26, 2009, 5:00 p.m. EDT), applicants invited to submit a full proposal should e-mail an electronic version of their transmittal letter, Grant Application Cover Sheet, proposal, and all appendices to the Commission at mdchrc@dhmh.state.md.us

Also by the required deadline, the following must be received at the address below by hand delivery, U.S. Postal Service, or private courier for each proposal: 1) original signed transmittal letter, original signed Grant Application Cover Sheet, original signed Contractual Obligations, Assurances, and Certifications, and original proposal, all bound together and labeled “original;” and 2) seven bound copies of transmittal letter, Grant Application Cover Sheet, signed Contractual Obligations, Assurances, and Certifications, the proposal, and appendices. The hard copy original and seven copies of all documents should be bound with two-prong report fasteners or spiral bound. If two-prong fasteners are used, cardboard or plastic covers and backs can be used. Do not use three ring binders.

Grace S. Zaczek
Executive Director
Maryland Community Health Resources Commission
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Baltimore, MD 21215

Inquiries

Conference Call for Applicants: The program office will host a conference call for interested applicants to provide information on the grants program and assistance with the application process. This conference call, on May 7 2009, at 3:00 p.m. EDT, is optional. Information on the conference call will be posted at <http://dhmh.state.md.us/mchrc/>. Registration is required. To register, send an e-mail by May 6, 2009, to dtuggle@dhmh.state.md.us with the name(s) of the individual(s) who will participate in the call, the name of the applicant organization, and contact information.

Questions from Applicants: Applicants may also submit written questions about the grants program. Send questions to brownlm@dhmh.state.md.us Questions may be submitted at any time. Responses to Frequently Asked Questions (FAQs) will be posted periodically at <http://dhmh.state.md.us/mchrc/>.



Program Office: The program office for the grants program is located at the Maryland Community Health Resources Commission. Staff members are:

Grace S. Zaczek, Executive Director
E-mail: zaczekg@dhhm.state.md.us

Lynda M. Brown, Health Policy Analyst
E-mail: brownlm@dhhm.state.md.us

Dee Tuggle, Executive Associate
E-mail: dtuggled@dhhm.state.md.us

Telephone: 410-764-4660
Fax: 410-358-4194
Website: <http://dhhm.state.md.us/mch>

Timetable

By close of business May 4, 2009	Call for Proposals Released
May 7, 2009 3:00 p.m. EDT	Frequently Asked Questions Call Optional Conference Call with Applicants Registration Required (FAQs) posted at http://dhhm.state.md.us/mchrc/ (to be updated periodically)
May 11, 2009 5:00 p.m. EDT	Deadline for Receipt of Letters of Intent
May 15, 2009	Selected Applicants Notified to Submit a Full Proposal
May 26, 2009 5:00 p.m. EDT	Deadline for receipt of applications
May 30 – June 18, 2009	Review of Applications
June 18, 2009	Applicant Presentations to the Commission
June 22, 2009	Successful Applicants will be Notified of Awards by June 22, 2009



Proposal Guidelines

Proposals should be well written, clear, and concise. Original and creative approaches to addressing access to health services are encouraged. Proposals may not exceed 12 pages single-spaced on standard 8 ½” x 11” paper with one-inch margins and using 12-point Times New Roman or Arial font. Tables and charts may use a 10-point font or larger. All pages of the proposal must be numbered. The budget and budget justification are included in the twelve page limit. The appendices specified in the guidelines below are excluded from the 12-page limit. The hard copy original and seven copies of all documents should be bound with two-prong report fasteners or spiral bound. If two-prong fasteners are used, cardboard or plastic covers and backs can be used. Do not use three ring binders.

The proposal should be structured using these topic headings:

Table of contents (not included in the 12 page limit)

1. Project Summary
2. The Project
3. Evaluation
4. Work Plan
5. Applicant Organization
6. Key Personnel
7. Partners and Collaborators
8. Project Budget

The suggested content of each of these eight sections is discussed below. Provide as much detail as necessary. Appendices should be limited to only the material necessary to support the application. The Commission will request additional material if required.

1. Project Summary

- Provide a one-page summary of the proposal. The first paragraph should clearly and concisely state:
 1. Applicant organization
 2. Project priority area
 3. Project title
 4. Project duration
 5. Fund amount requested
 6. Population to be served
 7. Baseline numbers of population to be served and total population to be served by the project’s end
 8. Whether this is a new service or expansion of an existing service
 9. Services to be provided with the grant funds
 10. Expected improved outcomes for the target population.



2. The Project

- *What will the project do?* Please “Project Summary for items to be addressed in the first paragraphs of the project description. What are the goals and measurable objectives of the project? Quite literally, who will do what for whom, with whom, where, and when? What will be the outcomes that will reduce infant mortality, pre-term births, low-birth weight babies, and teenage pregnancy?
- *Does the project address legislative priorities?* Discuss the extent to which the project addresses the priorities for community health resources in the *Community Health Care Access and Safety Net Act of 2005* (for more information, refer to the legislation or the discussion of legislative priorities in the Call for Proposals).
- *How will the project establish a primary care medical home for patients?* How will the project establish a primary care medical home for patients, either within the applicant organization or by case-managed referral to a primary care provider that accepts the patient’s healthcare coverage or offers a sliding fee scale. How will the applicant organization document that the patient is enrolled with and actually receiving care with the primary care provider?
- *Who is the target population?* Identify the population(s) to be served (i.e., estimated numbers, demographics, insurance coverage, income levels, other distinguishing characteristics) with baseline and total projected numbers of individuals to be served by the end of the project.
- .Document the needs of this population using qualitative and quantitative data. Specify the service area(s). Service maps, data, and other statistics on the target population may be provided as an appendix. Statistics and data should be concisely presented.
- *What problem will be addressed?* Identify the specific problem(s) encountered by the target population(s) in accessing health care services and how this project will ameliorate the problem(s).
- *Does the proposal address health disparities that exist in Maryland?* Discuss the specific health disparity(s) the project is intended to address and how the project will address that disparity(s).
- *Is there a precedent for this project?* Is the project based on a prior model or approach? What is the evidence that the proposed model or approach will be successful? If the project is a new, original approach, how does it improve service delivery to Marylanders?
- *What will be the benefits of success?* If the project is successful, what visible, tangible, objectively verifiable results will you be able to report at the end of the grant? What longer-term benefits do you expect for the target population and the broader community?
- *How will the project be sustained after grant support ends?* Will the project require ongoing outside support after the proposed grant ends? If so, describe your plans for securing ongoing funding or, if plans are not yet firm, the process you will employ to work towards sustainability. Do you foresee opportunities for expanding or replicating this project within the community, in neighboring areas, or more broadly?

3. Evaluation

- *How will you measure project success?* What will be your methodology for evaluation of project outcomes? What data will you collect and analyze? Does the applicant organization have the capacity to collect and analyze data, or must new capacity be acquired or developed?



4. Work Plan

- *What are the major milestones in carrying out the project?* List key benchmarks of project progress. Describe the process and timeframe for reaching these benchmarks.
- *What are the project deliverables?* What specific products would be submitted to the Commission as evidence of completion of project milestones? How and when will these deliverables be produced?
- *What is the timeline for accomplishing milestones and deliverables?* Prepare a Gantt chart or other timeline listing project tasks and the time period over which these tasks will be undertaken. This may be attached as an appendix to the proposal. The timeline for 30-month projects should begin on July 1, 2009 and end on December 31, 2011. The timeline for 36-month projects should begin on July 1, 2009 and end on June 30, 2012.

5. Applicant Organization

- *Is the applicant organization a community health resource?* Provide documentation that your organization qualifies as a community health resource pursuant to the Maryland *Community Health Care Access and Safety Net Act of 2005* and related regulations. If your organization has applied previously to the Commission, and not been notified that you are not eligible, please just include a statement of under which section of the regulations your organization qualifies as a community health resource.
- *What is the applicant organization's mission?* Describe your mission, programs, and service area. Discuss your organizational strengths and challenges.
- *What is the organizational structure?* Is the applicant a for-profit or not-for-profit organization? If applicable, attach as an appendix the organization's determination letter from the IRS indicating 501(c) (3) tax-exempt status. Describe the type of organization (e.g., federally qualified health center, free-standing clinic, clinic affiliated with a hospital or local health department, private primary care practice).
- *How is the organization governed?* Specify the governance structure. In an appendix, provide a list of the officers and board of directors or other governing body.
- *How is the organization staffed?* Describe the staffing and provide an organizational chart as an appendix.
- *How is the organization financed?* Specify revenue sources and the percentage of total funding. What is the annual budget? As appendices to the proposal, provide your overall organizational budget (projected revenues and expenses) for the current fiscal year, your most recent audited financial statements and accompanying management letter, and, if your organization files a Form 990, your most recent filing. If your organization has submitted audited financial statements and a Form 990 to the Commission that cover your organization's latest audited fiscal year, please provide just a statement listing which documents and their fiscal years have been submitted. The Commission will request additional information if necessary.
- *What facilities are available?* Describe the facilities owned and/or operated by the organization.
- *Does the organization publish an annual report?* If so, provide a copy as an appendix. If your organization has submitted the latest annual report for a previous grant round, please provide a statement that the report was submitted, and which year it covers.



6. Key Personnel

- *Who will direct the project?* Identify the project director and describe his/her level of responsibility within the applicant organization, qualifications to lead the project, and role in carrying out the project.
- *Who is the other key staff?* Identify other essential staff, their roles in the project, and their relevant qualifications. As an appendix, include résumés (**maximum three pages each**) for all key personnel.

7. Partners and Collaborators

- *Who are the key partners?* What other community organizations will play a crucial role in the proposed project? Why is their participation important?
- *In what ways will the partners contribute to the project?* Who are the leaders of these organizations and what is their role? Which staff will be involved, what will be their responsibilities, and how much time will they devote to the project? What other resources will partners contribute? In an appendix, provide letters of commitment from the leaders of these organizations and resumes (maximum three pages each) for key staff.
- *What is the management plan?* What processes and organizational structures will be put into place to ensure that the partnership(s) are effective?

8. Project Budget

- *General Format:* Provide a line-item budget. To the extent possible, break down the budget into major tasks or phases of work consistent with the project work plan. Provide a line item budget for the total project and for each project year. The beginning and ending date should be indicated for each budget period.
- *Personnel:* The name, title, percent effort, annual salary, and fringe benefits should be listed separately for each individual in the budget. Fringe benefits should be shown at the applicant organization's standard rate.
- *Project Co-Funding:* If the project will be supported by funder(s) other than the Commission, the line-item budget should include a separate column for each funding source along with a "total funding" column.
- *Indirect Costs:* Indirect costs may not exceed 10 percent of direct project costs. Direct costs generally include project-related personnel, consultants, travel, equipment, and office expenses.
- *Budget Justification:* A budget justification should accompany the line-item budget detailing the purpose of each budgeted expenditure.



About the Commission

Community Health Care Access and Safety Net Act of 2005 became law on May 10, 2005. The law authorized establishment of the 11-member Maryland Community Health Resources Commission to help communities in Maryland improve access to care for low-income families and under- and uninsured individuals. Governor Martin O'Malley appointed the current members of the Commission in May, 2007.

Maryland Community Health Resources Commission

John A. Hurson Chair
Judith L. Boyer-Patrick, M.D., M.P.H.
Maria Harris-Tildon
Kendall D. Hunter
Four vacant positions

Margaret Murray, M.P.A.
Karla Ruhe Roskos, B.S.N., M.P.H.
Douglas Wilson, Ph.D.

Appendix

Excerpt from: Community Health Care Access and Safety Net Act of 2005 - MD Community Health Resources Commission provisions, Annotated Code of Maryland, Health-General Article

Health General § 19-2201 (g)

In developing regulations under subsection (f) (1) of this section, the Commission shall:

- (1) Consider geographic balance; and
- (2) Give priority to community health resources that:
 - (i) In addition to normal business hours, have evening and weekend hours of operation;
 - (ii) Have partnered with a hospital to establish a reverse referral program at the hospital;
 - (iii) Reduce the use of the hospital emergency department for nonemergency services;
 - (iv) Assist patients in establishing a medical home with a community health resource;
 - (v) Coordinate and integrate the delivery of primary and specialty care services;
 - (vi) Promote the integration of mental and somatic health with federally qualified health centers or other somatic care providers;
 - (vii) Fund medication management or therapy services for uninsured individuals up to 200% of the federal poverty level who meet medical necessity criteria but who are ineligible for the public mental health system;
 - (viii) Provide a clinical home for individuals who access hospital emergency departments for mental health services, substance abuse services, or both; and
 - (ix) Support the implementation of evidence-based clinical practices.

