

**AHCA USE ONLY:**

File #:

Application #:

**Behavioral Health Teaching Hospital**

**Grant Application**

The Agency for Health Care Administration (AHCA) has established a grant program for behavioral health teaching hospitals pursuant to 395.903, Florida Statutes (F.S.). The grant program will support workforce development, innovative care and facility upgrades. The aim is to modernize the state’s behavioral health system. **Applicants applying for this grant must be in compliance with s. 395.902(2), F.S.**

The grant submission must include:

Completed Application.

Organizational Overview to include:

Summary of the hospital’s behavioral health services and educational programs.

Description of the hospital’s program to provide state treatment facility beds.

Project Plan: Detailed plan of how the grant funds will be used, including:

Project objectives and expected outcomes.

Implementation timeline and milestones.

Budget and spending plan.

Partnership Evidence: Documentation of partnerships with accredited medical schools.

Monitoring Plan: Plan to track progress on workforce development and service expansion.

**By submitting this application, your organization agrees that, if awarded a grant, it shall enter into and comply with all terms and conditions of the Agency’s Grant Funded Agreement (GFA), which includes requirements to comply with the Florida Single Audit Act and Executive Order 20-44, as applicable.**

**1. Applicant Information**

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| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **A. PROVIDER INFORMATION –** Please complete the following for the hospital name and location. | | | | | | | | |
| License # (if applicable) | | | Florida Medicaid #  (if applicable) | | | | | |
| Name of Hospital(if operated under a fictitious name, enter as it appears in Florida Division of Corporations) | | | | | | | | |
| Street Address | | | | | | | | |
| City | | County | | | State | | | Zip |
| Telephone Number | | | | Fax Number | | | | |
| Mailing Address or  Same as above | | | | | | | | |
| City | | County | | | State | | Zip | |
| Telephone Number | E-mail Address | | | | | NOTE: By providing your e-mail address you agree to accept e-mail correspondence from the Agency. | | |

|  |  |
| --- | --- |
| **B. CONTACT PERSON** - Please complete the following for the contact person for this application. | |
| Contact Person for this application | Contact Telephone Number |
| Contact e-mail address or  Do not have e-mail | NOTE: By providing your e-mail address you agree to accept e-mail correspondence from the Agency. |

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| --- | --- | --- | --- | --- | --- |
| **C. LICENSEE INFORMATION** –Please complete the following for the entity seeking to operate the hospital. | | | | | |
| Licensee Name (Owner) | | | Federal Employer Identification Number (EIN) | | |
| Mailing Address or  Same as above | | | | | |
| City | | | | State | Zip |
| Telephone Number | Fax Number | E-mail Address | | | |

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| **D**. **MEDICAL SCHOOL AFFILIATION** - List all medical schools with which the hospital has an affiliation. | |
| Name | Address |
|  |  |
|  |  |
|  |  |

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| --- | --- | --- |
| **E. WORKFORCE DEVELOPMENT PROGRAMS FOR UNIVERSITY STUDENTS** | | |
| Discipline/Area of Study | University | Number of Students |
| Medicine |  |  |
| Nursing |  |  |
| Psychology |  |  |
| Social Work |  |  |
| Public Health |  |  |
| Psychiatry |  |  |

|  |  |
| --- | --- |
| **F**. **MANAGING ENTITIES** – Please select the entity that you have a collaborative agreement with and provide a copy of the agreement. | |
|  | Big Bend Community Based Care, Inc. d/b/a NWF Health Network |
|  | Broward Behavioral Health Coalition |
|  | Central Florida Behavioral Health Network, Inc. |
|  | Central Florida Cares Health System |
|  | Lutheran Services Florida |
|  | Thriving Mind South Florida (South Florida Behavioral Network, Inc. |
|  | Southeast Florida Behavioral Health Network |

**2. Eligible Areas of Funding**

Pursuant to 395.903, F.S., grant funding may be used for operations and expenses and for fixed capital outlay, including, but not limited to, facility renovations and upgrades. Indicate the area of funding with an “X.”

Workforce Development:

* University student programs.
* Psychiatric residency programs.
* Postdoctoral clinical psychology fellowships.
* Continuing education programs for licensed behavioral health professionals.

Operations and Integrated Care Models

* Implementation of integrated behavioral health care models.
* Coordination with regional behavioral health care providers.

Capital Improvements

* Facility renovation and expansion to accommodate behavioral health services.
* Technological upgrades to support training and care delivery.

Public-Private Partnerships

* Developing partnerships that promote innovative research, care and education.

**3. Amount of Funding Requested\***

|  |  |
| --- | --- |
| **Funding Area** | **TOTAL AMOUNT** |
| Workforce Development | $ |
| Operations and Integrated Care Models | $ |
| Capital Improvements | $ |
| Public-Private Partnership | $ |
| **Total Amount Requested** | **$** |

**\*A detailed spending plan must be included.**

**4. Detailed Spending Plan and Grant Proposal Criteria**

Detailed spending plans must include line-item budgets for all expenses related to the grant funding. Please note that the behavioral health teaching hospital grant funds may only be used for students of the accredited Florida-based medical schools listed under s. 458.3145(1)(i)1.- 6., 8., or 10., F.S. Resident positions created under s. 409.909(6), F.S. cannot be funded concurrently by the behavioral health teaching hospital grant.

A. Workforce development programs must:

* Include the current number of students enrolled in each discipline and working at the hospital.
* Provide the target number increase in students in each discipline annually for the requested funding.
* Include the current number of psychiatric residents and postdoctoral clinical psychology fellows.
* Provide the target number increase in psychiatric residents and postdoctoral psychology fellows annually for the requested funding.
* Provide the number and position of licensed behavioral health professionals currently working at the hospital.
* Provide the target number of new behavioral health professionals to be employed annually using the requested funding.
* List stipends, salaries, benefit packages, and operational costs associated with these programs must be exact.
* Clearly identify positions as full-time or part-time.
* Provide a breakdown of anticipated time that staff, faculty, and students will perform functions paid with the behavioral health grant funding.
* Not duplicate staffing addressed in other areas of workforce development programs or integrated care models.
* Include costs associated with continuing education, conferences, travel for conferences, training supplies and materials must be justifiable and in compliance with s.112.061, F.S.

B. Operations and integrated care model plans must:

* Describe existing services and those anticipated to be offered if grant funding is approved.
* Provide numbers of patients served in the last 5 calendar years for each integrated care model.
* Provide the ratio of insured versus uninsured in each integrated care model served in the last 5 calendar years.
* Provide the target number of patients to be served annually in each integrated care model with the requested funding.
* Provide the target ratio of insured patients versus uninsured patients to be served annually in each integrated care models if the grant funding is approved.
* List positions and the associated salaries and benefit packages of behavioral health care professionals, students, and faculty providing services of the integrated care models.
* Not duplicate staffing addressed in the other workforce development programs of the grant proposal.

C. Fixed capital outlay projects for construction, renovation, and upgrades must include:

* Expenses for design services, demolition, labor costs, construction materials, finishes, fixtures, flooring, furniture, furnishings, painting, contractor fees, engineering fees, permitting fees, excavation costs, foundation costs, insurance and bonding costs, profit and contingency funding, electrical, plumbing, heating, air conditioning, ventilation systems, landscaping, security and surveillance equipment, and cost per square foot.
* Floor plans and renderings of the finished project.
* Specific quantities of items to be purchased.
* Copies of bid documents.

D. Behavioral health research, training, education or public-private partnerships must:

* Clearly state the objectives to be achieved through behavioral health research, training, or education.
* Detail objectives that are specific, measurable, achievable, relevant, and time bound.
* List costs of equipment, supplies, materials, positions, associated salaries, stipends, and benefit packages.
* Not duplicate staffing addressed in the workforce development programs.

If any part of the grant proposal requires leasing office space, include the cost of the leased office space, anticipated lease period, security deposits, office furniture, furnishings, equipment, supplies, and square footage of the office space. Quantities of items to be purchased must be specified.

**5. Partnering with the Department of Children and Families**

The Department of Children and Families needs additional capacity for state mental health long term involuntary treatment for civilly committed individuals. Include a plan to become a designated receiving and treatment facility, if not already designated as such. Describe the plan to engage the court as required to petition for involuntary services and continued involuntary services. The Department also needs additional short-term residential treatment beds. Provide a plan to include short-term residential treatment beds.

* Describe your approach to providing care for long-term voluntary inpatient treatment individuals, involuntary civil commitment patients, forensically committed individuals, and those admitted for short-term residential treatment.
* Provide the number of patients in each category that were served in the last 5 calendar years.
* Provide the ratio of insured patients versus uninsured in each of the categories in the past 5 calendar years.
* Provide the target number to be served annually in each group with the requested funding.
* Provide the anticipated ratio of insured vs uninsured in each group with the requested funding.
* Provide a line-item budget for positions, associated salaries and benefit packages of the behavioral health care professionals providing services to these patients.
* Do not duplicate staffing addressed in other workforce development programs of the proposal.
* If the proposal requires leasing office space, include the cost of leased office space, anticipated lease period, office furniture, furnishings, office equipment, and office supplies.
* Quantities of items to be purchased must be specified.

**6. Attestation**

I, \_\_\_\_     \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, attest as follows:

1. Pursuant to section 837.06, Florida Statutes, I have not knowingly made a false statement with the intent to mislead the Agency in the performance of its official duty.

     

Signature of Licensee or Authorized Representative Title Date

**RETURN THIS COMPLETED FORM TO:**

AGENCY FOR HEALTH CARE ADMINISTRATION

HOSPITAL AND OUTPATIENT SERVICES UNIT

2727 MAHAN DR., MS 31

TALLAHASSEE FL 32308-5407

**Questions?** Visit the Agency’s website : <http://ahca.myflorida.com> or contact the Hospital and Outpatient Services Unit at (850) 412-4549 or Email: [hospitals@ahca.myflorida.com](mailto:hospitals@ahca.myflorida.com)