

HEAL NY Program Grant Application

For Use with Grants Requested under HEAL NY 2818(2)

Application Cover Page

Project Name _____

Eligible Applicant Legal Corporate Name _____

Applicant's Category (ie, hospital, nursing home etc.)

Applicant's Address (include County) _____

Applicant Federal ID #: _____

NYS Charities Registration #: _____

Operating Certificate #: _____

Contact Information

Name _____ Title _____

Phone _____ Fax _____

E-mail _____

Signature of an individual who will be authorized to bind the Eligible Applicant to any grant disbursement agreement (GDA) resulting from this application:

Signature _____

Title, if signatory is different from contact person _____

Printed Name, if signatory is different from contact person _____

ELIGIBLE APPLICANT CERTIFICATION

CERTIFICATION FOR HEALTH CARE EFFICIENCY AND AFFORDABILITY LAW (HEAL NY) GRANTS

I hereby warrant and represent to the New York State Department of Health ("DOH") and the Dormitory Authority of the State of New York ("the Authority") that:

- Applicant will make every effort to ensure that the project described in this application will be consistent with the goals and recommendations of the Commission on Health Care Facilities in the Twenty-First Century, as established pursuant to Section 31 of Part E of Chapter 63 of the Laws of 2005, and with the goals and recommendations set forth in the Commission's report of November, 2006.
- All contracts entered into by the Grantee in connection with the Project shall (A) provide that the work funded by Grant funds covered by such contract shall be deemed "public work" subject to and in accordance with Articles 8, 9 and 10 of the Labor Law; and (B) shall provide that the contractors performing work under such contract shall be deemed a "state agencies" for the purposes of Article 15A of the Executive Law
- If awarded a HEAL NY grant, the funds will be expended solely for the project purposes described in this RGA and in the GDA and for no other purpose.
- I understand that in the event that the project funded with the proceeds of a HEAL NY grant ceases to meet one or more of the criteria set forth above, then DOH and/or the Dormitory Authority shall be authorized to seek recoupment of all HEAL NY grant funds paid to the Grantee and to withhold any grant funds not yet disbursed. If awarded a HEAL NY grant, the funds will be expended solely for the project purposes described in this proposal and in the GDA and for no other purpose.
- With respect to the process for the awarding of HEAL funds without the process set forth in subdivision one of HEAL NY Legislation (PHL 2818), I certify that as an eligible applicant for funding under PHL Section 2818 (2) we meet the following criteria:
 - (i) Have a loss from operations for each of the three consecutive preceding years as evidenced by audited financial statements; and
 - (ii) Have a negative fund balance or negative equity position in each of the three preceding years as evidenced by audited financial statements; and
 - (iii) Have a current ratio of less than 1:1 for each of three consecutive preceding years;

or

 - (iv) may be deemed to the satisfaction of the Commissioner to be a provider that fulfills an unmet health care need for the community as determined by the Department through consideration of the volume of Medicaid and medically indigent patients served; the service volume and case mix, including but not limited to maternity, pediatrics, trauma, behavioral and neurobehavioral, ventilator, and emergency room volume; and, the significance of the institution in ensuring health care service access as measured by market share within the region.

Applicant Name _____

Project Name _____

Signature _____ **Date** _____

Name (Please Print) _____

Title (Please Print) _____

Please note that in accordance with Part 86-2.6 of the Commissioner's Administrative Rules and Regulations, **ONLY** the following individuals may sign the attestation form: Proprietary Sponsorship – Operator/Owner

- Voluntary Sponsorship – Officer (President, Vice President, Secretary or Treasurer), Chief Executive Officer, Chief Financial Officer or any Member of the Board of Directors
- Public Sponsorship – Public Official Responsible for Operation of the Facility

MULTIPLE PROVIDER / PARTICIPANT CONSENT FORM

***REQUIRED FOR APPLICATIONS WITH MULTIPLE PARTICIPANTS IN PROJECT ***

Lead Applicant in Grant Application

- Lead Applicant has requested and received consent from the co-applicants listed below to fully participate and assist in the implementation of all aspects of the project described in the grant application. Lead Applicant understands that it will be asked to sign a Grant Disbursement Agreement relating to the entire project should the application lead to an award.

Lead Applicant Name: _____ (please type)

Lead Applicant Authorized Signature: _____

Date: _____

Participant in Grant Application (Please list all participants)

- Participant understands all aspects of the project described in the grant application submitted by the Lead Applicant (above) and consents to its inclusion therein.
- If the grant is awarded, Participant agrees to fully cooperate in the implementation of the project described in the grant application and consents to Lead Applicant executing a Grant Disbursement Agreement in connection therewith.

Participant Name: _____ (please type)

Participant Authorized Signature: _____

Date: _____

* For purposes of this form, a participant means any party who will have direct participation in the project whether they will be receiving HEAL NY funds or not.

Technical Application Format

Project Name: _____

Eligible Applicant Name: _____

Executive Summary

This part of the Technical Application must describe:

- A review of the project.
- The applicant must describe how they are eligible under PHL Section 2818 (2).
- Describe how will this project will address and remedy the condition that determined applicant eligibility under 2818(2).

A. Eligible Applicant

In this section, provide basic organizational information on the Eligible Applicant. Complete the Eligible Applicant Certification. This should include information such as the Eligible Applicant's exact corporate name, board composition, ownership and affiliations, staffing, and services provided. Also provide information that will allow DOH and DASNY to understand how the Eligible Applicant is prepared to proceed with the Project. Provide any experience the Eligible Applicant has with Projects of this type, how the Eligible Applicant fits within the public health community, and evidence that the Eligible Applicant will be able to implement the Project.

B. Project Description

1. Overview: Provide a general description of the Project, its goals and objectives. Describe how the goals and objectives of the Project are consistent with those outlined by the HEAL NY Program. Please be specific.
2. Community Need: Describe how the Project will relate to identified health needs in the community. This must be based on documented information, such as health status indicators, demographics, insurance status of the population, and data on service volume, occupancy, and discharges by existing providers. Identify areas of overcapacity and/or under-capacity.
3. Project Activities: Describe the project objectives to be attained and the activities to achieve each. Objectives may be process objectives or outcome objectives.
 - Process objectives involve an action or set of actions; for example, renovation of a building or development of a governance agreement.

- Outcome objectives address a measurable change or impact; for example an increase in number of patients served or a decrease in average length of inpatient stay.
- Objectives are attained through implementation of an accompanying set of activities (or sub-objectives), usually occurring in sequence. Objectives should be verifiable through measurable indicators wherever possible.

4. Project Timeline: Provide a timeline for the Project up through the date of implementation, including identification of major milestones and the person or entity accountable for each milestone. All project activities and milestones must be completed within a two year contract period. If applicable, the Eligible Applicant must describe in detail the phasing plan anticipated to achieve implementation. This phasing plan must identify specific milestones and dates of completion for each milestone. If applicable, the application and phasing plan must also address:

- Timeframes for any architectural and engineering design and construction necessary to accomplish each phase.
- Scheduled milestones for the preparation and processing of any application, as required by CON regulations (10 NYCRR Part 710), necessary to secure DOH approval for service revisions, relocations, or capital construction that rises to the level of CON review.

5. Continuation: Describe how the services and activities established or enhanced by the project will continue after its completion.

6. Project Team: Describe how the project team has the expertise and experience necessary to successfully complete the project within the timeframes outlined and achieve the goals and objectives set forth in the application. Provide information on any key contractors that the Eligible Applicant will contract with to facilitate the implementation of the project.

C. Project Monitoring Plan

Describe the methodology that will be used to track progress within the project, including any quality assurance testing that will be performed. Describe how the monitoring plan will include identification of barriers and strategies to resolve issues.

Financial Application Contact Information

Project Name _____

Eligible Applicant Legal Corporate Name _____

Applicant Federal ID #: _____

NYS Charity Registration #: _____

Operating Certificate #: _____

Provide the following information for a contact person.

Name _____ Title _____

Phone _____ Fax _____ E-mail _____

Provide the name and phone number of the person responsible for preparing the applicant's financial statements.

Name _____ Phone _____

Provide the name and phone number of the applicant's director of internal audit. If there is none, provide the name and phone number of the board member responsible for overseeing financial matters.

Name _____ Phone _____

Signature of an individual who would be authorized to bind the Eligible Applicant to any GDA resulting from this application:

Signature _____

Title, if signatory is different from contact person _____

Printed Name, if signatory is different from contact person _____

Financial Application Format

Project Name: _____

Eligible Applicant Name: _____

A. Project Budget

Provide a Project Budget that includes all components of the application, including those that will be funded with sources other than HEAL NY grant funds. Show the amount of each budget line that will be funded with HEAL NY grant funds. Provide a detailed discussion of the reasonableness of each budgeted item. These budget justifications should be specific enough to show what the Eligible Applicant means by each request and how the request supports the overall Project.

B. Project Fund Sources

Identify and describe all private or other sources of funding, if any, for the Project, including governmental agencies or other grant funds.

C. Cost Effectiveness

Describe why the project is a cost-effective investment as compared to other alternatives. Describe any savings to the health care system relative to the project costs. Include a discussion of all means by which projected savings can be verified after the project is complete.

D. Project Financial Stability

Provide a detailed discussion showing how the project will support the institution's financial viability upon completion. Provide financial feasibility projections for retiring any capital debt, associated with the project. Include supporting documents such as projected balance sheets, income statements, cash flows, etc. from the project start through three years after project completion.

E. Eligible Applicant Financial Stability

Provide evidence of the financial stability of the Eligible Applicant. This would include a copy of the prior two annual audited financial statements and any other evidence of this stability. Entities whose financial statements have not been subjected to an audit must include any additional information available to satisfy this test and appropriate certifications. If applying under PHL (2818) (2) (i), (ii) **and** (iii), please explain how the project and the grant funding will improve your financial situation.

F. General Corporate Information:

1. Provide a list of vendors or contractors who can be contacted regarding the applicant's business practices.
2. Provide the name of any parent, sibling, or subsidiary corporation of the applicant.

3. Include with the application a copy of Form 990 or evidence of an up-to-date filing with the Attorney General of New York State.
4. Provide a current NYS Vendor Responsibility Questionnaire.

Vendor Responsibility Questionnaire

New York State Procurement Law requires that state agencies award contracts only to responsible vendors. Vendors are invited to file the required Vendor Responsibility Questionnaire online via the New York State VendRep System or may choose to complete and submit a paper questionnaire. To enroll in and use the New York State VendRep System, see the VendRep System Instructions available at www.osc.state.ny.us/vendrep or go directly to the VendRep system online at <https://portal.osc.state.ny.us>. For direct VendRep System user assistance, the OSC Help Desk may be reached at 866-370-4672 or 518-408-4672 or by email at helpdesk@osc.state.ny.us.

Vendors opting to file a paper questionnaire can obtain the appropriate questionnaire from the VendRep website www.osc.state.ny.us/vendrep or may contact the Department of Health or the Office of the State Comptroller for a copy of the paper form. Applicants must also complete and submit the Vendor Responsibility Attestation (Attachment 15a).

Budget Forms Required

- Project Expenses and Justification; and,
- Project Fund Sources

These two forms must be completed to show all expenses and fund sources associated with the proposed project.

Total fund sources should equal total expenses. If fund sources exceed expenses, please write a detailed explanation.

The budget forms should include the name, phone number, and e-mail address of the person responsible preparing for the budget.

Project Expenses and Justification

Project Name: _____

Eligible Applicant Name: _____

Each category of expenses (left column) must be accompanied by a written justification (right column). Each justification must include a discussion of how the expense will support the project, and state whether the applicant believes the expense is capitalizable.

Cost Category EXAMPLES ONLY	Anticipated HEAL NY Funds	Total Expense	Capitalizable Expense Choose YES or NO for each line.	Justification
<u>Acquisition</u>				
Land Costs	\$	\$	YES NO	
Building Costs	\$	\$	YES NO	
Other (specify)	\$	\$	YES NO	
<u>Capital Work</u>				
New Construction	\$	\$	YES NO	
Equipment	\$	\$	YES NO	
Renovation	\$	\$	YES NO	
Other (specify)	\$	\$	YES NO	
<u>Fees</u>				
Architectural/Design	\$	\$	YES NO	
Engineering	\$	\$	YES NO	
Legal	\$	\$	YES NO	
Installation	\$	\$	YES NO	
Construction Management	\$	\$	YES NO	
Other (specify)	\$	\$	YES NO	
<u>Closure</u>				
Discharge of LT Debt	\$	\$	YES NO	
Payment of Debt	\$	\$	YES NO	
Security Contract	\$	\$	YES NO	
Employee Expenses	\$	\$	YES NO	
Demolition of Building	\$	\$	YES NO	
Medical Records Storage	\$	\$	YES NO	
Building Insurance	\$	\$	YES NO	
Medical Malpractice	\$	\$	YES NO	
Other (specify)	\$	\$	YES NO	
Other (specify)	\$	\$	YES NO	
<u>Debt Restructuring</u>	\$	\$	YES NO	
<u>Other Categories (specify)</u>				
-	\$	\$	YES NO	
-	\$	\$	YES NO	
-	\$	\$	YES NO	
TOTAL	\$	\$		

Name, phone number, and e-mail address of the person responsible preparing for the budget:

Name _____

Phone _____ E-mail _____

Project Fund Sources

Project Name: _____

Eligible Applicant Name: _____

	Currently Committed	Anticipated	Total	
HEAL NY	\$	\$	\$	
Other Funds	\$	\$	\$	A
Total	\$	\$	\$	B

Other Funds' Components

Applicant Direct Funds	\$	\$	\$
Program Income	\$	\$	\$
Federal Government	\$	\$	\$
Foundations	\$	\$	\$
Corporations	\$	\$	\$
Bonds	\$	\$	\$
Loans	\$	\$	\$
Board/Individual Contributions	\$	\$	\$
Other (describe)	\$	\$	\$
Total	\$	\$	\$

- Calculate the Other Funds as a Percent of Total Funds.

$$\mathbf{A / B = \underline{\hspace{2cm}}}$$

- Any program income realized during the project must be applied to project costs.

Name, phone number, and e-mail address of the person responsible preparing for the budget:

Name _____

Phone _____

E-mail _____