

**BEFORE YOU BEGIN**

ORGANIZATIONAL INFORMATION

FINANCIAL INFORMATION

MOST RECENT BOARD APPROVED BUDGET

PROJECT LIAISON

BUDGET OVERVIEW

PROPOSAL TITLE

PROPOSAL REQUEST

GRANT REQUEST AMOUNT

OUTCOMES

SUSTAINABILITY

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**BEFORE YOU BEGIN**

Please select Yes for each statement below that applies to your clinic/network. If a statement does not apply to your clinic/network, select No. If it is determined you are not eligible, please contact FAFCC to discuss your circumstances and see what arrangements may be made for your participation in the program.

\* Our clinic/network is a member of FAFCC and in good standing

--None--

\* Our clinic/network has a competent administrator to serve as Project Liaison for this program, and can provide a resume or biography upon request.

--None--

\* Our clinic/network has administered grants previously and can supply copies upon request of previous grant applications as well as programmatic and financial reports for grants.

--None--

FAFCC is the fiscal agent for the State of Florida's 9,500,000 appropriation to the free and charitable clinic sector, with all expenditures funded by this program to be incurred by June 30, 2024. There are no carry-over of funds. The number and size of the grants awarded will be based upon the number of applications received from eligible organizations, purpose(s) of funds requested, amount of funds requested in proportion to operating budget, organizational capacity, and total funding available. There is no predetermined number of awards, and the submission of a grant application does not guarantee that a grant will be awarded. This application package must be completed by August 18, 2023. This is a competitive grant process, late submissions will not be accepted and extensions will not be provided. We strongly encourage that grantseekers begin the proposal at least three days prior to the deadline as extensions WILL NOT be provided for technical difficulties.

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### Organization Information

\* DBA Name

\* Legal Name

**Clinic's Address**

Street

City  State/Province

Zip/Postal Code  Country

\* Website

\* Email

\* Phone

\* Tax ID

\* Our clinic/network is presently covered under the Sovereign Immunity statute (766.1115, F.S.) and plans to maintain that status through June 30.

\* Does your clinic have multiple clinic sites?

Please list the multiple sites

\* Mission Statement ?

\* Counties Served

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### FINANCIAL INFORMATION

\* Legal Status  
--None--

\* Fiscal Year Start Date *i*  
Jun 28, 2023

\* Fiscal Year End Date *i*  
Jun 28, 2023

\* Choose the Option that Corresponds to an Independent CPA Examination of your Finances *i*  
Our clinic/network (or the 501c3 organization of which it is a part) had an audit in 1

\* Date of Last Audit/Review/Compilation  
Jul 18, 2023

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### MOST RECENT BOARD APPROVED OPERATING BUDGET

If your clinic/network is part of a multi-service organization, only include the income/expenses, including personnel, allocable to the clinic/network; if your clinic owns and operates multiple sites or multiple programs under membership, be sure that the budget encompasses all sites; do not count capital expenditures or in-kind contributions.

FAFCC members who belong to parent organizations are required to submit an operating budget that reflects the cost to operate the clinic only, this should NOT include programs or other parent organization entities not included in FAFCC membership. If this cannot be reflected in the "income" field, this can at least be done so in the "expenses" field.

**Income**

\*Income

**Expenses**

\*The expenses inputted below will be used to determine whether request is no more than 20% or 25% depending on your organization's budget.

\*Date of when your most recent operating budget was approved by your board

### PREVIOUS FISCAL BUDGET, ACTUALS

If your clinic/network is part of a multi-service organization, only include the income/expenses, including personnel, allocable to the clinic/network; if your clinic owns and operates multiple sites or multiple programs under membership, be sure that the budget encompasses all sites; do not count capital expenditures or in-kind contributions.

FAFCC members who belong to parent organizations are required to submit an operating budget that reflects the cost to operate the clinic only, this should NOT include programs or other parent organization entities not included in FAFCC membership. If this cannot be reflected in the "income" field, this can at least be done so in the "expenses" field.

\*Income

\*Expenses

\*Is there is a 20% difference (positive or negative) in your operating expenses between the previous fiscal year's actual operating budget and the current, board approved operating budget?

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## PROJECT LIAISON

Is the Project Liaison the authorized signature for the grant agreement?

### Liaison Name

Salutation

--None--

First Name

First Name

Last Name

Last Name

\* Liaison Title

\* Liaison Email

you@example.com

\* Liaison Direct Phone

Liaison Ext.

### AUTHORIZED OFFICER FOR SIGNING GRANT AGREEMENT

#### Name

First Name

First Name

Last Name

Last Name

Title

Email

you@example.com

Phone

Ext.

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## BUDGET OVERVIEW

**The application process is a single grant proposal broken down and awarded by two Project Categories: Dental Health Services and Behavioral Health Services. Grantees may apply for either or both categories.**

Dental Health Services include dental procedures such as routine checkups and cleanings, fillings, extractions, root canals, dentures, braces, and orthodontics.

Behavioral Health Services encompasses a range of services that help patients with mental health and substance abuse disorders, including therapy, case management, and medication management.

**Budget line items within each Project Category must be identified as Clinical Staffing Expenses or Clinical Programming Expenses.**

Clinical Staffing Expenses include wages paid to healthcare providers and may include hourly, salaried, or contractors, regardless of whether they are employees or contracted for services. Personnel Costs may include fringe benefits such as Health Insurance, FICA, etc.

Clinical Programming Expenses are costs that can be explicitly attributed to the execution of a project or program and may include:

- Medical Equipment & Supplies
- Software (Dentrix, EMR software, etc.)
- Prescription medications
- Training and certifications

I, the Project Liaison, have read and understand the Dental and Behavioral Health Expansion Grant's budget Structure and parameters and hereby check the box as confirmation of my comprehension.



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## Proposal

The proposal title is intended to be specific to your grant proposal. However, the language should also be broad enough, that if your proposal is not fully funded, the title will still be relevant to your awarded balance. This should NOT be derivative of your organization's mission statement.

Please think critically when devising a proposal title that identifies an overarching or unifying theme of you grant request. A successful grant title will accurately and succinctly identify the scope of your grant proposal.

\* Proposal Title

\* Are you requesting funding for Dental Health Costs?

\* Are you requesting funding for Behavioral Health Costs?

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### PROPOSAL REQUEST

#### Behavioral Health Costs

Describe the scope of work to be performed under Behavioral Costs from implementation to completion by June 30. ⓘ

Budget Justification ⓘ

Have any of the provided line items in the budget justification been funded by FAFCC in the Previous Grant Cycle?

--None--

Statement of Need ⓘ

If FAFCC cannot fully fund this specific item, please indicate whether and how much you would still need to receive in order to implement and operationalize this item by June 30.

In the event your organization cannot be funded in all requested budget categories, please indicate your funding preference for Behavioral Costs

--None--

#### Behavioral Health Expenses

Date

Item

Designation Areas 

--None--

Service Type 

--None--

Funds Requested from FAFCC

Other Funding Sources

[Add Behavioral Expenses](#)

Showing 1 of 1 item

Date	Item	Capa...	Servi...	Fund...	Othe...
Jul 31, 2023		Clinical Staff	Clinical Programming	\$3,000.00	\$2,000.00

**Amount Requested: \$3,000**

### ▼ Dental Health Costs

Describe the scope of work to be performed under Dental Costs from implementation to completion by June 30 ⓘ

Budget Justification

Have any of the provided line items in the budget justification been funded by FAFCC in the Previous Grant Cycle?

--None--

Statement of Need ⓘ

If FAFCC cannot fully fund this specific item, please indicate whether and how much you would still need to receive in order to implement and operationalize this item by June 30th

In the event your organization cannot be funded in all requested budget categories, please indicate your funding preference for Dental Costs

--None--

### ▼ Dental Health Expenses

Date

Item

Designation Areas

--None--

Service Type

--None--

Funds Requested From FAFCC

Other Funding Sources

Add Dental Expense

Showing 1 of 1 item

Date	Item	Capa...	Servi...	Fund...	Othe...
Jul 31, 2023	item description	Personnel Costs for Healthcare Providers	Health Services	\$3,000.00	\$2,000.00

**Total Planned Expenses: \$3,000**

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### Grant Request Amount


Please note, no one grantseeker will be awarded more than \$250,000.00 to ensure availability of funds.


Calculated Grant Amount Requested for Grant Proposal \$18,125

\* As defined in the NOFA, grant requests are capped at 25% for operating budgets under 249,999, and 20% above 250,000. Have you met this requirement? If not, please provide an explanation.



### Grant Overview

\* Describe the demand for the grant by the community, including the target population (if appropriate). 



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## Outcomes

Prior to completing this section, please thoughtfully examine and review what your intended outcomes will be for the duration of the grant cycle as you are asked to report your progress on these outcomes for every reporting period. Goals for the grant cycle are strongly encouraged to incorporate measurable outcomes, as this is a tool used by the association to monitor progress, performance, and to determine if capacity building is occurring. Outcomes may include but are not limited to health/patient outcomes, development outcomes, as well as, administrative efficiencies and processes.

\*What are the specific outcomes you expect to achieve within the grant's scope of work?

\*Aside from patient services data, how will you track your progress?

\*How will you measure your successes, identify barriers, and make corrections in your program?

\*What is the anticipated timeline for achieving these results?

\*How will you know when your results have been achieved?

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## Sustainability

\* Aside from FAFCC are there any partners critical to your success? If so, please list them and describe what role they will play.

|

\* Total number of grant and award dollars received from funders in the last fiscal year. ⓘ

\* Total number of fundraising and private dollars received from donors in the last fiscal year.

\* Describe how you intend to sustain the grant's scope of work once the grant cycle is complete?

\* Outside of FAFCC funded projects, how has your clinic or network implemented steps toward self-sustainability?

\* Being aware that the theme and emphasis of this grant program is capacity building, how will the grant funding increase member clinics' capacity, surrounding support in delivering services, ability to fulfill their mission, and ability to sustain operations and expand service to clients?

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## ATTACHMENTS AND ACKNOWLEDGEMENTS

The required documents you need are:

1. Attachment 1 – 501c3 Letter
2. Attachment 2 – Most Recent Board Approved Operating Budget
3. Attachment 3 – Previous Fiscal year, Actual Operating Budget (actuals)

501c3 Letter

 [Upload Files](#) Or drop files

Most Recent Board Approved Operating Budget

 [Upload Files](#) Or drop files

Previous Fiscal year, Actual Operating Budget (actuals)

 [Upload Files](#) Or drop files

Please confirm all attachments have been uploaded

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## ACKNOWLEDGEMENTS

### Acknowledgment of the notification of funding availability (NOFA)

I, the Project Liaison, have read and understand the Notification of Funding Availability(NOFA) and hereby check the box as confirmation of my comprehension.

### Acknowledgement of the Member Management Fee

**Structure:**

Member organizations will be billed for the management fee quarterly  
 Member organizations must use other funds (besides the public and private funds raised by FAFCC) to pay the management fee

Member organizations must remain in good standing which means that annual membership dues, and management fees are paid and up-to-date

**Benefits:**

The management fee paid to the FAFCC covers administrative costs associated with managing the State Funds Grant such as managing and reporting the results of public and private funds provided to member organizations

Funds the association to develop additional sources of revenue for member organizations  
 Allows 100% of the State Funds Grant to be used for their intended purpose (i.e. without administrative or indirect costs)

Please read the Member Management Fee Policy above or by clicking on the link provided:  
 LINK TO FAFCC PAGE:

I, the Project Liaison, have read and understand FAFCC's Member Management Fee policy and hereby check the box as confirmation of my comprehension.

### Acknowledgement of the Purpose and Responsibilities of the Project

**Liaison**

The Project Liaison as outlined in the NOFA is capable of performing the duties required to manage and oversee the successful performance of the grant. The Project Liaison is the lead contact on all grant related matters which include forwarding FAFCC correspondences to additional team members as they relate to deadlines, management fees, and payments. Additionally, the project liaison will be expected by FAFCC staff to be knowledgeable of the progress and outcomes of funded projects, and to communicate them through written or verbal communications.

FAFCC WILL NOT be responsible for forwarding or sending grant correspondences to an organization's employees who are not the designated Project Liaison.

I, the Project Liaison, have read, understand, and will assume the responsibilities as outlined in the above statement.

**Signatures**

I, the Project Liaison, hereby certify that all of the information contained in this application, and the attached documentation, is true and accurate to the best of my knowledge. ⓘ

I, the Board Chair or Executive Director, hereby certify that all of the information contained in this application, and the attached documentation, is true and accurate to the best of my knowledge ⓘ