Southeast Volusia Hospital District

Program/Service Packet
Request for Funding
2021-2022

Required Criteria

In order for this application to be considered the organization ***must*** meet all of the following criteria:

- ***Must*** be a governmental entity or a registered Florida business organization and hold an active status with the Division of Corporations.
- ***Must*** hold all licenses legally required to perform program/service.
- Program/service must be provided within the District boundaries as set forth in Chapter 2003-310, House Bill No. 273 laws of Florida. Programs/services provided outside of the District boundaries will not be considered.
- Only programs/services which provide medical, health care related or access to health care service to indigent residents will be considered.
- Applicant ***must*** qualify their population using the District eligibility guidelines.
- **Applications *must* be submitted and postmarked between January 1 and April 30. (No exceptions)**
- Applications not signed or completely filled out will not be considered. If a section or question is not applicable, please explain why.
- This application ***must*** be used. No other application will be considered. Applications may be typed or written in black ink only if a question does not provide specific instructions on the format of the answer.
- Applications are limited to the required amount of pages (ie: Application, Service Packet, Financial Template, Description Pages, Copies of Licenses, Certificates of Insurance, Tax Determination Letter, Agency Financials, etc.). If the amount of pages is in excess of the allowed amount, the application will be considered incomplete.

Applications not meeting all of the criteria in this application will not be considered.

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Instructions

A. Complete one program/service packet for each program/service that you are requesting funding for.

B. Please complete all sections. If there is a section that is not applicable please write or type "N/A" and provide an explanation. **Packets that are incomplete will not be considered.**

C. For each program/service, one original and seven copies of the completed program/service and financial packet must be submitted.

Deliver via US mail, courier service to:
Attn: Chris Ilardi
305 Magnolia Street
New Smyrna Beach, FL 32168

***Application Submission Deadline: MUST be postmarked by April 30 (No exceptions)**

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Section 1: Description of Service/Program and Requested Funding

A. Date of application: _____ FEIN#:_____

B. Agency Legal Name:

_____

C. What is the title of the program/service?

_____

_____

D. Attach a **typed** detailed description of the program/service that funds are being requested for. The description should include a history of the program, identify the target population, how it addresses a community need, the specific purpose of the requested funding amount, and list other funding sources. The description should be no longer than two pages, double spaced, using an 11 point font, on an 8.5"x11" standard white paper. Please title it "Section 1: Description of (Title) Service/or Program."

E. Attach a list of the personnel involved in providing the program/service. The list should include their education, experience, qualifications and description of their roles.

F. Identify the program/service target population, estimate the number that will be served, and list the requested funding amount for the District's fiscal year (October – September):

Target Population (Children/Seniors/Pregnant)	Estimated number served (October – September)	Requested Amount (October - September)
_____	_____	$_____

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G. Describe the length of the program/service. Will it last for one day, a week, the whole fiscal year?

_____

_____

_____

_____

H. Are there similar programs/services in the District that currently serve the needs that this program/service offers?

_____

_____

_____

_____

I. Describe how the agency will qualify their target population given the District's eligibility criteria.

_____

_____

_____

_____

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J. What attempts have been made to locate other funding sources for this program/service?

_____

_____

_____

_____

K. What was the prior year funding by the District? $_____

Section 2: Program/Service Cost and Budget

A. Download and fill in the yellow highlighted cells in the "Financial Template" packet found on the District's website. The packet must be completed using the Microsoft Excel program. It cannot be hand written. Print and submit it with the application and program/service packet. Do not add additional information other than what is required. If a cell is not applicable, fill it in with a 0 (zero). If additional information is added the application will be considered incomplete.

B. What is the total projected cost for the program/service during the District's fiscal year (Oct-Sep):

Total Projected Cost	Requested Amount (October - September)	Amount/Cost
$_____	$_____	%_____

C. Attach a **typed** detailed description of the proposed reimbursement methodology for the program/service. The description should provide details that ensure the District reimbursement per unit will not exceed that charged to any other insurance payer, funding entity, public or private for the same or substantially the same services. The description should be no longer than two pages, double spaced, using an 11 point font, on an 8.5"x11" standard white paper. Please title it "Section 2: Proposed reimbursement methodology of (Title) Service/or Program."

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D. List the per unit cost & proposed reimbursement* Unit Defined =_____

Program/Service (P/S)	Organization cost per unit of (P/S)	Districts reimbursement per unit of (P/S)	Medicaid reimbursement per unit of (P/S)	Medicare reimbursement per unit of (P/S)	Private Insurance/Other reimbursement per unit of (P/S)	Other reimbursement per unit of (P/S)

*No cost or rate of reimbursement charged to the District may exceed that charged to any other insurance payer, funding entity, public or private for the same or substantially the same services.

E. Will the program/service exist if it does not receive the full amount requested? If yes, what if any is the minimum amount needed?

_____

_____

_____

Section 3: Location of Services

A. Provide the location(s) where the program/service will be provided that the requested fund will be used for. Locations **must** be within the District boundaries.

Location(s) (Please list addresses)

_____

_____

_____

_____

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Section 4: Reporting Requirements

Reporting requirements, including invoice frequency and details, will vary according to program/service and will be determined at the time of approval for funding. Invoices submitted to the District must include, at minimum, invoice amount, time period covered, services rendered, a de-identified reference number for the individual client program/service, the aggregate number of individuals served, and the actual cost per unit of service (if applicable).

Section 5: Future Anticipated Funding Requirements

A. What is the future anticipated financial yearly funding requirement for this program/service?

_____

_____

B. Where will that funding be expected to come from?

_____

_____

_____

Section 6: Other Information and Requirements

A. Please include copies of all licenses that are legally required for Applicant to perform proposed services. If a copy is not provided, the application will be incomplete and not considered.

B. If approved, funding is contingent on the collection of ad valorem dollars and will only be made available after January 1 of the following year. Approved documentation to support the funding must be submitted prior to funds being paid. **Pre-payment of funds will not be an option.**

C. District or its designated agent shall have the right, during usual business hours, after reasonable notice to Agency, and at District's expense, to audit, examine, and make copies of the books and records maintained by the Agency used in the compilation of the reports and invoices used to documents programs/services.

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Section 7: Submission

Signature of Agency's Designated Representative: _____

Printed Name of Representative: _____

Application Completion Date: ___/____/____

Internal District Office Use: Do not fill in section

Date received: _____

Approved/Amount: _____ Denied: _____ Date: _____

Denied Reason: _____