Community-Based Primary Care Clinic Grant Program

Kansas Department of Health and Environment

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Community-Based Primary Care Clinic Grant Resources

- Recorded version of both webinars
- Frequently Asked Questions
- Copy of Power Point presentation
- Technical assistance at primarycare@kdheks.gov or call Barbara or Cristi

All resources will be posted to webpage at http://www.kdheks.gov/olrh/pc_clinics.htm by Friday, January 17, 2014

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Community-Based Primary Care Clinic Grant Program Purpose

- Assist in development/operation of clinics that focus on improving access to quality healthcare with an emphasis on community-based services and reducing health disparities for underserved populations
- Make primary medical and dental care, prescription drugs, and preventive health care services accessible and affordable to underserved Kansas residents

Funding Information

- Currently funded clinics **may not request and will not receive a funding increase of greater than 20%** of the FY2014 level.
- No currently funded qualified applicant will receive a funding decrease of greater than 20% of the FY2014 level unless the grantee has been non-compliant with program requirements.
- Newly funded clinics will not receive greater than $80,000 in the first funding year unless exceptional qualifications/conditions exist.
- Geographic considerations may be taken into account

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Funding Categories

The application process has been changed from previous years. This application process is for all three funding categories below:

Dental Assistance:	• Funding may be used to provide access to dental services for clinic patients
General Primary Care:	• Funding may be used to provide access to medical or other health-related services for clinic patients (not including dental or prescription assistance)
Prescription Assistance:	• Funding may be used to provide access to pharmaceuticals, pharmaceutical services, and pharmaceutical supplies for clinic patients

Funding Information

- Funds are programmatically apportioned to include general primary care, dental, and/or prescription assistance activities. ***A minimum of $500,000 of the funds will be dedicated to support dental activities***
- Awards are competitive and are contingent upon the availability of funding

Funding Example

Example: "Kansas Clinic" received $100,000 in funding last year:
$40,000 for dental services
$20,000 for prescription assistance
$40,000 for general primary care services

They would like to expand services and request a funding increase. For the upcoming funding cycle, the max they can request is $120,000.
The additional $20,000 can be all in one funding category or can be spread across categories.

Eligibility

- Clinics must serve as "safety net" clinics in their communities.
- Clinics must be not-for-profit or publicly-funded clinics providing at least primary medical and/or dental care services (or planning to provide at least primary care medical and/or dental services for clinics not yet in operation).
- Clinics must provide services regardless of ability to pay

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Required Match

- Applicants are required to provide support that meets the match requirement of one dollar for each one dollar of state funding awarded.
  Match may come from
  - non-cash donations
  - in-kind services
  - donated sample medications
  - clinic expenses
  - Value of health services provided at no or reduced cost

Should be stated at an agreed upon market value

Required Match

- Capital Improvement Program funds, distributed through the Kansas Association for the Medically Underserved, and capital expenditures may not serve as part of the local match.

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Allowable Expenses

- Funding may be used for:
  - Salaries
  - Contracted professionals and services
  - Utilities
  - Vaccines not available through the Vaccines for Children Program
  - Supplies
- Travel expenses are only allowable for travel to and from in-state training/continuing education and must be categorized as general primary care in your budget.

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Unallowable Expenses

Expense	General Primary Care	Dental	Prescription Assistance
Capital equipment or other capital expenditures		Not allowable	
Costs associated with inpatient care		Not allowable	
Out-of state travel		Not allowable	
Salary expenses for staff member time spent in training or traveling to training		Not allowable	
Equipment		Not allowable	
In-state travel		√	√
Pharmaceuticals	√	√	
Laboratory materials			√
Office/clerical supplies		√	√
Utilities		√	√
340B discounts		√	

(√ denotes expenses that are not allowable for specific categories)

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Fiscal Requirements

- Clinics receiving state funds must submit a fiscal report or audit to KDHE within 12 months of fiscal year end.
- Awardees are expected to notify the Primary Care Office in advance of any proposed budgetary changes that:
  - Total 25% or more of award; and/or
  - Require shifting more than $500 of funding from an approved category (e.g. dental to prescription assistance)

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New Applicant Information

- Clinics that have **not** previously received funding from this grant program are required to contact the Primary Care Office **prior to February 15, 2014** to indicate their intent to apply.
- During the application process, all new applicants will be prompted to complete an additional form which will provide detailed background about the clinic and community.

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Applicant Material Submission

- All application materials must be submitted electronically! Follow the instructions on the Aid-to-Local Website (http://www.kdheks.gov/doc_lib/index.html):
  - Aid-to-Local "Application for Grant" Form
  - Community-Based Primary Care Clinic Grant Application Form
  - Budget
- The application form should be saved as a PDF and submitted with the budget via e-mail to aidtolocal@kdheks.gov.
- Appendices A-F of the grant application must be attached and submitted electronically via EMAIL to aidtolocal@kdheks.gov

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Aid to Local Application for Grant Form

- Can be downloaded at http://www.kdheks.gov/doc_lib/index.html
- **Must** be signed by the president or chairperson of the clinic's board and by the clinic's director.
- Only those entities that are applying for other KDHE Aid to Local funding and all clinics affiliated with a local health department will need to complete the Personnel Allocation by Program form

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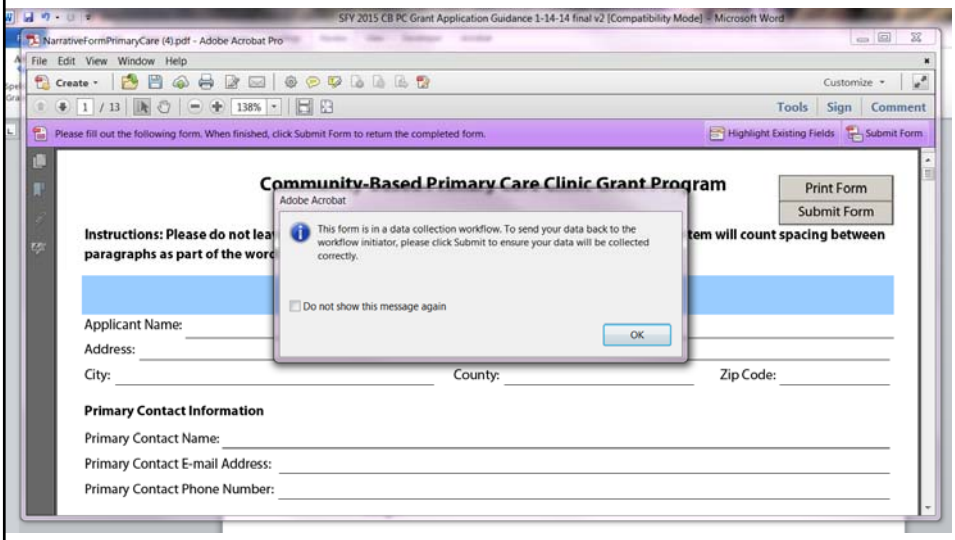

Application Information

- For all fields that have a word limit, the system will count spacing between paragraphs as part of the word limit. DO NOT include spaces between paragraphs.

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Community-Based Primary Care Clinic Grant Program

Print Form
Submit Form

Instructions: Please do not leave any questions blank. For all fields that have a word limit, the system will count spacing between paragraphs as part of the word limit. DO NOT include spaces between paragraphs.

Application Information

Applicant Name: _____

Address: _____

City: _____ County: _____ Zip Code: _____

Primary Contact Information

Primary Contact Name: _____

Primary Contact E-mail Address: _____

Primary Contact Phone Number: _____

Secondary Contact Information

Secondary Contact Name: _____

Secondary Contact E-mail Address: _____

Secondary Contact Phone Number: _____

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Request Summary

Total amount of FY2015 request: _____

Select services to be provided (check all that apply): General Primary Care: ☐ Dental: ☐ Prescription Assistance: ☐

Provide breakdown of estimated funding allocations for each category:

Type of Service	Estimated Funding Allocation
Dental	
General Primary Care	
Prescription Assistance	

Estimated total number of people to be served in FY2015 with this funding: _____

Provide breakdown of estimated number of people to be served in FY2015 for each category:

Type of Service	# of People Served
Dental	
General Primary Care	
Prescription Assistance	

This funding source requires a match of one dollar for each state dollar awarded. In the table below, please indicate how you anticipate providing matching funds by providing an estimated percentage for each type of matching fund source:

Type of Matching Fund Source	% of Total Matching Funds
Cash donations	
In-kind services (e.g. volunteer time or services)	
Other non-cash donations	
Clinic fees (e.g. patient payment for services)	
Other income (please specify):	

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Have you received Primary Care Clinic funding previously? ☐ Yes ☐ No

If no, please go to the following link to complete an additional form www.kdheks.gov/olrh/pc_clinics.htm.

If yes, what is the total number of people served by your clinic in 2013 (calendar year): _____

Provide the total number of unduplicated individuals served by zip code for the last 12 months (include each zip code for which you served patients):

	Zip Code	Total number of unduplicated individuals served
Add Another Zip Code		

Describe the importance of this funding to your clinic (300 word limit):

Comments regarding Request Summary (200 word limit):

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A. Local Community Data **12 points**

A1. Please list the counties that will be served by the clinic:

For questions A2-A3, include data for the county where your clinic is located and no more than four other counties in your service area.

A2. Utilize U.S. Census data from the following website (http://quickfacts.census.gov/qfd/states/20000.html) to answer the following questions for the primary county(ies) your clinic serves:

	Race/Ethnicity						
	County	White %	Hispanic or Latino %	Black or African American %	Asian %	Native Hawaiian or other Pacific Islander %	Two or more races %
Add Another County							

	Age Distribution				
	County	Under 5 years %	Under 18 Years %	Between 18 and 65 years %	Over 65 years %
Add Another County					

	County	**Percentage of persons living below the poverty level**
Add Another County		

A3. Utilizing Kansas Health Matters (see website below), identify and describe gaps in service, health disparities, or other health care issues that will be specifically targeted with this funding (500 word limit):
www.kansashealthmatters.org/modules.php?op=modload&name=NS-Indicator&file=index

A4. Has the community where your clinic is located completed a community health assessment (or community health needs assessment) within the last five years? ☐ Yes ☐ No

If yes, when? _____

If yes, was your clinic an active participant in the community health assessment process? ☐ Yes ☐ No

What organization(s) led the process?

Comments regarding Section A (200 word limit):

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B. Applicant Clinical Structure/Overview — 30 points

For the questions in Section B, if your clinic has more than one site, you may wish to choose your main site or the site which serves the most people (if not the main site) and provide further explanation of additional sites in the comments section.

B1. Describe your clinic (including history and importance to the community(ies) served) (200 word limit):

B2. When was your clinic founded? _____

B3. What are your hours and days of operation? _____

B4. What is the average wait time for appointments? _____

B5. Does your clinic serve patients on a walk-in basis? ☐ Yes ☐ No

B6. Does your clinic use electronic health records (EHR)? ☐ Yes ☐ No

If yes:

When did you begin using EHR? _____

What is the name of the EHR system that your clinic is currently using? _____

If no:

Does your clinic have plans to implement EHR? ☐ Within the next year ☐ Over the next 2 to 3 years ☐ No plans

B7. What is your clinic's average cost per patient? _____

B8. How was the figure in B7 calculated?

B9. What was your clinic's total operating budget during the last calendar or fiscal year (provide figure)? _____

B10. What was your clinic's total value of uncompensated care (i.e. care not paid by private insurance, Medicaid, Medicare, or other funding sources) provided during the last calendar or fiscal year (provide figure)? _____

Staffing

B11. In the table below, provide information regarding all staff members:

Position(s)	Number of FTE (paid staff)	% of FTE funded by this source
Physicians		
RNs		
APRNs/Physician Assistants		
Dentists		
Dental Hygienists		
Pharmacists		
Management staff		
Clerical staff		
Other (please specify below)		

B12. If your clinic has volunteers providing clinical and/or clerical support, plea

Position(s)	Estimated Number of Volunteer/In-kind Hours Provided to the Clinic per Month
Physicians	
RNs	
APRNs/Physician Assistants	
Dentists	
Dental Hygienists	
Pharmacists	
Management staff	
Clerical staff	
Other (please specify below)	

B13. Provide an overview of your clinic management structure and staff (200 word limit):

B14. Provide an organizational chart for your clinic that includes the management structure (see example provided). Attach as Appendix A.

B15. Does your clinic directly dispense prescription medications? ☐ Yes ☐ No

If yes, do you have a pharmacist in charge? ☐ Yes ☐ No

Partners

B16. What types of organizations in your community are key partners for your work (select all that apply)?

- ☐ Private practice physicians
- ☐ Community mental health center(s)
- ☐ School district(s)
- ☐ Local foundation(s)
- ☐ Private business(es)
- ☐ Other (please specify below):
- ☐ Local non-profit organization(s)
- ☐ Hospital(s)
- ☐ Local health department
- ☐ Faith based clinic(s)
- ☐ Local elected officials
- ☐ Local service clinic(s)

Describe how you work with one or more of the above partners (200 word limit):

Board of Directors

B17. Does your clinic have a Board of Directors? ☐ Yes ☐ No

If yes, please attach a copy of your Board of Directors roster, including the organization represented by each board member, as Appendix B.

Organization

B18. Does your clinic have a current strategic plan? ☐ Yes ☐ No

If no, do you have plans to develop a strategic plan? ☐ Yes ☐ No

If yes, by when? _____

Comments regarding Section B (200 word limit):

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C. Clinic Services **42 points**

C1. Has your clinic been formally recognized as a patient-centered medical (or dental) home by an accredited agency? ☐ Yes ☐ No

If no, is your clinic working toward recognition as a patient-centered medical (or dental) home? ☐ Yes ☐ No

Eligibility

C2. Does your clinic accept KanCare (Medicaid) patients? ☐ Yes ☐ No

If yes, describe any limits on number of patients accepted (100 word limit):

C3. Does your clinic accept Medicare patients? ☐ Yes ☐ No

C4. Does your clinic see patients regardless of their ability to pay? ☐ Yes ☐ No

C5. Does your clinic have a discounted fee schedule (sliding scale) for uninsured individuals at and below 200% of the current federal poverty level (based on current federal poverty guidelines available at http://aspe.hhs.gov/poverty/13poverty.cfm#guidelines)?
☐ Yes ☐ No

If yes, is the information in writing and publicly posted? ☐ Yes ☐ No

C6. Does your clinic have procedures in place for:

Referring patients to services (such as specialty care) outside your clinic? ☐ Yes ☐ No

Tracking referrals and following up with patients who receive services outside of clinic? ☐ Yes ☐ No

Assuring patients have access to care outside of clinic's normal business hours? ☐ Yes ☐ No

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Service Provision

C7. For the services listed below, indicate services that are provided by your clinic, services for which your clinic provides referrals to another organization, and services your clinic does not provide. Please provide a response for each service:

Service Provided	Provided by applicant clinic	Referred to another organization	Not provided/not referred
Prenatal care	☐	☐	☐
Delivery/post-natal care	☐	☐	☐
Newborn screenings & wellness checks	☐	☐	☐
Well Woman checks	☐	☐	☐
Other screenings & preventive care	☐	☐	☐
Dental screenings & preventive care	☐	☐	☐
Dental treatment	☐	☐	☐
Prescription assistance	☐	☐	☐
Immunizations	☐	☐	☐
Smoking cessation	☐	☐	☐
Substance abuse treatment	☐	☐	☐
Mental/behavioral health services	☐	☐	☐
Transportation	☐	☐	☐

Optional: Provide further explanation for any items checked above (200 word limit):

C8. Describe your clinic's role in providing pharmaceuticals. If you are using grant funds to provide this service, explain how the funds will be expended (200 word limit):

C9. Describe your clinic's role in providing dental services. If you are using grant funds to provide this service, explain how the funds will be expended (200 word limit):

C10. Describe your clinic's role in providing or linking to mental/behavioral health services (200 word limit):

C11. Describe your clinic's role in providing or linking to chronic disease management (200 word limit):

C12. How does your clinic ensure services are provided in a culturally competent and linguistically appropriate manner for the population in your service area (200 word limit)?

C13. What new activities do you plan to implement in FY2015 and how will overall priority health care needs and health disparities be addressed as a result (300 word limit)?

Comments regarding Section C (200 word limit):

D. Quality Improvement — 16 points

D1. Does your clinic have a quality improvement/quality assurance plan (QI/QA)? ☐ Yes ☐ No

D2. Describe your QI/QA plan (300 word limit):

D4. Have you found that tracking quality measures helps to improve patient outcomes? ☐ Yes ☐ No

If yes, in what ways (200 word limit)?

D5. What quality improvement and quality assurance work or projects do you have planned in the next year that this funding will support (200 word limit)?

Comments regarding Section D (200 word limit):

By submitting this application and signing the Aid to Local Application for Grant form, I am attesting that all of the information above is accurate and complete.

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D3. Below is a list of quality measures for medical, business/financial, and dental. The goal of these measures is to provide you with data to serve as a basis for quality improvement and also to provide you with a comparison to other similar (de-identified) clinics in the state. Last year, you identified one clinical measure (medical or dental) and one business/financial measure. In addition to the measures you are currently reporting, please select **one additional clinical measure and one additional business/financial measure**.

Clinical Measures

Medical Measures		
	√ if currently reporting on this measure	√ if you will begin to report on this measure in the upcoming year
Diabetic patients with HbA1c greater than 9% or no testing done	☐	☐
Hypertensive patients with HTN controlled	☐	☐
Tobacco use assessment	☐	☐
Tobacco cessation intervention	☐	☐
Adult weight screening & follow-up	☐	☐
Child & adolescent weight assessment & counseling	☐	☐
Dental Measures		
	√ if currently reporting on this measure	√ if you will begin to report on this measure in the upcoming year
# of emergent dental encounters	☐	☐
# of comprehensive dental encounters	☐	☐
# of recall dental encounters	☐	☐
# of all other dental encounters	☐	☐

Business/Financial Measures

	√ if currently reporting on this measure	√ if you will begin to report on this measure in the upcoming year
Average medical cost per medical patient	☐	☐
Average dental cost per dental patient	☐	☐
Average medical cost per medical visit	☐	☐
Average dental cost per dental visit	☐	☐

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Appendices

All appendices should be included in *one e-mail* if possible with the following subject line: Community-Based Primary Care Clinic Grant Appendices—[your clinic name].

Appendix A. Organizational Chart--must include all staff funded by this program

Appendix B. Board of Directors Roster—affiliations must be included

Appendix C. Audit/Fiscal Report (most recent for your entire organization)

Appendix D. Letters of Support/Memoranda of Understanding—letters must be dated in 2014

Appendix E. Schedule of Discounts and Sample Charges

Appendix F. (optional) Supplementary Materials

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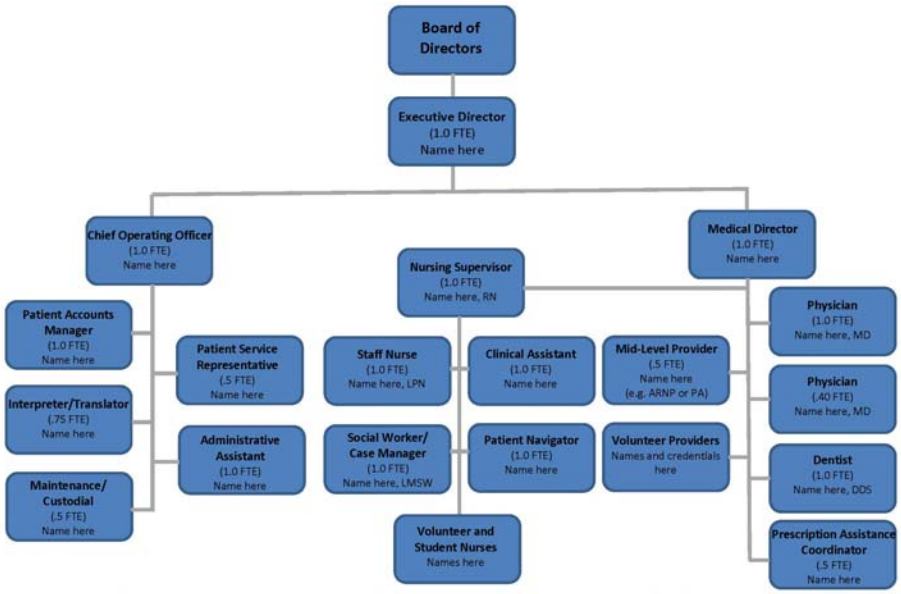
Kansas Medical Clinic Organizational Chart Example



*The organizational chart must include **all** staff funded through the Community-Based Primary Care Clinic Grant Program.*

Supplementary Materials

- Optional
- Can include any additional items from the past 12 months which would be helpful for reviewers (testimonials from someone who received services (de-identified), newspaper articles, resource materials, etc.)
- Should be referenced in the appropriate area of the narrative

Scoring of Applications

Section	Total points possible
Local Community Data	12 points
Applicant Clinical Structure/Overview	30 points
Clinic Services	42 points
Quality Improvement	16 points
Total Possible	100 points

Scoring Criteria

Overall Application		
Was the application complete?	☐ Yes	☐No
Is the benefit of the funding to the clinic and the community clearly communicated?	☐ Yes	☐No
Is the budget reasonable and clear?	☐ Yes	☐No
Were the sources of matching funds appropriate?	☐ Yes	☐No
Is it clear the organization has the capacity to carry out what is outlined in the proposal?	☐ Yes	☐No
The estimated number of people to be served seems reasonable for the amount requested.	☐ Yes	☐No
Overall application rating is:	☐ Excellent ☐ Fair	☐ Good ☐ Poor

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Scoring Criteria

A. Local Community Data	12 points (maximum)	
Scoring Criteria	Point Values	Points Awarded
Applicant provided all requested demographic data utilizing the website provided (A2)	Maximum= 3 points Minimum= 0 points	
Applicant effectively identified and described gaps in service, health disparities, or other health care issues to be targeted with this funding (A3)	Maximum= 6 points for clear description Minimum= 0 points for no description	
If the community conducted a community health assessment (community health needs assessment), the clinic was an active participant in the community health assessment process (A4)	Maximum= 3 points if community conducted a community health assessment and the clinic participated or if the community has not conducted an assessment Minimum= 0 points if community conducted a community health assessment but clinic did not participate	

B. Applicant Clinical Structure/Overview	30 points (maximum)	
Scoring Criteria	Point Values	Points Awarded
Applicant effectively described their clinic and the importance to the community(ies) served (B1)	Maximum= 5 points if clearly described Minimum= 0 points if not described	
Applicant provided requested overview information (B2-B6)	Maximum= 4 points Minimum= 0 points	
Average cost per patient is reasonable (B7-B8)	Maximum = 3 points Minimum = 0 points	
Clinic staffing is appropriate for the number of patients served and for the level of services provided (B11)	Maximum = 2 points Minimum = 0 points	
Clinic effectively uses volunteers (B12)	Maximum = 2 points Minimum = 0 points	
Applicant effectively described their management structure and staff (B13)	Maximum= 3 points if clearly described Minimum= 0 points if not described	

Organizational structure is clearly depicted in organizational chart (Appendix A)	Maximum= 2 points Minimum = 0 points	
Applicant collaborates with local hospital (B16)	Maximum= 1 point Minimum= 0 points	
Applicant collaborates with local health department (B16)	Maximum= 1 point Minimum= 0 points	
Applicant collaborates with other community organizations (B16)	Maximum= 1 point Minimum= 0 points	
Board of Directors roster is attached and demonstrates broad representation of community(ies) served (Appendix B)	Maximum = 3 points if clearly demonstrated Minimum = 0 points if not demonstrated	
Applicant demonstrates the capacity to effectively utilize and manage state funding (Section B)	Maximum= 3 points if clearly demonstrated Minimum= 0 points if not demonstrated	

C. Clinic Services	42 points (maximum)	
Scoring Criteria	Point Values	Points Awarded
Clinic is recognized as a patient-centered medical home (C1)	Maximum= 2 points Minimum= 0 points Award 1 point if clinic is working toward recognition as a patient-centered medical home	
Clinic has no limits on number of KanCare (Medicaid) patients accepted (C2)	Maximum = 2 points Minimum = 0 points	
Clinic accepts patients regardless of ability to pay (C4)	Maximum = 3 points Minimum = 0 points	
Clinic has a discounted fee schedule that is in writing and publicly posted (C5)	Maximum = 3 points Minimum = 0 points	
Clinic has procedures in place for referrals and afterhours access (C6)	Maximum = 3 points Minimum = 0 points	
Clinic services correlate to identified community needs (C7)	Maximum = 8 points Minimum = 0 points	

Applicant provides or has a referral process in place for oral health (C9)	**Maximum = 3 points** **Minimum = 0 points**	
Applicant provides or has a referral process in place for mental/behavioral health services (C10)	Maximum = 3 points Minimum = 0 points	
Applicant provides or has a referral process in place for chronic disease management (C11)	Maximum = 3 points Minimum = 0 points	
Applicant described how they ensure services are provided in a culturally competent and linguistically appropriate manner (C12)	Maximum = 6 points if clearly described Minimum = 0 points if not described	
Applicant described activities to be implemented and expected outcomes (C13)	Maximum = 6 points if clearly described Minimum = 0 points if not described	

D. Quality Improvement	16 points (maximum)	
Scoring Criteria	Point Values	Points Awarded
Applicant has a quality improvement/quality assurance plan (D1)	Maximum = 1 point Minimum = 0 points	
Applicant effectively described QI/QA plan (D2)	Maximum = 3 points Minimum = 0 points	
Applicant effectively described how quality measures are helping to improve patient outcomes (D4)	Maximum = 6 points if clearly described Minimum = 0 points if not described	
Applicant effectively described quality improvement/quality assurance work/projects that will be conducted in the next year (D5)	Maximum = 6 points if clearly described Minimum = 0 points if not described	

Grant Application Deadline

Applications must be submitted *electronically* by

Friday, March 14, 2014 at 5:00 p.m.

No late applications will be accepted.

Review Process

- Recommendations are based upon each clinic's submitted application and its annual data submission to KAMU on the Quality Reporting System (QRS)
- Committee composed of experts who do not have a vested interest in any applicant organization and representing all regions of the state
- Recommendations will be provided to the KDHE Secretary

Post-Award Requirements

- Instructions and forms are contained in separate materials that will be provided after grant awards have been made
- PCO reserves the right to review any documentation relevant to the award including organization bylaws, strategic plan, Board of Directors minutes, and other information

Feedback

- Compared with the previous application process, did you find it:

  More difficult About the same Less difficult

- Were any of the questions unclear?

  If so, please explain.

- Do you feel you were able to adequately communicate all relevant information about your clinic in order for a funding determination to be made? Yes No

  If no, please explain.

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Feedback

- Were the pre-application webinars helpful?

  Yes No Did not attend

- Was it necessary for you to contact KDHE for clarification at any time during the process?

  Yes No

  If yes, please explain.

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Questions

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Contact Information

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bhuske@kdheks.gov

Cristi Cain
Public Health Specialist, Local Public Health Program
785-296-3641
ccain@kdheks.gov

Contact the **KDHE Primary Care Office** at primarycare@kdheks.gov

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