Washington State Health Care Authority

Uninsured Care Expansion Grant Application

The Health Care Authority (HCA) developed this grant application process with the goals of fairness and equity, while ensuring only eligible organizations are awarded grant funds and minimizing administrative burden for the applicant.

HCA strongly recommends applicants read though all materials on the grant web page before beginning the online grant application. ***The grant application website times out after two hours. Edits cannot be made once submitted.***

Background and Critical Information

This application is in response to Substitute Senate Bill 5092, Section 211(60) which directs the Health Care Authority (HCA) to allocate $35 million in funds from the coronavirus state fiscal recovery account to distribute grants for the provision of health care services for uninsured and underinsured individuals under 200 percent of the federal poverty level, regardless of immigration status. Funds will be allocated as a lump sum to each awardee by June 30, 2022 and must be fully utilized by June 30, 2024.

Please Note:

- To be eligible for these grant funds, applicants must provide direct health care services and/or referrals to and payments for services off-site for uninsured and underinsured individuals under 200 percent of the federal poverty level, regardless of immigration status or provide outreach and education to inform patients and prospective patients that care is available free of charge. HCA strongly recommends that potential applicants review the eligibility criteria before starting this application process.
- A response is needed for each question/attestation in the application to be considered complete.
- An attestation statement is required at the end of this application that the organization's authorized representative (usually the Director/Senior Executive) is aware of and approves the content of this submission. However, the organization's primary point of contact may be a different person.
- Each organization may submit only one application for all the services covered at all their service locations.
- The system will time out after two hours. Therefore, HCA strongly recommends that applicants review the instructions and download the PDF version of the application to organize their responses before entering data into the online grant application tool.
- For questions that require a narrative response (e.g. those around retrospective reimbursement, Community Based Organization outreach activities, or the process to prevent clients from being billed), it is also recommended that the applicant prepare text responses offline to then simply cut/paste into the online tool. HCA is looking for a maximum of 2 pages of content for those responses.
- For numeric fields, insert only numbers. Do not add commas, hyphens, or other formatting.

The Grant Application Deadline is April 22, 2022 at 5:00 pm Pacific Time. To be considered eligible for funding consideration, each organization must submit all grant application sections, any requested edits/corrections, and all additional required documentation by that date. Late submissions will not be accepted.

Additional information including a Frequently Asked Question (FAQ) document, PDF version of this application, eligibility criteria, key definitions, required documentation to be sent with this application, overview of evaluation criteria and potential reporting requirements, can be found on the Uninsured Care Expansion Grant web page.

When to contact HCA

Please contact HCA for the following:

- To answer any questions you may have.
- If you need help with the application.
- To submit required supporting documentation.
- If you need an accommodation due to language barriers or lack of internet access.

When contacting HCA:

- Email the Uninsured Care Expansion Grant program (HCAUninsuredGrant@hca.wa.gov) with the subject line Uninsured Care Expansion Grant Application – (name of organization), or
- Call HCA at 360-725-1244

Uninsured Care Expansion Grant Application

1. Organization Name: _____
2. Organization Main Office Address: _____

   _____

Please provide information for your organization's primary grant application contact who may be contacted if there are questions about this submission.

3. Name: _____
4. Title: _____
5. Email: _____
6. Phone: _____

Please provide information for the authorized representative who approves this grant application on behalf of your organization. This is typically the organization's Director/Senior Executive.

7. Name: _____
8. Title: _____
9. Email: _____
10. Phone: _____
11. What is your Dun & Bradstreet data universal numbering system (DUNS) number? (Range: 0-999999999)

    _____

What are your billing numbers?

12. Enterprise level ProviderOne number (if you have one). *Note: ProviderOne numbers for individual locations are not acceptable. If you do not have a ProviderOne number, please enter 0.*

    _____
13. Statewide Vendor (SWV) number (if you have one). *If you do not have a SWV number, please enter 0.*

    _____
14. Organization Employer Identification Number (EIN) or Taypayer Identification Number (TIN).

    _____

Please provide the following information about your organization.

15. Which best describes your location(s)? *Please review definitions of these location types.*

    ☐ Urban ☐ Rural ☐ Multiple locations, both urban and rural

16. What best describes your organization type? Check all that apply. *Please review definitions of these organization types.*

- ☐ Federally Qualified Health Center (FQHC)
- ☐ Rural Health Clinic (RHC)
- ☐ Free clinic
- ☐ Public Hospital District
- ☐ Behavioral health provider or facility
- ☐ Mental health inpatient
- ☐ Mental health outpatient
- ☐ Substance Use Disorder (SUD) residential
- ☐ Substance Use Disorder (SUD) outpatient
- ☐ Substance Use Disorder (SUD) withdrawal management
- ☐ Both mental health & SUD services
- ☐ Behavioral health Administrative Service Organization (ASO)
- ☐ Community Based Organization (CBO)

17. Total organization revenue for 2019 _____

18. Total organization revenue for 2020 _____

19. Total number of current clients (current client panel for all services) _____

20. Total number of licensed providers, with a breakdown by type (e.g. ARNP = 3, MHP = 6, LMT = 10, DDS = 4, etc.)

_____

21. Approximate percentage of your organization's clients who do not have health insurance (uninsured). *Please review the definition for uninsured that HCA is using.* _____

22. Approximate percentage of your organization's clients who are underinsured. *Please review the definition for underinsured that HCA is using.* _____

23. Approximate percentage of your organization's clients that earn less than 200% of the current federal poverty level. *Please review the definition for federal poverty level that HCA is using.* _____

24. Estimated percentage of your organization's clients who lack proper immigration documentation. ____

25. Percent of clients who are Black, Indigenous, People of Color (BIPOC). _____

Please provide a demographic description of clients your organization served utilizing the categories specified below.

Age distribution – percentage of clients within each of these age groups served by your organization during 2020.

26. Age <19 _____

27. Age 19-25 _____

28. Age 26-34 _____

29. Age 35-44 _____

30. Age 45-54 _____

31. Age 55-64 _____

32. Age >65 _____

Gender distribution – percentage of clients within each of these gender groups served by your organization during 2020.

33. Male _____

34. Female _____

35. Non-binary _____

Ethnicity distribution – percentage of clients within each of these ethnicity groups served by your organization during 2020.

36. Hispanic _____

37. Non-Hispanic _____

38. None/unknown/not reported _____

39. What service types does your organization provide? Check all that apply. *Note: This can include direct services, care delivered via telehealth, as well as referrals to and payment for services provided off-site related to the following:*

- ☐ Testing, assessment, or treatment of the severe acute respiratory syndrome coronavirus (COVID-19)
- ☐ Primary and preventative care
- ☐ Behavioral health services (mental health inpatient or outpatient, substance use disorder inpatient or outpatient, SUD withdrawal management or a combination of these services)
- ☐ Oral health care
- ☐ Assessment, treatment and management of acute or chronic conditions, including but not limited to the cost of laboratory, prescription medications, specialty care, therapies, radiology, and other diagnostics
- ☐ Outreach and education needed to inform patients and prospective patients that care is available free of charge

Identify any and all federal, state, or local government financial assistance to help address the COVID-19 related pandemic losses your organization has incurred since January 31, 2020. Type NONE for each question if none received.

Note: if the organization has received COVID-19 related government financial assistance, supplemental documentation is required. Please review the required supporting documentation to submit a complete application

section of the grant web site for more information. This must be received by ***April 22, 2022, 5:00pm Pacific Time*** *to HCAUninsuredGrant@hca.wa.gov to be considered for funding under this grant opportunity.*

40. Total COVID funds received _____
41. Source # 1 name _____
42. Source #1 amount _____
43. Source #2 name _____
44. Source #2 amount _____
45. Source #3 name _____
46. Source #3 amount _____
47. Amount of COVID-19 relief funding that has been utilized to date _____
48. Amount of COVID-19 relief funding that has not been utilized to date _____
    Note: Organizations with COVID-19 relief funds remaining are still eligible for these grant funds; however, these funds may only be utilized to provide services where other funding sources, such as Families First Coronavirus Response Act (FFCRA) and the American Rescue Plan Act (ARPA), have not already been utilized.
49. How much funding are you requesting under this grant? _____

Intended use of these funds.

50. Permissible uses of grant funding. Check all that apply to identify your intended use(s). *Note: any funds received through this grant must only be utilized for services listed below.*

    ☐ Testing, assessment, or treatment of the severe acute respiratory syndrome coronavirus 2 (COVID-19)

    ☐ Primary and preventive care Behavioral health services (mental health inpatient or outpatient, substance use disorder inpatient or outpatient, SUD withdrawal management or a combination of these services)

    ☐ Oral health care

    ☐ Assessment, treatment, and management of acute or chronic conditions, including but not limited to the cost of laboratory, prescription medications, specialty care, therapies, radiology, and other diagnostics

    ☐ Outreach and education needed to inform patients and prospective patients that care is available free of charge

51. Funding can be utilized to reimburse the organization for eligible retrospective costs related to previous losses/uncompensated care and prospectively for patients in active care. Please indicate your intended use.

    ☐ Retrospective only

    ☐ Prospectively only

☐ Both retrospective and prospective

52. For **retrospective reimbursement** for prior eligible services delivered since July 1, 2021, provide a detailed description along with documentation outlining how your organization provided services to uninsured and underinsured clients under 200 percent of federal poverty level regardless of immigration status. Please review the required supporting documentation to submit a complete application section of the grant web site for more information. This must be received at HCAUninsuredGrant@hca.wa.gov by **April 22, 2022 at 5:00 pm Pacific Time** to be considered for funding under this grant opportunity.

53. For **prospective services:**

    Briefly describe how you will utilize funds to pay for additional care/services for clients.

    How many additional clients could you serve with these funds?

If no funds for prospective services requested, state NOT APPLICABLE.

54. Indicate counties where your organization has service locations that will utilize these grant funds. Check all that apply.

☐ Adams	☐ Grays Harbor	☐ Pierce
☐ Asotin	☐ Island	☐ San Juan
☐ Benton	☐ Jefferson	☐ Skagit
☐ Chelan	☐ King	☐ Skamania
☐ Clallam	☐ Kitsap	☐ Snohomish
☐ Clark	☐ Kittitas	☐ Spokane
☐ Columbia	☐ Klickitat	☐ Stevens
☐ Cowlitz	☐ Lewis	☐ Thurston
☐ Douglas	☐ Lincoln	☐ Wahkiakum
☐ Ferry	☐ Mason	☐ Walla Walla
☐ Franklin	☐ Okanogan	☐ Whatcom
☐ Garfield	☐ Pacific	☐ Whitman
☐ Grant	☐ Port Oreille	☐ Yakima

Community Based Organizations (CBOs).

55. Are you a Community Based Organization (CBO) providing outreach and education needed to inform patients and prospective patients that care is available free of charge? ☐ Yes ☐ No

If yes, there are three additional questions to answer:

55a. Describe the mission/goal of the organization. _____

_____

_____

_____

_____

55b. List the primary outreach and education services provided. _____

_____

_____

_____

_____

55c. How long has the organization been serving these communities (i.e. years)? _____

56. Describe your internal process to ensure that clients will not be billed for any eligible services funded by this grant. _____

_____

_____

_____

_____

Attestations.

By selecting "Yes" for each item below, you are attesting to the following:

Agreement to post a notice in multiple languages about the types of services available under this grant.

☐ Yes

Agreement to not bill any individuals for any portion of care and services covered by this grant. ☐ Yes

Agreement to post a notice in multiple languages that individuals are protected from being billed for these services, including information on who to contact if they do receive a bill. ☐ Yes

Agreement to not use any funds received through this grant for services for which other funds are available, such as the Families First Coronavirus Response Act and the American Rescue Plan Act. ☐ Yes

Agreement to not use any money received through this grant for general operating costs (e.g., staffing, supplies, equipment purchases), unless your organization is a "free clinic," as that term is defined in Laws of 2021, Chapter 334, Section 211(60)(g). ☐ Yes

Agreement to submit all reports, to be determined by HCA, on the use of grant funds, including data about utilization of services. ☐ Yes

Agreement to submit any additional supporting documentation to HCA if and when requested. ☐ Yes

Agreement to utilize all funds received through this grant by June 30, 2024. ☐ Yes

Agreement to return any unused grant funds to HCA by July 31, 2024. ☐ Yes

Agreement that if your organization uses funds in a manner other than authorized by this grant and by Laws of 2021, Chapter 334, Section 211(60), then HCA may reduce, suspend, or withhold grant payments, and/or require all or any part of the grant to be repaid to HCA. The organization must repay any amount required to be repaid under this condition within 30 calendar days of receiving HCA's demand for repayment. If the organization disagrees with HCA's action under this provision, then it may invoke the dispute resolution provisions of this grant. ☐ Yes

Agreement that the dispute resolution provision of this grant is the organization's sole remedy to challenge any HCA action related to this grant. ☐ Yes

Agreement to obtain a ProviderOne number or a Statewide Vendor Number by June 30, 2022, if the organization does not already have one and is awarded funds under this grant. Failure to obtain either of these numbers by this date will result in the organization not being eligible for funds. ☐ Yes

Agreement that this is the compete and only application submitted by this organization for this grant, at the entity or corporate level (not each site or local/regional area). ☐ Yes

Agreement that the organization's authorized representative (usually the Director/Senior Executive) is aware of and approves the content of this submission. ☐ Yes

By selecting "Yes" for each item below, you are further attesting to the following:

Acknowledgement that all information in this application is true, accurate and complete to the best of your knowledge and you are authorized to make such attestation on behalf of the grant applicant. ☐ Yes

Acknowledgement that any deliberate omission, misrepresentation, or falsification of information in this application or records relating to it may be punishable by criminal, civil, or administrative penalties. ☐ Yes

Acknowledgement that, on behalf of the organization, I attest to all the terms and conditions of this application, including those incorporated by reference and agree on behalf of the grant applicant to be bound to the same. ☐ Yes

Acknowledgment that (a) HCA will use information in this application to form the decision to disburse funds; (b) the application is a "public record" as defined by RCW 42.56.010(3); and (c) HCA may disclose records in accordance with Chapter 42.56 RCW (the Public Records Act) or other applicable law. ☐ Yes

Acknowledgement that you have read and understand the assistance listing number formerly known as Catalogue of Federal Domestic Assistance (CFDA) number 21.027 (incorporated by reference into the terms and conditions of this application) and agree to bound by the same. ☐ Yes

Acknowledgement that you will maintain all appropriate records and cost documentation, including, as applicable, documentation described in 45 CFR 75.302 and 45 CFR 75.361 through 45 CFR 75.365 and other information required by future instructions from HCA to substantiate information in this application. Further, you will promptly submit copies of such records and cost documentation upon request of federal and state officials or their designees and will fully cooperate in all audits or reviews conducted by federal and state officials or their designees to ensure compliance with the terms and conditions of the application.

☐ Yes

By entering the name of your signing authority below, your organization is submitting this application.

_____

Please ensure that your information is complete and accurate before submitting.

Please contact HCA for the following:

- To answer any questions you may have
- If you need help with the application
- To submit required supporting documentation
- If you need an accommodation due to language barriers or lack of internet access

*Submit an e-mail to HCA at **HCAUninsuredGrant@hca.wa.gov** with the Subject Line: **Uninsured Care Expansion GrantApplication – (name of organization)** or call 360-725-1244.*