Ohio Department of Health

Mike DeWine, Governor
Jon Husted, Lt. Governor

Amy Acton, M.D., MPH, Director

Date: July 22, 2019

To: Prospective Safety Net Dental Care Program Applicants

From: Anna Starr, Interim Chief
Bureau of Maternal, Child and Family Health
Ohio Department of Health

Subject: **Notice of Availability of Funds**
Competitive Grant Applications for Calendar Year 2020
Safety Net Dental Care Program I (1/1/2020 to 12/31/2020) – CD20
Safety Net Dental Care Program II (1/1/2020 to 12/31/2020) – DC20

The Ohio Department of Health (ODH), Bureau of Maternal, Child and Family Health, Oral Health Program, announces the availability of grant funds to support the Safety Net Dental Care Programs. The attached Solicitation will provide you guidance in completing the online application(s) for the competitive program period. **Proposals are due Monday, August 26, 2019 for the funding period January 1, 2020 through December 31, 2020. Late applications will not be accepted.**

Introduction/Background

The 2010 Ohio Family Health survey found that dental care remains the single leading unmet health care need identified for Ohio children regardless of family income status. For adults, more than 14.5% (1,281,000) reported that they did not receive needed dental care. Additionally, 44.9% of Ohio adults reported having no dental insurance. The target population for the Safety Net Dental Care Programs is uninsured Ohioans who cannot afford and are less likely to receive dental services in the private sector and who are considered high risk for dental disease. Those at high risk include, but are not limited to, those who are low-income, minority and/or are geographically isolated.

Public health programs often serve as a safety net for those who cannot afford preventive or restorative dental treatment. Safety net dental care programs are clinics that serve Medicaid recipients and offer sliding fee schedules, significantly reduced fees or free care to clients who otherwise cannot afford private dental care. Safety Net Dental Care Program I funds will be awarded to 4-5 agencies to serve the Maternal and Child Health (MCH) population (children through age 21 and women of childbearing age, up to age 45). Safety Net Dental Care Program II funds will be awarded to 2-3 agencies to serve females age 45 and older and males age 22 and older.

All interested parties must submit a *Notice of Intent to Apply for Funding* (NOIAF) form no later than Monday, August 5, 2019 to be eligible to apply for funding. The NOIAF form is included with the Solicitation (Appendix A). Please indicate on the NOIAF if applying for Safety Net Dental Care Program I, Safety Net Dental Care Program, or both grant programs.

Upon receipt of your completed NOIAF, ODH will:

a. Create the grant application account(s) for your organization[1]. The account number(s) will allow you to submit the application(s) via the Internet using the Grant Management Information System (GMIS). All grant applications must be submitted via the Internet using GMIS.

b. Assess your organization's GMIS training needs (as indicated on the completed *Notice of Intent to Apply for Funding* form). ODH will contact you regarding upcoming GMIS training dates. GMIS training is mandatory if your organization has never been trained on GMIS. Two people from an agency must attend the initial GMIS training for that agency.

Once a completed *Notice of Intent to Apply for Funding* form is received, the ODH creates the grant application(s) for your organization, and finalizes all GMIS training requirements, you may proceed with the application process as outlined in the Solicitation.

The Solicitation provides detailed information about the background, intent and scope of the grant, policy and procedures, performance expectations, general information and requirements associated with the administration of the grant.

Technical Assistance Session

A technical assistance session (Bidders' Conference) will be held on Tuesday, July 30, 2019 at 2:00 p.m. via a conference call. Bidders' Conference Information and Registration Form can be found in Appendix E of the Solicitation. Please return a registration form (included) to confirm your attendance at this session. Questions and answers from the session will be posted in the "News" section of the Oral Health Program website at https://odh.ohio.gov/wps/portal/gov/odh/know-our-programs/oral-health-program. If you have questions or need assistance in completing this grant application, every effort should be made to attend this session.

Please contact Mona Taylor, RDH, BS, Oral Health Access Program Coordinator via e-mail at Mona.Taylor@odh.ohio.gov or by phone at (614) 728-9236 if you have any questions regarding this application.

[1]Organizations with previous GMIS training will automatically receive a grant application account number upon receipt of a completed *Notice of Intent to Apply for Funding* form.

Ohio
Department of Health

ALL APPLICATIONS MUST BE SUBMITTED VIA THE INTERNET

OHIO DEPARTMENT OF HEALTH

BUREAU OF
Maternal, Child and Family Health

SAFETY NET DENTAL CARE PROGRAMS

(CD20 & DC20)

SOLICITATION
FOR
CALENDAR YEAR 2020
(01/01/2020 – 12/31/2020)

Local Public Applicant Agencies
Non-Profit Applicants

COMPETITIVE GRANT APPLICATION INFORMATION
100% Deliverable Funding

Revised 02/11/2019
For grant starts 10/1/2019 and thereafter

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I. APPLICATION SUMMARY and GUIDANCE

An application for an Ohio Department of Health (ODH) grant consists of a number of required components including an electronic portion submitted via the Internet website "ODH Application Gateway" and various paper forms and attachments. All the required components of a specific application must be completed and submitted by the application due date. **If any of the required components are not submitted by the due date indicated in sections D, G and R, the entire application will not be considered for review.**

This is a competitive solicitation; a *Notice of Intent to Apply for Funding* (NOIAF – Appendix A) must be submitted by Monday, August 5, 2019 so access to the application via the Internet website "ODH Application Gateway" can be established.

NEW AGENCIES ONLY or if UPDATES are needed: For non-profit agencies, the NOIAF must be accompanied by proof of non-profit status. Both non-profit and local public agencies must submit proof of liability coverage. Potential applicants and current subrecipients are required to maintain their current supplier information in the State of Ohio Supplier Portal. This information includes, but is not limited to, Electronic Funds Transfer (EFT), 1099 Form and current address.

This information is maintained on the following website: http://supplier.ohio.gov/

Note: Subrecipients future payments will be held if the agency receives a paper check due to the EFT information not being properly maintained in the supplier portal.

The application summary information is provided to assist your agency in identifying funding criteria:

A. Policy and Procedure: Uniform administration of all the ODH grants is governed by the ODH Grants Administration Policies and Procedures (OGAPP) manual and updates in policies that have been posted on the GMIS Bulletin Board. This manual and GMIS Bulletin Board policy updates must be followed to ensure adherence to the rules, regulations and procedures for preparation of all Subrecipient applications. The OGAPP manual is available on the ODH website: *https://odh.ohio.gov/wps/portal/gov/odh/home*.
(Click on Grant/Contracts, ODH Grants, Grants Administrative Policies and Procedures Manual (OGAPP)) or copy and paste the following link into your web browser:
https://odh.ohio.gov/wps/portal/gov/odh/about-us/funding-opportunities/resources/grants-administrative-policies-and-procedures-manual

Please refer to Policy and Procedure updates found on the GMIS bulletin board.

All budget justifications must include the following language and be signed by the agency head listed in GMIS. Please refer to the budget justification examples listed on the GMIS bulletin board.

Budget Justification Certification language

- Subrecipient understands and agrees that it must follow the federal cost principle that applies to its type of organization (2 CFR, Part 225; 2 CFR, Part 220; or, 2 CFR, Part 230).

- Subrecipient's budgeted costs are reasonable, allowable and allocable under OGAPP and federal rules and regulations.
- The OGAPP and the rules and regulations have been read and are understood.
- Subrecipient understands and agrees that costs may be disallowed if deemed unallowable or in violation of OGAPP and federal rules and regulations.
- The appropriate programmatic and administrative personnel involved in this application are aware of agency policy in regard to subawards and are prepared to establish the necessary inter-institutional agreements consistent with those policies.
- Subrecipient agrees and understands that costs incurred in the fulfillment of the Deliverables must be allowable under OGAPP and federal rules and regulations to qualify for reimbursement.

B. Application Name: Safety Net Dental Care Programs

C. Purpose: The purpose of the Safety Net Dental Care Programs is to provide access to comprehensive and emergency dental care services for a significant number of Ohioans who could not afford and would not otherwise receive dental care (by offsetting a portion of the costs of uncompensated care) and to reduce disparities in access to dental care. Funding will be used to assist agencies that are challenged in meeting operating expenses as a result of seeing uninsured patients. Agencies that receive funding are ones that are operating efficiently and are financially sound as evidenced by key indicators such as number of encounters, costs, revenues, etc., as specified in Appendix H, Budget Planning Worksheets. The program will help support efficient clinics that cannot otherwise financially support the mission of serving the uninsured. The Ohio Department of Health, Oral Health Program grant funds are intended to leverage other program resources to provide services.

D. Qualified Applicants: All applicants must be a local public or non-profit agency that currently operates one or more safety net dental clinics for a minimum of 36 hours per week (25 hours per week for school-based programs), Applicant agencies must attend or document in writing prior attendance at Grants Management Information System (GMIS) training and must have the capacity to accept an electronic funds transfer (EFT). If an applicant agency needs GMIS training prior to the establishment of access to the application, then a GMIS training form must be submitted (Appendix B).

The following criteria must be met for grant applications to be eligible for review:

1. Applicant does not owe funds to ODH and has repaid any funds due within 45 days of the invoice date.
2. Applicant has not been certified to the Attorney General's (AG's) office.
3. Applicant has submitted application and all required attachments by **4:00 p.m. on Monday, August 26, 2019.**

E. Service Area: The Safety Net Dental Care Programs may be designed to serve a city, county, combination of counties, school districts or other area defined by governmental subdivision of standard levels of geography (e.g. county, city, township, census tracts, census block groups, census blocks). Applicants serving populations located in higher need geographic areas (e.g., dental health professional shortage areas (HPSAs), Appalachia, etc.) or areas with limited resources, may be given priority in funding.

F. Number of Grants and Funds Available: Funding to support the Safety Net Dental Care

sub-grant programs are received from both state and federal sources. Programs may apply for either or both grant programs described below:

Safety Net Dental Care Program I: Up to $300,000 from HRSA's Maternal and Child Health (MCH) Block grant is available to be awarded to an anticipated 4-5 Safety Net Dental Care programs serving the MCH population (children through age 21 and women of childbearing age, up to age 45) for the first year of funding (1/1/2020-12/31/2020). Funding for each of the continuation budget periods (1/1/2021-12/31/2021 and 1/1/2022-12/31/2022) will be based on the availability of funds. Eligible agencies may apply for funding in the competitive grant budget period (1/1/20-12/31/2020) for a maximum award of $100,000. Funded clinics will be reimbursed for services provided to the target population at a rate of $100 per encounter. In order to eliminate disparities and improve health equity for this population, funded agencies may charge patients who are served with ODH funds a maximum co-pay amount of $20 per encounter.

Safety Net Dental Care Program II: Up to $100,000 of state funds are available to be awarded to an anticipated 2-3 Safety Net Dental Care programs serving serve females age 45 and older, and males age 22 and up. Funding for each of the continuation budget periods (1/1/2021-12/31/2021 and 1/1/2022-12/31/2022) will be based on the availability of funds. Eligible agencies may apply for funding in the competitive grant budget period (1/1/2020- 12/31/2020) for a maximum award of $50,000. Funded clinics will be reimbursed for services provided to the target population at a rate of $100 per encounter. In order to eliminate disparities and improve health equity for this population, funded agencies may charge patients who are served with ODH funds a maximum co-pay amount of $20 per encounter.

*No grant award will be issued for less than **$30,000**. The minimum amount is exclusive of any required matching amounts and represents only ODH funds granted. Applications submitted for less than the minimum amount will not be considered for review.*

G. **Due Date:** All parts of the application, including any required attachments, must be completed and received by ODH electronically via GMIS by **4:00 p.m. by Monday, August 26, 2019.** Applications and required attachments received after this deadline will not be considered for review.

Contact Mona Taylor, RDH, BS, Oral Health Access Program Coordinator at (614) 728-9236 or via e-mail at Mona.Taylor@odh.ohio.gov with any questions.

H. **Authorization:** Authorization of funds for this purpose is contained in Amended Substitute House Bill 166 and/or the *Catalog of Federal Domestic Assistance (CFDA) Number 93.994.*

I. **Goals:** The goal of the Ohio Department of Health's Safety Net Dental Care sub-grant programs is to reduce disparities and improve access to comprehensive and emergency dental care services for those Ohioans who are unlikely to receive dental services in the private sector and are considered high risk for dental disease. Those at high risk include, but are not limited to, people with disabilities, those who are low-income, minority and/or are geographically isolated.

Safety Net Dental Care Program I: Program funding is allocated to support clinics that serve the Maternal and Child Health (MCH) population (women of childbearing age, up to 45 years, and

children through age 21). The funding may only be used for MCH clients who are uninsured for dental care, have incomes at or below 200% of poverty and pay reduced fees.

Safety Net Dental Care Program II: Program funding is allocated to support clinics that serve females age 45 and older and males age 22 and up. The funding may only be used for clients in the target population who are uninsured for dental care, have incomes at or below 200% of poverty and pay reduced fees.

Eligible agencies may apply for either or both the Safety Net I or the Safety Net II Program. Check all applicable boxes on the NOIAF (Appendix A).

J. **Program Period and Budget Period:** The program period for both Safety Net I and Safety Net II Programs will begin January 1, 2020 and end on December 31, 2022. The budget period for both programs is January 1, 2020 through December 31, 2020. ***A separate application is required for each program.***

K. Public Health Accreditation Board (PHAB) Standard(s): Identify the PHAB Standard(s) that will be addressed by grant activities. (An example is: This grant program will address PHAB standard 3.1: Provide Health Education and Health Promotion Policies, Programs, Processes, and Interventions to Support Prevention and Wellness.) The PHAB standards are available at the following website:

http://www.phaboard.org/wp-content/uploads/PHABSM_WEB_LR1.pdf

L. **Public Health Impact Statement:** All applicant agencies that are not local health districts must communicate with local health districts regarding the impact of the proposed grant activities on the PHAB Standards.

1. *Public Health Impact Statement Summary* - Applicant agencies are required to submit a summary of the proposal to local health districts prior to submitting the grant application to ODH. The program summary, not to exceed one page, must include:

   Public Health Accreditation Board (PHAB) Standard(s) to be addressed by grant activities. Please select from the following:

   - Standard 1.3: Analyze Public Health Data to Identify Trends in Health Problems, Environmental Public Health Hazards, and Social and Economic Factors that Affect the Public's Health.
   - Standard 1.4: Provide and Use the Results of Health Data Analysis to Develop Recommendations Regarding Public Health Policy, Processes, Programs, or Intervention.
   - Standard 2.2: Contain/Mitigate Health Problems and Environmental Public Health Hazards.
   - Standard 3.2: Provide Information on Public Health Issues and Public Health Functions Through Multiple Methods to a Variety of Audiences.
   - Standard 4.1: Engage with the Public Health System and the Community in Identifying and Addressing Health Problems through Collaborative Processes.
   - Standard 10.2: Promote Understanding and Use of the Current Body of Research Results, Evaluations, and Evidence-Based Practices with Appropriate Audiences.

The applicant must submit the above summary as part of the grant application to ODH. This will document that a written summary of the proposed activities was provided to the local health districts with a request for their support and/or comment about the activities as they relate to the PHAB Standards**.**

2. *Public Health Impact Statement of Support* - Include with the grant application a statement of support from the local health districts, if available. If a statement of support from the local health districts is not obtained, indicate that point when submitting the program summary with the grant application. If an applicant agency has a regional and/or statewide focus, a statement of support should be submitted from at least one local health district, if available**.**

3. Evidence of Health Equity Strategies

The ODH is committed to the elimination of health disparities and health inequities. All applicants are required to:

a. Identify specific groups who experience a disproportionate burden of disease, health condition or health outcome targeted by this solicitation.

b. Identify specific social and environmental conditions (social determinants of health) associated with health disparities and health inequities. This must be based on data and include geographic reference points (i.e., census tracts, census block groups) to specify where program activities are focused.

c. Identify measurable health equity targets to be achieved through program activities. This information must also be supported by data.

d. Outline specific evaluation strategies to measure the impact of program activities to decrease and/or eliminate health disparities and health inequities.

e. Link proposed activities to health equity strategies identified in local, state or national planning documents. These documents include, but not limited to, current Healthy People goals and objectives; local Community Health Assessments; State Health Improvement Plan (SHIP); National Stakeholder Strategy for Achieving Health Equity; The Health Opportunity and Equity (HOPE) Initiative.

f. The above items should be explicitly incorporated into key components of the application (i.e., Goals, Program Narrative, Objectives, Deliverables and Review Criteria). The applicant cannot decide where to insert this information. Care should be taken to avoid repetition to keep the responses focused and specific.

Understanding Health Disparities, Health Inequities, Social Determinants of Health & Health Equity:

The following information is provided to explain key health equity concepts and terms.

Racial and ethnic minorities, people with disabilities, the LGBTQ community and Ohio's economically disadvantaged residents do not have the same opportunities as other groups to

achieve and sustain optimal health. Health disparities occur when these groups experience more disease, death or disability beyond what would normally be expected based on their relative size of the population. Health disparities are often characterized by such measures as disproportionate incidence, prevalence and/or mortality rates of diseases or health conditions. Health is largely determined by where people live, work and play. Health disparities are unnatural and occur because of low socioeconomic status, race/ethnicity, sexual orientation, gender, disability status, geographic location or some combination of these factors. Those most impacted by health disparities also tend to have less access to resources like healthy food, safe housing, quality education, safe neighborhoods, freedom from racism and other forms of discrimination. These are referred to as **social determinants of health (SDOH).** SDOH are the root cause of health disparities. The systematic nature of health disparities is considered unjust and is referred to as **health inequities**. The ability of everyone to have the same opportunity to achieve the best health possible is referred to as **health equity**. Public health programs that incorporate social determinants into the planning and implementation of interventions will greatly contribute to advancing health equity.

M. GMIS Health Equity Module (There are some functionality issues in GMIS and this module may not function properly. Applications can still be submitted without this being marked complete):

The GMIS Health Equity Module links important program interventions in grant proposals to health equity strategies identified in local, state or national strategies. These include, but are not limited to, the most current Healthy People goals and objectives; health equity targets in the State Health Improvement Plan (SHIP); National Stakeholder Strategy for Achieving Health Equity; Ohio Health Opportunity Index and/or the Health Opportunity and Equity (HOPE) Initiative. Applicants are required to select the goals and strategies from the module that best reflect how their particular grant proposal addresses health disparities and/or health inequities. Applicants can choose more than one goal and/or strategy.

N. Human Trafficking: The ODH is committed to the elimination of human trafficking in Ohio. If applicable to the subrecipient program, ODH will give priority consideration to those subrecipients who can demonstrate the following:

1. Victims of human trafficking are included in your agency's target population:
   a. At-risk population
   b. Mental health population
   c. Homeless population

2. Agency promotes the expansion of services to identify and serve those affected by human trafficking.

Applicable to Safety Net Dental Care Programs I and II)

O. Appropriation Contingency: Any award made through this program is contingent upon the availability of funds for this purpose. **The subrecipient agency must be prepared to support the costs of operating the program in the event of a delay in grant payments.**

P. Programmatic, Technical Assistance and Authorization for Internet Submission: Initial authorization for Internet submission, for new agencies, will be granted after participation in the GMIS training session. All other agencies will receive their authorization after the

posting of the Solicitation to the ODH website and the receipt of the NOIAF. Please contact Mona Taylor, RDH, BS, Oral Health Access Program Coordinator, via e-mail at Mona.Taylor@odh.ohio.gov, or by phone at (614) 728-9236 for questions regarding this solicitation.

Applicant must attend or must document in the NOIAF prior attendance at GMIS training in order to receive authorization for internet submission.

Q. **Acknowledgment:** An Application Submitted status will appear in GMIS that acknowledges ODH system receipt of the application submission.

R. **Late Applications:** GMIS automatically provides a time and date system for grant application submissions. Required attachments and/or forms sent electronically must be transmitted by the application due date. Required attachments and/or forms mailed that are non-Internet compatible must be postmarked or received on or before the application due date of **Monday, August 26, 2019 at 4:00 p.m.**

Applicants should request a legibly dated postmark or obtain a legibly dated receipt from the U.S. Postal Service or a commercial carrier. Private metered postmarks shall **not** be acceptable as proof of timely mailing. Applicants can hand-deliver attachments to ODH, Grants Services Unit (GSU), via the front desk at 246 N. High St., Columbus, Ohio; but they must be delivered by **4:00 p.m**. on the application due date. Fax attachments will not be accepted**. GMIS applications and required application attachments received late will not be considered for review.**

S. **Successful Applicants:** Successful applicants will receive official notification in the form of a Notice of Award (NOA). The NOA, issued over the signature of the Director of the Ohio Department of Health, allows for expenditure of grant funds.

T. **Unsuccessful Applicants:** Within 30 days after a decision to disapprove or not fund a grant application, written notification, issued over the signature of the Director of Health, or his designee, shall be sent to the unsuccessful applicant.

U. **Review Criteria:** All proposals will be judged on the quality, clarity and completeness of the application. Applications will be judged according to the extent to which the proposal:

1. Contributes to the advancement and/or improvement of the health of Ohioans;
2. Is responsive to policy concerns and program objectives of the initiative/program/ activity for which grant dollars are being made available;
3. Is well executed and is capable of attaining program objectives;
4. Describe Specific, Measureable, Attainable, Realistic & Time-Phased (S.M.A.R.T.) objectives, activities, milestones and outcomes with respect to time-lines and resources;
5. Estimates reasonable cost to the ODH, considering the anticipated results;
6. Indicates that program personnel are well qualified by training and/or experience for their roles in the program and the applicant organization has adequate facilities and personnel;
7. Provides an evaluation plan, including a design for determining program success;
8. Is responsive to the special concerns and program priorities specified in the Solicitation;
9. Has demonstrated acceptable past performance in areas related to programmatic and financial stewardship of grant funds;
10. Has demonstrated compliance to OGAPP;

11. Explicitly identifies specific groups in the service area who experience a disproportionate burden of the diseases; health condition(s); or who are at an increased risk for problems addressed by this funding opportunity; and,
12. Describe activities which support the requirements outlined in sections I. thru M. of this Solicitation.

Safety Net Dental Care Program I and II -Specific Criteria

1. Program provides comprehensive and emergency dental care services for a significant number of patients who are uninsured or covered by Medicaid or a Medicaid-contracting managed care plan. The projected number of patients should include detailed assumptions underlying that projection.

2. Application estimates the number and percentage of the maternal and child health (MCH) population to be served that includes children (through age 21 years) and women of child-bearing age (up to age 45 years). *Care must be available to children without a minimum age restriction.*

3. Application estimates the number and percentage of the non-MCH population (females age 45 and older, males age 22 and up) to be served.

4. Application demonstrates collaboration among community partners. Community agencies may choose to partner with neighboring communities to create target populations and service areas that meet the RFP criteria.

5. Clinical comprehensive and emergency dental care, including restorative care, is regularly available at least 36 hours per week (25 hours per week for school-based programs) and yields a number of patient visits equivalent to, or more than a full-time practice (minimum of 2,500 patient visits per full-time dentist and 1,300 patient visits per full-time dental hygienist. A proportionally reduced number of patient visits are allowable for school programs, based on the program's actual provider FTE).

6. Comprehensive dental care is the coordinated delivery of the total dental care required to meet each patient's oral health needs, recognizing that there are often a range of alternatives to restore function and freedom from pain and infection. Clinical comprehensive dental services provided must include:

    a. Diagnosis/preventive care (e.g., exams, x-rays, cleanings, fluoride treatments, sealants). Program demonstrates a commitment to assessing the individual caries risk of all clients whose care is funded, all or in part, by this grant and to provide preventive services consistent with that risk level and published guidelines of a reputable agency or organization. For example, it is important to individualize the clinic's recall system according to the patient's risk level. Some patients may need appointments less frequently than the standard six-month recall schedule, while a few others may require more frequent recall appointments. In addition, the program demonstrates a commitment to provide routine periodontal screening as part of the oral health evaluation in order to determine the periodontal status of all clients whose care is funded, all or in part, by this grant using tools and guidelines of a reputable agency or organization. The screening should identify patients requiring a more comprehensive assessment, as well as those who may require more extensive

periodontal therapy.

b. Emergency care (e.g. extractions, pain relief and trauma care);

c. Restorative care (e.g. amalgam and resin restorations, stainless steel crowns and pulpotomies for children);

d. Provision must be made for other services (e.g. dentures, partials, pulp therapy, periodontal therapy) when essential.

7. Program will provide services using the "quadrant dentistry" standard of care, in order to minimize the number of encounters per patient and avoid "churning" (maximizing revenue by maximizing the number of encounters).

8. Ensure services are available at convenient hours (e.g. evenings, weekends) for the patients.

9. Demonstrate a commitment to make dental care accessible by:

   a. Ensuring that clinical services are accessible to patients with disabilities and that clinic staff ask patients if they require disability accommodations in advance of their appointments;

   b. Ensuring all Medicaid-eligible patients are enrolled in the program, providing assistance as necessary;

   c. Billing Medicaid or the appropriate Medicaid-contracting managed care plan for all eligible services;

   d. Using funds collected from Medicaid to support the program;

   e. Utilizing a sliding fee schedule (SFS) or offering other fee arrangements that makes care affordable for low-income patients;

   f. Assuring that no one is denied care based on an inability to pay; and,

   g. Assuring that no one is denied care based on disability (physical, cognitive or sensory), and that services are accessible to patients with disabilities.

10. Reflect accurate information about all sources of revenue and expenses on the Budget Planning Worksheets (Appendix H).

11. Utilize Section 330 grant funds to provide partial support to the dental clinic(s) if agency is a federally qualified health center (FQHC). Indicate these funds on Budget Planning Worksheets (Appendix H).

12. Demonstrate efficient clinic operation as evidenced by the reasonable and measurable key indicators as specified in Appendix H, Budget Planning Worksheets.

13. Program has developed and implemented policies and procedures to assess, maintain and

improve the quality of clinical services provided, as well as administrative processes and systems in order to support the provision of high quality clinical care.

Applicants may not use Safety Net Dental Care Program funds to supplant existing funds. The Ohio Department of Health, Oral Health Program grant funds are intended to leverage other program resources to provide services.

IMPORTANT: Grant applications will not be considered without 2020 Safety Net Dental Care Program Appendix F, Appendix G and Appendix H. **NOTE: These required forms must be completed and submitted via GMIS 2.0 attachment by the application due date. Program attachments include:**

- Appendix F, 2020 Safety Net Dental Care Program I & II Information and Assurances
- Appendix G, 2020 Safety Net Dental Care Program I & II Objectives/Targets
- Appendix H, 2020 Safety Net Dental Care Program I & II Budget Planning Worksheets

Please note: An electronic version of the above items will be provided upon receipt of applicant's NOIAF. **Complete the electronic version of these documents for the proposal, not the hard copy example of Appendices F, G and H.**

Safety Net Dental Care Program Review Form/Score Sheet can be found in Appendix D.

The ODH will make the final determination and selection of successful/unsuccessful applicants and reserves the right to reject any or all applications for any given Solicitations; **There will be no appeal of the Department's decision.**

V. Freedom of Information Act: The Freedom of Information Act (5 U.S.C.552) and the associated Public Information Regulations require the release of certain information regarding grants requested by any member of the public. The intended use of the information will not be a criterion for release. Grant applications and grant-related reports are generally available for inspection and copying except that information considered being an unwarranted invasion of personal privacy will not be disclosed. For guidance regarding specific funding sources, refer to: 45 CFR Part 5 for funds from the U.S. Department of Health and Human Service.

W. Ownership Copyright: Any work produced under this grant, including any documents, data, photographs and negatives, electronic reports, records, software, source code, or other media, shall become the property of ODH, which shall have an unrestricted right to reproduce, distribute, modify, maintain, and use the work produced. If this grant is funded in whole, or in part, by the federal government, unless otherwise provided by the terms of that grant or by federal law, the federal funder also shall have an unrestricted right to reproduce, distribute, modify, maintain, and use the work produced. No work produced under this grant shall include copyrighted matter without the prior written consent of the owner, except as may otherwise be allowed under federal law.

ODH must approve, in advance, the content of any work produced under this grant. All work must clearly state:

"This work is funded either in whole or in part by a grant awarded by the Ohio Department of Health, Bureau of Maternal, Child and Family Health, Oral Health Program and as a sub-

award of a grant issued by Health and Human Services under the [Title V Maternal and Child Health Block Grant, CFDA number 93.994."

X. Reporting Requirements: Successful applicants are required to submit Subrecipient program and expenditure reports. Reports must adhere to the requirements of the OGAPP manual. Reports must be received in accordance with the requirements of the OGAPP manual and this Solicitation; before the department will release any additional funds.

Note: Failure to ensure the quality of reporting by submitting incomplete and/or late program or expenditure reports will jeopardize the receipt of future agency payments.

Reports shall be submitted as follows:

1. **Program Reports:** Subrecipients Program Reports must be completed and submitted via GMIS, as required by the subgrant program by the following dates. [Additional language is optional] **Program reports that do not include required attachments will not be approved**. All program report attachments must clearly identify the authorized program name and grant number.

   X Program Reports Required _____No Program Reports Required

Period	***Report Due Date***
January 1, 2020 – March 31, 2020	*April 10, 2020*
April 1, 2020 – June 30, 2020	*July 10, 2020*
July 1, 2020 – September 30, 2020	*October 10, 2020*
October 1, 2020 – December 31, 2020	*January 10, 2021*

2. **Subrecipient Reimbursement Expenditure Reports:** Subrecipients can choose monthly or quarterly reimbursement (expenditure report submission) from ODH (please check the reimbursement type on the attached NOIAF). Please note that no changes can be made to the reimbursement type during the fiscal year once the project numbers have been established in GMIS. Subrecipient Monthly Reimbursement Expenditure Reports **must** be completed and submitted **via GMIS** by the following dates:

Period	***Report Due Date***
January 1 – 31, 2020	*February 10, 2020*
February 1 – 29, 2020	*March 10, 2020*
March 1 – 31, 2020	*April 10, 2020*
April 1 – 30, 2020	*May 10, 2020*
May 1 – 31, 2020	*June 10, 2020*
June 1 – 30, 2020	*July 10, 2020*
July 1 – 31, 2020	*August 10, 2020*
August 1 – 31, 2020	*September 10, 2020*
September1 – 30, 2020	*October 10, 2020*
October 1 – 31, 2020	*November 10, 2020*
November 1 – 30, 2020	*December 10, 2020*
December 1 – 31, 2020	*January 10, 2021*

Subrecipient Quarterly Reimbursement Expenditure Reports **must** be completed and

submitted **via GMIS** by the following dates: **(please see example below)**

Period	***Report Due Date***
January 1 – March 31, 2020	*April 10, 2020*
April 1 – June 30, 2020	*July 10, 2020*
July 1 – September 30, 2020	*October 10, 2020*
October 1 – December 31, 2020	*January 10, 2021*

Note: Obligations not reported on the final monthly or 4th quarter expenditure report will not be considered for payment with the final expenditure report.

3. **Final Expenditure Reports:** A Subrecipient Final Expenditure Report reflecting total expenditures for the fiscal year must be completed and submitted **via GMIS by 4:00** p.m. on or before *February 5, 2021*. The information contained in this report must reflect the program's accounting records and supportive documentation. Any cash balances must be returned with the Subrecipient Final Expense Report. The Subrecipient Final Expense Report serves as an invoice to return unused funds.

Submission of the Monthly/Quarterly and Final Subrecipient Expenditure reports via the GMIS system indicates acceptance of OGAPP. Clicking the "Approve" button signifies authorization of the submission by an agency official and constitutes electronic acknowledgment and acceptance of OGAPP rules and regulations.

Y. Special Condition(s): A Special Conditions link is available for viewing and responding to special conditions within GMIS. The 30-day time period, in which the subrecipient must respond to special conditions will begin when the link is viewable. Subsequent payments will be withheld until satisfactory responses to the special conditions or a plan describing how those special conditions will be satisfied is submitted in GMIS.

Z. Unallowable Costs: Funds **may not** be used for the following:

1. To advance political or religious points of view or for fund raising or lobbying;
2. To disseminate factually incorrect or deceitful information;
3. Consulting fees for salaried program personnel to perform activities related to grant objectives;
4. Bad debts of any kind;
5. Contributions to a contingency fund;
6. Entertainment;
7. Fines and penalties;
8. Membership fees -- unless related to the program and approved by ODH;
9. Interest or other financial payments (including but not limited to bank fees);
10. Contributions made by program personnel;
11. Costs to rent equipment or space owned by the funded agency;
12. Inpatient services;
13. The purchase or improvement of land; the purchase, construction, or permanent improvement of any building;
14. Satisfying any requirement for the expenditure of non-federal funds as a condition for the receipt of federal funds;
15. Payments to any person for influencing or attempting to influence members of

Congress or the Ohio General Assembly in connection with awarding of grants;

16. *Include any additional program specific unallowable costs per CFDA, program regulations and directives or state law specifications*.

Subrecipients will not receive payment from ODH grant funds used for prohibited purposes. ODH has the right to recover funds paid to Subrecipients for purposes later discovered to be prohibited.

AA. Audit: Subrecipients currently receiving funding from the ODH are responsible for submitting an independent audit report. Every subrecipient will fall into one of two categories which determine the type of audit documentation required.

Subrecipients that expend $750,000 or more in federal awards per fiscal year are required to have a single audit which meets OMB's Federal Uniform Administrative Requirements. The subrecipient must submit, a copy of the auditor's management letter, a corrective action plan (if applicable) and a data collection form (for single audits) within 30 days of the receipt of the auditor's report, but no later than nine months after the end of the Subrecipient's fiscal year. The fair share of the cost of the single audit is an allowable cost to federal awards provided that the audit was conducted in accordance with the requirements of OMB's Federal Uniform Administrative Requirements.

Subrecipients that expend less than the $750,000 threshold require a financial audit conducted in accordance with Generally Accepted Government Auditing Standards. The Subrecipient must submit a copy of the audit report, the auditor's management letter, and a corrective action plan (if applicable) within 30 days of the receipt of the auditor's report, but no later than nine months after the end of the Subrecipient's fiscal year. **The financial audit is not an allowable cost to the program.**

Once an audit is completed, a copy must be sent to **https://harvester.census.gov/facweb/** or to the ODH, Grants Services Unit, (GSU) within 30 days. Reference: OGAPP and OMB's Omni Circular Federal Uniform Administrative Requirements regarding Audits of States, Local Governments, and Non-Profit Organizations for additional audit requirements.

Subrecipient audit reports (finalized and published, and including the audit Management Letters, if applicable) **which include internal control findings, questioned costs or any other serious findings, must include a cover letter which**:

- Lists and highlights the applicable findings;
- Discloses the potential connection or effect (direct or indirect) of the findings on subgrants passed through the ODH; and,
- Summarizes a Corrective Action Plan (CAP) to address the findings. A copy of the CAP should be attached to the cover letter.

AB. Submission of Application

Formatting Requirements:

- Properly label each item of the application packet (e.g., Budget Narrative, Program Narrative).
- Each section should use 1.5 spacing with one-inch margins.
- Program and Budget Narratives must be submitted in portrait orientation on 8 ½ by

11 paper.

- Number all pages (print on one side only).
- Program Narrative should not exceed 10 pages (**excludes** appendices, attachments, budget and budget narrative).
- Use a 12-point font.
- Forms must be completed and submitted in the format provided by ODH

The GMIS application submission must consist of the following:

Complete & Submit Via Internet

1. Application Information
2. Project Narrative
3. Project Contacts
4. Budget
   - Primary Reason
   - Funding
   - Justification
   - Personnel
   - Other Direct Costs
   - Equipment
   - Contracts
   - Compliance Section
   - Summary
5. Civil Rights Review Questionnaire
6. Assurances Certification
7. Federal Funding Accountability and Transparency Act (FFATA) reporting form
8. Change request in writing on agency letterhead **(Existing agency with tax identification number, name and/or address change(s)).**
9. Health Equity Module
10. Public Health Impact Statement Summary (non-health department only)
11. Statement of Support from the Local Health Districts (non-health department only)
12. Attachments as required by Program:
    a. Appendix F, Program Information and Assurances;
    b. Appendix G, Program Objectives/Targets;
    c. Appendix H, Budget Planning Worksheets;
    d. Position descriptions;
    e. Copies of proof of current licensure or certification for safety net program professional staff who are required to be licensed or certified;
    f. Letters of support;
    g. Copy of full fee schedule by CDT code; and,
    h. Copy of sliding fee schedule.

One original and one copy of the following document(s) must be e-mailed to **https://harvester.census.gov/facweb/** or mailed to the address listed below:

Complete Copy & E-mail or Mail to ODH

Current Independent Audit (latest completed organizational fiscal

period; **only if not previously submitted**)

Ohio Department of Health
Grants Services Unit
Central Master Files, 4th Floor
35 E. Chestnut Street
Columbus, Ohio 43215

II. APPLICATION REQUIREMENTS AND FORMAT

GMIS access will be provided to an agency after it has completed the required ODH sponsored training. Agencies who have previously completed GMIS training will receive access after the Notice of Intent to Apply for Funding for is submitted to ODH.

All applications must be submitted via GMIS. Submission of all parts of the grant application via the ODH's GMIS system indicates acceptance of OGAPP. Submission of the application signifies authorization by an agency official and constitutes electronic acknowledgment and acceptance of OGAPP rules and regulations in lieu of an executed Signature Page document.

A. Application Information: Information on the applicant agency and its administrative staff must be accurately completed. This information will serve as the basis for necessary communication between the agency and the ODH.

B. Budget: Prior to completion of the budget section, please review page 13 of the Solicitation for unallowable costs.

Match or Applicant Share is not required by this program. Do not include Match or Applicant Share in the budget and/or the Applicant Share column of the Budget Summary. Only the narrative and Appendix H, Budget Planning Worksheets may be used to identify additional funding information from other resources.

1. **Primary Reason and Justification Pages:** Provide a budget justification narrative outlining how the deliverable will be met. Use scenario #1 from the budget justification example that can be found in Appendix I.

2. **Other Direct Costs:** Submit a budget for this section and the necessary form(s) to support costs for the period January 1, 2020 to December 31, 2020.

   The applicant shall retain all original fully executed contracts on file.

3. **Compliance Section:** Answer each question on this form in GMIS as accurately as possible. ***Completion of the form ensures your agency's compliance with the administrative standards of ODH and federal grants.***

C. Assurances Certification: Each subrecipient must submit the Assurances (Federal and State Assurances for subrecipients) form within GMIS. This form is submitted as a part of each application via GMIS. The Assurances Certification sets forth standards of financial conduct relevant to receipt of grant funds and is provided for informational purposes. The listing is not all-inclusive, and any omission of other statutes does not mean such statutes are not assimilated under this certification. Review the form and then press the "Complete" button.

By submission of an application, the subrecipient agency agrees by electronic acknowledgment to the financial standards of conduct as stated therein.

D. Project Narrative: (total 11 page limit, including Executive Summary)

1. **Executive Summary: (One page limit)** Identify the target population, services and programs to be offered and what agency or agencies will provide those services, burden of health disparities and health inequities. Describe the public health problem(s) that the program will address. Describe the program goals, caries risk assessment, preventive services and treatment guidelines that will be used to reach the target population. Describe how the program will be evaluated. Describe the plan for quality assurance for the program. Specify the program's objectives. At a minimum these should include realistic estimates of: a) the clinic's hours of operation each day and the average number of clinic hours per week for clinical care (Appendix F, Item #1); b) percentage of unduplicated patients from the target populations to receive care (Appendix F, Item #2), anticipated program income and how it is estimated (Appendix H, Budget Reporting Worksheets, page 2, *Patient Encounters* and page 3, *Project Revenues*); and, e) total program budget and proportion represented by this grant (Appendix H, page 4, *Summary*).

2. **Description of Applicant Agency/Documentation of Eligibility/Personnel:** Briefly discuss the applicant agency's eligibility to apply. Summarize the agency's structure as it relates to this program and, as the lead agency, how it will manage the program.

   Describe the capacity of your organization, its personnel or contractors to communicate effectively and convey information in a manner that is easily understood by diverse audiences. This includes persons of limited English proficiency, those who are not literate, have low literacy skills, and individuals with disabilities.

3. **Problem/Need:** Identify and describe the local health status concern(s) that will be addressed by the program. Only restate national and state data if local data is not available. The specific health status concerns that the program intends to address may be stated in terms of health status (e.g., morbidity and/or mortality) or health system (e.g., accessibility, availability, affordability, appropriateness of health services) indicators. The indicators should be measurable in order to serve as baseline data upon which the evaluation will be based. Clearly identify the target population. Explicitly describe segments of the target population who experience a disproportionate burden for the health concern or issue; or who are at an increased risk for the problem addressed by this funding opportunity.

   Include a description of other agencies/organizations, in your area, also addressing this problem/need.

4. **Methodology:** In narrative form, identify the program goals, **Specific, Measurable, Attainable, Realistic & Time-Phased (SMART) process, impact, or outcome objectives and activities.** Indicate how they will be evaluated to determine the level of success of the program. If health disparities and/or health inequities have been identified, describe how program activities are designed to address these issues. Complete 2020 Safety Net I and II Program Objectives/Targets (Appendix G) to identify program targets. NOTE: Objectives for reduction in broken appointment rates and treatment plan completion are measures of program quality.

   The following SMART objectives pertain to both Safety Net Dental Care Programs I and II and must be submitted as the objectives the agency will be working toward accomplishing (insert numbers specific to your program):

   a. Program will serve_____ (#) of unduplicated patients by December 31, 2020;
   b. Program will provide dental care to_____ (#) of unduplicated maternal and child health (MCH) patients (children through age 21, women of childbearing age up to age 45) by December 31, 2020;
   c. Program will provide dental care to_____(#) of uninsured MCH patients with low incomes who pay reduced fees by December 31, 2020;
   d. Program estimates_____(#) encounters for uninsured MCH patients with low incomes who pay reduced fees by December 31, 2020;
   e. Program will provide dental care to_____(#) of non-MCH patients (females age 45 and older, males age 22 and up) by December 31, 2020;
   f. Program will provide dental care to_____(#) of uninsured non-MCH patients with low incomes who pay reduced fees by December 31, 2020;
   g. Program estimates_____ (#) encounters for uninsured non-MCH patients with low incomes who pay reduced fees by December 31, 2020;
   h. Program's "No Show/Broken Appointment" rate will decrease from _____% to _____% by December 31, 2020, if currently greater than 15%;
   i. Program estimates_____(%) of unduplicated patients currently have treatment plans; and,
   j. Program will complete _____% of current treatment plans by December 31, 2020.

E. Civil Rights Review Questionnaire - EEO Survey: The Civil Rights Review Questionnaire Survey is a part of the Application Section of GMIS. Subrecipients must complete the questionnaire as part of the application process. This questionnaire is submitted automatically with each application via the Internet.

F. Federal Funding Accountability and Transparency Act (FFATA): All applicants applying for ODH grant funds are required to complete the FFATA reporting form in GMIS. Applicants must ensure that the information contained in SAM.gov, DUN & Bradstreet and the FFATA reporting form match. ODH will hold all payments if an applicant's information does not successfully upload into the federal system.

All applicants for ODH grants are required to obtain a Data Universal Number System (DUNS), register in SAM.gov and submit the information in the grant application. For information about the DUNS, go to www.dnb.com. For information about System for Award Management (SAM) go to https://beta.sam.gov/.

Information on Federal Spending Transparency can be located at www.usaspending.gov or the Office of Management and Budget's website for Federal Spending Transparency at https://www.whitehouse.gov/.

(Required by all applicants, the FFATA form is located on the GMIS Application page and must be completed in order to submit the application.)

G. Attachment(s): Attachments are documents which are not part of the standard GMIS application but are deemed necessary to a given grant program. All attachments must clearly identify the authorized program name and program number. All attachments submitted to GMIS must be attached in the "Project Narrative" section and be in one of the following formats: PDF, Microsoft Word or Microsoft Excel. Please see the GMIS bulletin board for instructions on how to submit attachments in GMIS. Attachments that are non-Internet compatible must be postmarked or received on or before the application due date. An original and the required number of copies of non-Internet compatible attachments must be mailed to the ODH, Grants Services Unit, Central Master Files address by **4:00 p.m. on or before Monday, August 26, 2019**.

A minimum of one original and one copy of non-Internet attachments is required.

III. APPENDICES

A. Notice of Intent to Apply for Funding
B. GMIS Training Form
C. C1 Deliverable – Objective Descriptions
C2 Deliverable – Objective Allocations
D. Application Review Form
E. Bidders' Conference Information and Registration Form
F. 2020 Safety Net Dental Care Program I & II Information and Assurances
G. 2020 Safety Net Dental Care Program I & II Objectives/Targets
H. 2020 Safety Net Dental Care Program I & II Budget Planning Worksheets
I. Budget Justification Example
J. Sample Safety Net Dental Care Program I & II Report Form

Reimbursement Type
Select one of the options below:

☐ Monthly
OR
☐ Quarterly

NOTICE OF INTENT TO APPLY FOR FUNDING

Ohio Department of Health
Bureau of Maternal, Child and Family Health

ODH Program (choose one or both):
☐ Safety Net Dental Care Program I (CD20)
☐ Safety Net Dental Care Program II (DC20)

Appendix A

Submission Required

See Due Date Below

New Applicants must submit the GMIS Training form with the Notice of Intent to Apply for Funding Form

ALL INFORMATION REQUESTED MUST BE COMPLETED

County of Applicant Agency_____**Federal Tax Identification Number** _____

Geographic Area Applying to Cover_____

NOTE: The applicant agency/organization name must be the same as that on the IRS letter. This is the legal name by which the tax identification number is assigned.

Type of Applicant Agency ☐ County Agency ☐ Hospital ☐ Local Schools
(Check One) ☐ City Agency ☐ Higher Education ☐ Not-for Profit

Applicant Agency/Organization _____

Applicant Agency Address _____

_____

Agency Contact Person Name and Title _____

Telephone Number_____**E-mail Address**_____

_____ _____
Agency Head (Print Name) **Agency Head (Signature)**

Please note that the agency head listed above must match the agency head listed in GMIS. Unless a new agency, NOIAF's will not be accepted if name doesn't match what is listed in GMIS. If the agency head needs updated in GMIS, please include a letter on agency letterhead outlining the change. The new agency head's signature will be accepted with receipt of the update letter.

Does your agency have at least two staff members who have been trained in and currently have access to the ODH GMIS system? ☐ YES ☐ NO

If yes, no further action is needed.

If no, at least two people from your agency are **REQUIRED** to complete the training before you will be able to access the ODH GMIS system and submit a grant proposal. Complete the GMIS training request form in the Request for Proposal.

The NOIAF must be accompanied by the agency's Proof of Non-Profit status (if applicable) and Proof of Liability Coverage (if applicable). Potential applicants and current subrecipients are required to set-up and maintain their current supplier information in the State of Ohio Supplier Portal. This information includes, but is not limited to, Electronic Funds Transfer (EFT), 1099 Form and current address.

This information must be set-up and maintained in the following website: http://supplier.ohio.gov/

Note: Subrecipients future payments will be held if the agency receives a paper check due to the EFT information not being properly maintained in the supplier portal.

Forms are only required for NEW AGENCIES or if UPDATES are needed for current agencies. THE NOIAF AND REQUIRED FORMS MUST BE EMAILED TO Mona.Taylor@odh.ohio.gov BY Monday, August 5, 2019.

NOTE: NOIAF's will be considered late if any of the required forms listed above are not received by NEW AGENCIES by the due date. NOIAF's considered late will not be accepted.

Appendix B

If new applicant, this form must be submitted with the Notice of Intent to Apply for Funding Form.

GMIS Training, User Access, Access Change or Deactivation Request

One request per person. Requests will only be honored when signed by your **Agency Head** or **Agency Financial Head** and complete. In addition, if a user leaves your agency, you are to notify ODH so that their account is rendered inactive and submit a form for the replacement. The user will receive his/her username and password via e-mail once the request is processed. *Please note: GMIS Training is only required for New Agencies to ODH. If you are new to your agency someone there should train you. Refresher guides can be found on the ODH web site: https://odh.ohio.gov/wps/portal/gov/odh/about-us/funding-opportunities/ODH-Grants/. ODH Grants Page – "GMIS Training Resource" Section.* Confirmation of your GMIS training session will be e-mailed once a date has been assigned by ODH. Also use this form when user changes are needed.

Date: _____

Check the type of access and complete the information requested: **[ ] Employee - needs GMIS Training**

[ ] New Employee - needs GMIS Access. Effective Date of Activation: _____

[ ] Existing Employee - New GMIS User or GMIS User Access Change. Effective/Change Date:

_____

[ ] Deactivation – User no longer needs access to ODH Application Gateway/GMIS 2.0 or GMIS 2.0 only:

Effective Date of Deactivation (ODH Application Gateway/GMIS 2.0): _____

Or **Effective Date of Deactivation (GMIS 2.0 access only):** _____

Agency Name & Address: _____

_____

Employee Name (no nicknames):

Employee Job Title:

Employee Office Phone Number:

Employee Office Fax Number:

Employee Office Email Address:

User Access Section: Please check all that applies and enter requested information:

Email Notifications: [ ] Yes [ ] No

GMIS Project Number(s) user needs access to: _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

Authorization Signature for User Access/Change/Deactivation:

_____ _____

Signature of Agency Head or Agency Financial Head | Printed Name of Agency Head or Agency Financial Head

To be completed by Grants System Officer ONLY - Date Received: **Date Processed:**

Deliver Requests to Karen Tinsley, Grants System Officer, (614) 644-7546
Mail: ODH/OFA, 35 E. Chestnut St.,4th Floor, Columbus, Ohio 43215 ***Or***
Scan & Email: karen.tinsley@odh.ohio.gov

Name of Subgrant Program:
Safety Net Dental Care Program I (CD20)
Safety Net Dental Care Program II(DC20)
Budget Period: January 1, 2020 – December 31, 2020
# of Deliverables: 1
Use Budget Justification Scenario #1 (Appendix I)

X Deliverables Only

Deliverable – Objective 1: Applicant agency will define the total number of encounters to be provided to clients who meet program-specific criteria as outlined below during the budget period. Agencies may choose one or both programs, but must submit separate applications for each. ODH will reimburse sub-recipient agencies $100 per encounter for the target population.

Safety Net Dental Care Program I	Safety Net Dental Care Program II
Objective 1: By December 31, 2020, sub-recipient will provide dental services through_____(insert #) visits/encounters to maternal and child health (MCH) clients (children through age 21 and women of childbearing age up to 45) who are uninsured for dental care, have low incomes (≤200% of poverty) and pay reduced fees.	**Objective 1:** By December 31, 2020, sub-recipient will provide dental services through_____(insert #) visits/encounters to non-MCH clients (males age 22 and older, females ≥ age 45) who are uninsured for dental care, have low incomes (≤200% of poverty) and pay reduced fees.

Appendix C2

Name of Subgrant Program: Safety Net Dental Care Program
Budget Period: January 1, 2020 to December 31, 2020
# of Deliverables: 1
Use Budget Justification Scenario #1

X Deliverables Only

Safety Net Dental Care Program I	
Deliverable - Objective 1, MCH Patient Encounters	3,000 @ $100 per encounter
Safety Net I Total	$300,000.00
Safety Net Dental Care Program II	
Deliverable - Objective 1, Non-MCH Patient Encounters	1,000 @ 100 per encounter
Safety Net II Total	$100,000.00

APPENDIX D

2020 SAFETY NET DENTAL CARE PROGRAM
I & II APPLICATION REVIEW FORM

Applicant Agency _____ _____ Total Budget Request _____ _____

Grant Number_____ Reviewer Name _____ _____

Application Quality	**Maximum Score**	**Reviewer Score**	**Notes**
☐ Proposal is well organized and clearly written	2		
☐ Proposal is complete with all required attachments, including: • Appendices F, G and H • Position descriptions • Copies of proof of licensure/certifications • Letters of support • Copy of full fee schedule with CDT codes • Copy of sliding fee schedule	2		
☐ Proposal adheres to solicitation guidance regarding formatting requirements (see Solicitation Section I, AB)	1		
Total Application Quality	**5**		
Project Narrative: Executive Summary	**Maximum Score**	**Reviewer Score**	**Notes**
☐ Outlines the program's goals and objectives	1		
☐ Estimates number of unduplicated patients from the target population to be served	1		
☐ Provides a realistic estimate of the total number of encounters for target population proposed for funding by the grant	1		

☐ Describes how the program will be evaluated and the agency's plan for quality assurance	1		
☐ Specifies total program budget and proportion represented by the grant	1		
Total Executive Summary	**5**		
Project Narrative: Description of Applicant Agency/ Documentation of Eligibility/Personnel	**Maximum Score**	**Reviewer Score**	**Notes**
☐ Summarizes agency's eligibility to apply and its structure as it relates to management of this grant program	3		
☐ Describes agency's experience operating safety net dental clinics and its capacity to fulfill the needs and requirements of the project	3		
☐ Describes personnel and their qualifications to implement and carry out this project, as well as plans for hiring additional staff	3		
☐ Demonstrates agency's commitment to cultural competency	1		
Total Applicant Agency/Documentation of Eligibility/Personnel	**10**		
Project Narrative: Problem/Need	**Maximum Score**		**Notes**
☐ Identifies, describes and provides data about access to dental care issues for the target population in the service area	4		
☐ Describes the segments of the target population who experience oral health disparities and who are at high risk for dental disease	3		
☐ Describes other agencies in the service area addressing access to dental care issues and how this project will remedy gaps	3		
Total Problem/Need	**10**		

Project Narrative: Methodology	Maximum Score	Reviewer Score	Notes
☐ Describes SMART objectives, including: • Number and percentage of the maternal and child health (MCH) population (children, through age 21, and women of childbearing age, up to age 45) to be served • Number and percentage of non-MCH population (females age 45 and older, males age 22 and up) to be served	4		
☐ Describes plan for accomplishing objectives and indicates how objectives will be evaluated	2		
☐ Describes how activities are designed to address health disparities	2		
☐ Demonstrates a staffing plan that results in opportunities for underserved populations to access care	2		
☐ Demonstrates consistency with Safety Net Dental Care Program Criteria, including: • Clinical comprehensive and emergency dental care is available for at least 36 hours per week and program provides a number of patient visits equivalent to a full-time practice (at least 2,500 patient visits per full-time dentist and 1,300 patient visits per full-time dental hygienist per year) • Services are comprehensive in scope • Services are available at convenient hours (e.g., evenings, weekends) for patients • Children are served without a minimum age restriction • Program demonstrates a commitment to provide diagnostic and preventive services based on individual patient risk assessment • Program demonstrates a commitment to provide routine periodontal screening as part of the oral health evaluation in order to determine the periodontal status of all patients, as well as appropriate follow-up care • Program assures care is provided using the “quadrant dentistry” standard of care in order to minimize the number of encounters and avoid “churning” (maximizing the amount	20		

of revenue by maximizing the number of encounters) • Program demonstrates a commitment to make care accessible by: a) Ensuring all Medicaid-eligible patients are enrolled in a Medicaid Managed Care Plan, providing assistance as necessary b) Billing Medicaid or Medicaid Managed Care Plans for all eligible services c) Utilizing funds from Medicaid to support the program d) Utilizing a sliding fee scale or other fee arrangements that makes care affordable for low-income patients, and e) Assuring no one is denied care based on an inability to pay • Program documents collaboration with other agencies within the community or in neighboring communities, as appropriate • Program has developed and implemented policies and procedures to assess, maintain and improve the quality of clinical services provided, as well as administrative processes and systems in order to support the provision of high quality clinical care • Applicant provides a realistic plan for, and commitment to, sustaining the program after the grant period			
Total Methodology	**30**		
Project Narrative: Objectives/Targets (Appendix G)	**Maximum Score**	**Reviewer Score**	**Notes**
☐ Appendix G (Objectives/Targets) is completed ☐ Appendix G includes target numbers for all required objectives as outlined in Solicitation, Section II, D (4)	5 5		
Total Objectives/Work Plan	**10**		
Budget	**Maximum Score**	**Reviewer Score**	**Notes**
☐ The required 2020 Budget Planning Worksheets (Appendix H) are completed	2		

☐ Budget Planning Worksheets provide accurate information about all sources of revenue and expenses	2		
☐ Budget Planning Worksheets demonstrate efficient clinic operations	2		
☐ Correct Budget Justification is utilized as specified in Appendix C1 and C2	1		
☐ Budget elements are consistent with other information in application (e.g. narrative and Budget Planning Worksheets)	1		
☐ Proposal does not use grant funds to supplant existing funds	1		
☐ Program leverages ODH dollars with funds from other sources	1		
Total Budget	**10**		
Provision of Uncompensated Care	**Maximum Score**	**Reviewer Score**	**Notes**
☐ Program demonstrates a financial shortfall (as supported by Appendix H, Budget Planning Worksheets) due to serving a **significant** number of uninsured, low-income patients who pay reduced fees (the greater the proportion of uninsured patients served, the more points received)	10		
☐ Program demonstrates a commitment to serving uninsured patients by reducing fees to such an extent that care becomes affordable for the poorest clients (the greater fees are reduced, the more points are received)	10		
Total Provision of Uncompensated Care	**20**		
TOTAL POINTS	**100**		

APPENDIX E

2020 SAFETY NET DENTAL CARE GRANT PROGRAM
Bidders' Conference Information and Registration Form

BIDDERS' CONFERENCE

A Bidders' Conference will be held for those interested in the Ohio Department of Health, Oral Health Program's Safety Net Dental Care Program I and II Grants. Potential applicants are strongly encouraged to participate; however, it is ***not*** required. The conference will be held via conference call; details are below. This format should significantly reduce the time and travel commitments needed for agency staff to attend a meeting held in Columbus.

During the conference, Oral Health Program staff will provide detailed information on the goals and objectives of the Safety Net Dental Care grant program, as well as the review criteria that will be used to score proposals. This meeting will also provide an opportunity for applicants to ask questions that may arise while working on proposals. Questions and answers from the conference will be posted in the "News" section of the Oral Health Program's website, https://odh.ohio.gov/wps/portal/gov/odh/know-our-programs/oral-health-program/.

When: Tuesday, July 30, 2019
2:00 p.m.

Phone #: (855) 405-1648
Meeting ID #: 27199#
PIN #: Not required

TO REGISTER for the Bidders' Conference: Please complete the registration form below and e-mail the form to Mona Taylor at Mona.Taylor@odh.ohio.gov. Additional meeting details will be emailed to those applicants who register to attend the conference.

Please respond by Monday, July 29, 2019 with the following information:

The number of people from your agency that will attend: _____

_____
Agency Name/County

_____ (_____) _____
Contact person's name Phone number

Contact person's e-mail address: _____

Appendix F

2020 SAFETY NET DENTAL CARE PROGRAM I & II

INFORMATION AND ASSURANCES

GRANT APPLICATION WILL NOT BE CONSIDERED WITHOUT THIS FORM

	Answers (Type answers in tan-shaded cells)
Agency Name:	
Proposal Number:	

1. Restorative care is available, on average, how many hours per week?:	
Hours per week:	
List the clinic's hours of operation each day (Ex: 9-12; lunch12-1,1-6)	
Monday	
Tuesday	
Wednesday	
Thursday	
Friday	
Saturday	
2. Provide an estimate of the number or percentage of patients in each category for whom your program will provide clinical dental care services. (Include all dental clinic patients, not just those whose care may be paid for by ODH.)	
a) the total **number** of unduplicated patients to receive dental care in 2020	
b) the **percentage** of unduplicated patients to receive comprehensive dental care (as opposed to emergency only care) in 2020	
c) the **percentage** of unduplicated patients who are MCH patients (children through age 21, women of childbearing age up to age 45)	
d) the **percentage** of patients who have low incomes, are uninsured for dental care and pay reduced fees	
e) the **percentage** of uninsured, low-income patients who are MCH patients (children through age 21 and women of childbearing age up to age 45)	
3a. Services that will be provided include (place an "X" next to all that apply).	
examination:	
oral prophylaxis:	
fluoride treatment:	
dental sealants:	
amalgam restorations:	
resin restorations:	
pulpotomies:	

stainless steel crowns:	
pulp therapy (endodontics):	
extractions:	
partial dentures:	
dentures:	
emergency care:	
other (explain):	
3b. Referrals will be made for (place an "X" next to all that apply):	
endodontics:	
extractions:	
periodontics:	
other (explain):	
4. Will your program fully comply with all provisions of the Dental Practice Act: Ohio Revised Code Chapter 4715. (laws), and Ohio Administrative Code Chapter 4715. (rules)?	
Yes:	
No:	
5. Will your program fully comply with all provisions of the Health Insurance Portability and Accountability Act (HIPAA)?	
Yes:	
No:	
6. The Occupational Safety and Health Administration (OSHA) requires that dental staff receive infection control training annually.	
a) Who will provide the training?	
b) Date of the training?	
c) Will your staff be provided with a written protocol for infection control?	
Yes:	
No:	
7. What are the number of operatories:	
a) combined total of all dental clinic locations?	
b) per dentist per typical clinic session?	
c) per dental hygienist per typical clinic session?	
d) that are unused for a significant amount of time?	
8. Has your agency made efforts to leverage ODH dollars with funds and resources from other sources?	
Yes:	
No:	
If yes, describe the efforts and outcomes. Attach documentation of other funding commitments to the program.	
9. Is there a dental assistant and/or dental hygienist who is trained in Expanded Functions (EFDA)?	

Yes:	
No:	
10. Describe scheduling practices (e.g., length of appointment determination, double-booking appointments):	
11. Describe your agency's broken appointment/"no show" policy:	
12. What is your dental clinic's current rate of broken appointment/"no shows"?	
13. What is the goal and method to improve the broken appointment/"no show" rate?	
14. How are canceled appointments (canceled at least 24 hours before scheduled appointment time) filled?	
15a. How long does it take to get an appointment for:	
a) a new patient?	
b) recall?	
c) emergency?	
d) follow-up restorative care?	
15b. Is there a waiting list?	
Yes:	
No:	
If yes, how many names are on it?	
16. How does your office handle emergency patients, with regard to the daily schedule?	
17. How is productivity measured? (place an "X" next to all that apply)	
a) by number of encounters per dentist or dental hygienist	
b) by charges generated per dentist or dental hygienist	
c) time spent seeing patients/dentist or dental hygienist	
d) services provided per dentist or dental hygienist	
e) Other (describe):	
18a. Are productivity reports generated on a regular basis?	
Yes:	
No:	
18b. If so, how frequently?	
18c. Is practice management software used?	
Yes:	
No:	
If yes, name of software:	

Appendix G

2020 SAFETY NET DENTAL CARE PROGRAMS I AND II OBJECTIVES/TARGETS

Agency Name:	
Proposal Number:	

PROGRAM OBJECTIVES/TARGETS	NUMBER OR PERCENTAGE
1. Estimate the total number of unduplicated patients the dental program (all clinics) will serve during calendar year (CY) 2020.	
2. Estimate the total number of unduplicated maternal and child health (MCH) patients (women of childbearing age up to age 45 and children through age 21) to be served by the dental program in CY2020.	
3. Estimate the total number of uninsured MCH patients with low incomes who pay reduced fees to be served by the dental program in CY2020.	
4. Estimate the total number of encounters for uninsured MCH patients with low incomes who pay reduced fees in CY2020.	
5. Estimate the total number of non-MCH patients (women age 45 and older, men age 22 and up) to be served by the dental program in CY2020.	
6. Estimate the total number of uninsured non-MCH patients with low incomes who pay reduced fees to be served by the dental program in CY2020.	
7. Estimate the total number of encounters for uninsured non-MCH patients with low incomes who pay reduced fees in CY2020.	
8. If program's current "No Show/Broken Appointment" rate is >15%, estimate the reduction in rate for CY2020.	
9. Estimate the percentage of patients who currently have treatment plans.	
10.Of those with current treatment plans, estimate the percentage of treatment plans the program will complete in CY2020.	

APPENDIX H
DIRECTIONS FOR USING THE 2020 SAFETY NET DENTAL CARE PROGRAM I & II BUDGET PLANNING WORKSHEETS (1/1/2020 - 12/31/2020)

There are four budget worksheets contained in this file (Appendix H). Each worksheet has a tab below. Click on the tab to activate the worksheet.

PLEASE NOTE:
COMPLETE THIS FOR THE BUDGET PERIOD OF TWELVE MONTHS.
Please be certain to submit this completed file with your application.

STEP 1 Open the Expenses worksheet. **Type your program name in cell A1** (automatically enters this information in the other worksheets). Complete the **unshaded** cells. Column F should represent the total budget.

STEP 2 Open the Patient Encounters worksheet. Complete the **unshaded** cells. Do not count "hygiene checks" as a dentist patient encounter. The total number of patient visits will automatically appear on the Revenue worksheet.

STEP 3 Open the Revenue worksheet. Complete the **unshaded** cells. Estimated number of encounters/year is the total number of Dentist/Hygienist patient visits per year calculated in the Patient Encounters worksheet. Be sure the percent of encounters total 100%. **DO NOT include funds you are requesting from the ODH Safety Net Dental Care Program in your estimated revenues.**

STEP 4 Summary - "The Bottom Line" worksheet. You do not need to enter any figures into this worksheet. All figures are automatically imported from the Expenses and Revenue worksheets.

General Notes: If you see a **red triangle** in the upper-right hand corner of a cell, roll your mouse pointer over the cell for an explanation or instructions on that item. If you click in the cell, you can then right-click, highlight "show comment" and the comment box will remain displayed even if you move your mouse. You can right-click again, and select "Hide Comment".

If the print in a comment box is too small, increase the magnification by:
-clicking "File" on your menu bar at the top of your screen,
-click "Zoom",
-select a higher percentage - or enter a higher number next to "custom"

Any references to "chapters", "sections", "topics", or additional resources refer to information which can be found at **www.dentalclinicmanual.com.**

If you need to add any rows in the Expenses, Patient Encounters or Revenue worksheets, call Mona Taylor at (614) 728-9236 for assistance with this feature. We will help you be certain that your changes are reflected in any cells which calculate totals or sub-totals.

5/15/2019

	Appendix H: **2020 Safety Net Dental Care Program I and II Budget Planning Worksheet--Projected Expenses**				
INSERT PROGRAM-SPECIFIC ESTIMATES IN UN-SHADED CELLS					
EXPENSES					
I. Start-up Costs					**Total Program Budget**
Construction/Remodeling Cost					
# of square feet		0			
Cost per square foot		$0			$0
Dental Equipment Costs					
Large Equipment (See Dental Clinic Comparison Chart in Ch. 2) or enter your own figures per dental supply company.					$0
Supplies, Instruments and Small Equipment (See Dental Clinic Comparison Chart in Ch. 2) or enter your own figures per dental supply company. ($14,000-$15,000/operatory)					$0
Office Equipment					
Modular Furniture					$0
Record Filing System					$0
Phone/intercom system					$0
Computer/data/billing					$0
Copier/fax					$0
Supplies					$0
Office Equipment Subtotal					$0
START-UP COSTS TOTAL					$0
II. Operating Expenses					
Personnel					
Salaries		**Annual Salary**	**% Dental**	**FTE (40hrs/wk=1.0 FTE)**	
Executive Director		$0	0%	0.0	$0
Financial Officer		$0	0%	0.0	$0
Other _____		$0	0%	0.0	$0
Billing Clerk		$0	0%	0.0	$0
Dental Director		$0	0%	0.0	$0
Clinical Dentist(s)		$0	0%	0.0	$0
Dental Hygienist(s)		$0	0%	0.0	$0
EFDA(s)		$0	0%	0.0	$0
Dental Assistants		$0	0%	0.0	$0
Receptionist		$0	0%	0.0	$0
Salaries Subtotal					$0
Total Fringe Benefit Rate (%):				0%	
Fringe Benefits					$0
Personnel Total					$0
Miscellaneous Operating Expenses					
Contracts					
Dentist		$0	0%	0.0	$0
		QTY	**Unit Price**		
Clinical Supplies (# of operatories x $/operatory)		0	$0		$0
Office Supplies					$0
Equipment Maintenance (# of operatories x $/operatory)		0	$0		$0
Housekeeping					$0
Utilities					$0
Rent/Mortgage (months/yr x $/mo.)		0	$0		$0
Staff Training					$0
Lab fees					$0
Copying and Postage					$0
Share of audit					$0
Communications (telephone, internet)					$0
Insurance					$0
Equipment Depreciation					$0
Equipment Reserve Fund					$0
Other--list:					$0
Financial Services					$0
Building and Grounds Maintenance					$0
Fees, Registrations, Taxes and Advertising					$0
					$0
					$0
Miscellaneous Operating Expenses Subtotal					$0
TOTAL START-UP EXPENSES					$0
TOTAL ANNUAL OPERATING EXPENSES					$0

0	Appendix H: **2020 Safety Net I and II Provider Information and Patient Encounters**						
Dentist	# patient visits per day (do not include "hygiene checks")	# days per week worked	# patient visits per week	# weeks per month worked	# patient visits per month	# months worked per year	# patient visits per year
Dentist 1	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Dentist 2	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Dentist 3	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Dentist 4	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Dentist 5	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Total			0.0		0.0		0.0
Dental Hygienist	# patient visits per day	# days per week worked	# patient visits per week	# weeks per month worked	# patient visits per month	# months worked per year	# patient visits per year
RDH 1	0.0	0.0	0.0	0.0	0.0	0.0	0.0
RDH 2	0.0	0.0	0.0	0.0	0.0	0.0	0.0
RDH 3	0.0	0.0	0.0	0.0	0.0	0.0	0.0
RDH 4	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Total			0.0		0.0		0.0
Dentist/Hygienist Total			0.0		0.0		0.0

0	APPENDIX H: **2020 Safety Net I and II Budget Planning Worksheet - PROJECTED REVENUES**								
	INSERT PROGRAM-SPECIFIC ESTIMATES IN UN-SHADED CELLS								
REVENUES	Column: B	C	D	E	F	G	H	I	J
I. Patient Care Revenue		**0**							
Estimated number of encounters/year									
A. Non-Medicaid		**% of encounters**	**# of encounters**	**Avg Charge/ encounter**	**Total Charges (D*E)**	**Average Adjustment/ encounter (E-I)**	**Total Charge Reductions (D*G)**	**Adjusted charge/ encounter**	**Amount To Be Billed (D*I)**
Self-pay:									
Full		0%	0	$0	$0	$0	$0	$0	$0
Sliding Fee Schedule		0%	0	$0	$0	$0	$0	$0	$0
Minimum		0%	0	$0	$0	$0	$0	$0	$0
Commercial Insurance :									
Indemnity (Fee-for-service)		0%	0	$0	$0	$0	$0	$0	$0
Other (HMO - PPO)--List dental plans:									
		0%	0	$0	$0	$0	$0	$0	$0
		0%	0	$0	$0	$0	$0	$0	$0
		0%	0	$0	$0	$0	$0	$0	$0
Non-Medicaid Revenue Subtotal					$0		$0		**$0**
B. Medicaid									
ODJFS Fee-for-Service		0%	0	$0	$0	$0	$0	$0	$0
			# of adult co-pay encounters	**Rate**					**Amount to Be Billed (D*E)**
Adult Patient Co-pay ($3.00) for ODJFS Fee-for-Service Payments			0	$3					$0
		% of encounters	**# of encounters**	**Avg Charge/ encounter**	**Total Charges (D*E)**	**Average Adjustment/ encounter (E-I)**	**Total Charge Reductions (D*G)**	**Adjusted charge/ encounter**	**Amount To Be Billed (D*I)**
Managed Care Plans (MCP)--(List):									
		0%	0	$0	$0	$0	$0	$0	$0
		0%	0	$0	$0	$0	$0	$0	$0
		0%	0	$0	$0	$0	$0	$0	$0
		0%	0	$0	$0	$0	$0	$0	$0
		0%	0	$0	$0	$0	$0	$0	$0
		0%	0	$0	$0	$0	$0	$0	$0
		0%	0	$0	$0	$0	$0	$0	$0
		0%	0	$0	$0	$0	$0	$0	$0
FQHCs and look-alikes only:				0					
ODJFS wrap-around (FQHCs only)			0	$0					$0
				Rate					**Amount to Be Billed (D*E)**
Prospective Payment System (FQHCs and look-alikes only)--PPS		0%	0	$0					$0
Medicaid Revenue Subtotal									**$0**
PATIENT CARE REVENUE TOTAL									**$0**
II. Non-Patient Care Revenue Sources									
A. Grants and Contracts									
Federal									$0
State									$0
City/County									$0
Foundation(s):									$0
									$0
									$0
									$0
Grants and Contracts Subtotal									**$0**
B. Fundraising									
Individual Donations									$0
Corporate Donations									$0
Events									$0
Other									$0
Fundraising Subtotal									**$0**
NON-PATIENT CARE REVENUE TOTAL(excluding ODH Safety Net funds)									**$0**
REVENUE (ALL SOURCES - excluding ODH Safety Net funds)									**$0**

0	APPENDIX H: **2020 Safety Net I and II Program Interactive Budget Planning Worksheet - Summary**

REVENUES

I. PATIENT CARE REVENUE

A. Non-Medicaid

Self-Pay:	
Full	$0
Sliding Fee Schedule	$0
Minimum	$0
Commercial Insurance:	
Indemnity (Fee-for-service)	$0
Other (HMO - PPO)--plans:	
0	$0
0	$0
0	$0

B. Medicaid

Managed Care Counties	
ODJFS Fee-for-Service	$0
Adult Patient Co-pay ($3.00) for ODJFS Fee-for-Service payments	$0
Managed Care Plans (MCP):	
0	$0
0	$0
0	$0
0	$0
0	$0
0	$0
FQHCs and look-alikes only:	$0
ODJFS wrap-around (FQHCs only)	$0
PATIENT CARE REVENUE TOTAL	$0

II. NON-PATIENT CARE REVENUE (exclude Safety Net grant)

Grants & Contracts	$0
Fundraising	$0
NON-PATIENT CARE REVENUE TOTAL	$0

EXPENSES

I. Start-up Costs

Construction/Remodeling Cost	$0
Large Equipment	$0
Supplies, Instruments and Small Equipment	$0
Office Equipment	$0
START-UP COSTS TOTAL	$0

II. Operating Expenses

A. Personnel

Salaries	$0
Fringe Benefits	$0
PERSONNEL TOTAL	$0

B. Miscellaneous Operating Expenses

Contracts	$0
Clinical Supplies	$0
Office Supplies	$0
Equipment Maintenance	$0
Housekeeping	$0
Utilities	$0
Rent/Mortgage	$0
Staff Training	$0
Lab fees	$0
Copying and Postage	$0
Share of audit	$0
Communications	$0
Insurance	$0
Depreciation	$0
Equipment Reserve Fund	$0
Other--list:	$0
0	$0
0	$0
MISCELLANEOUS OPERATING EXPENSES TOTAL	$0

The Bottom Line				
Non-patient Care REVENUE	**$0**		**TOTAL START-UP EXPENSES**	**$0**
Patient Care REVENUE	**$0**		**TOTAL ANNUAL OPERATING EXPENSES**	**$0**
SHORT			**$0.00**	

5/15/2019

APPENDIX I

BUDGET JUSTIFICATION EXAMPLE (Deliverable Funding Only)

NOTES:

1. **Budget justification line items MUST be in the same order as in the GMIS budget.**

OTHER DIRECT COSTS

Deliverable – Objectives

(PLEASE REFER TO SUBGRANT SOLICITATION FOR THE REQUIRED SCENARIO)
(Note: Budget leverage cannot be used to move funding into or out of any Deliverables – Objective line item. Also, indirect cannot be charged against this line item.)

Scenario 1 (please refer to the solicitation to determine which scenario to use)

- Deliverable – Objective 1 $10,000

  Note: A brief description of how agency will accomplish meeting the deliverable may be required. Please refer to the solicitation to determine if this is required to be included in the budget justification. A detailed breakout of the deliverable budget is not required and should not be included in the budget justification.

- Deliverable – Objective 2 $45,000

  Note: A brief description of how agency will accomplish meeting the deliverable may be required. Please refer to the solicitation to determine if this is required to be included in the budget justification. A detailed breakout of the deliverable budget is not required and should not be included in the budget justification.

- Deliverable – Objective 3 $75,000

  Note: A brief description of how agency will accomplish meeting the deliverable may be required. Please refer to the solicitation to determine if this is required to be included in the budget justification. A detailed breakout of the deliverable budget is not required and should not be included in the budget justification.

Scenario 2 (please refer to the solicitation to determine which scenario to use)

- Deliverable – Objective 1

Franklin County	$40,000
Union County	$11,000
Madison County	$20,000
Licking County	$15,000

  Note: A brief description of how agency will accomplish meeting the deliverable may be required. Please refer to the solicitation to determine if this is required to be included in the budget justification. A detailed breakout of the deliverable budget is not required and should not be included in the budget justification.

- Deliverable – Objective 2

Franklin County	$52,500
Union County	$9,500
Madison County	$12,500
Licking County	$16,500

Note: A brief description of how agency will accomplish meeting the deliverable may be required. Please refer to the solicitation to determine if this is required to be included in the budget justification. A detailed breakout of the deliverable budget is not required and should not be included in the budget justification.

- Deliverable – Objective 3

Franklin County	$78,750
Union County	$16,750
Madison County	$8,750
Licking County	$38,750

Note: A brief description of how agency will accomplish meeting the deliverable may be required. Please refer to the solicitation to determine if this is required to be included in the budget justification. A detailed breakout of the deliverable budget is not required and should not be included in the budget justification.

Scenario 3 (please refer to the solicitation to determine which scenario to use)

- Deliverable – Objective 1

Objective A	$10,000
Objective B	$20,000
Objective C	$30,000
Objective D	$40,000

Note: A brief description of how agency will accomplish meeting the deliverable may be required. Please refer to the solicitation to determine if this is required to be included in the budget justification. A detailed breakout of the deliverable budget is not required and should not be included in the budget justification.

- Deliverable – Objective 2

Objective A	$12,500
Objective B	$2,500
Objective C	$1,500
Objective D	$16,500

Note: A brief description of how agency will accomplish meeting the deliverable may be required. Please refer to the solicitation to determine if this is required to be included in the

budget justification. A detailed breakout of the deliverable budget is not required and should not be included in the budget justification.

- Deliverable – Objective 3

Objective A	$28,750
Objective B	$8,750
Objective C	$1,750
Objective D	$38,050

Note: A brief description of how agency will accomplish meeting the deliverable may be required. Please refer to the solicitation to determine if this is required to be included in the budget justification. A detailed breakout of the deliverable budget is not required and should not be included in the budget justification.

Total Other Direct Costs **$Total**

Notes:

1. **The budget justification must be signed by the agency head listed in GMIS.**
2. **Budget revisions that do not include a signed budget justification by the agency head listed in GMIS will be disapproved.**
3. **Authorized representative certification language must also be included with agency head signature.**

Subrecipient's authorized representative certifies the foregoing:

- Subrecipient understands and agrees that it must follow the federal cost principle that applies to its type of organization (2 CFR, Part 225; 2 CFR, Part 220; or, 2 CFR, Part 230).
- Sub-recipient's budgeted costs are reasonable, allowable and allocable under OGAPP and federal rules and regulations.
- The OGAPP and the rules and regulations have been read and are understood.
- Subrecipient understands and agrees that costs may be disallowed if deemed unallowable or in violation of OGAPP and federal rules and regulations.
- The appropriate programmatic and administrative personnel involved in this application are aware of agency policy in regard to subawards and are prepared to establish the necessary inter-institutional agreements consistent with those policies.
- Subrecipient agrees and understands that costs incurred in the fulfillment of the Deliverables must be allowable under OGAPP and federal rules and regulations to qualify for reimbursement.

_____
[Signature]

_____
[Print Name & Title]

_____
[Date]

APPENDIX J

SAMPLE SAFETY NET DENTAL CARE PROGRAM I

& II REPORT FORM

Agency Name:													
Grant Project #:													
PATIENT ID	PATIENT BIRTHDATE (MM/DD/YYYY)	PATIENT GENDER M = MALE F = FEMALE	PATIENT ID/ACCOUNT #	PROVIDER NPI	GROUP NPI	OTHER FEE	TOTAL FEE	LINE NUMBER	PROCEDURE DATE MM/DD/YYYY	TOOTH NUMBER(S) OR LETTER(S)	TOOTH SURFACE	PROCEDURE CODE	QTY.