MEMORANDUM

Date: June 12, 2024

To: CD25 and DC25 Subrecipient agencies

From: Dyane Gogan Turner, MPH, RD/LD, IBCLC DGT
Chief, Bureau of Child and Family Health Ohio
Department of Health

Subject: Subrecipient Continuation Grant Applications for Calendar Year 2025
Safety Net Dental Care Program I (CD25, 1/1/2025 to 12/31/2025)
Safety Net Dental Care Program II (DC25, 1/1/2025 to 12/31/2025)

The Ohio Department of Health (ODH), Bureau of Child and Family Health has announced the availability of grant funds.

All electronic applications and attachments are due by **4:00 p.m., Monday, July 29, 2024**. Applications received after the due date will not be considered for funding. Faxed, hand-delivered or mailed applications will not be accepted.

Electronic application components must be submitted via the on-line Grants Management Information System (GMIS). For new staff requiring GMIS access, you must successfully complete GMIS training offered by ODH.

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 until receipt of grant payments.

Submission of the **continuation application** constitutes acknowledgment and acceptance of ODH Grants Administration Policies and Procedures (OGAPP) Manual rules, policy and procedure updates posted on the GMIS Bulletin Board, and any other program-specific requirements as outlined in the competitive Solicitation . Reference the competitive Solicitation for more information. The competitive Solicitation for this grant program can be found on the ODH website (CD23 Safety Net Dental Care Program I and DC23 Safety Net Dental Care Program II Competitive Solicitation).

If you have questions, please contact Mona Taylor, Oral Health Access Program Coordinator at (614) 728-9236 or e-mail at Mona.Taylor@odh.ohio.gov.

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I. CONTINUATION FUNDING APPLICATION GUIDANCE

100% Deliverable Funding

A. Policy and Procedures: The Continuation Funding Application consists of three parts: Program Updates(if applicable), Program Budget and Budget Narrative, and Other Required Attachments.

Submission of the continuation application constitutes acknowledgment and acceptance of ODH GAPP(OGAPP) manual rules, and any other program-specific requirements as outlined in the competitive Solicitation. This Solicitation pertains to the budget period: Wednesday, Jan. 1, 2025 through Wednesday, Dec. 31, 2025 of the total project period, Sunday, Jan. 1, 2023 through Wednesday, Dec. 31, 2025. Reference the competitive Solicitation, CD23 Safety Net Dental Care Program I and DC23 Safety Net Dental Care Program II for more information.

Subrecipient personnel paid using the deliverable funding must complete daily timesheets. Time and Effort reporting must be completed if staff are charged to multiple funding sources.

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.

- 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. Number of Grants and Funds Available: Funding to support the Safety Net Dental Care sub-grant program is received from both federal and state sources.

Safety Net Dental Care Program I: Up to $365,000 from HRSA's Maternal and Child Health (MCH) Block Grant is available to be awarded to five agencies in the continuation budget period (Wednesday, Jan. 1, 2025 through Wednesday, Dec. 31, 2025). Eligible agencies serving the MCH population (children through age 21 and women of childbearing age up to age 45) may apply for funding in the continuation grant budget period for a maximum award of $100,000. Funded agencies will be reimbursed for services provided to the target population at a rate of $125 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 $40 per encounter. Funded clinics may choose to be funded for one or both of the following:

1. Reimbursement for services provided to the target population at a rate of $125 per encounter (required).
2. Reimbursement for dentures provided to the target population at the following rates (optional):
    a. $764.40 per complete maxillary or mandibular denture (codes D5110 and D5120).
    b. $391.76 per partial denture, resin (codes D5211 and D5212).
    c. $1,032.42 per partial denture, metal (codes D5213 and D5214).
    d. $350.00 per interim partial denture, one or two anterior teeth, also known as a "flipper" (codes D5820 and D5821).

The Safety Net Dental Care Program will continue to focus funds on preventive and restorative dental services. For agencies that wish to be reimbursed for dentures, a maximum of 25% of total funding requested may be for dentures. 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 copay amount of $40 per encounter. A maximum copay will not apply to dentures.

Only those agencies currently funded through the Safety Net Dental Care Program I are eligible to apply. Eligible applicants are Cincinnati Health Department, Columbus Neighborhood Health Center, Erie County Health Department, Mercy Health Youngstown, and Third Street Community Clinic.

Safety Net Dental Care Program II: Up to $300,000 from state funds is available to be awarded to four agencies in the continuation budget period (Wednesday, Jan. 1, 2025 through Wednesday, Dec. 31, 2025). Eligible agencies serving the non-MCH population (females aged 45 and older, males aged 22 and up) may apply for funding in the continuation grant budget period for a maximum award of $100,000. Funded agencies will be reimbursed for services provided to the target population at a rate of $125 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 $40 per encounter. Funded clinics may choose to be funded for one or both of the following:

1. Reimbursement for services provided to the target population at a rate of $125 per encounter (required).
2. Reimbursement for dentures provided to the target population at the following rates (optional):
    a. $764.40 per complete maxillary or mandibular denture (codes D5110 and D5120).
    b. $391.76 per partial denture, resin (codes D5211 and D5212).
    c. $1,032.42 per partial denture, metal (codes D5213 and D5214).
    d. $350.00 per interim partial denture, one or two anterior teeth, also known as a "flipper" (codes D5820 and D5821).

The Safety Net Dental Care Program will continue to focus funds on preventive and restorative dental services. For agencies that wish to be reimbursed for dentures, a maximum of 25% of total funding requested may be for dentures. 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 copay amount of $40 per encounter. A maximum copay will not apply to dentures.

Only those agencies currently funded through the Safety Net Dental Care Program II are eligible to apply. Eligible applicants are Columbus Neighborhood Health Center, Erie County Health Department, Mercy Health Youngstown, and Third Street Community Clinic.

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.

C. Formatting Requirements for Attachments:

- Properly label each item of the application packet (ex. 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 and fit on 8 ½ x 11 paper when printed.
- Number all pages (print on one side only). Place agency name and GMIS number on each page.
- Use a 12-point Calibri font.
- Forms must be completed and submitted in the format provided by ODH.

D. Qualified Applicants:

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

1. The Applicant does not owe funds to ODH and has repaid any funds due with 45 days of the invoice date.
2. The Applicant has not been certified to the Attorney General's (AG's) office.
3. The Applicant has submitted an application and all required attachments by **4:00 p.m. on Monday, July 29, 2024.**

II. PROGRAM UPDATES

Program should review the Evidence of Health Equity Strategies Checklist in Appendix C when drafting the program narrative, objectives, and workplan.

A. Program Progress Report: Submit quarterly program report for the current grant period. If the program report is not scheduled to be submitted before the application due date, then it must be submitted with the application. Complete and submit Attachment 1, 2024 Program Progress Report. The progress report should describe any accomplishments for the program to date (for the current 2024 budget period) that are not reflected in the quarterly program reports. Clearly include reasons for less than expected progress toward accomplishing planned activities or achieved milestones or outcome objectives. Describe problems encountered and planned approaches to overcome them.

B. Program Narrative: Complete and submit a narrative statement (do not exceed 4 pages) which explains any changes to program scope, personnel, partnerships with agencies or organizations, or other information the subrecipient wishes to share for continuation funding. Applicants should highlight changes to clinical operations, including which sites are currently open, hours of operation, current staffing and level of services provided (e.g., emergency dental services only, non-aerosol generating services only, etc.). If clinics are not operating at full capacity, applicants should provide a plan for increasing capacity. Additionally, all applicants must submit Attachment 3, 2025 Budget Planning Worksheets, indicating anticipated program expenses, estimated provider FTEs and associated patient encounters and projected program revenues.

C. Objectives and Work Plan: Complete and submit a short summary of any changes in the Specific, Measurable, Achievable, Results-Oriented, and Time-Based (SMART) objectives and submit an updated work plan. Reference the competitive Solicitation for information. This should be based on a review of the Progress Plans submitted

to date. Provide a brief report addressing elements of each objective and activity, including current status (met, ongoing or unmet); major findings; and barriers and how barriers were addressed. Consider adopting SMART-IE goals which incorporate inclusivity and equity into each of the measures. In addition to a narrative summary of objectives and work plan, all applicant must complete Attachment 2, 2025 Program Objectives/Targets for year three of the three-year project period.

D. Documentation and Progress on Health Equity and Disparity Reduction Activities: Please provide detailed updates on the goals, objectives and deliverables specified in the Competitive Solicitation relating to health equity. This information must be supported by data. Continuation Solicitations should prepare a summary of activities completed during the previous funding period, to outreach to the priority populations and / or neighborhoods specified in their plan.

E. Program Budget: Prior to completion of the budget section, reference the competitive Solicitation for unallowable costs and review criteria. (CD23 Safety Net Dental Care Program I and DC23 Safety Net Dental Care Program II).

1. **Budget Narrative:** Provide a budget justification narrative outlining how the deliverable will be met. A budget justification example can be found on GMIS. For your convenience, a budget justification example is available in Appendix D (use Scenario #3 from the budget justification example.

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 may be used to identify additional funding information from other resources. Applicants will also identify all sources of funding in Attachment 3, 2025 Budget Planning Worksheets.

2. **2025 Budget via GMIS:** Complete requested budget information as follows:

- **Other Direct Costs:** Submit a budget for this section and the necessary form(s) to support costs for the period Jan. 1, 2025 to Dec. 31, 2025.

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

- **Compliance:** Answer each question on this form. Completion of the form ensures your agency's compliance with the administrative standards of ODH and federal grants.

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

- To advance political or religious points of view or for fund raising or lobbying.
- To disseminate factually incorrect or deceitful information.
- Consulting fees for salaried program personnel to perform activities related to grant objectives.
- Bad debts of any kind.
- Contributions to a contingency fund.
- Entertainment.
- Fines and penalties.
- Membership fees — unless related to the program and approved by ODH.
- Interest or other financial payments (including but not limited to bank fees).

- Contributions made by program personnel.
- Costs to rent equipment or space owned by the funded agency.
- Inpatient services.
- The purchase or improvement of land; the purchase, construction, or permanent improvement of any building (unless allowable by the grant).
- Satisfying any requirement for the expenditure of non-federal funds as a condition for the receipt of federal funds.
- Payments to any person for influencing or attempting to influence members of Congress or the Ohio General Assembly in connection with awarding of grants.

Applicants may not use Safety Net Dental Care Program funds to supplant existing funds.

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. Please refer to the OGAPP manual for additional information.

F. Other Application Requirements:

Program Specific Attachments: Please complete and submit the following attachments via GMIS:

- Attachment 1, 2024 Program Progress Report.
- Attachment 2, 2025 Program Objectives/Targets.
- Attachment 3, 2025 Budget Planning Worksheets.
- Copies of proof of licensure or certification for all dental clinic staff required to be licensed or certified (***required only for new staff hired since submission of 2024 application***).

All attachments must be completed and submitted electronically. Oral Health Program staff will email the electronic versions of Attachments 1-3 once Appendix A has been submitted. All attachments must clearly identify the authorized program name and GMIS project number.

Other Required Documentation:

- 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: Subrecipient's 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.

- **Audit:** Subrecipient agencies are responsible for submitting an audit report. Once an audit is completed, a copy must be sent to ODH via audits@odh.ohio.gov. Reference the GMIS Bulletin Board for more information.

- **Civil Rights Review Questionnaire — EEO Survey:** The Civil Rights Review Questionnaire (EEO) 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 online automatically with each application.

- **Assurances Certification:** Each subrecipient must acknowledge the Assurances (Federal and State Assurances for Sub-grantees) form in 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.

- **Federal Funding Accountability and Transparency Act (FFATA):** All new 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 register in SAM.gov and submit the information in the grant application. For information about System for Award Management (SAM) go to https://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.)

- **For Non-Profit Organizations Only:**

  1. **Liability Coverage:** Liability coverage is required for all non-profit agencies. Non-profit organizations must submit documentation validating current liability coverage. Attach the current Certificate of Insurance Liability in GMIS.

  2. **Non-Profit Organization Status:** Non-profit organizations must submit documentation validating current status. If changed, attach in GMIS the Internal Revenue Services (IRS) letter approving non-tax-exempt status.

G. Human Trafficking: Human trafficking is defined by the use of force, fraud, or coercion to compel victims into performing labor or commercial sex acts. Populations at increased risk include but are not limited to lesbian-gay-bisexual-transgender-questioning individuals, individuals with disabilities, undocumented immigrants, runaway and homeless youth, temporary guest-workers, and low-income individuals.

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 that may include, but are not limited to the following:

a. Populations at increased risk.
b. Mental health population.
c. Homeless population.

2. Agencies that promote the expansion of services to identify and serve those affected by human trafficking.

X Applicable to Safety Net Dental Care Programs I and II.

H. Post Submission Requirements: Continuation applicants are required to submit subrecipient program and expenditure reports.

Note: Failure to assure quality of reporting such as 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:** Subrecipient Program Reports for the Safety Net Dental Care Program must be completed and submitted via the online REDCap reporting system (subrecipients will receive a link to the online report each quarter). Program reports must include data for the agency's entire dental program. After completing and submitting the online report, subrecipient agencies must verify the submission in GMIS. Online submission and verification are due by the following dates:

X Program Reports Required _____No Program Reports Required

Period	Report Due Date
Jan. 1 – March 31, 2025	April 10, 2025
April 1 – June 30, 2025	July 10, 2025
July 1 – Sept. 30, 2025	Oct. 10, 2025
Oct. 1 – Dec. 31, 2025	Jan. 10, 2026

2. **Subrecipient Reimbursement Expenditure Reports:** Subrecipient Expenditure Reports **must** be completed and submitted quarterly **via GMIS** by the following dates:

Period	Report Due Date
Jan. 1 – March 31, 2025	April 10, 2025
April 1 – June 30, 2025	July 10, 2025
July 1 – Sept. 30, 2025	Oct. 10, 2025
Oct. 1 – Dec. 31, 2025	Jan. 10, 2026

In order to facilitate verification of patient encounters and approval of GMIS Expenditure Reports, subrecipients must submit the Safety Net Dental Care Program Expenditure Report Form with detailed encounter information monthly (see sample report in Appendix E). Safety Net Dental Care Program Expenditure Report Forms are due by the following dates:

Period	Report Due Date
Jan. 1 – 31, 2025	Feb. 10, 2025
Feb. 1 – 28, 2025	March 10, 2025

March 1 – 31, 2025	April 10, 2025
April 1 – 30, 2025	May 10, 2025
May 1 – 31, 2025	June 10, 2025
June 1 – 30, 2025	July 10, 2025
July 1 – 31, 2025	Aug. 10, 2025
Aug. 1 – 31, 2025	Sept. 10, 2025
Sept. 1 – 30, 2025	Oct. 10, 2025
Oct. 1 – 31, 2025	Nov. 10, 2025
Nov. 1 – 30, 2025	Dec. 10, 2025
Dec. 1 – 31, 2025	Jan. 10, 2026

Note: Obligations not reported on the final monthly or fourth 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 Thursday, Feb. 5, 2026. 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, which serves as an invoice to return unused funds.

   Attachment 4, 2025 Budget Reporting Worksheets (electronic) that reflect actual revenues and expenditures for the Safety Net Dental Care Program must be submitted via GMIS attachment no later than Thursday, Feb. 5, 2026.

Submission of ALL Subrecipient program and expenditure reports via the ODH's GMIS system indicates acceptance of OGAPP. Clicking the "Submit" or "Approve" button constitutes your authorization of the submission as an agency official and serves as your electronic acknowledgment and acceptance of OGAPP rules and regulations.

III. APPENDICES

A. Continuation Solicitation Reimbursement Type Form
B. B1. Deliverable — Objective Descriptions
   B2. Deliverable — Objective Allocations
C. Evidence of Health Equity Strategies Checklist
D. Budget Justification Example
E. Sample Expenditure Report Form
F. Sample Dentures Expenditure Report Form
G. Program-Required Documents
   - Attachment 1, 2024 Program Progress Report
   - Attachment 2, 2025 Program Objectives/Targets
   - Attachment 3, 2025 Budget Planning Worksheets
   - Attachment 4, 2025 Budget Reporting Worksheets

Appendix A

Submission Required

CONTINUATION SOLICITATION
REIMBURSEMENT TYPE FORM

See due date below

Ohio Department of Health
Bureau of Child and Family Health

ODH Program Title:

☐ Safety Net Dental Care Program I (CD25)
☐ Safety Net Dental Care Program II (DC25)

Reimbursement Type (please check) ☐ Quarterly

(Please note that no changes to the reimbursement type can be made after the project number is created in GMIS. No waivers/appeals will be accepted.)

Please print:

Current Project Number _____

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.

Due to ODH by **Thursday, June 20, 2024**.

Please email completed form to Maria Kapenda (Maria.Kapenda@odh.ohio.gov).

Appendix B1

Name of Subgrant Program: Safety Net Dental Care Program I (CD25) and II (DC25)
Budget Period: Wednesday, Jan. 1, 2025 – Wednesday, Dec. 31, 2025
# of Deliverables: 2
Use Budget Justification: Scenario #3, Appendix D

100% Deliverables

Deliverable — Objective 1: Encounters/Visits Providing Dental Services to Target Population (Required)
Applicant agency will define the total number of encounters to be provided to clients who meet the program-specific criteria as outlined during the budget period. ODH will reimburse subrecipient agencies $125 per encounter/visit for the target population. Subrecipient agency may charge a maximum co-pay of $40 per encounter/visit for encounters/visits submitted to ODH for reimbursement.

Deliverable — Objective 2: Provision of Dentures (Optional)
Maximum funding for Deliverable 2 is 25% of total funding requested.
Applicant agency will define the total number and type of dentures to be provided to clients who meet the program-specific criteria as outlined during the budget period. ODH will reimburse agencies providing dentures to the target population the following:

a. $764.40 per complete maxillary or mandibular denture (dental codes D5110 and D5120).
b. $391.76 per partial denture, resin (dental codes D5211 and D5212).
c. $1,032.42 per partial denture, metal (dental codes D5213 and D5214).
d. $350.00 per interim partial denture, one or two anterior teeth, also known as a “flipper” (dental codes D5820 and D5821).

A maximum co-pay does not apply to denture units submitted to ODH for reimbursement.

Appendix B2

Name of Subgrant Program: Safety Net Dental Care Program I (CD25) and II (DC25)
Budget Period: Wednesday, Jan. 1, 2025 – Wednesday, Dec. 31, 2025
# of Deliverables: 2
Use Budget Justification: Scenario #3, Appendix D

Deliverable Allocations

Deliverable – Objective 1		
Deliverable Objective 1a – Patient encounters	# encounters x $125 each	$
Total Deliverable Objective 1		***$***
Deliverable – Objective 2		
Deliverable Objective 2a – Complete Denture Units	# units X $764.40	$
Deliverable Objective 2b – Partial Denture Units, Resin	# units x $391.76	$
Deliverable Objective 2c – Partial Denture Units, Metal	# units x $1,032.42	$
Deliverable Objective 2d – Interim Partial Denture Units	# units x $350.00	$
Total Deliverable Objective 2		***$***
TOTAL OTHER DIRECT COSTS BUDGET = $		

Appendix C

ODH Evidence of Health Equity Strategies Checklist

This checklist should be used to support planning, implementation, and evaluation of equitable strategies to reduce disparities and overcome social determinants of health. This checklist is a guide to establish a baseline criterion that all projects funded by ODH to support alignment with established priorities to achieve optimal health for all Ohioans.

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

Racial and ethnic minorities, those living in rural communities, 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, learn, work, play, and age. 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 and freedom from racism and other forms of discrimination. These are referred to as **social determinants of health (SDOH)**. SDOH are a 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**. Programs that incorporate social determinants into the planning and implementation of interventions will greatly contribute to advancing health equity.

The ODH is committed to the elimination of health disparities and achieving health equity for all Ohioans. The items below are requirements for all applicants to ensure health equity is embedded within all components of the application (e.g., Goals, Program Narrative, and Objectives.)

1) Identify specific groups who experience a disproportionate burden of disease, health condition or health outcome targeted by this solicitation. See Ohio's State Health Assessment Ohio's health data. https://odh.ohio.gov/wps/portal/gov/odh/explore-data-and-stats/interactive-applications/2019-online-state-health-assessment.

2) Identify geographic reference points (i.e., census tracts, census block groups or zip codes) to specify where program activities are focused.

3) Use direct or indirect feedback from the prioritized population, community, group, or community agency to identify specific social and environmental conditions (social determinants of health) associated with health disparities and health inequities.

4) Identify measurable health equity targets that demonstrate reducing disparities and improving health equity are critical goals to be achieved through program activities. This information must also be supported by data. For guidance on methodology to establish equity targets, review 2030 Target Setting Methodologies for Objectives in Healthy People 2030.

5) Outline specific evaluation strategies to measure the impact of program activities on decreasing and/or eliminating health disparities and health inequities.

The following are best practices aimed at eliminating disparities and achieving health equity. They are not required, but highly encouraged to use.

1) Link proposed activities to health equity strategies identified in local, state, or national planning documents. These documents include, but are not limited to strategies, goals and objectives outlined in Healthy People 2030, the State Health Improvement Plan (SHIP) and local Community Health Assessments.
   - State Health Improvement Plan - https://odh.ohio.gov/wps/portal/gov/odh/about-us/sha-ship
   - Healthy People 2030 - https://health.gov/healthypeople

2) Develop staffing plans where board members, leadership and program staff reflect the race, ethnicity, background, and/or culture of the population being served.

3) Identify up and downstream approaches to address social determinants of health and reduce disparities. Upstream factors like food, housing and income insecurity that focus on addressing social determinants of health decrease barriers and improve supports that provide opportunity for people to achieve their full health potential. Downstream approaches focus on providing equitable access to care and services to reduce the negative impact of social determinants on health outcomes.

4) Establish non-traditional partnerships among different sectors of the community (e.g., faith-based organizations, community organizations, businesses, universities, healthcare) that can provide valuable insight, new perspective, and more effective ways to achieve program goals. Non-traditional partners create opportunity to collaborate across sectors and may serve as a new source of support for the program.

[Note to Program: These requirements and best practices should be tied to deliverables and review criteria when possible and appropriate.]

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	$Total
Budget Grand Total	**$**

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 listedin 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).
- 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.

_____

_____

[Signature]

_____

[Print Name and Title]

APPENDIX E

SAMPLE SAFETY NET DENTAL CARE PROGRAM EXPENDITURE REPORT FORM

Agency Name:													
Grant Project #:													
CLAIM #	PATIENT ID OR ACCOUNT #	PATIENT BIRTHDATE (MM/DD/YYYY)	PATIENT SEX M = MALE F = FEMALE	PATIENT RACE	PATIENT ETHNICITY	LINE NUMBER	DATE OF SERVICE (MM/DD/YYYY)	PROCEDURE CODE	TOOTH NUMBER OR LETTER	TOOTH SURFACE	FEE	PATIENT BILLED AMOUNT	TOTAL FEE

APPENDIX F

SAMPLE SAFETY NET DENTAL CARE PROGRAM DENTURES EXPENDITURE REPORT FORM

Agency Name:											
Grant Project #:											
CLAIM #	PATIENT ID OR ACCOUNT #	PATIENT BIRTHDATE (MM/DD/YYYY)	PATIENT SEX M = MALE F = FEMALE	PATIENT RACE	PATIENT ETHNICITY	DATE OF SERVICE (MM/DD/YYYY)	PROCEDURE CODE	TOOTH NUMBER OR LETTER	FEE	PATIENT BILLED AMOUNT	TOTAL FEE

ATTACHMENT 1

Agency Name	*Grant Number*

2024 SAFETY NET DENTAL CARE PROGRAM
Progress Report

A. Describe any accomplishments for the Safety Net Dental Care Program to date (2024 budget year) that are not reflected in the quarterly program reports.

Click or tap here to enter text.

B. Describe your agency's SMART objectives for the 2024 Safety Net Dental Care Program and the progress made toward meeting objectives/targets.

Click or tap here to enter text.

C. Describe any barriers to achieving the program's objectives in 2024, and activities taken to resolve the barriers.

Click or tap here to enter text.

ATTACHMENT 2

2025 SAFETY NET DENTAL CARE PROGRAM 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) 2025.	
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 CY2025.	
3. Estimate the total number of unduplicated non-MCH patients (women aged 45 and older, men aged 22 and up) to be served by the dental program in CY2025.	
4. Estimate the total number of uninsured MCH patients with low incomes who pay reduced fees to be served by the dental program in CY2025.	
5. Estimate the total number of uninsured non-MCH patients with low incomes who pay reduced fees to be served by the dental program in CY2025.	
6. Estimate the total number of encounters for uninsured MCH patients with low incomes who pay reduced fees in CY2025.	
7. Estimate the total number of encounters for uninsured non-MCH patients with low incomes who pay reduced fees in CY2025.	
8. If program's current "No Show/Broken Appointment" rate is >15%, estimate the reduction in rate for CY2025.	
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 CY2025.	

ATTACHMENT 3

DIRECTIONS FOR USING THE 2025 SAFETY NET DENTAL CARE PROGRAM BUDGET PLANNING WORKSHEETS (1/1/2025 - 12/31/2025)

There are four budget worksheets contained in this file. 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.

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ATTACHMENT 3: **2025 Safety Net Dental Care Program**
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

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0	ATTACHMENT 3: **2025 Safety Net 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

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0	ATTACHMENT 3: **2025 Safety Net Program 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									
Estimated number of encounters/year		**0**							
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**

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0	ATTACHMENT 3: **2025 Safety Net Dental Care 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
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
Financial Services	$0
Building and Grounds Maintenance	$0
Fees, Registrations, Taxes and Advertising	$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**	

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ATTACHMENT 4

DIRECTIONS FOR USING THE SAFETY NET DENTAL CARE GRANT INTERACTIVE BUDGET REPORTING WORKSHEETS for the period 1/1/25 through 12/31/25

ATTACHMENT 4

There are three budget worksheets contained in this file. Each worksheet has a tab below. Click on the tab to activate the worksheet.

PLEASE NOTE:
Due: February 5, 2026. Please submit as a GMIS attachment and via email to Program Coordinator.

This version has an additional column (G) on the Expenses tab to indicate the portion of your total budget that was charged to this grant.

STEP 1 Open the Expenses worksheet. **Type your program name and GMIS number in cell A1,** and complete the **unshaded** cells. Column F should represent the total budget, while column G should reflect only the amount charged to this grant. These amounts may, or may not, be equal.

Rows for "other" costs have been added for your convenience. They are Row 19 (for Start-up Costs) and Row 69 (for Miscellaneous Operating Expenses). You can click in column C to type in a **brief** description of your "other" costs, then list those charges in columns F & G.

STEP 2 Open the Revenue worksheet. Complete the **unshaded** cells. In Part I, Patient Care Revenue, the "# of encounters" is the total number of patient visits for each payer type (row). Note that the "Actual number of encounters/year" (cell C4) is a total of entries in Column D, except cells D21, D28 and D33.

STEP 3 Open the 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: (These comments remain the same as the comments that were in the Budget Planning Worksheets). If you see a red triangle in the upper-right hand corner of a cell, roll your mouse pointer over the cell to get more explanation or instructions on that item.
If the print in a comment box is too small, increase the magnification by:
-clicking "View" on your menu bar at the top of your screen; then
-click "Zoom"; and
-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 in the online Safety Net Dental Clinic Manual .

https://www.dentalclinicmanual.com/

If you need to add or delete any rows in the Expenses or Revenue worksheets, call the Oral Acces Program Coordinator 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.

Revised 4/22/2024

Program Name & GMIS #	Att. 4: Safety Net Dental Care Grant Interactive Budget Reporting Worksheets - 2025 Actual Expenses					
INSERT PROGRAM-SPECIFIC EXPENSES IN UN-SHADED CELLS						
EXPENSES						
I. Start-up Costs					**Total Program Budget**	**Amount charged to this ODH grant**
Construction/Remodeling Cost						
# of square feet		0				
Cost per square foot		$0			$0	$0
Dental Equipment Costs						
Large Equipment					$0	$0
Supplies, Instruments and Small Equipment					$0	$0
Office Equipment						
Modular Furniture					$0	$0
Record Filing System					$0	$0
Phone/intercom system					$0	$0
Computer/data/billing					$0	$0
Copier/fax					$0	$0
Supplies					$0	$0
Office Equipment Subtotal					**$0**	**$0**
Other Start-up Costs not specified elsewhere	List:				$0	$0
START-UP COSTS TOTAL					**$0**	**$0**
II. Operating Expenses						
Personnel						
Salaries		**Annual Salary**	**% dental**	**FTE (40hrs/wk=1.0 FTE)**		
Executive Director		$0	0%	0.0	$0	$0
Financial Officer		$0	0%	0.0	$0	$0
Other _____		$0	0%	0.0	$0	$0
Billing Clerk		$0	0%	0.0	$0	$0
Dental Director		$0	0%	0.0	$0	$0
Clinical Dentist 1		$0	0%	0.0	$0	$0
Clinical Dentist 2		$0	0%	0.0	$0	$0
Clinical Dentist 3		$0	0%	0.0	$0	$0
Clinical Dentist 4		$0	0%	0.0	$0	$0
Clinical Dentist 5		$0	0%	0.0	$0	$0
Dental Hygienist 1		$0	0%	0.0	$0	$0
Dental Hygienist 2		$0	0%	0.0	$0	$0
EFDA 1		$0	0%	0.0	$0	$0
EFDA 2		$0	0%	0.0	$0	$0
Dental Assistant 1		$0	0%	0.0	$0	$0
Dental Assistant 2		$0	0%	0.0	$0	$0
Dental Assistant 3		$0	0%	0.0	$0	$0
Dental Assistant 4		$0	0%	0.0	$0	$0
Dental Assistant 5		$0	0%	0.0	$0	$0
Dental Assistant 6		$0	0%	0.0	$0	$0
Receptionist		$0	0%	0.0	$0	$0
Salaries Subtotal					**$0**	**$0**
Total Fringe Benefit Rate (%):				0%		
Fringe Benefits					$0	$0
Personnel Total					**$0**	**$0**
Miscellaneous Operating Expenses						
Contracts						
Dentist		$0	0%	0.0	$0	$0
		QTY	**Unit Price**			
Clinical Supplies (# of operatories x $/operatory)		0	$0		$0	$0
Office Supplies					$0	$0
Equipment Maintenance (# of operatories x $/operatory)		0	$0		$0	$0
Housekeeping					$0	$0
Utilities					$0	$0
Rent/Mortgage (months/yr x $/mo.)		0	$0		$0	$0
Staff Training					$0	$0
Lab fees					$0	$0
Copying and Postage					$0	$0
Share of audit					$0	$0
Communications (telephone, internet)					$0	$0
Insurance					$0	$0
Bad Debt					$0	$0
Equipment Depreciation					$0	$0
Equipment Reserve Fund					$0	$0
Other Operating Expenses not specified elsewhere	List:				$0	$0
					$0	$0
					$0	$0
					$0	$0
					$0	$0
					$0	$0
Miscellaneous Operating Expenses Subtotal					**$0**	**$0**
TOTAL START-UP EXPENSES					**$0**	**$0**
TOTAL ANNUAL OPERATING EXPENSES					**$0**	**$0**
TOTAL EXPENSES CHARGED TO ODH GRANT						**$0**

Revised 4/22/2024

Program Name & GMIS #	Att. 4: Safety Net Dental Care Grant Interactive Budget Worksheets 2025 Actual Revenues								
	INSERT PROGRAM-SPECIFIC NUMBERS IN UN-SHADED CELLS								
REVENUES	Column: B	C	D	E	F	G	H	I	J	K
I. Patient Care Revenue										
Actual number of encounters/year		**0**								
A. Non-Medicaid		**% of encounters (D/C4)**	**# of encounters**	**Avg Charge/ encounter (F/D)**	**Total Charges (UCR)**	**Average Adjustment/ encounter (E-I)**	**Total Charge Reductions (D*G)**	**Adjusted charge/ encounter (J/D)**	**Amount Billed**	**Amount Collected**
Self-pay:										
Full		#DIV/0!	0	#DIV/0!	$0	#DIV/0!	#DIV/0!	#DIV/0!	$0	$0
Sliding Fee Schedule		#DIV/0!	0	#DIV/0!	$0	#DIV/0!	#DIV/0!	#DIV/0!	$0	$0
Minimum		#DIV/0!	0	#DIV/0!	$0	#DIV/0!	#DIV/0!	#DIV/0!	$0	$0
Commercial Insurance :										
Indemnity (Fee-for-service)		#DIV/0!	0	#DIV/0!	$0	#DIV/0!	#DIV/0!	#DIV/0!	$0	$0
Other (HMO - PPO)--List dental plans:										
		#DIV/0!	0	#DIV/0!	$0	#DIV/0!	#DIV/0!	#DIV/0!	$0	$0
		#DIV/0!	0	#DIV/0!	$0	#DIV/0!	#DIV/0!	#DIV/0!	$0	$0
		#DIV/0!	0	#DIV/0!	$0	#DIV/0!	#DIV/0!	#DIV/0!	$0	$0
Non-Medicaid Revenue Subtotal					$0		#DIV/0!		**$0**	**$0**
B. Medicaid										
Managed Care Counties										
ODJFS Fee-for-Service		#DIV/0!	0	#DIV/0!	$0	#DIV/0!	#DIV/0!	#DIV/0!	$0	$0
			# of adult co-pay encounters							
Adult Patient Co-pay ($3.00) for ODJFS Fee-for-Service Payments			0	$3					$0	$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 Billed**	**Amount Collected**
Managed Care Plans (MCP)--(List):										
		#DIV/0!	0	#DIV/0!	$0	#DIV/0!	#DIV/0!	#DIV/0!	$0	$0
		#DIV/0!	0	#DIV/0!	$0	#DIV/0!	#DIV/0!	#DIV/0!	$0	$0
		#DIV/0!	0	#DIV/0!	$0	#DIV/0!	#DIV/0!	#DIV/0!	$0	$0
		#DIV/0!	0	#DIV/0!	$0	#DIV/0!	#DIV/0!	#DIV/0!	$0	$0
ODJFS wrap-around (FQHCs only)			0	#DIV/0!	$0	#DIV/0!	#DIV/0!	#DIV/0!	$0	$0
Non-managed Care Counties										
ODJFS Fee-for-Service		#DIV/0!	0	#DIV/0!	$0	#DIV/0!	#DIV/0!	#DIV/0!	$0	$0
			# of adult co-pay encounters	**Rate**						
Adult Patient Co-pay ($3.00) for ODJFS Fee-for-Service Payments			0	$3	$0				$0	$0
Prospective Payment System (FQHCs only)--PPS			0	0	$0				$0	$0
Medicaid Revenue Subtotal									**$0**	**$0**
PATIENT CARE REVENUE TOTAL									**$0**	**$0**
II. Non-Patient Care Revenue Sources										
A. Grants and Contracts (including ODH Safety Net Dental Care grant, if applicable)									**Amt Awarded or Raised**	**Funds Spent**
Federal									$0	$0
State (include ODH Safety Net Dental Care grant)									$0	$0
City/County									$0	$0
Foundation(s):									$0	$0
									$0	$0
									$0	$0
									$0	$0
Grants and Contracts Subtotal									**$0**	**$0**
B. Fundraising										
Individual Donations									$0	$0
Corporate Donations									$0	$0
Events									$0	$0
Other									$0	$0
Fundraising Subtotal									**$0**	**$0**
NON-PATIENT CARE REVENUE TOTAL (including SNDC* grant)									**$0**	**$0**
REVENUE (ALL SOURCES - including ODH SNDC grant)									**$0**	**$0**

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*SNDC = Safety Net Dental Care

Program Name & GMIS #	Att. 4: Safety Net Dental Care Interactive Budget Reporting Worksheet - 2025 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
ODJFS wraparound (FQHCs only)	$0
Non-managed Care Counties	
ODJFS Fee-for-Service	$0
Adult Patient Co-pay ($3.00) for ODJFS Fee-for-Service payments	$0
Prospective Payment System (FQHCs only)--PPS	$0
PATIENT CARE REVENUE TOTAL	**$0**

II. NON-PATIENT CARE REVENUE

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
Bad Debt	$0
Depreciation	$0
Equipment Reserve Fund	$0
Other Operating Expenses not specified elsewhere	$0
Miscellaneous Operating Expenses Subtotal	**$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**	
Amount charged to this ODH grant (from Expenses worksheet)		**$0.00**	

Revised 4/22/2024