



OHIO DEPARTMENT OF HEALTH

246 North High Street
Columbus, Ohio 43215

614/466-3543
www.odh.ohio.gov

Ted Strickland/Governor

Alvin D. Jackson, M.D./Director of Health

Date: August 20, 2009
To: Prospective Safety Net Dental Care Program Applicants
From: Karen F. Hughes, MPH, Chief *KAREN F. HUGHES (RPH)*
Division of Family and Community Health Services
Ohio Department of Health
Subject: Notice of Availability of Funds

**Competitive Grant Applications for Calendar Year 2010
Safety Net Dental Care Program (1/1/2010 to 12/31/2010)**

The Ohio Department of Health (ODH), Division of Family and Community Health Services, Bureau of Oral Health Services, announces the availability of grant funds to support the Safety Net Dental Care Program. The Request for Proposals (RFP) will provide you guidance in completing the online application for the competitive program period. **Proposals are due Monday, October 19, 2009 for the funding period January 1, 2010 through December 31, 2010. Late applications will not be accepted.**

Introduction/Background

The 2003-04 Ohio Family Health survey found that dental care remains the No. 1 unmet health care need identified for both Ohio children and adults. The target population for the program is Ohioans who cannot afford and are less likely to receive dental services in the private sector and who are considered at risk for dental disease due to financial accessibility barriers and/or past disease patterns.

Public health programs often serve as a safety net for those who cannot afford preventive or restorative care. Safety net dental care programs are clinics that care for Medicaid recipients and offer sliding fee schedules, significantly reduced fees or free care to clients who otherwise cannot afford private dental care. A risk-based approach can reduce the cost and improve access to preventive and restorative care.

All interested parties must submit a Notice of Intent to Apply for Funding (NOIAF) form, no later than Monday, September 14, 2009 to be eligible to apply for funding (attached to the RFP). Upon receipt of your completed NOIAF, ODH will:

- a. Create the grant application account for your organization¹. This account number will allow you to submit an application via the Internet using the Grants Management Information System (GMIS 2.0). All grant applications must be submitted via the Internet using the GMIS 2.0.

- b. Assess your organization's GMIS 2.0 training needs (as indicated on the completed *Notice of Intent to Apply for Funding* form) and ODH will contact you regarding upcoming GMIS 2.0 training dates. GMIS 2.0 training is mandatory if your organization has never been trained on GMIS 2.0. Two people from an agency must attend the initial GMIS 2.0 training for that agency.

Once ODH receives your completed *Notice of Intent to Apply for Funding* form, creates the grant application account for your organization, and finalizes all GMIS 2.0 training requirements, you may proceed with the application process as outlined in the RFP.

The RFP will provide detailed information about the background, intent and scope of the grant, policy, 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 in the Columbus area on Wednesday, September 9, 2009 at 2:00 p.m. at the Westerville Library. Please return a registration form (included) to the Bureau of Oral Health Services to confirm your attendance at this session. 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, by e-mail at Mona.Taylor@odh.ohio.gov, by phone at (614) 466-4180 or by fax at (614) 564-2421, if you have any questions regarding this application.

Mail the original and two (2) copies of the material not electronically filed to:

**Ohio Department of Health
Grants Administration
Central Master Files, 4th Floor
246 N. High Street
Columbus, OH 43215**

¹ Organizations with previous GMIS 2.0 training will automatically receive a grant application account number upon receipt of a completed Notice of Intent to Apply for Funding form.

Safety Net Dental Care Grant

Bidders' Conference

REGISTRATION FORM

BIDDERS' CONFERENCE

A Bidders' Conference will be held for those interested in the Ohio Department of Health, Bureau of Oral Health Services' Safety Net Dental Care Program Grant. Potential applicants are strongly encouraged to attend; however, attendance is *not* required. At this meeting, Bureau of Oral Health Services staff will provide detailed information on the goals and objectives of the dental grant program and the review criteria that will be used to score proposals. This meeting also will provide an opportunity for applicants to ask questions that may arise while working on proposals.

When: Wednesday, September 9, 2009
2:00 p.m. Safety Net Dental Care Grant Funds

Where: Westerville Library
126 South State Street
Westerville, OH 43081
614-882-7277

Northeast of Columbus, North of I-270, for map/directions:
<http://www.westervillelibrary.org/index.html> and click on Driving Directions on the home page (in lower right quadrant).

TO REGISTER for the Bidders' Conference: In order for us to have adequate seating and materials available, please register for the Bidders' Conference *by faxing the Bureau of Oral Health Services at 614-564-2421 or by e-mailing Mona Taylor at Mona.Taylor@odh.ohio.gov*.

Please respond by Friday, September 4, 2009 with the following information:

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

Agency Name/County

Contact person name

(_____) _____
phone number

Contact person's e-mail address: _____

NOTICE OF INTENT TO APPLY FOR FUNDING

Ohio Department of Health
Division of Family and Community Health Services

Bureau of Oral Health Services
ODH Program Title: Safety Net Dental Care Program

ALL INFORMATION REQUESTED MUST BE COMPLETED.
(Please Print Clearly or Type)

County of Applicant Agency _____

Federal Tax Identification Number _____

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
(Check One)

- County Agency Hospital Local Schools
 City Agency Higher Education Not-for Profit

Applicant Agency/Organization _____

Applicant Agency Address _____

Agency Contact Person/Title _____

Telephone Number _____

E-mail Address _____

Please check all applicable:

- Our agency will need GMIS 2.0 training
 Our agency has completed GMIS 2.0 training
 First time applying for an ODH grant

Mail, E-mail or Fax To:

Mona Taylor, RDH, BS
Oral Health Access Coordinator
Bureau of Oral Health Services
Ohio Department of Health
246 N. High Street
Columbus, Ohio 43215
E-mail: Mona.Taylor@odh.ohio.gov

Fax: (614) 564-2421



ALL APPLICATIONS MUST BE SUBMITTED VIA THE INTERNET

OHIO DEPARTMENT OF HEALTH

**DIVISION OF
FAMILY AND COMMUNITY HEALTH SERVICES**

**BUREAU OF
ORAL HEALTH SERVICES**

**SAFETY NET DENTAL CARE PROGRAM
REQUEST FOR PROPOSALS (RFP)**

**FOR
FISCAL YEAR 2010
(01/01/10 – 12/31/10)**

**Local Public Applicant Agencies
Non-Profit Applicants**

COMPETITIVE GRANT APPLICATION INFORMATION

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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 parts – an electronic component submitted via the Internet Website: ODH Application Gateway – GMIS 2.0 which includes various paper forms and attachments. All the required parts of a specific application must be completed and submitted by the application due date. **Any required part that is not submitted on time will result in the entire application not being considered for review.**

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 (GAPP) Manual. This manual must be followed to ensure adherence to the rules, regulations and procedures for preparation of all subgrantee applications. The GAPP Manual is available on the ODH Website <http://www.odh.ohio.gov>. (Click on “Funding Opportunities” [located under At a Glance]; click on “ODH Grants” and then click on “GAPP Manual.”)
- B. Application Name:** Safety Net Dental Care Program.
- C. Purpose:** The purpose of the Safety Net Dental Care Program is to provide access to comprehensive and emergency dental care services for a significant number of Ohioans who cannot 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/underinsured 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 Attachment #2, Budget Planning Worksheets. The program will help support efficient clinics that cannot otherwise financially support the mission of serving the uninsured/underinsured. Funds may be requested to partially offset the cost of clinic operations in providing care to uninsured/underinsured patients, primarily personnel costs and other operating expenses (e.g. supplies). In limited situations, ODH may approve funding for the purchase of equipment. The Ohio Department of Health, Bureau of Oral Health Services 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. All applicant agencies must attend or document in writing prior attendance at GMIS 2.0 training and must have the capacity to accept an electronic funds transfer (EFT).
- E. Service Area:** A Safety Net Dental Care program may be designed to serve a city, county, combination of counties, school districts, or other area *defined by governmental subdivision or standard levels of geography (e.g., county, city, or township, census tracts, census block groups, census block.)*

- F. Number of Grants and Funds Available:** A range of \$851,455 to \$1,270,155 is available to be awarded to an anticipated 15-20 Safety Net Dental Care programs for the first year of funding (1/1/2010–12/31/2010). Funding for each of the continuation budget periods (1/1/2011–12/31/2011 and 1/1/2012–12/31/2012) will be based on the availability of funds. Eligible agencies may apply for funding in the competitive grant budget period (1/1/2010–12/31/2010) for a maximum award of \$65,000.

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:** Applications including any required forms and required attachments mailed or electronically submitted via GMIS 2.0 are due by **Monday, October 19, 2009**. Attachments and/or forms sent electronically must be transmitted by the application due date. Attachments and/or forms mailed that are non-Internet compatible must be postmarked or received on or before the application due date.

Please contact Mona Taylor, Oral Health Access Program Coordinator, at 614.466.4180 or by email at Mona.Taylor@odh.ohio.gov with any questions.

- H. Authorization:** Authorization of funds for this purpose is contained in Amended Substitute House Bill 1 and 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 Program 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 at high risk for dental disease. Those at high risk include, but are not limited to those who are low-income, minority and/or geographically isolated. A substantial portion of the program funding is allocated to support programs that serve the Maternal and Child Health (MCH) population (women of childbearing age, up to 45 years, and children through age 21 years).

- J. Program Period and Budget Period:** The program period will begin January 1, 2010 and end on December 31, 2012. The budget period for this application is January 1, 2010 through December 31, 2010.

- K. Local Health Districts Improvement Standards:** This grant program will address Local Health Districts Improvement Goal 5 – “Address the Need for Personal Health Services,” Standard 3701-36-08-02 – “Information is available that describes the local health system, including resources critical for public health protection and information about healthcare providers, facilities and support services.” The Local Health District Improvement Standards are available on the ODH Website <http://www.odh.ohio.gov>. (Click on “Local Health Departments” then “Local Health Districts Improvement Standards,” then click “Local Health District Improvement

Goals/Standards/Measures.”)

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 Local Health Districts Improvement Standards.

1. *Public Health Impact Statement Summary* - Applicant agencies are required to submit a summary of the program to local health districts prior to submitting the grant application to ODH. The program summary, not to exceed one page, must include:
 - a) The Local Health District Improvement Standard(s) to be addressed by grant activities:
 - A description of the demographic characteristics (e.g., age, race, gender, ethnicity) of the target population and the geographical area in which they live (e.g. census tracts, census blocks, block groups;
 - A summary of the services to be provided or activities to be conducted; and,
 - A plan to coordinate and share information with appropriate local health districts.

The applicant must submit the above summary as part of their 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 Local Health Districts Improvement 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 when the program summary is submitted with the grant application. If an applicant agency has a regional and/or statewide focus, a statement of support must be submitted from at least one local health district, if available

M. Statement of Intent to Pursue Health Equity Strategies

The ODH is committed to the elimination of health inequities. All applicant agencies must submit a statement which outlines the intent of this application to address health disparities. This statement should not exceed 1 ½ pages and must: (1) explain the extent in which health disparities are manifested within the health status (e.g., morbidity and/or mortality) or health system (e.g., accessibility, availability, affordability, appropriateness of health services) focus of this application; (2) identify specific group(s) who experience a disproportionate burden for the disease or health condition addressed by this application; and (3) identify specific social and environmental conditions which lead to health disparities (social determinants). This statement must be supported by data. The following section will provide a basic

framework and links to information to understand health equity concepts. This information will also help in the preparation of this statement as well as respond to other portions of this application. **(Required for competitive cycle only; not required for continuation cycle, if unchanged)**

- ***Basic Health Equity Concepts:***

Certain groups in Ohio experience a disproportionate burden with regard to the incidence, prevalence and mortality of certain diseases or health conditions. These are commonly referred to as **health disparities**. Health disparities are not mutually exclusive to one disease or health condition and are measurable through the use of various public health data. Most health disparities affect groups marginalized because of socioeconomic status, race/ethnicity, sexual orientation, gender, disability status, geographic location or some combination of these factors. People in such groups also tend to have less access to resources like healthy food, good housing, good education, safe neighborhoods, freedom from racism and other forms of discrimination. These are referred to as **social determinants**. Social determinants are necessary to support optimal health. The systematic and unjust distribution of social determinants among these groups is referred to as **health inequities**. As long as health inequities persist, marginalized groups will not achieve their best possible health. The ability of marginalized groups to achieve optimal health (like those with access to social determinants) is referred to as **health equity**. Public health interventions that incorporate social determinants into the planning and implementation of programs will contribute to the elimination of health disparities. For more resources on health equity, please visit the ODH website at:

<http://www.healthyohioprogram.org/healthequity/equity.aspx>.

N. Appropriation Contingency: Any award made through this program is contingent upon the availability of funds for this purpose. **In view of this, the subgrantee agency must be prepared to cover the costs of operating the program in the event of a delay in grant payments.**

O. Programmatic, Technical Assistance and Authorization for Internet Submission: Initial authorization for Internet submission will be distributed at your GMIS 2.0 Training Session (new agencies). All other agencies will receive their authorization upon the posting of the Request for Proposal to the ODH Website. Please contact Mona Taylor, Oral Health Access Program Coordinator, at 614.466.4180 or by email at Mona.Taylor@odh.ohio.gov for questions regarding this RFP.

Applicant must attend or must document, in writing, prior attendance at GMIS 2.0 training in order to receive authorization for Internet submission.

Please note: There will be a Bidders' Conference held in the Columbus area to provide guidance and answer questions related to the RFP. Registration information is included in the Notice of Availability of Funding or by contacting Mona Taylor

[contact information in Section I (O)].

- P. Acknowledgment:** An ‘Application Submitted’ status will appear in GMIS 2.0 that acknowledges ODH system receipt of the application submission.
- Q. Late Applications:** Applications are dated the time of actual submission via the Internet utilizing GMIS 2.0. 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 October 19, 2009.

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 Administration, Central Master Files; but they must be delivered by 4:00 p.m. on the application due date. FAX attachments will not be accepted. **GMIS 2.0 applications and required application attachments received late will not be considered for review.**

- R. Successful Applicants:** Successful applicants will receive official notification in the form of a “Notice of Award” (NOA). The NOA, issued under the signature of the Director of Health, allows for expenditure of grant funds.
- S. Unsuccessful Applicants:** Within 30 days after a decision to disapprove or not fund a grant application for a given program period, written notification, issued under the signature of the Director of Health, or his designee shall be sent to the unsuccessful applicant.
- T. 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. Describes specific 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 request for proposal;
 - 9. Has demonstrated acceptable past performance in areas related to**

- programmatic and financial stewardship of grant funds; and**
- 10. Has demonstrated compliance to GAPP, Chapter 100.**
 - 11. Explicitly identifies specific groups in the service area who experience a disproportionate burden of the diseases or health condition(s) and explains the root causes of health disparities.**

Programs will include a scoring sheet and/or provide further details of scoring.

Safety Net Dental Care Program 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 percentage of the 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 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.
4. 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 program) and yields a number of patient visits equivalent to, or more than, a full-time practice (approximately 2500 patient visits per full-time dentist per year and 1300 patient visits per full-time dental hygienist per year. A proportionally reduced number of patient visits is allowable for school programs based on the program's actual provider FTE).
5. Comprehensive dental care is the coordinated delivery of the total dental care required to meet each patient's oral health needs, recognizing that there often are a range of alternatives to restore function and freedom from pain and infection. Clinical comprehensive dental care services provided must include:
 - a. Diagnosis/preventive care (e.g. exams, x-rays, cleanings, fluoride treatments, sealants). Program demonstrates 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.
 - 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) when essential.
6. Services are available at convenient hours (e.g. evenings, weekends) for the patients.
7. Program demonstrates a commitment to make dental care accessible by:
 - a. Billing Medicaid or the appropriate Medicaid-managed care plan for all eligible services provided;
 - b. Using funds collected from Medicaid to support the dental program;
 - c. Utilizing a sliding fee schedule (SFS) or offering other fee arrangements that makes care affordable for low-income patients; and
 - d. Assuring that no one is denied care based on an inability to pay.
8. For Federally Qualified Health Centers (FQHCs), Section 330 grant funds should provide partial support to the dental clinic(s) (indicated on Budget Planning Worksheets).
9. Accurate information about all sources of revenue and expenses must be reflected on the Budget Planning Worksheets.
10. Efficient clinic operation as demonstrated by the reasonable and measurable key indicators as specified in Attachment #2, Budget Planning Worksheets.
11. ODH may require programs to obtain technical assistance from a source with substantial experience in evaluating and advising safety net dental clinics in order to identify strengths and weaknesses and improve operational efficiencies and/or grant reporting. In such cases, ODH must approve selection of the technical assistance provider.
12. Safety Net programs that have received technical assistance through the Oral Health Capacity Building (OHCB) program should address how they have implemented the recommendations and/or how they plan to address them during the 2010 grant funding period. The OHCB project is a collaborative effort between the ODH and three Ohio charitable foundations. The implementation plans should be clearly articulated and prioritized based on the consultants' report, and should include a timeline.

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

Grant applications will not be considered without:
Attachment #1-A: 2010 Safety Net Dental Care Program Information Report;

Attachment #1-B: 2010 Safety Net Dental Care Program Methodology Supplement;
Attachment #1-C (if applicable): 2010 Safety Net Dental Care Target School/Grade Report; and

Attachment #2: Budget Planning Worksheets

Please note: An electronic version of these items will be provided upon availability of the RFP on the ODH Web site and receipt of Notice of Intent to Apply. **Complete the electronic version of these items for the proposal, not the hard copy example of Attachments #1-A, #1-B, #1-C (if applicable), and #2.**

Further details of how proposals will be evaluated by the grant review team are provided in Appendix #1, Safety Net Dental Care Program Application Review Form.

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 request for proposals. **There will be no appeal of the Department's decision.**

- U. **Freedom of Information Act:** The Freedom of Information Act and the associated Public Information Regulations (45 CFR Part 5) of the U. S. Department of Health and Human Services 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 to be an unwarranted invasion of personal privacy will not be disclosed. For specific guidance on the availability of information, refer to 45 CFR Part 5.

- V. **Ownership Copyright:** Any work produced under this grant will be the property of the Ohio Department of Health/Federal Government. The department's ownership will include copyright. The content of any material developed under this grant **must** be approved in advance by the awarding office of the ODH. All material(s) must clearly state:

Funded by Ohio Department of Health/Federal Government
Bureau of Oral Health Services
Safety Net Dental Care Program

- W. **Reporting Requirements:** Successful applicants are required to submit subgrantee program and expenditure reports. Reports must adhere to the ODH, GAPP manual. Reports must be received before the department will release any additional funds.

Note: Failure to assure quality of reporting such as submitting incomplete and/or late program or expenditure reports will jeopardize the receipt of agency flexibility status and/or further payments.

Reports shall be submitted as follows:

- 1. Program Reports:** Subgrantee Program Reports **must** be completed and submitted **via the Subgrantee Performance Evaluation System (SPES)** by the following dates: April 15, 2010, July 15, 2010, October 15, 2010 and January 15, 2011. Any paper non-Internet compatible report attachments must be submitted to Central Master Files by the specific report due date. Bureau of Oral Health Services electronic report forms will be provided for reporting via SPES attachment. **Program Reports that do not include required attachments (non-Internet submitted) will not be approved.** All program report attachments must clearly identify the authorized program name and grant number.

Submission of Subgrantee Program Reports via the ODH's SPES indicates acceptance of the ODH GAPP.

- 2. Subgrantee Program Expenditure Reports:** Subgrantee Program Expenditure Reports **must** be completed and submitted **via GMIS 2.0** by the following dates: April 15, 2010, July 15, 2010, October 15, 2010 and January 15, 2011.

Submission of Subgrantee Program Expenditure Reports via the ODH's GMIS 2.0 system indicates acceptance of ODH GAPP. Clicking the "Approve" button signifies your authorization of the submission as an agency official and constitutes your electronic acknowledgment and acceptance of GAPP rules and regulations.

- 3. Final Expenditure Reports:** A Subgrantee Final Expenditure Report reflecting total expenditures for the fiscal year must be completed and submitted **via GMIS 2.0** on or before February 15, 2011. The information contained in this report must reflect the program's accounting records and supportive documentation. Any cash balances must be returned with the Subgrantee Final Expense Report. The Subgrantee Final Expense Report serves as an invoice to return unused funds.

2010 Budget Reporting Worksheets (electronic) that reflect actual revenues, expenditures and key indicators for the Safety Net Dental Care Program are required to be completed and submitted via GMIS 2.0 attachment by February 15, 2011.

Submission of the Subgrantee Final Expenditure Report via the GMIS 2.0 system indicates acceptance of ODH GAPP. Clicking the "Approve" button signifies authorization of the submission by an agency official and constitutes electronic acknowledgment and acceptance of GAPP rules and regulations.

- 4. Inventory Report:** A listing of all equipment purchased in whole or in part with **current** grant funds (Equipment Section of the approved budget) must be submitted via GMIS 2.0 as part of the Subgrantee Final Expenditure Report. At least once every two years, inventory must be physically inspected by the

subgrantee. Equipment purchased with ODH grant funds must be tagged as property of ODH for inventory control. Such equipment may be required to be returned to ODH at the end of the grant program period. An Equipment Inventory Form provided by the Bureau of Oral Health Services must be submitted as a GMIS 2.0 attachment by February 15, 2011.

- X. Special Condition(s):** Responses to all special conditions **must be submitted via GMIS 2.0 within 30 days of receipt of the first quarter payment.** A Special Conditions link is available for viewing and responding to special conditions. This link is viewable only after the issuance of the subgrantee's first payment. The 30 day time period, in which the subgrantee must respond to special conditions, will begin when the link is viewable. Failure to submit satisfactory responses to the special conditions or a plan describing how those special conditions will be satisfied will result in the withholding of any further payments until satisfied.

Submission of response to grant special conditions via the ODH's GMIS 2.0 system indicates acceptance of ODH GAPP. Checking the "selection" box and clicking the "approve" button signifies authorization of the submission by an agency official and constitutes electronic acknowledgment and acceptance of GAPP rules and regulations.

- Y. 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; but must be used solely for the purpose as specified in this announcement;
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. Lump sum indirect or administrative costs;
6. Contributions to a contingency fund;
7. Entertainment;
8. Fines and penalties;
9. Membership fees -- unless related to the program and approved by ODH;
10. Interest or other financial payments;
11. Contributions made by program personnel;
12. Costs to rent equipment or space owned by the funded agency;
13. Inpatient services;
14. The purchase or improvement of land; the purchase, construction, or permanent improvement of any building;
15. Satisfying any requirement for the expenditure of non-federal funds as a condition for the receipt of federal funds;
16. Travel and meals over the current state rates (see OBM Website: <http://obm.ohio.gov/MiscPages/Publish/TravelPolicy.aspx>);
17. Costs related to out-of-state travel, unless otherwise approved by ODH, and

- described in the budget narrative;
18. Training longer than one week in duration, unless otherwise approved by ODH;
 19. Contracts for compensation with advisory board members;
 20. Grant-related equipment costs greater than \$300, unless justified and approved by ODH;
 21. Payments to any person for influencing or attempting to influence members of Congress or the Ohio General Assembly in connection with awarding of grants.

Use of grant funds for prohibited purposes will result in the loss and/or recovery of those funds.

- Z. Audit:** *Subgrantees currently receiving funding from the ODH are responsible for submitting an independent audit report that meets OMB Circular A-133 requirements, 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 not later than 9 months after the end of the subgrantee's fiscal year.*

Subgrantees that have an agency fiscal year that ends on or after January 1, 2004 (and expend \$500,000 or more in federal awards per fiscal year) are required to have a single audit. 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 Circular A-133.

Subgrantees that have an agency fiscal year that ends on or after January 1, 2004 which expend less than the \$500,000 threshold require a financial audit conducted in accordance with Generally Accepted Government Auditing Standards. The financial audit is not an allowable cost to the program.

Once an audit is completed, **a copy must be sent to the ODH, Grants Administration, Central Master Files address within 30 days.** Reference: *GAPP Chapter 100, Section 108 and OMB Circular A-133, Audits of States, Local Governments, and Non-Profit Organizations for additional audit requirements.*

Subgrantee 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;
- Summarizes a Corrective Action Plan (CAP) to address the findings. A copy of the CAP should be attached to the cover letter.

AA. Submission of Application:

The GMIS 2.0 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
 - Cash Needs
 - Justification
 - Personnel
 - Other Direct Costs
 - Equipment
 - Contracts
 - Compliance Section D
 - Summary
5. Civil Rights Review Questionnaire (EEO Survey)
6. Assurances Certification
7. Attachments as required by Program:
 - Attachments #1-A, #1-B, #1-C (if applicable)
 - Attachment #2 Budget Planning Worksheets
 - Position Descriptions
 - Copies of proof of current licensure or certifications required for safety net program professional staff that are required to be licensed or certified
 - Letters of support
 - Copy of full fee schedule by CDT code
 - List of 20 most frequent procedures by CDT code
 - Copy of sliding fee schedule
 - Floor plan of dental clinic

An original and one copy of the following forms, available on GMIS 2.0, must be completed, printed, signed in blue ink with original signature by the Agency Head or Agency Financial Head and mailed to the address listed below:

**Complete,
Sign &
Mail To
ODH**

1. Electronic Funds Transfer (EFT) Form **(Required if new agency, thereafter only if banking information has changed.)**
2. IRS W-9 Form **(Required if new agency, thereafter only when tax identification number or agency address information has changed.) One of the following forms**

must accompany the IRS W-9 Form:

- a. Vendor Information Form (**New Agency Only**)
- b. Vendor Information Change Form (**Existing Agency with tax identification number, name and/or address change(s).**)
- c. Change request in writing on Agency letterhead (**Existing Agency with tax identification number, name and/or address change(s).**)

Two copies of the following documents must be mailed to the address listed below:

**Copy &
Mail To
ODH**

1. Public Health Impact Statement (**for competitive cycle only; for continuation, only if changed**)
2. Statement of Support from the Local Health Districts (**for competitive cycle only; for continuation, only if changed**)
3. Liability Coverage (**Non-Profit Organizations only; proof of current liability coverage and thereafter at each renewal period**)
4. Evidence of Non-Profit Status (**Non-Profit Organizations only; for competitive cycle only; for continuation, only if changed**).

One copy of the following documents must be mailed to the address listed below:

**Complete
Copy &
Mail To
ODH**

1. Current Independent Audit (latest completed organizational fiscal period; **only if not previously submitted**)
2. Declaration Regarding Material Assistance/Non Assistance to a Terrorist Organization (DMA) Questionnaire (**Required by ALL Non-Governmental Applicant Agencies**)
3. An original and one (1) copy of **Attachments** (non-Internet compatible) as required by program: **NONE**

**Ohio Department of Health
Grants Administration
Central Master Files, 4th Floor
246 N. High Street
Columbus, Ohio 43215**

II. APPLICATION REQUIREMENTS AND FORMAT

Access to the on-line GMIS 2.0, will be provided after GMIS 2.0 training for those agencies requiring training. All others will receive access after the RFP is posted to the ODH Website.

All applications must be submitted via GMIS 2.0. Submission of all parts of the grant application via the ODH's GMIS 2.0 system indicates acceptance of ODH GAPP. Submission of the Application signifies authorization by an agency official and constitutes electronic acknowledgment and acceptance of GAPP 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 pages 10 and 11 of the RFP for unallowable costs.

Match or Applicant Share is not required by this program. Do not include Medicaid income, match or Applicant Share in the budget and/or the Applicant Share column of the Budget Summary. Only the narrative and Budget Planning Worksheets (Attachment #2) may be used to identify additional funding information from other resources. [An interactive electronic version of the worksheets will be provided to an agency upon receipt of Notice of Intent to Apply for Funding. Use the electronic version for the proposal, not the hard copy example of Attachment #2]

- 1. **Primary Reason and Justification Pages:** Provide a detailed budget justification narrative that describes how the categorical costs are derived. Discuss the necessity, reasonableness, and allocability of the proposed costs. Describe the specific functions of the personnel, consultants and collaborators. Explain and justify equipment, travel, (including any plans for out-of-state travel), supplies and training costs. If you have joint costs refer to GAPP Chapter 100, Section 103 and the Compliance Section D (9) of the application for additional information.
- 2. **Personnel, Other Direct Costs, Equipment and Contracts:** Submit a budget with these sections and form(s) completed as necessary to support costs for the period January 1, 2010 to December 31, 2010.

Funds may be used to support personnel, their training, travel (see OBM Web site <http://obm.ohio.gov/MiscPages/Publish/TravelPolicy.aspx> and supplies directly related to planning, organizing and conducting the Initiative/program activity described in this announcement.

When appropriate, retain all contracts on file. The contracts should not be sent to

ODH. A completed “Confirmation of Contractual Agreement” (CCA) form must be submitted via GMIS 2.0 for each contract once it has been signed by both parties. The submitted CCA must be approved by ODH before contractual expenditures are authorized.

Submission of the “Confirmation of Contractual Agreement” (CCA) via the ODH’s GMIS 2.0 system indicates acceptance of ODH GAPP. Clicking the “Approve” button signifies authorization of the submission by an agency official and constitutes electronic acknowledgement and acceptance of GAPP rules and regulations. CCAs cannot be submitted until after the 1st quarter grant payment has been issued.

Where appropriate, itemize all equipment (**minimum \$300 unit cost value**) to be purchased with grant funds in the Equipment Section.

3. **Compliance Section D:** Answer each question on this form as accurately as possible. Completion of the form ensures your agency’s compliance with the administrative standards of ODH and federal grants.
 4. **Funding, Cash Needs and Budget Summary Sections:** Enter information about the funding sources and forecasted cash needs for the program. Distribution should reflect the best estimate of need by quarter. Failure to complete and balance this section will cause delays in receipt of grant funds.
- C. **Assurances Certification:** Each subgrantee must submit the Assurances (Federal and State Assurances for Subgrantees) form. This form is submitted as a part of each application via GMIS 2.0. 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 subgrantee agency agrees by electronic acknowledgment to the financial standards of conduct as stated therein.
- D. **Project Narrative: (limit: 7 pages)**
1. **Executive Summary: (One page limit, see Example of Executive Summary, Appendix #2):** Identify the target population, services and programs to be offered and what agency or agencies will provide those services. Describe the public health problems that the program will address. Describe the program goals, caries risk assessment, preventive services and treatment planning guidelines that will be used to reach and serve 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:
 - o the number to receive comprehensive care (Attachment #1, Part 1-A., Item 2a)

- the number to receive diagnostic/preventive care only (Attachment #1, Part 1-A, Item 2b.
- the number to receive emergency care only (Attachment #1, Part 1-A, Item 2c)
- the average number of clinic hours per week for restorative care (Attachment #1, Part 1-A, Item 1)
- the average number of clinic hours per week for preventive care
- anticipated program income and how it is estimated
- total budget and proportion represented by this grant (Attachment #2, Budget Planning Worksheets, summary page).

2. Description of Applicant Agency/Documentation of Eligibility/Personnel: Briefly discuss the applicant agency's eligibility to apply. Describe how the agency's mission relates to the purposes of this grant. 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.

Note any personnel or equipment deficiencies that will need to be addressed in order to carry out this grant. Describe plans for hiring and training, as necessary. Delineate all personnel who will be directly involved in program activities. Include the relationship between program staff members, staff members of the applicant agency, and other partners and agencies that will be working on this program. Include position descriptions for these staff.

3. Problem/Need: Identify and describe the local health status concern that will be addressed by the program. Do not restate national and state data. The specific **health status concerns that the program intends to address may be stated in terms** of untreated dental caries and/or those with an unmet need for dental care (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, methods that will be utilized to assess the caries risk of individuals and the risk-appropriate caries prevention plans. Include copies of the full fee schedule and the sliding fee schedule or other fee arrangement that makes care affordable for low-income patients. Include a description of other agencies/organizations also addressing dental care access for the target population. Describe the next nearest source of care and the barriers to your target population and how your program will address the barriers. [A list of Schools Which Meet Eligibility Criteria is available upon request for school-based, school-linked programs.]

Explicitly describe segments of the target population who experience a disproportionate burden of the local health status concern (this information must correlate with the Statement of Intent to Pursue Health Equity Strategies.)

- 4. Methodology:** In narrative form, identify the program goals, *Specific, Measureable, Attainable, Realistic & Time-Phased (SMART) process, impact, or outcome objectives* and activities. Demonstrate the ability to provide comprehensive and emergency dental care services for the target population who would not receive dental care otherwise. Describe how the program will meet the comprehensive dental care needs of the population to be served, as opposed to serving primarily patients who only receive emergency or diagnostic/preventive services. *Describe how program activities will address health disparities.* Provide an overview of the implementation plan and complete a program activities timeline to identify program activities (grouped by objective) and the start and completion date of each (Attachment #1, Part 1-B: Safety Net Dental Care Program Methodology supplement). Indicate how progress toward meeting goals and objectives will be evaluated to determine the level of success of the program. Document a plan for identifying patients covered by Medicaid/Medicaid Managed Care Plans and for billing the appropriate third party for services provided. Describe an accessible, productive and efficient clinic function, in terms of:
- facility capacity (i.e. number of operatories);
 - staffing (FTE dentists, dental assistants, dental hygienists, business office staff, etc.);
 - practices and/or plans for recruitment, training and retention of personnel;
 - hours of operation for providing dental care;
 - scope of services provided and accessibility of safety net dental clinic location to target population;
 - quality assurance plan;
 - key indicators that reflect an efficient, productive operation.
- E. Civil Rights Review Questionnaire - EEO Survey:** The Civil Rights Review Questionnaire (EEO) Survey is a part of the Application Section of GMIS 2.0. Subgrantees must complete the questionnaire as part of the application process. This questionnaire is submitted automatically with each application via the Internet.
- F. Attachment(s):** Attachments are documents deemed necessary to the application that are not a part of the GMIS 2.0 system. 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 Administration Central Master Files address on or before October 19, 2009. All attachments must clearly identify the authorized program name and program number. **A minimum of an original and one (1) copy of non-Internet attachments are required.**

- G. Electronic Funds Transfer (EFT) Form:** Print in PDF format and mail to ODH, Grants Administration, Central Master Files address. The completed EFT form **must be dated and signed, in blue ink, with original signatures.** Submit the original and one copy. **(Required only if new agency, thereafter only when banking information has changed.)**
- H. Internal Revenue Service (IRS) W-9 and Vendor Forms:** Print in PDF format and mail to ODH, Grants Administration, Central Master Files address. The completed IRS W-9 form **must be dated and signed, in blue ink, with original signatures.** Submit the original and one copy. **(Required if new agency, thereafter only when tax identification number or agency address information has changed.) One of the following forms must accompany the IRS, W-9:**
- 1. Vendor Information Form (New Agency Only), or**
 - 2. Vendor Information Change Form (Existing Agency with tax identification number, name and/or address change(s).)**
 - 3. Change request in writing on Agency letterhead (Existing Agency with tax identification number, name and/or address change(s).)**

Print in PDF format and mail to ODH, Grants Administration, Central Master Files address. The completed appropriate Vendor Form **must be dated and signed, in blue ink, with original signatures.** Submit the original and one copy of each.

- I. Public Health Impact Statement Summary:** Submit two copies of a one-page program summary regarding the impact to proposed grant activities on the Local Health Districts Improvement Standards **(for competitive cycle only; for continuation, only if changed).**
- J. Public Health Impact & Intent to Pursue Health Equity Statements:** Submit two copies of the response/statement(s) of support from the local health district(s) to your agency's communication regarding the impact of the proposed grant activities on the Local Health Districts Improvement Standards and [Intent to Pursue Health Equity Statements](#). If a statement of support from the local health district is not available, indicate that and submit a copy of the program summary your agency forwarded to the local health district(s).
- K. Liability Coverage:** Liability coverage is required for all non-profit agencies. Non-profit organizations **must** submit documentation validating current liability coverage. Submit two copies of the Certificate of Insurance Liability **(Non-Profit Organizations only; current liability coverage and thereafter at each renewal period.)**
- L. Non-Profit Organization Status:** Non-profit organizations **must** submit documentation validating current status. Submit two copies of the Internal Revenue Services (IRS) letter approving non-tax exempt status.

M. Declaration Regarding Material Assistance/Non-Assistance to a Terrorist Organization (DMA) Questionnaire: The DMA is a questionnaire that must be completed by all non-governmental grant applicant agencies to certify that they have not provided “material assistance” to a terrorist organization (Sections 2909.32, 2909.33 and 2909.34 of the Ohio Revised Code). The completed DMA Questionnaire **must be** dated and signed, in blue ink, with the Agency Head’s signature. The DMA Questionnaire (in PDF format. [Adobe Acrobat](http://www.adobe.com/products/acrobat) is required) is located at the Ohio Department of Public Safety /Ohio Homeland Security website:

<http://www.publicsafety.ohio.gov/links/HLS0038.pdf>

- Print a hard copy of the form once it has been downloaded. The form must be completed in its entirety and your responses must be truthful to the best of your knowledge. **(Required by all Non-Governmental Applicant Agencies.)**

N. Attachments as Required by Program: A single attachment containing an interactive version of Attachments #1, Parts A, B and C, and #2 will be provided to the applicant agencies via e-mail upon receipt of a Notice of Intent to Apply for Funding. These attachments must be submitted via GMIS 2.0 by the due date, Monday, October 19, 2009.

1. Attachment #1, Part 1-A: Year 2010 Access to Dental Care Program Information Report
2. Attachment #1, Part 1-B: Access to Dental Care Methodology Supplement
3. Attachment #1, Part 1-C (if applicable): Target School/Grade Report (for school-based/school-linked programs only)
4. Attachment #2: Budget Planning Worksheets
5. Position Descriptions (Include for all positions to be paid through program funds.)
6. Copies of proof of current licensure or certifications required for professional staff that are required to be licensed or certified.
7. Letters of support: Include letters of support from local agencies and program partners that indicated their acceptance of this proposed program and describe specific commitments to the program.
8. Copy of full fee schedule by CDT code
9. List of 20 most frequent procedures by CDT code
10. Copies of Sliding Fee Schedule
11. Copies of dental clinic floor plan

III. APPENDICES

- A.** GMIS 2.0 Training Form
- B.** Safety Net Dental Care Application Review form
- C.** Example – Executive Summary
- D.** Reference Materials for Completing Application
 - 1. For School-based, School-linked Programs:
Schools Which Meet Eligibility Criteria, Appendix #3A is available upon request to the Bureau of Oral Health Services. Please contact Mona Taylor, RDH, BS, Oral Health Access Program Coordinator at Mona.Taylor@odh.ohio.gov or 614-466-4180.
 - 2. Valuable references on the Web:
<http://www.dentalclinicmanual.com> addresses the many considerations in operating a dental clinic; and,
<http://www.mobile-portabledentalmanual.com> discusses the start-up and operation of mobile and/or portable dental programs.

Ohio Department of Health
GMIS 2.0 TRAINING

**ALL INFORMATION REQUESTED MUST BE COMPLETED for EACH EMPLOYEE
FROM YOUR AGENCY WHO WILL ATTEND A GMIS 2.0 TRAINING SESSION.**
(Please Print Clearly or Type)

Grant Program _____ RFP Due Date _____

County of Applicant Agency _____

Federal Tax Identification Number _____

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 and as listed, if applicable, currently in GMIS.

Applicant Agency/Organization _____

Applicant Agency Address _____

Agency Employee to attend training _____

Telephone Number _____

E-mail Address _____

GMIS 2.0 Training Authorized by: _____
(Signature of Agency Head or Agency Fiscal Head)

Required
Please Check One:

_____ Yes – I ALREADY have access to the
ODH GATEWAY (SPES, ODRS, LHIS, etc)

_____ No – I DO NOT have access to the ODH GATEWAY

Please indicate your training date choices: 1st choice _____, 2nd choice _____, 3rd choice _____

Mail, E-mail, or Fax To:

GAIL BYERS
Grants Administration Unit
Ohio Department of Health
246 N. High Street
Columbus, Ohio 43215
E-mail: gail.byers@odh.ohio.gov **Fax: 614-752-9783**

CONFIRMATION OF YOUR GMIS 2.0 TRAINING SESSION WILL BE E-MAILED TO YOU

APPENDIX B

SAFETY NET DENTAL CARE PROGRAM APPLICATION REVIEW FORM

Reviewers will assess compliance with each category. The numbered items in each category will help the reviewers with the assessment of that category.

- A.** Overall quality of application
 - 1. Clarity
 - 2. Completeness
 - 3. Adherence to RFP guidance

- B.** Program will contribute to the improved health of Ohioans
 - 1. Target population:
 - a. Individuals are at high risk for dental disease, with high-risk including, but not limited to low-income, minority and/or geographic isolation
 - b. Children are served without a minimum age restriction.
 - c. If applicable, schools/school districts meet BOHS eligibility criteria
 - 2. Estimate number of targeted population to receive services:
 - a. Projected number to receive care is based on reasonable assumptions which are clearly articulated in the proposal.
 - b. Include the percentage of the MCH population (children, through age 21 years and women of childbearing age, up to age 45) and the percentages of minority populations to be served.

- C.** Program has well-developed plan for accomplishing objectives
 - 1. Describes specific measurable objectives for Years 2 and 3.
 - 2. Describes reasonable and efficient plan for accomplishing objectives.
 - 3. If adding more staff or operatories, provides a timeline through which proposed activities can reasonably be accomplished within the budget period, including the date that the new facility/additional operatory is expected to be open/available).
 - 4. For applicants that participated in the Oral Health Capacity Building technical assistance project, recommendations from performance improvement plan are provided and incorporated into the proposed grant activities.

- D.** Budget and narrative
 - 1. Anticipated program expenditures are clearly explained and provide detail on how calculations for individual budget items were determined.
 - 2. The required Budget Planning Worksheets (SFY 2008) are completed.
 - 3. Budget is appropriate for completing the proposed plan.
 - 4. Budget elements are consistent with other information in application (e.g., staff time budgeted is consistent with amount of time needed to accomplish objectives).

APPENDIX B

5. Full fee schedules and sliding fee scale/fee arrangements make dental care affordable for low-income patients (copies of each must be included with proposal).
 6. Staffing plan results in opportunity for underserved populations to access care, without impacting dental care services already present in the community.
- E. Evidence of support**
1. Letters of support and/or commitment from community agencies and partners in this grant program.
 2. Success of efforts to leverage ODH dollars with funds and resources from other sources.
 3. Applicant share (not a requirement but demonstrates commitment to the program). Only the budget narrative and Budget Planning Worksheets may be used to describe applicant share, e.g., FQHC Section 330 funding, health levy funds.
 4. Budget Planning Worksheets demonstrate that for FQHCs (Federally Qualified Health Centers), Section 330 grant funds provide partial support to the dental clinic(s).
 5. Program proposal does not supplant existing funds.
- F. Program is responsive to concerns and objectives of the Safety Net Dental Care Program**
1. Adequate quality assurance mechanisms are in place
 2. Applicant provides a realistic plan for, and commitment to, sustaining the program after the grant period.
- G. Extent to which the proposal's objectives are consistent with BOHS objectives and plan**
1. Demonstrates a commitment to providing diagnostic and preventive services (specific services and frequency of recall visits) based on individual patient risk assessment.
 2. Hours of availability of clinical dental care is available at least 36 hours per week and program provides a number of patient visits equivalent to a full-time practice (at least 2500 patient visits per full-time dentist per year).
 3. Extent to which convenient appointment hours are offered.
 4. Extent to which care provided will be comprehensive, rather than emergency only or diagnostic/preventive only.
 5. Comprehensiveness (scope) of services offered.
 6. Extent to which program reports billing and collecting Medicaid/Medicaid Managed Care Plan reimbursement for which it is eligible.
 7. Extent to which applicant documents collaboration with other agencies within the community or in neighboring communities, as appropriate.

APPENDIX C

EXAMPLE: Executive Summary

ODH funds requested: \$65,000 for clinical operations.
It is anticipated that the project will serve 3000 patients 1/1/10 – 12/31/10.

The Jones County Safety Net Dental Care Program will provide preventive, diagnostic, and restorative dental services for people who have considerable difficulty in accessing private dental care. The Jones County population is 18% African-American, 2% Asian and 80% White, with 6% reporting Hispanic ethnicity. At least 75% of the target population to be served will be Maternal and Child Health (MCH) patients (children through age 21 years and women of childbearing age up to age 45 years).

The clinic is a well-known source of care to the community and is promoted in Prenatal, Well Child and WIC clinics. Patients will be assessed for their caries risk using the guidelines in the *ADA Caries Diagnosis and Risk Assessment: A Review of Preventive Strategies and Management* and will receive preventive services on an individual basis, consistent with those guidelines. Basic restorative care will be provided in the clinic. Specialty care such as endodontics and oral surgery (beyond simple extractions) will be referred to community dentists who have agreed to offer reduced fees.

We anticipate that a total of 3000 patients will receive diagnostic and necessary preventive and restorative services during the 2010 calendar year. Project staff of 1.5 FTE dentists, 3.0 FTE dental assistants and a 0.5 FTE dental hygienist will work, on site at the Jones County Health Department. The dental clinic will provide restorative services 2,650 hours per year (including two evenings/week and two Saturdays/month) and has four fully equipped operatories, donated by local businesses. The program will comply with all applicable federal, state, and local codes related to the provision of dental care.

Jones County Health Department contracts with all three Medicaid Managed Care Plans in the county and will bill for Medicaid (ODJFS) fee-for-service patients as well. All other patients will be billed for services using a sliding fee scale, with a minimum payment of \$15 per visit. If a patient has private insurance, the clinic will bill the insurance company. This grant will represent 22% of the clinic's \$447,000 budget (includes requested grant funds). Other funding sources are The Smith Family Foundation (\$52,000), patient fees and insurance (\$60,000), Medicaid/Medicaid Managed Care (\$110,000) and a health levy (\$125,000). The required attachments including letters of support, position descriptions, copies of staff's current required licenses/certifications and copies of the dental clinic floor plan, full fee schedule and sliding fee schedule and Attachments #1 (Parts 1-A, 1-B, & 1-C) and #2 (budget planning worksheets) are included in the GMIS 2.0 submission.

APPENDIX D

OHIO DEPARTMENT OF HEALTH BUREAU OF ORAL HEALTH SERVICES

2010 SAFETY NET DENTAL CARE GRANT

Reference Materials

1. PROPOSALS THAT INCLUDE SCHOOL-BASED, SCHOOL-LINKED PROGRAMS: Schools Which Meet Eligibility Criteria for 2010 BOHS Grants (Free and Reduced Price Meal Program)

Appendix #3A is available upon request to the Bureau of Oral Health Services. Please contact Mona Taylor, Oral Health Access Program Coordinator at 614-466-4180 or by e-mail at Mona.Taylor@odh.ohio.gov.

2. VALUABLE REFERENCES AVAILABLE ON THE WEB:

<http://www.dentalclinicmanual.com> addresses the many considerations in starting or expanding a dental clinic. This manual was developed collaboratively by the Ohio Department of Health, Bureau of Oral Health Services, the Association of State and Territorial Dental Directors and the Indian Health Service. The required Budget Planning Worksheets were modified from this resource.

The Ohio Dental Safety Net Information Center (ODSNIC) Web site, <http://ohiodentalclinics.com>, is a new one-stop-shop for information of interest to those who operate safety net clinics and those who want to learn about them. The ODSNIC links directly to a large array of tools such as The Safety Net Dental Clinic Manual (above) and includes distance learning opportunities (CE).

At <http://www.mobile-portabledentalmanual.com>, a Mobile-Portable Dental Manual is available regarding the start-up and operation of mobile and/or portable dental programs.

2010 SAFETY NET DENTAL CARE PROGRAM INFORMATION REPORT
Attachment #1 Part 1-A
 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; 12-1 lunch,1-6)

Monday
 Tuesday
 Wednesday
 Thursday
 Friday
 Saturday

2. Provide an estimate of the number of patients in each category for whom your program will provide clinical dental care services. (Include all patients. Therefore, if your program serves 2,000 patients but ODH funds represent 10% of the budget, you should report all 2,000 patients.)

- a) the **number** to receive comprehensive dental care
- b) the **number** to receive diagnostic/preventive care **only**
- c) the **number** to receive emergency care **only**

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. 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:

6. What are the number of operatories:

- a) per dentist per typical clinic session?
- b) per dental hygienist per typical clinic session?
- c) that are unused for a significant amount of time?

7. 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.

8. Is there a dental assistant and/or dental hygienist who is trained in Expanded Functions (EFDA)?

Yes:
No:

9. Describe scheduling practices (e.g., length of appointment determination, double-booking appointments):

10. Describe your agency's broken appointment/"no show" policy:

11. What is your dental clinic's current rate of broken appointment/"no shows"?

50%

--

12. What is the goal and method to improve the broken appointment/"no show" rate?

13. How are cancelled appointments (cancelled at least 24 hrs. before scheduled appointment time) filled?

14a. How long does it take to get an appointment for:
a new patient?
recall?
emergency?
follow-up restorative care?

14b. Is there a waiting list?

Yes:
No:

If yes, how many names are on it?

15. How does your office handle emergency patients, with regard to the daily schedule?

16. 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):

17a. Are productivity reports generated on a regular basis?

Yes:
No:

17b. If so, how frequently?

17c. Is practice management software used?

Yes:
No:

If yes, name of software:

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**DIRECTIONS FOR USING THE 2010 SAFETY NET DENTAL CARE GRANT
BUDGET PLANNING WORKSHEETS (1/1/10 - 12/31/10)
Attachment #2**

There are four budget worksheets contained in this file (Attachment #2). Each worksheet has a tab below. Click on the tab to activate the worksheet.

PLEASE NOTE:

COMPLETE THIS FOR THE GRANT BUDGET PERIOD OF TWELVE MONTHS.

Please be certain to submit this revised file with your application.

- STEP 1** Open the Expenses worksheet. **Type your program name and GMIS number in cell A1** (automatically enters this information in the other worksheets). Complete the **unshaded** cells. Column F should represent the total budget, while column G should reflect only the amount to be budgeted to this grant. The amount budgeted to this ODH grant may be equal to the Total Program Budget in GMIS if you are not including any project income in the GMIS 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 the money you are requesting from ODH for the Safety Net Dental Care grant in your estimated grant 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 the Bureau of Oral Health Services at 614 466-4180 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.

SPECIAL

NOTE: Similar forms, completed to reflect actual revenues and expenditures by revenue source and patient type, will be due in successful applicants' end of grant year report on February 15, 2011. Forms will be sent to each grantee, via e-mail, approximately 4-6 weeks prior to the due date.

INSERT PROGRAM-SPECIFIC ESTIMATES IN UN-SHADED CELLS

EXPENSES					Total Program Budget	Amount budgeted to this ODH grant
I. Start-up Costs						
Construction/Remodeling Cost						
# of square feet		0			\$0	\$0
Cost per square foot		\$0				
Dental Equipment Costs						
Large Equipment (See Dental Clinic Comparison Chart in Ch. 2) or enter your own figures per dental supply company					\$0	\$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	\$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
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(s)		\$0	0%	0.0	\$0	\$0
Dental Hygienist(s)		\$0	0%	0.0	\$0	\$0
Dental Assistants		\$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--list:					\$0	\$0
					\$0	\$0
Miscellaneous Operating Expenses Subtotal					\$0	\$0
TOTAL START-UP EXPENSES					\$0	\$0
TOTAL ANNUAL OPERATING EXPENSES					\$0	\$0
TOTAL EXPENSES BUDGETED TO ODH GRANT					\$0	\$0

Program Name & GMIS #		Attachment #2: 2010 Safety Net Dental Care Grant 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	\$0	\$0
Sliding Fee Schedule		0%	0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Minimum		0%	0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Commercial Insurance :											
Indemnity (Fee-for-service)		0%	0	\$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	\$0	\$0	\$0	\$0	\$0	\$0
Non-Medicaid Revenue Subtotal					\$0					\$0	
B. Medicaid											
ODJFS Fee-for-Service		0%	0	\$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
FQHCs and look-alikes only:											
ODJFS wrap-around (FQHCs only)					\$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	
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 grant)										\$0	
REVENUE (ALL SOURCES - excluding ODH Safety Net grant)										\$0	

Program Name & GMIS #

Attachment #2: **2010 Safety Net Dental Care 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

ODJFS wraparound (FQHCs & look-alikes only) \$0

Prospective Payment System (FQHCs & look-alikes only)--PPS \$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 .

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--list: \$0

0 \$0

0 \$0

Miscellaneous Operating Expenses Subtotal \$0

The Bottom Line

Non-patient Care REVENUE	\$0	TOTAL START-UP EXPENSES	\$0
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Patient Care REVENUE	\$0	TOTAL ANNUAL OPERATING EXPENSES	\$0
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SHORT

\$0.00

Amount budgeted to this ODH grant (from Expenses worksheet)

\$0.00