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| OPTIONAL APPLICATION TEMPLATE |
| APPLICATION DUE DATE:  Instructions: If using the template complete all sections. Completed applications must be submitted to via e-mail or mailed hard copy. If mailed, the application must be submitted to the and received by. The envelope should be clearly marked to:  WA State Department of Health BCCHP  310 Israel RD, SE PO Box 47855 Olympia, WA 98504-7855  Email to: |

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| Applicant Contact Information | |
| Health Center | Click here to enter text. |
| Contact Name & Title | Click here to enter text. |
| Contact Email | Click here to enter text. |
| Address | Click here to enter text. |
| Phone | Click here to enter text. |
| FED ID # | Click here to enter text. |

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| SECTION 1: Proposal Summary (5 Points) | |
| Applying for:  Breast & Cervical funding Colorectal funding | |
| Total Amount Requested for grant period | B&C: $ Click here to enter text.  CRC: $ Click here to enter text. |

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| SECTION 2: Organization Description and History (25 Points) |
| Describe the history of the health center, its structure, information about clinic locations that will be participating in the grant, and major accomplishments of the health center.  Click here to enter text. |
| Describe experience and any evidence of success in implementing quality improvement projects related to breast and cervical cancer screening. If the cancer screening project is new, describe relevant experience with other quality improvement projects.  Click here to enter text. |
| Describe the organizational commitment for improving breast and cervical cancer screening rates. This can include leadership support, similar activities, and/or alignment with the strategic plan.  Click here to enter text. |
| Describe the stage of Meaningful Use that the majority (more than half) of your participating providers are at currently (i.e., what is the stage for which they most recently received payments). |

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| Click here to enter text. |
| *Eligibility Requirements*   1. The health center attests that it is in good standing with Health Resources and Services Administration (HRSA) and that there are no unresolved or pending conditions.   Yes No   1. The health center attests that it is Patient Centered Medical Home (PCMH) recognized, accredited, or certified. (Level 2 or 3 if applicable)   Yes  No  If applicable, what level are you recognized? Click here to enter text.   1. The health center attests that it has a certified Electronic Health Record software system.1   Yes  No  Vendor: Click here to enter text. Version: Click here to enter text.  Are there any plans to upgrade to a new version or change EHR vendor in the next year?  Click here to enter text.   1. The health center currently uses or commits to using a Food and Drug Administration (FDA) approved breast and cervical cancer screening method recommended by the US Preventative Services Task Force (USPSTF)   Yes  No |

1 CEHRT certification

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| SECTION 3: Statement of Work (50 Points Total) |
| *Background- Provide an explanation of the problem that has created the need for the funding. (20 Points)* |
| Current Breast Cancer Screening rate: Click here to enter text.% as of (date) Click here to enter a date.  Based on: UDS HEDIS Other: Click here to enter text.  Current Cervical Cancer Screening rate: Click here to enter text.% as of (date) Click here to enter a date.  Based on: UDS HEDIS **☐** Other: Click here to enter text. |
| What is your geographic catchment area in Washington? Please describe any priority populations for your health center :  Click here to enter text. |
| How many patients aged 50-74 are eligible to be screened for breast cancer? Click here to enter text.  How many patients aged 50-74 will be included in the grant? Click here to enter text.  How many patients aged 21-64 are eligible to be screened for cervical cancer? Click here to enter text.  How many patients aged 21-64 will be included in the grant? Click here to enter text. |
| Are there populations the health center intends to focus for this grant funding? If so, which populations and why? Use any applicable race, ethnicity, and/or socioeconomic status data.  Click here to enter text. |

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| *Project Description* – *Describe the project and provide information on how it will be implemented. For definitions, please reference Appendices 1-3 of the Request for Funding Application. (30 Points)* |
| Please check all Priority EBIs2 that health center plans to implement using this funding.  Patient (Client) Reminders -  B&C Provider Reminders -  B&C  Provider Assessment & Feedback -  B&C Reducing Structural Barriers -  B&C |
| Please check all Supportive Activities that health center plans to implement using this funding. (see Appendix 1 in RFA for descriptions)  Small media -  B&C  Patient Navigation (through initial screening) -  B&C  Patient Navigation (to follow up care—diagnostic & treatment) -  B&C Partnering with other organizations-  B&C  Staff training related to screening - B&C  Outreach activities (radio spots, health fairs, social media, etc.) -  B&C  Other: (please describe) Click here to enter text.  B&C |
| Describe the project goals and objectives  Click here to enter text. |

2 Evidence Based Intervention (EBI)

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| Selected Priority EBI (complete for those that your health center plans to implement/continue using grant funding): | What data measures (metrics) will your CRC Team use to monitor effectiveness of this intervention? | Planned steps with approximate implementation dates (rough outline) |
| EXAMPLE:  *Reducing Structural Barriers through MammoVan program*  *(all Clinics in health center— to be phased in over the course of the project year)* | *Metrics: On a monthly basis, reports will be run based on EMR data for breast cancer screening rate, abnormal rate, # of follow-ups completed, status of patients referred to follow up/tx* | *Sept 1—Start development of intro letters, instructions, and determine reporting needs & tracking metrics*  *Nov 15—Complete arrangements with contracted facilities for mobile unit dispatch/dates*  *Jan 1--Begin scheduling patients on MammoVan on a monthly basis*  *April 30—Assess implementation and plan PDSAs to improve processes* |
| 1)  Click here to enter text. | Click here to enter text. | Click here to enter text. |
| 2)  Click here to enter text. | Click here to enter text. | Click here to enter text. |
| 3) if applicable  Click here to enter text. | Click here to enter text. | Click here to enter text. |

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| 4) if applicable  Click here to enter text. | Click here to enter text. | Click here to enter text. |
| Total number of clinics that will be/are participating in grant activities: Click here to enter text.  List the names AND locations of the clinics that are or will be participating in the grant activities:  *(example: 1) Seattle Med, 123 Main Street, Seattle)*  Click here to enter text. | | |
| List the staff who will be responsible for the implementation of grant related activities. Describe their qualifications, certifications and/or skills relevant to this project.  Click here to enter text. | | |
| List the partners that your health center intends to collaborate with on this project. Describe how you plan to partner with them.  Click here to enter text. | | |

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| SECTION 4: Ability to Fulfill Contract (10 Points) |
| Describe the health center’s fiscal capacity to pay costs related to this project ‘up front’ and be reimbursed within 30-60 days.  Click here to enter text. |
| SECTION 5: PROPOSED BUDGET (10 Points) |
| In the Budget Narrative, explain proposed expenditures and how costs were determined. Justify all requested items and clearly show how they relate to the proposed service. Only enter amounts for those items which are anticipated to need funding, based upon the selected EBIs. Note: We reserve the right to award partial funding. |
| Budget Narrative (500-750 words):  Click here to enter text. |
| Proposed Budget: Provide an itemized list of your costs needed to complete the activities listed in the application. Justify all requested items and clearly show how they relate to the proposed service. This can be attached separately or pasted below. Note that direct payment of clinical services like mammography or a pap or purchase of clinical equipment are not allowed. |