***COMMONWEALTH OF MASSACHUSETTS***

***EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES***

***OFFICE OF MEDICAID***

***ONE ASHBURTON PLACE, 11TH FLOOR***

***BOSTON, MA 02108***

**ATTACHMENT A**

**BEHAVIORAL HEALTH URGENT CARE** **EXPANSION GRANT APPLICATION**

**TABLE OF CONTENTS**

[SECTION 1 APPLICATION 3](#_Toc136872501)

[1.1 Applicant Profile 3](#_Toc136872502)

[1.2 Proposal 3](#_Toc136872503)

[SECTION 2 Conflicts of Interest 5](#_Toc136872504)

[SECTION 3 Behavioral Health Urgent Care Grant Budget 6](#_Toc136872505)

[3.1 Budget Request 6](#_Toc136872506)

[3.2 Narrative Form 6](#_Toc136872507)

[SECTION 4 Implementation Plan 7](#_Toc136872508)

[4.1 Timeline: 7](#_Toc136872509)

# APPLICATION

All information requested on the application must be supplied. If any question or request is not applicable to an Applicant’s proposal, the Applicant must indicate that it is not applicable by writing “N/A.”

Each application must include, at a minimum, the following information provided in the form, format, and manner requested through the Grant Solicitation on COMMBUYS:

## Applicant Profile

|  |  |
| --- | --- |
| Name of Applicant Organization | Click or tap here to enter text. |
| Parent Company Name (If Applicable) | Click or tap here to enter text. |
| Primary Contact PersonFirst Name, Last Name, title | Click or tap here to enter text. |
| Address | Click or tap here to enter text. |
| Phone | Click or tap here to enter text. |
| Email | Click or tap here to enter text. |
| Secondary Contact Person: (If Any)First Name, Last Name, title | Click or tap here to enter text. |
| Address | Click or tap here to enter text. |
| Phone | Click or tap here to enter text. |
| Email | Click or tap here to enter text. |
| NPI # (MMARS Vendor Code) | Click or tap here to enter text. |
| Total Grants Funds Requested. Note:(Please Round To The Nearest Thousand) | Click or tap here to enter text. |

## Proposal

Please provide responses to the following questions using no more than 2 pages, single spaced, 12-point font to respond to each question.

1. Describe the proposed use of grant funding including how this grant funding will help your organization become a Behavioral Health Urgent Care provider.
2. Describe your proposed outreach or communications plan to promote your services as a Behavioral Health Urgent Care provider under this grant.
3. What steps has your organization already taken to become a Behavioral Health Urgent Care provider? What are the barriers that you faced to becoming a BHUC provider and how, specifically, will these funds help you overcome those barriers?
4. Describe your current clients, potential clients, and community, including whether your organization already provides services to communities with particular cultural/linguistic or Deaf/Hard of Hearing need.
5. Describe how grant funding will allow your organization to increase services you provide to community members with cultural/linguistic or Deaf/Hard of Hearing needs.
6. Describe your proposed budget and how the funds from this grant will be used to achieve the grant goals.

Click or tap here to enter text.

# Conflicts of Interest

Please disclose any interests, including interests of any vendor identified in an Applicant’s application as expected to perform specific work in the proposed Qualifying Program or experience specific benefits from the proposed Qualifying Program, that may conflict with the performance of services required under any Contract resulting from this Grant Solicitation, or that may be otherwise anti-competitive, as determined by EOHHS.

EOHHS may require the Applicant to submit any additional relevant information regarding its financial, legal, contractual or other business interests, including those of any vendors identified in an Applicant’s application as expected to perform specific work in the proposed Qualifying Program or experience specific benefits from the proposed Qualifying Program.

If EOHHS in its sole judgment determines that an Applicant, including of any vendor identified in an Applicant’s application as expected to perform specific work in the proposed Qualifying Program or experience specific benefits from the proposed Qualifying Program, possesses a conflicting interest, EOHHS may propose or consider any proposal of the Applicant for any measures that would eliminate or mitigate such conflicting interest to EOHHS’s satisfaction.

Click or tap here to enter text.

# Behavioral Health Urgent Care Grant Budget

## Budget Request

Please fill in the Budget Request Form for the costs of developing and implementing your program. Additional rows can be added to accommodate additional activities and costs.

Description of Funds should be a brief description of the budget item (ex. retention bonuses; advertising; subscription to job boards; professional development.). The Budget Narrative should be utilized to provide a more comprehensive detail of each item.

|  |  |
| --- | --- |
| ***Description of Funds***  | ***Fiscal Year Costs*** |
| ***FY24*** | ***FY25*** |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
| ***Total Budget Request***  | ***$*** | ***$*** |

## Narrative Form

Please provide any additional information that is not included above but will help to explain how your agency will use funds to become a Behavioral Health Urgent Care provider.

Click or tap here to enter text.

# Implementation Plan

## Timeline:

Please add your implementation plan that your agency is using to complete the requirements and become a Behavioral Health Urgent Care provider. You may add additional rows.

|  |  |  |  |
| --- | --- | --- | --- |
| **Activity/ Task** | **Description** | **Start Date** | **End Date** |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |