CharitableHealthcare Network
Funding Request
Technology Development &
Quality of Care Development

SECTION 1

Clinic Name	
Executive Director/CEO	
Executive Director Phone	
Executive Director Email	
Clinic Address	
City/State/Zip	
Clinic Phone Number	
County Service Area	
Address that checks should be mailed to	
Primary Grant Contact and Title	
Grant Contact Phone Number	
Grant Contact Email	
Grant Request Amount **(Not to exceed $20,000.00 per project)**	

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SECTION 2

1. Are you applying for the **Technology Development Grant**, the **Quality of Care Development Grant** or **both**?

2. If you are applying for both funding opportunities, both requests will be considered, but depending on the number of applications, it is possible that only one request will get funded. If we are able to fund only one request, which one would you prefer get funded?

Please refer to the instruction sheet attached and complete the appropriate funding request that follows.

SECTION 3

TECHNOLOGY DEVELOPMENT

1. You are applying for this grant funding because: (check only one)

_____ You currently have no EHR

_____ You have an EHR, but you want to change to a different system

_____ You are seeking funding to maintain your current system

_____ Other reasons

2. If you are replacing an existing system with a new or different system, explain why you are replacing it. **(500 word limit)**

3. Provide a detailed narrative describing your specific technology needs. **(500 word limit**)

4. What are your SMART goals and anticipated outcomes with this funding? You may have up to three (3) goals. **(500 word limit)**

5. Provide a detailed implementation plan including a timeline with a six (6) month benchmark. **(1,000 word limit**)

6. What key staff will be involved in this project and what will their role be? **(500 word limit)**

7. What challenges do you anticipate and how do you plan to overcome them? Challenges may be related to staff (resistance to change), patients (concerns about data collection) or any other challenges you anticipate. **(500 word limit)**

8. What will the impact of improved technology be on your organization? **(500 word limit)**

9. Please provide a detailed budget for this project.

Expense Item	Amount From CHN	Amount from Other Sources	Total

10. Please attach a copy of your board-approved operating budget.

11. Will you want or need assistance identifying affordable hardware, software and/or IT Development?

SECTION 4

QUALITY OF CARE DEVELOPMENT GRANT

Refer to the instruction sheet for detailed explanation of the funding categories.

There are three (3) areas of performance that will be funded. They are:

- Preventative Care
- Chronic or acute care
- Utilization measurers affecting health care costs

1. Please provide a narrative describing the one Quality of Care performance area that you want to address in your clinic. **(750 word limit)**

2. Why is this performance area important to your practice? **(500 word limit)**

3. What are your SMART goals and anticipated outcomes? You may have up to three (3) goals. **(500 word limit)**

4. Provide a detailed implementation plan including a timeline with a six (6) month benchmark. **(1,000 word limit)**

5. Based on your SMART goals, what is your current baseline for the improvement measure you want to improve? **(500 word limit).** You may use the baseline chart at the end of the application as a **template**.

6. What key staff will be involved in this project and what will their role be? (**500 word limit)**

7. What challenges do you anticipate and how do you plan to overcome them? Challenges may be related to staff (resistance to change), patients (compliance or knowledge deficit) or any other challenges you anticipate. **(500 word limit)**

8. What outcomes do you anticipate as a result of this program? Include specific outcomes based on your baseline data. **(500 word limit)**

9. Provide a detailed budget for this project.

Expense Item	Amount From CHN	Amount from Other Sources	Total

10. Please attach a copy of your board-approved operating budget for the current year.

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11. Template that may be used for gathering your baseline data.

Development Grant Baseline Data

Patient Population Characteristics					
	Total # in clinic	**# in the project**		**Total # in clinic**	**# in the project**
Number of Women			Number of patients White		
Number of Men			Number of patients Black or African American		
Number of Children			Number of patients Asian		
Number where gender is not tracked			Number of patients Hawaiian or Pacific Islander		
Number of patients uninsured			Number of patients American Indian		
Number of patients Medicaid			Number of patients more than one race		
Number of patients other insurance			Number not tracked by race		
Number not tracked by insured status					
BASELINE DATA - for 12 months before project begins					
Baseline data collected from EHR or Chart Audit?			Number of patients in project		
Baseline data start date (12 months before beginning project)			Number of patients that currently meet your goal		
Baseline end date					
Does your clinic **currently** have a policy in place addressing the Improvement area you want to address?					yes / no
Does your clinic have a process in place to determine the effectiveness of your implementation plan?					yes / no
** Data for patient demographics is based on your current practice.					