VERMONT
AGENCY OF HUMAN SERVICES

Application Introduction

Thank you for taking the time to complete this grant application from the Vermont Agency of Human Services (AHS). This application takes approximately 2 hours to complete if all information and documentation is gathered prior to entering content. You can preview the grant application questions and find more information about program requirements on the AHS website.

The Home and Community-Based Services (HCBS) Grant Opportunity is a pivotal initiative aimed at bolstering the quality, accessibility, and sustainability of Vermont's system of care for individuals and their families who rely on HCBS to lead independent and fulfilling lives. With an allocation of up to $21 million, this grant program serves as a catalyst for transformative improvements within the HCBS sector.

Instructions: Please ensure you have answered all sections of the application; incomplete applications may be considered ineligible. This grant application will be open from September 7, 2023, to October 12, 2023 at 5:00pm EDT. All responses are saved as they are entered, allowing applicants to start and stop as needed while using the same device to complete the application.

Some questions prompt applicants to submit optional supporting materials. There will be an opportunity for applicants to upload any supporting materials at the end of the application.

Questions are best directed to:

AHS.HCBSGrants@vermont.gov

Demographics

Application is being submitted by:

- Single organization
- Partnership between two organizations
- Partnership between more than two organizations

Lead Applicant Organization Business Legal Name:

Lead Applicant DBA (Doing Business As):

Lead Applicant Organization Physical Location

Street address

City

State

Zip Code

Lead Applicant Organization Mailing Address (if different than physical location)

Street address

City

State

Zip Code

Primary Point of Contact (Name, Role at Applicant Organization, Business Email, Phone #)

Name

Role

Business Email

Phone #

Secondary Point of Contact (Name, Role at Applicant Organization, Business Email, Phone #)

Name

Role

Business Email

Phone #

Partner Organization(s) Business Legal Name (more than one partner name can be entered below):

Partnership Point of Contact (Name, Role at Organization, Business Email, Phone #)

Name

Role at Organization

Business Email

Phone #

Name

Role at Organization

Business Email

Phone #

What is your organization type?

Note: If you are a Hospital, Community Health Center, or Healthcare Organization, System, or Network partnering with an HCBS Provider Organization, the HCBS Provider Organization must be the Lead Applicant and submit the application.

- HCBS Provider Organization
- Community-Based Organization
- Provider Membership Organization
- Educational Institution
- School District or School
- Workforce Development Organization

Select HCBS Provider Type (Check all that apply)

- Home Health Agencies
- Adult Day Facilities
- Agencies designated to provide mental health or developmental disability services, or both (Designated Agencies)

- Agencies with which the Commissioner of Mental Health or Disabilities, Aging, and Independent Living, or both, has contracted to provide specialized services (Specialized Service Agencies)
- Substance use treatment providers in the Department of Health's preferred provider network
- Area Agencies on Aging
- Therapeutic Community Residences
- Brain Injury Providers
- Family Supportive Housing Providers
- Durable Medical Equipment Providers
- Therapy Providers contracted by a Home Health Agency
- Assistive Community Care Services Providers
- Providers of Programs licensed by the Department of Children and Families as Residential Treatment Programs
- Medicaid-enrolled Parent Child Centers
- Children's Integrated Services Fiscal Agents
- Applied Behavior Analysis Providers

Proposals from Community-Based Organizations must demonstrate a strong linkage to Medicaid HCBS programs by meeting one of the following criteria. Please select all that apply:

- Our organization is partnering with an HCBS provider organization and will include a letter of partnership or memorandum of understanding with our application; and/or
- Our organization is piloting a service that is in the process of becoming a Medicaid HCBS service or program and can demonstrate a pathway to become a Medicaid HCBS provider; and/or,
- Our organization will demonstrate through our application that our proposal improves the quality of or access to a Vermont Medicaid HCBS service.

Your organization is partnering with an HCBS provider organization and is required to submit a letter of partnership or memorandum of understanding with your application. Please upload a letter of partnership or MOU from an HCBS provider below, name the document/s using the following naming convention: orgname_MOU_yyyy.mm.dd.

To upload more than one document for this question, please put your documents into a file and zip/compress the file. You can then upload the zip file.

Your organization is required to submit letters of commitment from HCBS providers to be eligible. Please upload a letter/letters of commitment below, name the document/s using the following naming convention: orgname_MOU_yyyy_mm_dd
There is capacity at the end of the application for additional uploads, if needed.

To upload more than one document for this question, please put your documents into a file and zip/compress the file. You can then upload the zip file.

Proposals from HCBS providers that partner with a Hospital, Community Health Center, or Healthcare Organization, System, or Network require documentation of partnership. If applicable, please upload a letter of intent or MOU below, name the document/s using

the following convention: orgname_MOU_yyyy_mm_dd

To upload more than one document for this question, please put your documents into a file and zip/compress the file. You can then upload the zip file.

National Provider Identifier (NPI) Number

10-digit NPI Number (Only if Medicaid Provider)

Not Applicable

Unique Entity Identifier (from SAM.GOV, 12-character alphanumeric UEI)

How long has your organization been serving individuals receiving HCBS services?

- 0-6 Months
- 7-12 Months
- 1-3 Years
- 4-10 Years
- 10+ Years
- My organization does not currently serve individuals receiving HCBS services.
- My organization supports the HCBS workforce.

How long has your organization been serving individuals receiving Medicaid?

- 0-6 Months
- 7-12 Months
- 1-3 Years
- 4-10 Years
- 10+ Years
- My organization does not currently serve individuals receiving HCBS services.
- My organization supports the workforce that serves individuals receiving Medicaid.

Does your organization receive payments from other payers in order to serve individuals receiving HCBS? (Check all that apply)

- Medicare
- Commercial
- Private
- My organization does not receive payments from other payers.

Grant Track Choice(s)

- Infrastructure Improvements
- Workforce Development

Care Model Innovation

Organizational Performance and Compliance

Grant Track Choice(s)

Workforce Development

Care Model Innovation

Organizational Performance and Compliance

Grant Track Choice(s)

Workforce Development

Infrastructure Improvements

What is the title of your Infrastructure Improvement proposal?

Provide a brief overview of the Infrastructure Improvement grant proposal and how it expands, enhances, or strengthens HCBS in Vermont. (250 words maximum)

Please provide an explanation of the issue the Infrastructure Improvement project seeks to address. Use applicable evidence and

data where available. Applicants may include links to data sources and/or attach data, photos etc. to their application. (250 words maximum)

What is the Infrastructure Improvement total grant amount requested?

	Round to the nearest dollar
Infrastructure Improvements (Minimum amount $50,000 - Maximum amount $1,800,000)	$ 0

Which of the following Infrastructure Improvement track goals does your proposal address? (Select all that apply).

- Enhance Service Delivery
- Expand Service Capacity
- Bolster HCBS System Stability

How will you measure the impact of your Infrastructure Improvement proposal on the goal(s) you selected above? Please provide at least two metrics that you will use to evaluate the impact. (500 word maximum)

List the activities that will be a part of the Infrastructure Improvement project. Explain how these activities align with the grant track's goals and objectives. (500 word maximum)

Who do you intend to benefit from this Infrastructure Improvement project? About how many people (general estimate) do you think will benefit from this project? (200 word maximum)

Infrastructure Improvement projects must take place in a setting that meets one of the following criteria. Please select which setting your proposal applies to:

Setting that is fully compliant with the HCBS Settings Criteria. (Please explain)

Setting that will become fully compliant with the HCBS Settings Criteria due to improvements funded through this grant opportunity. (Please explain)

Setting related to the delivery of Medicaid State Plan services in community-based non-residential settings. (Please explain)

As an Authorized Signatory, I attest that, if awarded, our Infrastructure Improvement project will continue to support the goals and objectives

outlined above in an approved setting for at least five years following the award.

Yes

No

From which types of entities will you require assistance (e.g., architects, contractors) for your Infrastructure Improvements? If you have entities identified, please list them here. Please provide documentation in the addendum.

Architects (Please explain)

Contractors (Please explain)

Technicians (Please explain)

Other (Please explain)

Does this Infrastructure Improvement project comply with relevant regulations, safety standards, and building codes including the ADA? Please include any evidence of adherence to these requirements as an addendum to this application.

Yes

No

Does this Infrastructure Improvement project increase energy efficiency?

- Yes
- No

Clearly outline the roles and contributions of each partner organization in the Infrastructure Improvement project. Explain how their expertise, resources, and support will enhance the project's implementation and outcomes. (500 word maximum)

Does your Infrastructure Improvement proposal reduce or address health disparities or improve health equity? Please explain below and use any data to support. (250 word maximum)

- Yes (Please explain)
- No

List the major milestones you expect to achieve throughout the Infrastructure Improvement project's duration. Break down your project into specific activities and assign estimated start and end dates for each. All projects must conclude by December 2024.

Quarter One Ending March 2024

Quarter Two Ending June 2024

Quarter Three Ending September 2024

Quarter Four Ending December 2024

Please briefly highlight the key challenges you believe your organization(s) will encounter in implementing your proposed Infrastructure Improvements project. All projects must conclude by December 2024.

Break down your Infrastructure Improvement budget into specific categories for Personnel Services. Please round up all amounts to the nearest dollar.

	Personnel Services
Salaries	$ 0
Fringe	$ 0
Contracted Staff	$ 0
Other	$ 0
#Conjoint, Total#	$ 0

For personnel costs for your Infrastructure Improvement project, list each position title, percentage of time towards grant funded by grant, percentage of time towards grant as in-kind support, and annual wage. If you have more than 10 staff members supporting this project, please upload additional information in the addendum.

	Percentage of time towards grant funded by grant	Percentage of time towards grant as in-kind support	Annual Wage
Position Title			
Position Title			
Position Title			
Position Title			
Position Title			

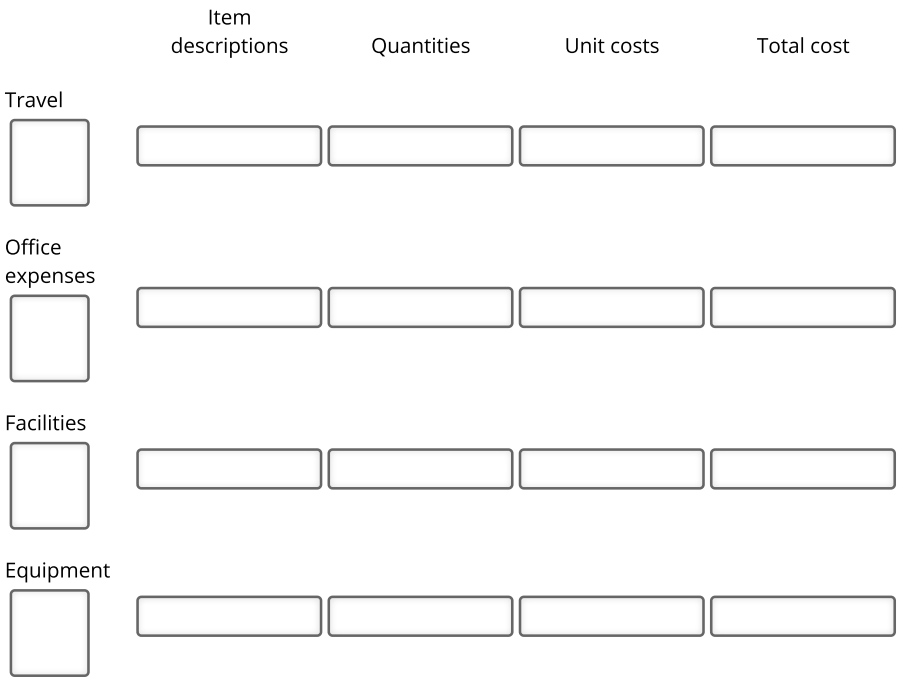
	Percentage of time towards grant funded by grant	Percentage of time towards grant as in-kind support	Annual Wage
Position Title			
Position Title			
Position Title			
Position Title			
Position Title			

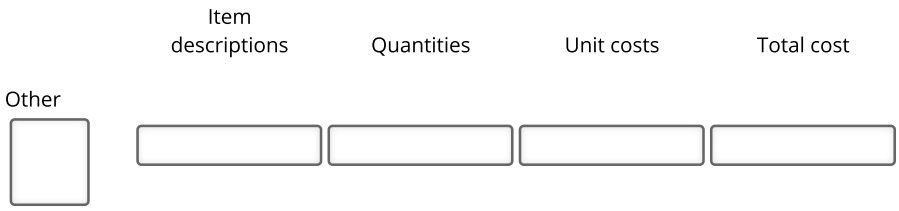
Break down your Infrastructure Improvement project's budget into specific categories for Operating Expenses. Please round up all amounts to the nearest dollar.

	Operating Expenses
Travel	$ 0
Office expenses	$ 0
Facilities	$ 0
Equipment	$ 0
Other	$ 0
Indirect (10% allowability)	$ 0
#Conjoint, Total#	$ 0

For Operating Expenses, for each budget category for your Infrastructure Improvement project, provide a detailed explanation of

the costs, including item descriptions, quantities, unit costs, and the total cost for each item.





Infrastructure Improvement projects are required to include 3rd party cost estimates for the scope of work (e.g., project quote from a contractor, Kelly Blue-Book estimate for a vehicle). Attach any bid/pricing information below. Please use the following naming convention: Orgname_Title of documentation_yyyy_mm_dd

To upload more than one document for this question, please put your documents into a file and zip/compress the file. You can then upload the zip file.

Is your organization (and/or partner organization) receiving or requesting any additional funding from AHS, its departments, or the federal government for the same purpose? (200 word maximum)

Yes (Please explain)

No

Is your Infrastructure Improvement proposal for a one-time expense or do you anticipate that it will create ongoing operating expenses beyond the grant award period?

One-time

Ongoing

Please explain how you plan to support ongoing Infrastructure Improvement operating expenses beyond the grant award period. If a sustainability plan or funding source has not been identified, please describe what steps or strategies you will take to meet ongoing funding needs. (250 word maximum)

Indicate any match funding or additional resources, including in-kind (if applicable), that will be contributed to the Infrastructure

Improvement project and how they will be utilized. (150 word maximum)

What methods will you use to collect relevant Infrastructure Improvement data for evaluation?

- Surveys
- Interview
- Focus groups
- Other data collection tools (Please explain)

Any additional relevant documentation supporting the Infrastructure Improvement proposal. Examples: MOUs, letters of commitment, bids, permits, photographs, supporting data, etc.

To upload more than one document for this question, please put your documents into a file and zip/compress the file. You can then upload the zip file.

Please rate your organization's capacity to carry out your Infrastructure Improvement project.

- Strong organizational capacity to carry out the proposed project.
- Moderate organizational capacity to carry out the proposed project.
- Limited organizational capacity to carry out the proposed project.
- Uncertain organizational capacity to carry out the proposed project.

Please rate your organization’s expertise in the field of HCBS and related services.

- Highly experienced and knowledgeable in the field of HCBS and related services.
- Moderately experienced and knowledgeable in the field of HCBS and related services.
- Limited experience and knowledge in the field of HCBS and related services.
- No demonstrated experience and knowledge in the field of HCBS and related services.

Please rate your organization’s sustainability plan for your Infrastructure Improvement project.

- Comprehensive and well-structured sustainability plan beyond the grant period.
- Partially developed sustainability plan with some strategies identified.
- Limited sustainability plan with few strategies identified.
- No clear sustainability plan outlined.
- Proposal is for a one-time expense and does not require a sustainability plan.

Workforce Development

What is the title of your Workforce Development proposal?

Provide a brief overview of the Workforce Development grant proposal and how it expands, enhances, or strengthens HCBS in Vermont. (250 words maximum)

Please provide an explanation of the issue the Workforce Development project seeks to address. Use applicable evidence and data where available. Applicants may include links to data sources and/or attach data, photos etc. to their application. (250 words maximum)

What is the Workforce Development total grant amount requested?

Round to the nearest dollar

Workforce Development (Minimum amount $50,000 - Maximum amount $1,000,000)

$ 0

Which of the following Workforce Development track goals does your proposal address? (Select all that apply).

- Expand training support and professional development opportunities.
- Foster employee recruitment, retention, and growth.
- Reduce administrative burden, improve staff experience, and enhance productivity through the purchase of equipment, software, and secure technology.

How will you measure the impact of your Workforce Development proposal on the goal(s) you selected above? Please provide at least

two metrics that you will use to evaluate the impact. (500 word maximum)

List the activities, modalities, and/or training title(s) that will be a part of the Workforce Development project. Explain how these activities align with the grant track's goals and objectives.

If a training will be provided, please include any available training description/syllabus as a website link or as an addendum to this application. (500 word maximum)

Who is your Workforce Development target audience? Check all that apply. (Please review the User Guide for more details regarding which types of HCBS providers are eligible.)

- Direct care workers
- Nursing Professionals
- Mental Health and Substance use Disorder Treatment Staff
- Therapists
- Community Health Workers
- Other HCBS staff necessary for ensuring high quality of care: (Please explain)

About how many people (general estimate) do you think will benefit from this Workforce Development project? Please explain. (200 word maximum)

Clearly outline the roles and contributions of each partner organization in the Workforce Development project. Explain how their expertise, resources, and support will enhance the project's implementation and outcomes. (500 word maximum)

Does your Workforce Development proposal reduce or address health disparities or improve health equity? Please explain below and use any data to support. (250 word maximum)

Yes (Please explain)

No

List the major milestones you expect to achieve throughout the Workforce Development project's duration. Break down your project into specific activities and assign estimated start and end dates for each. All projects must conclude by December 2024.

Quarter One Ending March 2024

Quarter Two Ending June 2024

Quarter Three Ending Septmeber 2024

Quarter Four Ending December 2024

Please briefly highlight the key challenges you believe your organization(s) will encounter in implementing your proposed Workforce Development project. All projects must conclude by December 2024.

Break down your Workforce Development budget into specific categories for Personnel Services. Please round up all amounts to the nearest dollar.

	Personnel Services
Salaries	$ 0
Fringe	$ 0
Contracted Staff	$ 0
Other	$ 0
#Conjoint, Total#	$ 0

For personnel costs for your Workforce Development project, list each position title, percentage of time towards grant funded by grant, percentage of time towards grant as in-kind support, and annual wage. If you have more than 10 staff members supporting this project, please upload additional information in the addendum.

	Percentage of time towards grant funded by grant	Percentage of time towards grant as in-kind support	Annual Wage
Position Title			
Position Title			
Position Title			
Position Title			

	Percentage of time towards grant funded by grant	Percentage of time towards grant as in-kind support	Annual Wage
Position Title			
Position Title			
Position Title			
Position Title			
Position Title			

	Percentage of time towards grant funded by grant	Percentage of time towards grant as in-kind support	Annual Wage
Position Title			

Break down your Workforce Development budget into specific categories for Operating Expenses. Please round up all amounts to the nearest dollar.

	Operating Expenses
Travel	$ 0
Office expenses	$ 0
Facilities	$ 0
Equipment	$ 0
Other	$ 0
Indirect (10% allowability)	$ 0

	Operating Expenses
#Conjoint, Total#	$ 0

For Operating Expenses, for each budget category, provide a detailed explanation of the costs, including item descriptions, quantities, unit costs, and the total cost for each item for your Workforce Development project.

	Item descriptions	Quantities	Unit costs	Total cost
Travel				
Office expenses				

	Item descriptions	Quantities	Unit costs	Total cost
Facilities				
Equipment				
Other				

Is your organization (and/or partner organization) receiving or requesting any additional funding from AHS, its departments, or the federal government for the same purpose? (200 word maximum)

Yes (Please explain)

No

Is your proposal for a one-time expense or do you anticipate that it will create ongoing operating expenses beyond the Workforce Development grant award period?

One-time

Ongoing

Please explain how you plan to support ongoing operating expenses beyond the Workforce Development grant award period. If a

sustainability plan or funding source has not been identified, please describe what steps or strategies you will take to meet ongoing funding needs. (250 word maximum)

Indicate any match funding or additional resources, including in-kind (if applicable), that will be contributed to the Workforce Development project and how they will be utilized. (150 word maximum)

What methods will you use to collect relevant Workforce Development data for evaluation?

- Surveys
- Interview
- Focus groups
- Other data collection tools (Please explain)

Any additional relevant documentation supporting the Workforce Development proposal. Examples: MOUs, letters of commitment, bids,

permits, photographs, supporting data, etc.
Please use the following naming convention: Orgname_Title of documentation_yyyy_mm_dd

To upload more than one document for this question, please put your documents into a file and zip/compress the file. You can then upload the zip file.

Please rate your organization's capacity to carry out your Workforce Development project.

- Strong organizational capacity to carry out the proposed project.
- Moderate organizational capacity to carry out the proposed project.
- Limited organizational capacity to carry out the proposed project.
- Uncertain organizational capacity to carry out the proposed project.

Please rate your organization’s expertise in the field of HCBS and related services.

- Highly experienced and knowledgeable in the field of HCBS and related services.
- Moderately experienced and knowledgeable in the field of HCBS and related services.
- Limited experience and knowledge in the field of HCBS and related services.
- No demonstrated experience and knowledge in the field of HCBS and related services.

Please rate your organization’s sustainability plan for your Workforce Development project

- Comprehensive and well-structured sustainability plan beyond the grant period.
- Partially developed sustainability plan with some strategies identified.
- Limited sustainability plan with few strategies identified.
- No clear sustainability plan outlined.
- Proposal is for a one-time expense and does not require a sustainability plan.

Care Model Innovation

What is the title of your Care Model Innovation proposal?

Provide a brief overview of the Care Model Innovation grant proposal and how it expands, enhances, or strengthens HCBS in Vermont. (250 words maximum)

Please provide an explanation of the issue the Care Model Innovation project seeks to address. Use applicable evidence and data where available. Applicants may include links to data sources and/or attach data, photos etc. to their application. (250 words maximum)

What is the Care Model Innovation total grant amount requested?

	Round to the nearest dollar
Care Model Innovation (Minimum amount $50,000 - Maximum amount $1,300,000	$ 0

Which of the following Care Model Innovation track goals does your proposal address? (Select all that apply).

Improve health and functional outcomes and enhance quality of life by addressing the Health-Related Social Needs of people with HCBS needs.

Reduce health disparities and inequities for individuals who use HCBS by implementing targeted interventions to improve outcomes for marginalized communities or populations that face health disparities.

Improve health and functional outcomes and enhance quality of life through implementation or expansion of evidence-based and evidence-informed health and wellness programs for individuals who use HCBS.

Improve care integration and continuity of care for people who use HCBS and have complex healthcare needs.

How will you measure the impact of your Care Model Innovation proposal on the goal(s) you selected above? Please provide at least two metrics that you will use to evaluate the impact. (500 word maximum)

List the activities that will be a part of the Care Model Innovation project. Explain how these activities align with the grant track's goals and objectives. If your proposal includes evidence-based or evidence-informed models, please include links or additional information in the addendum to this application. (500 word maximum)

If applicable, please describe what services are included in your proposed care model and the qualifications of the providers who deliver those services. (500 word maximum)

The target audience for this grant track includes individuals who meet at least one of the following descriptions:

- Individuals receiving Medicaid HCBS with identified Health-Related Social Needs that are at risk of experiencing adverse health outcomes.
- Individuals receiving Medicaid HCBS from marginalized communities or populations that face health disparities.
- Individuals receiving Medicaid HCBS that can benefit from evidence-based and evidence-informed health and wellness interventions.
- Individuals receiving Medicaid HCBS with complex healthcare needs that would benefit from integrated care models.

About how many people (general estimate) do you think will benefit from this Care Model Innovation project? Please explain (200 word maximum).

Clearly outline the roles and contributions of each partner organization in the Care Model Innovation project. Explain how their expertise, resources, and support will enhance the project's implementation and outcomes. (500 word maximum)

Does your Care Model Innovation proposal reduce or address health disparities or improve health equity? Please explain below and use any data to support. (250 word maximum)

Yes (Please explain)

No

List the major milestones you expect to achieve throughout the Care Model Innovation project's duration. Break down your project into specific activities and assign estimated start and end dates for each. All projects must conclude by December 2024.

Quarter One Ending March 2024

Quarter Two Ending June 2024

Quarter Three Ending September 2024

Quarter Four Ending December 2024

Please briefly highlight the key challenges you believe your organization(s) will encounter in implementing your proposed Care Model Innovation project(s). All projects must conclude by December 2024.

Break down your Care Model Innovation budget into specific categories for Personnel Services. Please round up all amounts to the nearest dollar.

	Personnel Services
Salaries	$ 0
Fringe	$ 0
Contracted Staff	$ 0
Other	$ 0
#Conjoint, Total#	$ 0

For personnel costs for your Care Model Innovation project, list each position title, percentage of time towards grant funded by grant, percentage of time towards grant as in-kind support, and annual wage. If you have more than 10 staff members supporting this project, please upload additional information in the addendum.

	Percentage of time towards grant funded by grant	Percentage of time towards grant as in-kind support	Annual Wage
Position Title			
Position Title			

	Percentage of time towards grant funded by grant	Percentage of time towards grant as in-kind support	Annual Wage
Position Title			
Position Title			
Position Title			
Position Title			
Position Title			

	Percentage of time towards grant funded by grant	Percentage of time towards grant as in-kind support	Annual Wage
Position Title			
Position Title			
Position Title			

Break down your Care Model Innovation budget into specific categories for Operating Expenses. Please round up all amounts to the nearest dollar.

	Operating Expenses
Travel	$ 0

	Operating Expenses
Office expenses	$ 0
Facilities	$ 0
Equipment	$ 0
Other	$ 0
Indirect (10% allowability)	$ 0
#Conjoint, Total#	$ 0

For Operating Expenses, for each budget category, provide a detailed explanation of the costs, including item descriptions, quantities, unit costs, and the total cost for each item for your Care Model Innovation project.

	Item descriptions	Quantities	Unit costs	Total cost
Travel				

	Item descriptions	Quantities	Unit costs	Total cost
Office expenses				
Facilities				
Equipment				
Other				

Is your organization (and/or partner organization) receiving or requesting any additional funding from AHS, its departments, or the federal government for the same purpose? (200 word maximum)

Yes (Please explain)

No

Is your proposal for a one-time expense or do you anticipate that it will create ongoing operating expenses beyond the Care Model Innovation grant award period?

One-time

Ongoing

Please explain how you plan to support ongoing operating expenses beyond the Care Model Innovation grant award period. If a sustainability plan or funding source has not been identified, please describe what steps or strategies you will take to meet ongoing funding needs. (250 word maximum)

Indicate any match funding or additional resources, including in-kind (if applicable), that will be contributed to the Care Model Innovation project and how they will be utilized. (150 word maximum)

What methods will you use to collect relevant Care Model Innovation data for evaluation?

- Surveys
- Interview
- Focus groups
- Other data collection tools (Please explain)

Any additional relevant documentation supporting the Care Model Innovation proposal. Examples: MOUs, letters of commitment, bids, permits, photographs, supporting data, etc.
Please use the following naming convention: Orgname_Title of documentation_yyyy_mm_dd

To upload more than one document for this question, please put your documents into a file and zip/compress the file. You can then upload the zip file.

Please rate your organization's capacity to carry out your Care Model Innovation project

- Strong organizational capacity to carry out the proposed project.
- Moderate organizational capacity to carry out the proposed project.
- Limited organizational capacity to carry out the proposed project.
- Uncertain organizational capacity to carry out the proposed project.

Please rate your organization’s expertise in the field of HCBS and related services

- Highly experienced and knowledgeable in the field of HCBS and related services.
- Moderately experienced and knowledgeable in the field of HCBS and related services.
- Limited experience and knowledge in the field of HCBS and related services.
- No demonstrated experience and knowledge in the field of HCBS and related services.

Please rate your organization’s sustainability plan for your Care Model Innovations project

- Comprehensive and well-structured sustainability plan beyond the grant period.
- Partially developed sustainability plan with some strategies identified.
- Limited sustainability plan with few strategies identified.
- No clear sustainability plan outlined.
- Proposal is for a one-time expense and does not require a sustainability plan.

Organizational Performance Improvement and Compliance

What is the title of your Organizational Performance Improvement and Compliance proposal?

Provide a brief overview of the Organizational Performance Improvement and Compliance grant proposal and how it expands, enhances, or strengthens HCBS in Vermont. (250 words maximum)

Please provide an explanation of the issue the Organizational Performance Improvement and Compliance project seeks to address. Use applicable evidence and data where available. Applicants may include links to data sources and/or attach data, photos etc. to their application. (250 words maximum)

What is the Organizational Performance and Compliance total grant amount requested?

	Round to the nearest dollar
Organizational Performance and Compliance (Minimum amount $30,000 - Maximum amount $600,000)	$ 0

Which of the following Organizational Performance Improvement and Compliance track goals does your proposal address? (Select all that apply).

- Adoption of Best Practices to Improve HCBS Access and Quality
- Improved Organizational Functioning
- Strengthened Partnerships
- Compliance with State and Federal Requirements

How will you measure the impact of your Organizational Performance Improvement and Compliance proposal on the goal(s) you selected above? Please provide at least two metrics that you will use to evaluate the impact. (500 word maximum)

Clearly outline the roles and contributions of each partner organization in the project. Explain how their expertise, resources, and support will enhance the Organizational Performance Improvement and Compliance project's implementation and outcomes. (500 word maximum)

List the activities that will be a part of the Organizational Performance Improvement and Compliance project. Explain how these activities align with the grant track's goals and objectives. If your proposal includes evidence-based or evidence-informed models, please include links or additional information in the addendum to this application. (500 word maximum)

Does your Organizational Performance Improvement and Compliance proposal reduce or address health disparities or improve health equity? Please explain below and use any data to support. (250 word maximum)

Yes (Please explain)

No

List the major milestones you expect to achieve throughout the Organizational Performance Improvement and Compliance project's duration. Break down your project into specific activities and assign estimated start and end dates for each. All projects must conclude by December 2024.

Quarter One Ending March 2024

Quarter Two Ending June 2024

Quarter Three Ending September 2024

Quarter Four Ending December 2024

Please briefly highlight the key challenges you believe your organization(s) will encounter in implementing your proposed Organizational Performance Improvement and Compliance project. All projects must conclude by December 2024.

Break down your Organizational Performance Improvement and Compliance budget into specific categories for Personnel Services. Please round up all amounts to the nearest dollar.

	Personnel Services
Salaries	$ 0
Fringe	$ 0
Contracted Staff	$ 0
Other	$ 0
#Conjoint, Total#	$ 0

For personnel costs for your Organizational Performance Improvement and Compliance project, list each position title, percentage of time towards grant funded by grant, percentage of time towards grant as in-kind support, and annual wage. If you have more than 10 staff members supporting this project, please upload additional information in the addendum.

	Percentage of time towards grant funded by grant	Percentage of time towards grant as in-kind support	Annual Wage
Position Title			
Position Title			
Position Title			
Position Title			
Position Title			

	Percentage of time towards grant funded by grant	Percentage of time towards grant as in-kind support	Annual Wage
Position Title			
Position Title			
Position Title			
Position Title			
Position Title			

Break down your Organizational Performance Improvement and Compliance budget into specific categories for Operating Expenses. Please round up all amounts to the nearest dollar.

	Operating Expenses
Travel	$ 0
Office expenses	$ 0
Facilities	$ 0
Equipment	$ 0
Other	$ 0
Indirect (10% allowability)	$ 0
#Conjoint, Total#	$ 0

For your Organizational Performance Improvement and Compliance project's Operating Expenses, for each budget category, provide a

detailed explanation of the costs, including item descriptions, quantities, unit costs, and the total cost for each item.

	Item descriptions	Quantities	Unit costs	Total cost
Travel				
Office expenses				
Facilities				
Equipment				

	Item descriptions	Quantities	Unit costs	Total cost
Other				

Is your organization (and/or partner organization) receiving or requesting any additional funding from AHS, its departments, or the federal government for the same purpose? (200 word maximum)

Yes (Please explain)

No

Is your proposal for a one-time expense or do you anticipate that it will create ongoing operating expenses beyond the Organizational Performance Improvement and Compliance grant award period?

One-time

Ongoing

Please explain how you plan to support ongoing operating expenses beyond the Organizational Performance Improvement and Compliance grant award period. If a sustainability plan or funding source has not been identified, please describe what steps or strategies you will take to meet ongoing funding needs. (250 word maximum)

Indicate any match funding or additional resources, including in-kind (if applicable), that will be contributed to the Organizational Performance Improvement and Compliance project and how they will be utilized. (150 word maximum)

What methods will you use to collect relevant Organizational

Performance Improvement and Compliance data for evaluation?

- Surveys
- Interview
- Focus groups
- Other data collection tools (Please explain)

Any additional relevant documentation supporting the proposal. Examples: MOUs, letters of commitment, bids, permits, photographs, supporting data, etc.
Please use the following naming convention: Orgname_Title of documentation_yyyy_mm_dd

To upload more than one document for this question, please put your documents into a file and zip/compress the file. You can then upload the zip file.

Please rate your organization’s capacity to carry out your Organizational Performance Improvement and Compliance project.

- Strong organizational capacity to carry out the proposed project.
- Moderate organizational capacity to carry out the proposed project.
- Limited organizational capacity to carry out the proposed project.
- Uncertain organizational capacity to carry out the proposed project.

Please rate your organization’s expertise in the field of HCBS and related services.

- Highly experienced and knowledgeable in the field of HCBS and related services.
- Moderately experienced and knowledgeable in the field of HCBS and related services.
- Limited experience and knowledge in the field of HCBS and related services.
- No demonstrated experience and knowledge in the field of HCBS and related services.

Please rate your organization’s sustainability plan for your Organizational Performance Improvement and Compliance project.

- Comprehensive and well-structured sustainability plan beyond the grant period.
- Partially developed sustainability plan with some strategies identified.
- Limited sustainability plan with few strategies identified.
- No clear sustainability plan outlined.
- Proposal is for a one-time expense and does not require a sustainability plan.

Risk

The following questions are pulled from the Federal Subrecipient Risk Checklist and will allow the Agency of Human Services to more quickly complete pre-award activities and process your grant award if you are selected.

Has your entity been suspended or debarred by the federal government?

- Yes
- No

Has your entity submitted a Subrecipient Annual Report in the last three years?

- Yes
- No

Has your entity received a single audit in the last three years?

- Yes
- No

Does your entity have a unique entity identifier (UEI)?

- Yes
- No

Does your entity plan to purchase real property, equipment, or supplies for the program using federal funds?

Programs that involve real property, equipment, and supplies have more significant monitoring requirements, which increases the risk of non-compliance. Uniform Guidance defines these as follows:

Equipment: *Tangible personal property (including information technology) that has a useful life of more than one year and a per-unit acquisition cost of at least $5,000.*

Real Property*: Land, including land improvements, structures and appurtenances, but excluding moveable machinery and equipment.*

Supplies*: Tangible personal property other than those described in Equipment. This includes computing devices acquired for less than $5,000.*

- Yes
- No

Is this your entity's first time receiving a federal award?

- Yes
- No

Does your entity have experience administering a similar program?

- Yes
- No

Does your entity have adequate and qualified staff to comply with the terms and conditions of the agreement?

Key staff responsible for compliance may include financial staff, such as CFO, Controller, Treasurer, or Accountant. Key staff responsible for performance may include municipal administrators or program managers.

- Yes
- No

How much has your entity's key staff changed in the past year?

- Minor Changes: Changes in support staff or a change in one key staff member.
- Significant Changes: Changes in key staff for both grant compliance and performance.
- No Changes.

Does your entity have written standard operating procedures and/or administrative manuals?

- Yes
- No

Does your entity have a financial management system in place that can track and record program expenditures?

- Yes
- No

If staff will be required to track their time associated with the award, does the your entity have a system in place that will account for 100% of each employee's time?

- Yes
- No
- Not Applicable.

Does your entity have a written compensation policy?

- Yes
- No

Does your entity have a current organizational chart?

Clear reporting lines and areas of authority must be established prior to the expending of subaward funds. Everyone is responsible for ensuring internal controls are followed, but ultimate accountability lies within leadership.

- Yes
- No

Does your entity have a written conflict of interest policy?

Subrecipients must maintain written standards of conduct preventing conflicts of interest as part of their procurement policy.

For more information see: 2 CFR 200.318(c)

- Yes
- No

Does your entity's financial management system include written procedures to implement federal payment requirements and determine cost allowability?

Subrecipients must have written procedures for implementing federal payment requirements (200.305) and determining cost

allowability (Subpart E). Written procedures for determining cost allowability should include or supplement employee compensation and travel policies if the subrecipient will pay employees or travel expenses through the Federal award. For more information see: 2 CFR 200.302 2 CFR 200.305 2 CFR 200 Subpart E

- Yes
- No

Does your entity have a written employee travel policy?

Only required for entities that plan to charge travel expenses to the federal award.

- Yes
- No
- Not Applicable.

Does your entity have a written procurement policy that complies with all applicable federal and state guidelines?

Subrecipients must have and use documented procurement procedures for the acquisition of property or services under the Federal subaward. These procedures must: 1. Consider the most economical purchase option. 2. Require procurement transactions be conducted in a manner providing full and open competition. 3. Follow appropriate methods for micro purchases (<$10,000), small purchases (<$250,000) and formal purchases. For more information see: 2 CFR 200.318-200.327

- Yes
- No

Does your entity have a written record retention policy?

Subrecipients must maintain financial records, supporting documents, statistical records, and all other records pertinent to a Federal award for three years after the submission of the final expenditure report as reported by the pass-through entity. * Subrecipients must maintain SLFRF records for 5 years. For more information see: 2 CFR 200.334,*

- Yes
- No

Signature

You have reached the end of the application. Once the application is submitted, it CAN NOT be edited. Please ensure all sections are

complete.

Please also remember to submit a current copy of your organization's W-9 to: AHS.HCBSGrants@vermont.gov

Authorized Signature: *By typing my name into this box, I hereby agree that this action constitutes my electronic signature to this Application.*

Name

Title

Date

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