

**AHCA USE ONLY:**

File #:

Application #:

**Behavioral Health Teaching Hospital**

**Grant Application**

The Agency for Health Care Administration (AHCA) has established a grant program for behavioral health teaching hospitals pursuant to 395.903, Florida Statutes (F.S.). The grant program will support workforce development, innovative care and facility upgrades. The aim is to modernize the state’s behavioral health system. **Applicants applying for this grant must be in compliance with 395.902(2), F.S.**

The grant submission must include:

Completed Application.

Organizational Overview to include:

Summary of the hospital’s behavioral health services and educational programs.

Description of the hospital’s program to provide state treatment facility beds.

Project Plan: Detailed plan of how the grant funds will be used, including:

Project objectives and expected outcomes.

Implementation timeline and milestones.

Budget and spending plan.

Partnership Evidence: Documentation of partnerships with accredited medical schools.

Monitoring Plan: Plan to track progress on workforce development and service expansion.

**By submitting this application, your organization agrees that, if awarded a grant, it shall enter into and comply with all terms and conditions of Attachment XX, Agency’s Grant Funded Agreement (GFA), which includes requirements to comply with the Florida Single Audit Act and Executive Order 20-44, as applicable.**

**1. Applicant Information**

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **A. PROVIDER INFORMATION –** Please complete the following for the hospital name and location. | | | | | | | | |
| License # (if applicable) | | | Florida Medicaid #  (if applicable) | | | | | |
| Name of Hospital(if operated under a fictitious name, enter as it appears in Florida Division of Corporations) | | | | | | | | |
| Street Address | | | | | | | | |
| City | | County | | | State | | | Zip |
| Telephone Number | | | | Fax Number | | | | |
| Mailing Address or  Same as above | | | | | | | | |
| City | | County | | | State | | Zip | |
| Telephone Number | E-mail Address | | | | | NOTE: By providing your e-mail address you agree to accept e-mail correspondence from the Agency. | | |

|  |  |
| --- | --- |
| **C. CONTACT PERSON** - Please complete the following for the contact person for this application. | |
| Contact Person for this application | Contact Telephone Number |
| Contact e-mail address or  Do not have e-mail | NOTE: By providing your e-mail address you agree to accept e-mail correspondence from the Agency. |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **D. LICENSEE INFORMATION** –Please complete the following for the entity seeking to operate the hospital. | | | | | |
| Licensee Name (Owner) | | | Federal Employer Identification Number (EIN) | | |
| Mailing Address or  Same as above | | | | | |
| City | | | | State | Zip |
| Telephone Number | Fax Number | E-mail Address | | | |

|  |  |
| --- | --- |
| **E**. **MEDICAL SCHOOL AFFILIATION** - List all medical schools with which the hospital has an affiliation. | |
| Name | Address |
|  |  |
|  |  |
|  |  |

|  |  |  |
| --- | --- | --- |
| **F. WORKFORCE DEVELOPMENT PROGRAMS FOR UNIVERSITY STUDENTS** | | |
| Discipline/Area of Study | University | Number of Students |
| Medicine |  |  |
| Nursing |  |  |
| Psychology |  |  |
| Social Work |  |  |
| Public Health |  |  |
| Psychiatry |  |  |

|  |  |
| --- | --- |
| G. **MANAGING ENTITIES** – Please select the entity that you have a collaborative agreement with and provide a copy of the agreement. | |
| Big Bend Community Based Care, Inc. d/b/a NWF Health Network |  |
| Broward Behavioral Health Coalition |  |
| Central Florida Behavioral Health Network, Inc. |  |
| Central Florida Cares Health System |  |
| Lutheran Services Florida |  |
| Thriving Mind South Florida (South Florida Behavioral Network, Inc. |  |
| Southeast Florida Behavioral Health Network |  |

**2. Eligible Areas of Funding**

Pursuant to 395.903, F.S., grant funding may be used for operations and expenses and for fixed capital outlay, including, but not limited to, facility renovations and upgrades. Indicate the area of funding with an “X.”

Workforce Development:

* University student programs.
* Psychiatric residency programs.
* Postdoctoral clinical psychology fellowships.
* Continuing education programs for licensed behavioral health professionals.

Operations and Integrated Care Models

* Implementation of integrated behavioral health care models.
* Coordination with regional behavioral health care providers.

Capital Improvements

* Facility renovation and expansion to accommodate behavioral health services.
* Technological upgrades to support training and care delivery.

Public-Private Partnerships

* Developing partnerships that promote innovative research, care and education.

**3. Amount of Funding Requested\***

|  |  |
| --- | --- |
| **Funding Area** | **TOTAL AMOUNT** |
| Workforce Development | $ |
| Operations and Integrated Care Models | $ |
| Capital Improvements | $ |
| Public-Private Partnership | $ |
| **Total Amount Requested** | **$** |

**\*A detailed spending plan must be included.**

**4. Attestation**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, attest as follows:

1. Pursuant to section 837.06, Florida Statutes, I have not knowingly made a false statement with the intent to mislead the Agency in the performance of its official duty.

Signature of Licensee or Authorized Representative Title Date

**RETURN THIS COMPLETED FORM TO:**

AGENCY FOR HEALTH CARE ADMINISTRATION

HOSPITAL AND OUTPATIENT SERVICES UNIT

2727 MAHAN DR., MS 31

TALLAHASSEE FL 32308-5407

**Questions?** Visit the Agency’s website : <http://ahca.myflorida.com> or contact the Hospital and Outpatient Services Unit at (850) 412-4549 or Email: [hospitals@ahca.myflorida.com](mailto:hospitals@ahca.myflorida.com)