Adult Day Program Provider Supports Program Grant Application

The Adult Day Program Provider Supports Program is established to stabilize Adult Day Program providers so as to mitigate potential exposure to COVID-19 during the pandemic by maintaining the capacity for home-based long term care services as an alternative to the use of higher risk institutional care settings.

The **Adult Day Program Provider Supports Program** will distribute up to $1,500,000 in grant funding to eligible Adult Day Program providers in Rhode Island. The grants will address the costs of business interruption and increased COVID-19 related costs.

For additional information, please refer to the Program Guidance available on the EOHHS website at: http://www.eohhs.ri.gov/Initiatives/LTSSResiliencyPrograms.aspx, under the link for Adult Day Program Provider Supports: Program Guidance

Application Instructions:
To apply for funding through the **Adult Day Program Provider Supports Program,** please complete the following Application and submit to EOHHS via email to OHHS.LTSSResiliency@ohhs.ri.gov. with “Application for Adult Day Provider Supports” and applicant name in the subject line.

Applicants must attach the following three (3) documents:

1. Completed and signed Application Form using fillable pdf starting on next page.
2. Submission of a re-opening plan detailing the following: current status of Adult Day programs (including actual or planned date of re-opening); current enrollment if open; projected enrollment by 12/30/2020; approach to ensure access to Medicaid beneficiaries with active service plans; procedures to safely begin resuming in-person care; and staff hiring/re-hiring plan. Providers must commit to achieve pre-COVID enrollment of individuals receiving services according to their re-opening plans.
3. Excel spreadsheet demonstrating financial need following the template shown in Exhibit A.

Application Dates:

- **October 30, 2020**: Applications available online at EOHHS website.
- **November 6, 2020**: Applications due to the State by 5pm.
- **November 2020:** Funds disbursed

APPLICATION FORM

1. Contact Information	
Contact Name	[ENTER]
Contact Phone	[ENTER]
Contact Email	[ENTER]

2. Application Information	
Facility Name	<FACILITY NAME>
Facility Address	<FACILITY ADDRESS>
Subrecipient DUNS	<DUNS #>
FEIN/Tax ID Number	<FEIN / TAX ID>
National Provider ID Number	<NATIONAL PROVIDER ID>
Amount Requested Enter amount based on demonstrated need calculation using table in Exhibit A.	[ENTER AMOUNT]

3. Attestations – All Applicants

a. **Legal Entity:** The Applicant certifies that it is is a Rhode Island corporation or other legal entity authorized to conduct business in the State of Rhode and enter into this Agreement with the State.

b. **Financial Controls:** Applicant agrees to retain and track funds and expenditures in a separate general ledger account, provide periodic status and financial reports in a format approved by EOHHS, and respond to state auditing requests as needed.

c. **Financial Need:** Applicant attests to a demonstrable financial need in the amount of the funds requested through this grant based on revenue loss sustained during the COVID-19 public health emergency due to reduced occupancy or other business interruption, or added costs to prevent, prepare for, or respond to COVID-19, after taking into account any other federal/state assistance received. Applicant shall be prepared to provide evidence of this COVID-19 related demonstrated need upon request.

d. **Infection Control**: Applicant attests that they will continue to maintain minimum required infection control standards and staffing.

e. **Reopening Plan**: Applicant attests to the intention to reopen their programs by December 1, 2020, if not already open.

f. **Other Relief Funding:** Applicant attests to having applied for all available federal and state funding relief offered to date, specifically HRSA PRF General Distribution Phase 2 and Phase 3.

g. **Reporting**: Applicant agrees to provide reporting to EOHHS on utilization, attendance, and staffing of programs in accordance with specifications to be provided.

h. **Compliance with DOH Guidelines**: Applicant attests that plans for resuming in-person care will adhere to all public health guidelines and will preserve compliance with Medicaid rules and regulations to ensure 100% compliance.

______________________________ ______________

Signature Date (MM/DD/YY)

5. Acknowledgement

By submitting this application, I acknowledge that I am authorized to submit this request on behalf of the business and that all the information provided is accurate to the best of my knowledge and ability. I acknowledge the State of Rhode Island is relying upon the information as submitted in order to determine whether to issue a grant. Therefore, if I become aware of any inaccuracies in the information provided, I will immediately notify the State of Rhode Island through email at OHHS.LTSSResiliency@ohhs.ri.gov.

______________________________ ______________

Signature Date (MM/DD/YY)

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Name & Title

EXHIBIT A: Demonstration of Financial Need

All Applicants must demonstrate financial need of the amount requested in this Application by documenting revenue loss and increased costs resulting from the pandemic, and subtracting from that amount any amounts received from any federal or state sources of pandemic relief.

Applicants must demonstrate this need by submitting the following calculation:

<table>
<tr><td>A. Loss of Revenue:</td><td colspan="2">Revenue March – October 2019 minus Revenue March – October 2020</td><td>$A</td></tr>
<tr><td>B. COVID-related costs</td><td colspan="2">COVID-related increased costs and expected increase in costs incurred between March – December 30, 2020</td><td>$B</td></tr>
<tr><td rowspan="6">C. COVID-related assistance</td><td colspan="2">All COVID-related assistance from any federal or state sources received beginning March 2020 through submission of this Progam application
Enter amounts below and sum to right:</td><td rowspan="6"></td></tr>
<tr><td>PPP (Payroll Protection Program)</td><td>$C1</td></tr>
<tr><td>Retainer Payments</td><td>$C2</td></tr>
<tr><td>HRSA PRF Funding</td><td>$C3</td></tr>
<tr><td>Other Grants</td><td>$C4</td></tr>
<tr><td>Total Assistance
Sum C1-4, enter to right</td><td>$C</td></tr>
<tr><td>Demonstrated Need</td><td colspan="2">Calculate $A + $B - $C
Enter here and in the “Demonstrated Need” field in this Application.</td><td><b>$ Need</td></tr>
</table>

Detailed backup for these calculations must be submitted in Excel format using the template below. Applicants may request a template for the Excel spreadsheet by emailing OHHS.LTSSResiliency@ohhs.ri.gov.

COVID-19 Long Term Services and Supports Resiliency Program: Adult Day Program Provider Support Program
State of Rhode Island

A. Revenue Loss due to COVID

Next to each revenue type, please list the dollar amount for each month.

Revenue Based on the Services Rendered for Each Month	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Total
Total Monthly RI Medicaid (fee for service) Revenue									$ -
Total Managed Care Revenue									$ -
Total Commercial Revenue									$ -
Other (please describe)									$ -
Other (please describe)									$ -
Mar-Oct 2020 Revenue									$ -

Revenue Based on the Services Rendered for Each Month	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Total
Total Monthly RI Medicaid (fee for service) Revenue									$ -
Total Managed Care Revenue									$ -
Total Commercial Revenue									$ -
Other (please describe)									$ -
Other (please describe)									$ -
Mar-Oct 2020 Revenue									$ -
A. TOTAL Revenue Loss due to COVID									$ -

B. Anticipated Expenditures due to COVID recovery efforts

Next to each anticipated expenditure, please list the dollar amount for each month for actual and anticipated COVID related costs.

	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Total
Staff hiring/rehiring											$ -
Staff training											$ -
Personal Protective Equipment (PPE) - masks, shields, gloves, etc.											$ -
Technology											$ -
Cleaning Supplies - hand sanitizer, surface sanitizer, etc.											$ -
Thermometers											$ -
Other (please describe)											$ -
Other (please describe)											$ -
Other (please describe)											$ -
Other (please describe)											$ -
B. Mar-Dec 2020 COVID related costs											$ -

C. Federal/State Relief Funds Information - COVID related Assistance Received

Please list any grants or other funds that your agency has applied for and/or received. Add lines as needed.
Examples: PPP (Paycheck Protection Program), Small Business Loan , RI Foundation COVID Relief, federal Provider Relief Fund, Economic Injury Disaster Loans (EIDL), HHS Provider Relief Funds, Health Resources & Services Administration (HRSA) Medicaid Relief Funds, Restore RI grants, and any other state or federal relief funding.

Fund Name	Amount Applied for	Date Applied	Received (Yes/No)	Date Received	Amount Received
C. TOTAL Federal/State Relief Received					$ -

TOTAL FUNDS REQUESTED	$ -
Revenue loss plus COVID related costs minus federal/state relief received	