Nursing Facility Transformation Program Application

ATTACHMENT A: APPLICATION FORM

1. Contact Information	
Name of Facility	
Contact Name	
Contact Phone	
Contact Email	

2. Bed Reduction/Reservation Commitment	
a. # Licensed Beds	
b. # Beds to delicense/take out of service/reserve for specialized use by December 15, 2020[1]	
c. Remaining Beds	[subtract b from a]
d. Investment option proposed (select one)	___ Diversification ___ Targeted, Specialized Capacity Building
e. Indicate method for bed reduction (must be consistent with investment option selected in (d), see guidance)	____ Delicensed ____ Taken out of service ____ Reserved for specialized capacity
f. If Diversification selected, indicate type of diversification planned [ENTER SHORT DESCRIPTION]	
g. If Capacity Building selected, indicate which at-risk population will be targeted (total to the right must sum to # indicated in (e) above)	Enter # beds reserved for each population: ____ Populations with a behavioral health diagnosis, especially SPMI/SMI ____ Populations with I/DD ____ Populations in need of memory care services ____ Hospital transitions of populations with complex behavioral health and medical conditions (e.g. Eleanor Slater Hospital) ____ Populations with a Traumatic Brain Injury (TBI) in need of Habilitative Services ____ Populations either dependent upon or transitioning from a Ventilator ____ Pediatric long term care services

[1] Note: The Medicaid Director may consider restoring the beds at a future date if occupancy is greater than 95% and the facility demonstrates significant unmet need. In accordance with the Nursing Facility Principles of Reimbursement, the Medicaid Director must approve an increase to the licensed bed capacity, new beds or beds out of service brought back into service, for participation and payment in Title XIX Medicaid.

	____ Populations wih complex social needs, such as people with prior criminal convictions, prior sex offenders, or people who have a history of assaultive behavior ____ Other specialized populations (please specify in Business Proposal)
Total Amount Requested Grants will be issued for either up to $500,000 or up to $1,000,000. Amount requested should be supported by Attachment B.	

3. Attestations
a. **Legal Entity:** This assures that Applicant is a Rhode Island corporation or other legal entity able to accept an agreement with the State. b. **Facility Transformation:** Applicant agrees to either a reduction in beds (either delicensed or taken out of service) or a commitment to reserve a predetermined number of current licensed beds to support targeted at-risk populations (as defined in the Guidance) as indicated in (2b) above. c. **Active Medicaid Participation:** Applicant commits to participating in the Medicaid program and accepting Medicaid eligible populations, such that at least forty (40%) of the residents/users in the new/transformed facility will be Medicaid eligibles. d. **Comply with the Federal Minimum Data Set (MDS):** Applicant commits to completing Section Q for all residents and actively participating in nursing facility transition initiatives including the Money Follows the Person (MFP) and the Care Transitions Program. Grant recipients will need to provide a monthly referral list to EOHHS in accordance with EOHHS specifications. e. **Minimum Medicaid partner**: Applicant attests to providing at least 10,000 Medicaid days in CY 2019 (or 20% of days provided in CY 2019 were for Medicaid days), based on the EOHHS 2019 BN-64 Cost Report for Total Medicaid days provided, including managed care days; or at least 20% of residents at Applicant facility were Medicaid eligible as of January 15, 2020. f. **Implement Financial Controls:** Applicant agrees to retain and track funds and expenditures in a separate operating account consistent with sound grant management practices; provide periodic status and financial reports in a format approved by EOHHS and DOA, and respond to state auditing requests as needed. g. **Financial Need:** Applicant attests to a demonstrable financial needs in the amount of the funds requested through this grant based on revenue loss sustained due to reduced occupancy or business interruption, after taking into account any other federal/state

assistance received. Applicant must be able to provide evidence of this demonstrated need upon request.

h. **Evidence of Reduction**: Applicant commits to providing evidence in accordance with EOHHS specifications by December 15, 2020, of either a reduction of nursing facility beds (either delicensed or taken out of service), or evidence of beds specifically reserved for targeted, specialized capacity.

____ _______________________

Signature Date (MM/DD/YY)

4. Acknowledgement

By submitting this application for the Nursing Facility Transformation Grant Program, 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