

Blue Cross Blue Shield of Michigan
Helping Free Clinics Meet the Health and Dental Needs of
Michigan's Uninsured

FEBRUARY 2008



Nonprofit corporations and independent licensees
of the Blue Cross and Blue Shield Association

INTRODUCTION

Blue Cross Blue Shield of Michigan announces the availability of funds to help strengthen and expand Michigan's network of free clinics and the services delivered there. This Request for Proposal provides information needed for you to prepare proposals for funding consideration.

BACKGROUND

Blue Cross Blue Shield of Michigan has a heritage of commitment to the people of Michigan that differentiates us from every other health insurance company doing business in our state. Our mission is to promote access to health care coverage for all Michigan residents. For many of the approximately 1 million uninsured in Michigan (nearly 10 percent of the state's population), the free clinics provide a vital safety net. The Blues are also committed to focusing on reducing health care costs, improving quality and improving the health status of Michigan's residents, particularly children.

THE INITIATIVE

In an effort to help improve the health status of Michigan residents, an important part of the Blues' social mission, the Blues have established grants totaling \$1 million to support free clinics. The grants covered by this RFP range from \$5,000 to \$50,000 and will allow clinics to stabilize and increase the services currently offered to their patients.

ELIGIBILITY & GUIDELINES

New or existing clinics operating in Michigan with a primary mission to provide free health or dental services and that have 501(c)(3) designation are eligible to apply. Additionally, free clinic clinical staff must provide clinical care without reimbursement and may not be paid by another organization for medical or dental services rendered to uninsured patients.

Organizations that previously received funding from BCBSM are eligible to apply. However, the clinic must be in good standing, as demonstrated by fully completed, BCBSM-approved status reports showing significant progress toward completion of its objectives.

Applications will be assessed based on community needs, planned objectives and the services the clinic provides. Priority will be given to clinics that are able to provide services to a larger number of patients or increase the number of services delivered. Special consideration will also be given to clinics offering dental care.

BCBSM does not provide funding for malpractice insurance.

Clinics must be able to collect and provide summary demographic and other data including:

- Total number of patients seen per month and annually
- Patient counts by male, female, pediatric and adult
- Estimates of the percentage of patients served that are African American, Hispanic, Native American, or Asian/Pacific Islanders. Any additional data that may validate your value to the community you serve.

MiChild is a low cost health insurance program for uninsured children of Michigan's low income, working families. Eligible clinics must agree to educate their clients about MiChild. Blue Cross Blue Shield of Michigan will provide free educational materials and applications that can be used to raise awareness about the program. Information about MiChild can be found online at michigan.gov and healthcare4mi.com.

Application Instructions

If your program meets the eligibility criteria and guidelines described above, please submit your grant proposal (single-spaced, 12-point font) in the order indicated and include the following information.

The conditions that apply to grants made by Blue Cross and Blue Shield of Michigan can be found in attachment IV. Please read them carefully before signing this form. Your signature on this form constitutes acceptance in full of all conditions contained herein.

- I. *Cover Letter* – Please attach a cover letter on organizational letterhead as the first page of your grant application. *Limit: 2 pages*. Briefly describe:
 - a. What you are requesting funding for
 - b. How much money you are requesting
 - c. Your target population
 - d. What impact the funding will have on delivery of services at your clinic
- II. *Project Contact Form* (attached)
- III. *Description of need* (attached)
- IV. *Budget to Support Planned Activities* (attached)
- V. *Conditions of Grant and required signature page* (attached)
- VI. *Letters of support* - From collaborating partners.
- VII. *Copy of your documentation verifying 501(c)3 status*

Incomplete proposals will not be eligible for funding.

The application deadline is Thursday, March 13, 2008 by 5 p.m.

Applicants should submit four copies of the completed proposal on three-hole punch paper to:

Project Leader: Carolyn Wiener
Address: 27000 W. 11 Mile Road, MC B761
City, State ZIP: Southfield, MI 48034

Please do not staple your proposals.

QUESTIONS

You may obtain additional Information on this grant program by contacting Carolyn Wiener via email at cwiener@bcbsm.com or by phone at 248-448-5026.

Blue Cross and Blue Shield of Michigan
CONTACT FORM

APPLICANT ORGANIZATION:		Date:
Mailing Address:		
City:	County:	ZIP:
Phone:		Fax:
Web Site Address:		
Executive Director:	Email:	Phone:
Chair, Board of Directors:	E-mail:	
Grantee Contact:	E-mail:	
Title:		
Phone:	Cell Phone:	
Fiscal Agent: If your agency is not a 501(c)(3) organization, please indicate the name of the 501(c)(3) organization to which your check can be made payable if we choose to fund your program:		
Contact Person:		
Check Mailing Address		
City:	County:	ZIP:
Phone:	Cell Phone	Fax:
Executive Director:	E-mail:	
Chair, Board of Directors:	E-mail:	

Description of Need	
Services/Program offered:	
Average number of clients treated on monthly basis:	Estimate of additional clients served or services that will be provided as a result of BCBSM funding:
Average number of patient visits per month:	
Average number of volunteers hours per month:	
Location Rural_____ Urban_____ Suburban_____	
Hospital Affiliation(s):	
Estimate the number of patients you treat who are below 200 percent of the federal poverty level: _____	
Estimate the number of patients you treat who are employed part-time _____percent and full-time _____percent	
Estimate the percentage of patients you treat who are uninsured: _____%	
Description of Need:	
Expected Benefits of Funding:	

Have you received funding from BCBSM/BCN in the past? Yes _____ No _____

If yes, in what year(s) did you receive the funding? _____

Budget To Support Planned Activities

Date:

Name of Grant:

BCBSM 2008 Free Clinic Grant Program

Amount Requested From BCBSM (up to \$50,000):

Initiatives Planned Expenses (indicate \$0 if NA to this request)	Requested	Description
Salary/Wages and Benefits (Details must be included in chart below)*		
Contract Services		
Travel		
Printing		
Equipment/Supplies		
Rent		
Medications		
Other (Please specify)		
Total		

*List Staff Position's	Full or Part Time & Number of Hours Per Week	Responsibilities	Salary/Wages and Benefits \$

CONDITIONS OF GRANT

By signing below, I accept and agree to comply with the terms and conditions outlined below, in the event a grant is awarded and certify that I am authorized to execute this application on behalf of _____ (Organization Name) and that the information contained in this application is correct.

1. PURPOSE AND ADMINISTRATION. The grant shall be used exclusively for the purposes specified in the grantee's proposal, dated _____. In the event that the funds are not used for these purposes within the time specified in the grantee's proposal (or within any approved extension of said time period), the unspent funds shall be returned to BCBSM.

The grantee will directly administer the project or program being supported by the grant and agrees that no grant funds shall be disbursed to any organization or entity, whether or not formed by the grantee, other than as specifically set forth in the grant proposal referred to above.

All copyright interests in materials produced as a result of this grant are owned by the grantee. BCBSM, however, retains a royalty-free, nonexclusive and irrevocable license to reproduce, publish, use in modified form (e.g., shortened, summarized or abbreviated) or otherwise use and to authorize use of any such materials for any lawful purpose in furtherance of BCBSM's mission to enhance quality, control costs, and improve access to health care in Michigan. Notice will be provided to the grantee should BCBSM use or authorize the use of such materials.

2. No part of the grant shall be used for a grant contract or subcontract to another person or organization without prior written approval of BCBSM.
3. BUDGET. Expenditures of the grant funds must adhere to the specific line items in the grantee's approved grant budget. Transfers among line items (increases and decreases) must be requested in writing, and approved in advance by BCBSM.
4. ACCOUNTING AND AUDIT. A systematic record on a fund-accounting basis shall be kept by the grantee of the receipt and disbursement of funds and expenditures incurred under the terms of the grant, and the substantiating documents, such as bills, invoices, canceled checks, receipts, etc., shall be retained in the grantee's files for a period of not less than four (4) years from the date of the expiration of the grant period or earlier termination of the grant by BCBSM. The grantee agrees to promptly furnish BCBSM with copies of such documents upon BCBSM's request, and without charge to BCBSM.

BCBSM, at its expense, may audit or have audited the records of the grantee insofar as they relate to the disposition of funds granted by BCBSM, and the grantee shall provide all necessary assistance in connection therewith without charge to BCBSM. BCBSM may randomly select projects for ad hoc or routine audits.

5. REPORTS. Narrative and financial reports shall be furnished by the grantee to BCBSM on a semi-annual and annual basis as specified in the BCBSM grantee award letters. The narrative report should briefly summarize the objective of the project, describe grant-related activities completed including, the progress made by the grantee towards

achieving the grant's objectives, and discuss any problems or obstacles encountered including the strategy used to resolve the problem(s).

The financial report is to be in the same format as the approved grant budget, and for each line item, show the original project budget, the balance carried forward as of the report date, the amount expended against each line item for the current period, and the resulting balance remaining in each line. A total is to be shown for each column.

Reports that are incomplete and not provided in the correct format will not be approved by BCBSM. This will jeopardize subsequent payments to the grantee.

BCBSM may, at its expense, monitor and conduct an evaluation of operations under the grant, which may include visits by representatives of BCBSM or its designees to observe the grantee's program procedures and operations, and to discuss the program with the grantee's personnel.

The final report shall be presented to BCBSM within 30 days of the end of the grant period. The final report must be approved by BCBSM.

6. PUBLIC REPORTING. BCBSM may report this grant, if made, in its next Annual Report. The grantee may be asked to review and approve a project summary briefly describing the grantee's activity which will be used by BCBSM to respond to inquiries and for other public information purposes. Blue Cross Blue Shield of Michigan may use the grantee's name at any time in discussing BCBSM's social mission efforts with or without the grantee's prior knowledge. Moreover, grantee will cooperate with BCBSM fully in its efforts to promote the Free Clinic Grant program to the media, the public and other constituents.

All publications, press releases, annual reports, or other announcements prepared by the grantee must refer to the full name of the grantor as the Blue Cross and Blue Shield of Michigan .

7. GRANT REVERSION AND TERMINATION. If the grant is intended to support a specific project or to provide support for a specific period of time, any portion of the grant unexpended at the completion of the project and the end of the relevant time period (or any authorized extension thereof) shall be returned to BCBSM within fifteen (15) days.

BCBSM may, for its sole convenience, with or without cause cancel a grant in whole or part, at anytime by giving the grantee thirty (30) days written notice of its intention to do so. In the event of such termination, the grantee will be entitled to recover all approved project costs incurred prior to date of termination.

If the grant is terminated prior to the scheduled completion date, the grantee shall, upon request of BCBSM, provide to BCBSM a full accounting of the receipt and disbursement of the funds and expenditures incurred under the grant as of the effective date of termination. The grantee shall repay within thirty (30) days after written request by BCBSM all grant funds unexpended as of the effective date of termination and all grant funds expended for purposes or items allocable to the period of time subsequent to the effective date of termination.

9. LIMITATIONS AND CHANGES. It is expressly understood that BCBSM, or any of its subsidiaries, by making this grant, have no obligation to provide support to the grantee for purposes of this project or any other purposes. Any changes, additions, or deletions

to the conditions of the grant must be made in writing only and must be approved by BCBSM. If the grant is awarded, BCBSM agrees to fund projects for a period of one year. BCBSM will annually review requests for funding for subsequent years and approve or deny such requests as it deems appropriate.

10. Indemnification.

_____ (Organization Name) agrees to indemnify, defend and hold harmless BCBSM and its trustees, directors, officers, agents and employees from and against all claims, losses, damages, liabilities, costs, expenses, judgments, causes of action and obligations whatsoever, including all costs and reasonable attorneys fees, incurred for or in connection with an injury, death or damage to any business entity person or property, arising out of, resulting from, or in any way connected with the negligence or wrongful acts, errors, omissions, incompetence, malpractice, misfeasance and/or malfeasance of the grantee or any entity or person associated with the grantee including but not limited to employees, officers, contractors, agents and volunteers which may be filed or alleged in connection with the grantee's performance of the responsibilities described in this RFP and/or subsequent grant documents.

The foregoing conditions are hereby accepted and agreed to as of the date indicated.

Organizational Approval
(name and title of official authorized to sign for organization)

(name, typed or printed)

(signature)

(title)

(date)

(Revised 1/31/08)