COLORADO
Department of Health Care Policy & Financing
1570 Grant Street
Denver, CO 80203

GRANT APPLICATION
Peer Support Grants for Housing Stability
ARPA 3.07

APPLICATION INSTRUCTIONS

In order to fill out this application, you need to download it from Google Drive.
There are two options for downloading it as a Word document:

1) Right click on the document from the folder view and click download
2) Open the file in Google and click File – Download - Microsoft Word

Each applicant must complete the following sections to be considered for this funding opportunity. Points will be awarded based on the completeness of answers and alignment with the grant's overall goal: *To expand access to Peer Support Services for Medicaid members with complex needs and a history of homelessness.*

Organizational Structure Questions – Type response in designated text boxes

Attestation – Electronically sign the attestation page OR print, sign & submit with application

Population Narrative – Type response in designated text boxes and be aware of word limits

Project Narrative - Type response in designated text boxes and be aware of word limits

Budget Workbook - Download a copy of the Budget Workbook. Fill it out and submit the Excel spreadsheet via email along with your written application. Download here: https://hcpf.colorado.gov/arpa/arpa-grant-opportunities#3.07b

Budget Narrative – Type response in designated text boxes and be aware of page limit

Also attach the following documents, if applicable, to your submission email:

- Proof of nonprofit status (if applicable)
- Certificate of Good Standing (or Certificate of Fact) from the Secretary of State (501(c)3 organizations only)
- Certificate of Insurance including Privacy Insurance Policy or statement that agency will add policy during grant period

Email all application materials to: hcpf_housing_supports@state.co.us
Application Deadline: July 31, 2023 at 5:00pm MST

Organizational Structure Questions

Each question within this section is worth 1 point for completion.

1. **General Information:**
    - Organization/Business Name: Click or tap here to enter text.
    - Region/Area(s) served: Click or tap here to enter text.
    - Medicaid Provider ID: Click or tap here to enter text.
    - Primary Contact/Submitter of Application (This should be someone with authority to enter into financial obligations on behalf of the organization):
        - Name: Click or tap here to enter text.
        - Title: Click or tap here to enter text.
        - Email: Click or tap here to enter text.
        - Phone: Click or tap here to enter text.

2. **Diversification Classification. Please identify whether your organization fits one or more of the following categories:**

    Note: Select all that apply

    ☐ Small business (500 or fewer employees)
    ☐ Minority-owned business
    ☐ Woman-owned business
    ☐ Veteran-owned business
    ☐ Business that employs people with disabilities (employs any Home and Community Based Services Waiver member in Integrated Jobs)

3. **The organization's mission and vision:** Click or tap here to enter text.

4. **Counties to be served:** Click or tap here to enter text.

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Attestation

Please place a checkmark next to all attestation statements. Please have a person with fiscal authority in your agency sign the bottom of the attestation section.

☐ I attest that no funds within this application will be used for existing costs within our organization (supplanting efforts).

☐ I attest my agency had read and understood the reporting requirement for this grant and can comply with all quarterly reporting needs.

☐ I attest that the team will not request for the same services from any HCBS ARPA grant programs that are awarded within this proposal.

☐ I attest no funds will be utilized for existing Medicaid reimbursement services.

☐ I attest I have the authority to enter into a financial agreement on behalf of my organization.

☐ I attest my agency will work to increase the availability of these services to Health First Colorado Members.

Signature of Authorizing Official:

Name: Click or tap here to enter text.

Title: Click or tap here to enter text.

Date: Click or tap here to enter text.

Population Narrative

Total possible points: 16

Provide a comprehensive description of the population currently being served by the applicant, as well as the population you intend to serve through the grant funding. In your response, please provide the information requested below and use the suggested response structure. (max. 1000 words total)

1. **A) Describe the population currently being served by the applicant, including:**
    - **a.** Population demographics, characteristics, geographic distribution, etc. (Please include age, disability, race/ethnicity, as well as other factors that may demonstrate an underserved or special population status)
    - **b.** Size of the population you serve regularly (ie. Not just total count of how many are served in a year, but how many people are served on a consistent basis)

Click or tap here to enter text.

1. **B) Describe the population the applicant intends to serve through this grant funding, and explain the extent to which (if at all) this differs from the population currently being served, including:**
    a. Population demographics, characteristics, geographic distribution, etc. (Please include: age, disability, race/ethnicity, as well as other factors that may demonstrate an underserved or special population status)
    b. Size of the population you intend to serve regularly (ie. Not just total count of how many are served in a year, but how many people will be served on a consistent basis)

Click or tap here to enter text.

2. **Describe the applicant's experience working with complex populations (such as individuals experiencing homelessness who also have behavioral and/physical health needs), including:**
    - **a.** Experience in serving individuals with a history of homelessness or housing instability (Include years of experience)
    - **b.** Experience working with individuals who have experienced or currently experience:
        - **i.** Substance Use Disorder
        - **ii.** Mental Health issues or Dual Diagnosis issues (including SMI or SPMI)
        - **iii.** Trauma
        - **iv.** Criminal Justice involvement

c. Estimate the portion of people in any of these populations that also have ongoing physical health issues. (This assists in understanding the complexity level of your population and the relevance of different forms of peer services)

Click or tap here to enter text.

Service Narrative

Total possible points: 16

1. **Please provide a comprehensive description of the current services provided by the applicant, as well as staffing composition and location/physical space. In your response, please provide the information requested below and use suggested response structure (max. 750 words)**

    a) **Describe the services currently being provided by the applicant, the cadence of service delivery, and what type(s) of staff deliver these services.**

    b) **Explain how the applicant is set up in terms of staffing capacity, including:**
        - Number of licensed professionals
        - Number of non-licensed professionals
        - Number of administrative staff
        - Number of Peer Support Professionals

    c) **Describe how the applicant is set up in terms of location/physical space, including:**
        - Where do/would Peer Support Professionals provide services?
        - Do/would Peer Support Professionals have dedicated or shared office space?

Click or tap here to enter text.

2. **Provide a description of the applicant's previous or current experience in providing and supervising Peer Support Services, including the following information. If the applicant does not have experience in any of these areas, explain why not and demonstrate your knowledge of best practices in this area. (max 750 words)**

    a. Explain the services that Peers Support Professionals currently provide within your organization

    b. Describe the applicant's current practices in terms of peer outreach and engagement

    c. Describe the applicant's current practices in terms of peer training and/or certification

d. Describe the applicant's current practices regarding supervision of Peer Support Professional

Click or tap here to enter text.

Project Narrative

Total possible points: 48

Applicants who are a currently a Medicaid provider, please only answer Question #1 (A & B). Applicants who are not currently a Medicaid provider, but plan to become one during the grant period, please answer Questions #1 and #2 (including parts A & B for both). Scoring will be weighted equally for both types of applicants.

1. A) [All Applicants] Describe in detail your plans to use grant funding to expand the delivery of billable Peer Support Services in the context of housing stability, as well as your plans to provide appropriate supervision for Peer Support Professionals. (max 1000 words)

In your narrative response, please include the following:

a) Overview of your vision for this grant funding and how it will be used to expand the delivery of Peer Support Services for the target population, in the context of housing stability. Please reference allowable expenditures listed on the RFA.
b) List of Medicaid billable Peer Support Services that will be provided to the target population. (Reference the USCS Coding Manual in Appendix A)
c) Plans for Peer Support Professional supervision structure
d) Expected outcomes of this financial award. Please include estimated number of Medicaid members who will receive Peer Support Services during the grant period.
e) Plans for sustainability past the grant period

Click or tap here to enter text.

1. B) [All Applicants] Use the template provided to demonstrate a proposed work plan. Include a minimum of 3 key project objectives, as well as relevant tasks and expected completion dates for each. (max 1 page) ***See example in Appendix B*****.**

Key Project Objective: Click or tap here to enter text.	**Expected Completion Date**
Task 1: Click or tap here to enter text.	Click or tap here to enter text.
Task 2: Click or tap here to enter text.	Click or tap here to enter text.
Task 3: Click or tap here to enter text.	Click or tap here to enter text.
Task 4: Click or tap here to enter text.	Click or tap here to enter text.
Task 5: Click or tap here to enter text.	Click or tap here to enter text.

Key Project Objective: Click or tap here to enter text.	**Expected Completion Date**
Task 1: Click or tap here to enter text.	Click or tap here to enter text.
Task 2: Click or tap here to enter text.	Click or tap here to enter text.
Task 3: Click or tap here to enter text.	Click or tap here to enter text.
Task 4: Click or tap here to enter text.	Click or tap here to enter text.
Task 5: Click or tap here to enter text.	Click or tap here to enter text.

Key Project Objective: Click or tap here to enter text.	**Expected Completion Date**
Task 1: Click or tap here to enter text.	Click or tap here to enter text.
Task 2: Click or tap here to enter text.	Click or tap here to enter text.
Task 3: Click or tap here to enter text.	Click or tap here to enter text.
Task 4: Click or tap here to enter text.	Click or tap here to enter text.
Task 5: Click or tap here to enter text.	Click or tap here to enter text.

Key Project Objective: Click or tap here to enter text.	**Expected Completion Date**
Task 1: Click or tap here to enter text.	Click or tap here to enter text.
Task 2: Click or tap here to enter text.	Click or tap here to enter text.
Task 3: Click or tap here to enter text.	Click or tap here to enter text.
Task 4: Click or tap here to enter text.	Click or tap here to enter text.
Task 5: Click or tap here to enter text.	Click or tap here to enter text.

2. A) [<u>Non-Medicaid Provider Applicants</u>] Explain how grant funds will be used to build administrative capacity to become a Medicaid provider and successfully provide and bill for Peer Support Services by the end of the grant period. (max 750 words)

In your response, please include the following:

a) Explain your viable pathway to completing enrollment as a Medicaid provider by the end of the grant period
b) If applicable, list any steps you have already taken to enroll as a Medicaid provider
c) Explain how funding will be used to build administrative capacity. Please reference the allowable uses of funding listed in the RFA.

Click or tap here to enter text.

2. B) [<u>Non-Medicaid Provider Applicants</u>] Use the template provided to demonstrate a proposed work plan. Include a minimum of 3 key project objectives, as well as relevant tasks and expected completion dates for each. (max 1 page) ***See example in Appendix B*****.**

Key Project Objective: Click or tap here to enter text.	**Expected Completion Date**
Task 1: Click or tap here to enter text.	Click or tap here to enter text.
Task 2: Click or tap here to enter text.	Click or tap here to enter text.
Task 3: Click or tap here to enter text.	Click or tap here to enter text.
Task 4: Click or tap here to enter text.	Click or tap here to enter text.
Task 5: Click or tap here to enter text.	Click or tap here to enter text.

Key Project Objective: Click or tap here to enter text.	**Expected Completion Date**
Task 1: Click or tap here to enter text.	Click or tap here to enter text.
Task 2: Click or tap here to enter text.	Click or tap here to enter text.
Task 3: Click or tap here to enter text.	Click or tap here to enter text.
Task 4: Click or tap here to enter text.	Click or tap here to enter text.
Task 5: Click or tap here to enter text.	Click or tap here to enter text.

Key Project Objective: Click or tap here to enter text.	**Expected Completion Date**
Task 1: Click or tap here to enter text.	Click or tap here to enter text.
Task 2: Click or tap here to enter text.	Click or tap here to enter text.
Task 3: Click or tap here to enter text.	Click or tap here to enter text.
Task 4: Click or tap here to enter text.	Click or tap here to enter text.
Task 5: Click or tap here to enter text.	Click or tap here to enter text.

Key Project Objective: Click or tap here to enter text.	**Expected Completion Date**
Task 1: Click or tap here to enter text.	Click or tap here to enter text.
Task 2: Click or tap here to enter text.	Click or tap here to enter text.
Task 3: Click or tap here to enter text.	Click or tap here to enter text.
Task 4: Click or tap here to enter text.	Click or tap here to enter text.
Task 5: Click or tap here to enter text.	Click or tap here to enter text.

3. Each awardee will be required to report data on a quarterly basis, including the following:

- Awardees will be responsible for tracking and reporting data related to training and supervision hours
- Awardees will be required to provide a narrative overview of the progress toward grant goals and expenditures

Please describe your administrative capacity for data collection and reporting, including any data tracking tools currently used. (max 500 words)

Click or tap here to enter text.

4. Please describe how trauma-informed and culturally sensitive practices are incorporated into the applicant's service delivery model. (max 300 words)

Click or tap here to enter text.

Budget Workbook

Total possible points: 8

Please download a copy of the Budget Workbook here:
https://hcpf.colorado.gov/arpa/arpa-grant-opportunities#3.07b

Fill out the Budget Workbook Excel spreadsheet and submit it with your written application.

Screenshot of Budget Workbook:

Grant Budget Summary				
Budget Category	**Calendar Year 2023**	**Calendar Year 2024**	**Total**	**Brief Description**
Personnel	$0	$0	$0	
Fringe Benefits	$0	$0	$0	
Training	$0	$0	$0	
Travel	$0	$0	$0	
Equipment	$0	$0	$0	
Supplies	$0	$0	$0	
Contracts	$0	$0	$0	
Services	$0	$0	$0	
Other	$0	$0	$0	
Total Direct Costs	**$0**	**$0**	**$0**	
Indirect Cost	$0	$0	$0	
Total Project Costs	**$0**	**$0**	**$0**	

Instructions -

Please provide amounts and a brief description for each budget category. If needed, add additional tables on new tabs to accurately reflect your proposed budget. Then, use the Budget Narrative template to provide a comphrensive narrative justification for each line item in the budget.
Please note the following:
(1) All funds must be spent by September 30, 2024.
(2) Funding may not be used to supplant existing services, including current Medicaid billable services.
(3) Capital expenditures over $5,000 will require an additional approval process.
(4) Indirect Costs are the costs incurred in support of general business operations but which are not attributable to a specific funded project. The assumed indirect cost rate is 10% of direct costs, with a maximum of $25,000 annually. This amount is calculated automatically in the table above. If your business has a federally negotiated indirect cost rate you may adjust the calculation to reflect that rate. To do so, you must also provide proof of your negotiated rate.

Budget Narrative

Total possible points: 8

Use the below template to provide an explanation for each line item in the budget. Include the total amount requested, calculations for the cost, and a narrative justification for the need. (max 5 pages) ***See Appendix C. Example Budget Narrative***

Personnel

Please provide employee title, salary, how many months of time are being requested, purpose of the role, and what percentage of the salary will be paid for with the grant. Please include information on your typical hiring process and timeline, as well as how you plan to sustain any additional personnel past the grant period.

Total Amount Requested: Click or tap here to enter text.

Calculations for the Cost: Click or tap here to enter text.

Narrative Justification: Click or tap here to enter text.

Fringe Benefits

Please provide how your agency calculates fringe benefits for employees per each personnel request.

Total Amount Requested: Click or tap here to enter text.

Calculations for the Cost: Click or tap here to enter text.

Narrative Justification: Click or tap here to enter text.

Training & Certification

Please provide the number and type of trainings and/or certifications you plan to fund through the grant. This may include training for both Peer Support Professionals, as well as supervisors. Please indicate the number of individuals who will be trained and/or certified, as well as an estimated timeline.

Total Amount Requested: Click or tap here to enter text.

Calculations for the Cost: Click or tap here to enter text.

Narrative Justification: Click or tap here to enter text.

Travel

Please include information on the number of staff included, purpose of travel, destination of travel, estimated total number of trips, and calculate based on the CO state mileage rate of $0.56 per mile.

Total Amount Requested: Click or tap here to enter text.

Calculations for the Cost: Click or tap here to enter text.

Narrative Justification: Click or tap here to enter text.

Capital Expenditures

Capital expenditures are subject to additional approval and may not exceed 10% of the total funds requested. Please provide any cost related to purchase of property, rental of property, computers, furniture, and software. Please separate out into three categories: space, equipment, and supplies.

Space

Please provide any equipment requests, cost estimate, rationale and justification for the request.

Total Amount Requested: Click or tap here to enter text.

Calculations for the Cost: Click or tap here to enter text.

Narrative Justification: Click or tap here to enter text.

Equipment

Please provide any equipment requests, cost estimate, rationale and justification.

Total Amount Requested: Click or tap here to enter text.

Calculations for the Cost: Click or tap here to enter text.

Narrative Justification: Click or tap here to enter text.

Supplies

Please provide any supplies requests, cost estimate, rationale and justification. Equipment can include office furniture, office supplies, equipment to support care provision of behavioral health.

Total Amount Requested: Click or tap here to enter text.

Calculations for the Cost: Click or tap here to enter text.

Narrative Justification: Click or tap here to enter text.

Contractor Costs:

Please provide any contractor costs including rationale, justification, and typical hourly cost for the vendor.

Total Amount Requested: Click or tap here to enter text.

Calculations for the Cost: Click or tap here to enter text.

Narrative Justification: Click or tap here to enter text.

Other

Total Amount Requested: Click or tap here to enter text.

Calculations for the Cost: Click or tap here to enter text.

Narrative Justification: Click or tap here to enter text.

Indirect Costs

Indirect Costs are the costs incurred in support of general business operations but which are not attributable to a specific funded project. The assumed indirect cost rate is 10% of direct costs, with a maximum of $25,000 annually. Please review: Outgoing ARPA Grant Indirect Cost Limit Standard Operating Procedure

Total Amount Requested: Click or tap here to enter text.

Calculations for the Cost: Click or tap here to enter text.

Narrative Justification: Click or tap here to enter text.

Appendix A
USCS Coding Manual page on Peer Support Services

H0038	Self-help/peer services, 15 mins	MINS
HE (SP) *child/adol;/young adult TT (Recovery)	Child (0-11), Adol (12-17), Young Adult (18-20), Adult (21-64), Geriatric (65+)	**Min:** 8 mins **Max:** 15 mins
Place of Service • 03 School • 04 Shelter • 11 Office • 12 Home • 13 ALF • 14 Grp Home • 15 Mobile Unit • 21 Inpt Hosp • 23 ER • 31 SNF • 32 NF • 33 Cust Care • 50 FQHC • 51 Inpt PF • 52 PF-PHP • 53 CMHC • 54 ICF-MR • 56 PRTC • 72 RHC • 99 Other	**Service Description:** (Including example activities) Member services (individual/group) provided by person meeting Peer Specialist definition in Section V of this manual. Activities are member-motivated, initiated and/or managed, encourage socialization, recovery, wellness, self-advocacy, development of natural supports, and maintenance of community living skills by: • Exploring member purposes beyond the identified MI or substance use disorder and the possibilities of recovery • Tapping into member strengths related to illness self-management (including developing skills and resources and using tools related to communicating recovery strengths and health needs/concerns, and self-monitoring progress) • Emphasizing hope and wellness • Helping members develop and work toward achievement of specific personal recovery goals (including attaining meaningful employment if desired) • Assisting members with relapse prevention planning **Example Activities include:** • Peer support services • Peer-run employment services • Peer mentoring for children/adolescents • Recovery groups • Warm lines • Advocacy service **Notes:** (Including specific documentation and/or diagnosis requirements) Units can be bundled up to a total of 8 hours H0038 is the primary code to be used for services rendered by a Peer/Mentor/Specialist/Recovery Coach. When provided in conjunction with specific programs, including psychosocial rehab, ACT, Community-Based Wraparound, Clubhouse, Supported Employment and a prevention class, documentation of services provided should be tied to the program/class goals and the program/class procedure code should be used. **See Section X. Service Documentation Standards in this coding manual for documentation expectations**	**Service Provider** • Peer Specialist **Provider Types That Can Bill:** 01, 02, 05, 16, 24, 25, 26, 32, 35, 37, 38, 39, 41, 45, 63, 64, 89

Appendix B

Proposed Work Plan Example

Key Project Objective: Recruit and train five new Peer Support Professionals by 10/1/2023.	**Expected Completion Date**
Task 1: Develop a plan for peer outreach, recruitment, and training.	5/1/2023
Task 2: Create outreach materials	6/1/2023
Task 3: Conduct outreach & recruitment	7/1/2023
Task 4: Enroll peers in training	8/1/2023
Task 5: Peers complete training	10/1/2023

Appendix C
Budget Narrative Example

Personnel
Please provide employee title, salary, how many months of time are being requested, purpose of the role, and what percentage of the salary will be paid for with the grant. Please include information on your typical hiring process and timeline, as well as how you plan to sustain any additional personnel past the grant period.

Total Amount Requested: $ X

Calculations for the Cost:
Billing Administrator: Typical salary of $ X per month x 16 months =
Wages for Peer Support Professionals while they are going through training:
Hourly wage x # of hours x # of peers =

Narrative Justification: We are requesting that the grant pay 50% of the salary for a Billing Administrator who will be responsible for all Medicaid billing throughout the duration of the grant. This will support the strengthening of our administrative capacity in order to ensure compliance with all Medicaid requirements. The other 50% of the Billing Administrator's salary will be paid through the organization's general fund. This demonstrates our commitment to sustainability past the grant period.

We are also requesting grant funds to pay peers an hourly wage while they are going through a training program. This will support the development of the Peer Support Professional workforce as training programs are often cost prohibitive for this population when the training time is not paid.

Fringe Benefits
Please provide how your agency calculates fringe benefits for employees per each personnel request.

Total Amount Requested: $ X

Calculations for the Cost: Billing Administrator x typical salary x Fringe percentage x 16 months

Narrative Justification: Fringe includes benefits including health insurance, dental insurance and other benefits offered to all employees at the agency.

Training & Certification
Please provide the number and type of trainings and/or certifications you plan to fund through the grant. This may include training for both Peer Support Professionals, as well as supervisors. Please indicate the number of individuals who will be trained and/or certified, as well as an estimated timeline.

Total Amount Requested: $ X

Calculations for the Cost: 4 Peer Support Professional trainings x Cost =
2 peer supervisor trainings x Cost =

Narrative Justification: We are requesting funds to train 4 new Peer Support Professionals during the grant period, as well as to pay for two supervisors to go through a peer supervision training program. We intend to cover 80% of the training costs for Peer Support Professionals and to require that peers pay 20% of the cost in

order to ensure appropriate buy-in.

Travel

Please include information on the number of staff included, purpose of travel, destination of travel, estimated total number of trips, and calculate based on the CO state mileage rate of $0.56 per mile.

Total Amount Requested: $ X

Calculations for the Cost: Peer Support Professionals will travel 2 times weekly for 12 months to deliver services in the community. Service locations are X and Y. A supervisor will accompany them once quarterly for oversight. The estimated budget is calculated through the table below:

Who	***Where***	***Mileage***	***Frequency***	***TOTAL***
Peer Support Professional + Supervisor 1 time monthly	*Address 1*	*54 miles round trip * $0.56*	*5 times monthly*	
Peer Support Professional + Supervisor 1 time monthly	*Address 2*	*20 miles round trip * $.056*	*5 times monthly*	

Narrative Justification: The delivery of Peer Services in the community strengthens our program objectives because it enables clients to receive services in their home or other familiar locations. This contributes towards our program goals of accessibility and empowerment, as well promotes housing stability through providing life skills training and other prosocial activities within the client's home.

Capital Expenditures

Capital expenditures are subject to additional approval and may not exceed 10% of the total funds requested. Please provide any cost related to purchase of property, rental of property, computers, furniture, and software. Please separate out into three categories: space, equipment, and supplies.

Space

Please provide any equipment requests, cost estimate, rationale and justification for the request.

Total Amount Requested: $ X

Calculations for the Cost: Rent ($1000 / month) x 12 months =

Narrative Justification: To increase service accessibility for clients in rural settings, we are requesting funds to rent office space in a new location of Smith, Colorado. This location will serve as a hub for homeless services in this region, with a specific focus on providing Peer Support Services. Renting an office space will allow our staff to provide Peer Support Services in a confidential space, as well as connect clients to other available resources through a community hub model.

Equipment

Please provide any equipment requests, cost estimate, rationale and justification.

Total Amount Requested: $ X

Calculations for the Cost: # of cell phones x Cost =

Narrative Justification: We are requesting funds to purchase agency cell phones for the 4 new Peer Support Professionals who will be recruited and onboarded through this grant. The use of agency cell phones will protect the privacy of our staff, as well as promote timely communication for all work-related matters.

Supplies

Please provide any supplies requests, cost estimate, rationale and justification. Equipment can include office furniture, office supplies, equipment to support care provision of behavioral health.

Total Amount Requested: $ X

Calculations for the Cost: Types of furniture x Cost =

Narrative Justification: We are requesting funds to furnish Peer Service rooms with appropriate furniture and wall hangings. We aim to create a welcoming and comforting space in which Peer Support Professionals can meet with clients.

Contractor Costs:

Please provide any contractor costs including rationale, justification, and typical hourly cost for the vendor.

Total Amount Requested: $ X

Calculations for the Cost: Contractor rate x 6 months =

Narrative Justification: We are requesting funds to hire a contractor to support Medicaid billing for the first 6 months of the project while our administrative staff is getting up to speed. The contractor will support our Billing Administrator in learning the appropriate processes for coding and billing.

Other

Total Amount Requested: $ X

Calculations for the Cost: Monthly insurance policy cost x 12 months =

Narrative Justification: We are requesting funding to pay for the insurance that is required as a Medicaid provider for the duration of the grant period. Following the grant period, this cost will be written into the agency's general budget.

Indirect Costs

Indirect Costs are the costs incurred in support of general business operations but which are not attributable to a specific funded project. The assumed indirect cost rate is 10% of direct costs, with a maximum of $25,000 annually. Please review: Outgoing ARPA Grant Indirect Cost Limit Standard Operating Procedure

Total Amount Requested: $ X

Calculations for the Cost: Direct Costs x 10%

Narrative Justification: We are requesting funding to cover indirect costs related to general operations in order to ensure sufficient funding to expand Peer Support Services for the target population.