PROGRAM AWARD – IHS SERVICE UNITS

APPLICATION TEMPLATE

## APPLICATION CHECKLIST

* Letter(s) of support from Tribal agencies, offices, or enterprises with a significant role in the proposal.
* A letter of endorsement for the application from the Area Director or Area Chief Medical Officer and from the facility’s Chief Executive Officer.
* Completed Required Program Award Application components to include service unit and project information, primary contact, funding information, and signed acknowledgement of expectations.
  + Selection of the type of program award: Comprehensive Model of Care or New Care and Services.
  + New Care and Services program award applications must indicate in the title the specific care or services that will be implemented or improved.
* Abstract summarizing the project (1-page limit).
* Project Narrative (10-page limit; double-spaced except for tables which can be single-spaced)
* Baseline Data (1-page limit) that includes specified data
* Budget and Budget Narrative (5-page limit).
* Contractor or consultant resumes or qualifications and their related scope of work, as applicable.

**Optional documents may be submitted, including:**

* Organizational chart.
* Map of area identifying project location(s).
* Letters of support from other project collaborators.
* Additional documents to support narrative (e.g., data tables, news articles, etc.).

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# Part 1 (Required)

## SERVICE UNIT & PROJECT INFORMATION

|  |  |
| --- | --- |
| **PROGRAM NAME** |  |
| **LOCATION (CITY, STATE)** |  |
| **I.H.S. AREA** |  |
| **TRIBE(S) SERVED** |  |
| **PROJECT TITLE** |  |
| **OPTION SELECTED** | * Comprehensive Model of Care * New Care and Services |
| **DATE SUBMITTED** |  |

## PRIMARY CONTACT INFORMATION

Who is the primary contact for this initiative? This individual will be the one that the IHS Division of Clinical and Community Services communicates with regarding this initiative and the one who will be responsible for submitting progress reports and the continuation application if this project is funded.

|  |  |
| --- | --- |
| **Contact Name, Credentials** |  |
| **E-mail Address** |  |
| **Phone Number** |  |

## FUNDING INFORMATION

If your program is funded, a transfer of funds will be made from IHS Headquarters Division of Clinical and Community Services to your respective program. Please provide the following information in order to expedite this transfer.

|  |  |
| --- | --- |
| **Common Accounting Number (if IHS-Direct)** |  |
| **Annual Funding Agreement Number (if Tribal/Urban)** |  |
| **Area/Tribe Finance Point of Contact Name** |  |
| **Area/Tribe Finance Point of contact E-mail** |  |
| **Area/Tribe Finance Point of Contact Phone Number** |  |

## ACKNOWLEDGEMENT OF EXPECTATIONS AND REQUIREMENTS

To be considered for this project, you must attest to each of the following statements by checking the boxes (click on the box to mark).

* I agree to submit progress reports as outlined in the RFA.
* I agree to provide required evaluation, baseline, and 6-month data as required for the type of project application submitted.
* I agree to participate in up to quarterly conference calls in support of this project, where I will provide updated progress and data from my program.
* I agree develop a Driver Diagram (action-oriented logic model) by the end of year two of the project.
* I agree to develop a brief sustainability plan at the start of year two that outlines reimbursement and funding streams available to my program.
* I am not working with a Tribe who is currently receiving or who has applied for an IHS grant under the Addressing Alzheimer’s in Indian Country grant program.
* I agree to share project findings and disseminate project resources with I/T/U systems and staff.
* I give permission to the IHS Division of Clinical and Community Services’ Elder Health Program, to share best practices learned from my program’s implementation of this project, including data results.

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Signature and Date – Primary Project Contact**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Signature and Date – Senior Sponsor**

*Facility leadership with oversight and support responsibility for the project*

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Signature and Date - of Authorizing Authority**

# Part 2 (Optional Fillable Template)

**Use of the fillable template that follows is optional. You are welcome to use your preferred format(s) from this point forward.**

## ABSTRACT (1 page limit)

## NARRATIVE (10 page limit)

### Section 1. Organizational Overview

*Provide a brief description of the Service Unit and the Tribe(s) or Tribal Organization(s) served, including the health care delivery system and resources, elderly services and resources, long-term services and supports, and other Tribal or community-based services that might be involved.*

### Section 2: Needs

*Include any quantitative data on the existing dementia patient population and a narrative description of any dementia or caregiving-related activities undertaken to support the need for the proposed project. Identify the gaps in care and services and/or quality of care the project is intended to fill. If data is not currently available describe in detail how the applicant will obtain or develop this data in the first year of the program.*

### Section 3: Program Plan

*Describe in 2-3 sentences how the application specifically addresses the identified problem.*

Project Goals

SMART Objectives

Proposed Plan & Approach

*Describe the proposed plan and approach, including plans to demonstrate new or expanded services and enhanced patient outcomes. Identify specific potential sources of revenue that may, eventually, support service delivery. Applicants should consider existing evidence-based or evidence-informed strategies that meet their needs or describe the rationale and evaluation approach for new strategies.*

Key Personnel

*Identify all key personnel and any contractors or consultants instrumental to the project’s success, and both current and expected roles and responsibilities, including details about the Senior Sponsor (Service Unit leadership accountable for the program’s success). Comprehensive Model of Care applicants shall specifically note which staff will be allocated to coordinate development and implementation.*

|  |  |  |  |
| --- | --- | --- | --- |
| FIRST NAME LAST NAME | TITLE AND CREDENTIALS | PROJECT ROLES AND RESPONSIBILITIES  *Be sure to identify Senior Sponsor (see above) and note which staff is/are specifically allocated to coordinate development and implementation.* | # OF YEARS WITH YOUR PROGRAM |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
| *Add additional rows as needed.* |  |  |  |

### 

### Work Plan (2 page limit)

**You are welcome to use your own Work Plan format.**

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| ACTIVITY OR TASK | TIMELINE (Expected QUARTER of completion) | | | | | | | | LEAD STAFF |
| Year 1  Quarter 1 | Y1Q2 | Y1Q3 | Y1Q4 | Y2Q1 | Y2Q2 | Y2Q3 | Y2Q4 |
| E.g., Project kick-off meeting | **X** |  |  |  |  |  |  |  | **John Smith** |
| E.g., Review and analyze current clinical workflow | **X** |  |  |  |  |  |  |  | **Jill Smith** |
| E.g., Schedule staff training |  | **X** |  |  |  |  |  |  | **John Smith** |
|  |  |  |  |  |  |  |  |  |  |
| *Add additional rows as needed.* |  |  |  |  |  |  |  |  |  |

### Section 4: Evaluation Plan (1 page limit)

**You are welcome to use your own Evaluation Plan format.**

*Note: New Care and Services applicants will likely only select and describe activity, outputs/ outcomes, and data sources for one or two of the following five Key Activity areas.* *The evaluation plan for both applicant types must include metrics about the number of persons newly diagnosed, and persons living with a pre-existing dementia diagnosis. The evaluation plan for Comprehensive Model of Care applicants and New Care and Services applicants proposing a project focused on* ***Accurate and Timely Diagnosis*** *must also include metrics for screening and case-finding efforts among their patient population.*

|  |  |  |
| --- | --- | --- |
| KEY ACTIVITY | OUTPUTS / OUTCOMES | DATA SOURCES |
| 1. Awareness & Recognition | [e.g., # of screenings or # of referrals]   * # of persons newly diagnosed with dementia (see ICD codes)   Total # of person diagnosed with dementia (new diagnosis and existing) |  |
| 1. Accurate & Timely Diagnosis |  |  |
| 1. Interdisciplinary Assessment |  |  |
| 1. Management & Referral |  |  |
| 1. Support Caregivers |  |  |
| 1. *Add additional rows as needed.* |  |  |

Data Development Needs

*If the applicant needs to obtain or develop data as an element of this funding, the data needed and a description of how that data will be developed or acquired in the first year should be identified.*

Significant Factors Influencing Evaluation Efforts

*In one paragraph, describe any significant factors that influenced the evaluation planning and implementation, including opportunities or constraints that affected or will affect decisions about plan implementation.*

### 

### Section 5: Dissemination (2 page limit)

New Tools or Products Anticipated

## BASELINE DATA (1 page limit)

|  |  |
| --- | --- |
| At what age does your community consider an individual to be an older adult? |  |
| Total number of user population\* |  |
| Total number of individuals from the user population that have been diagnosed with dementia\*\* |  |
| Number of individuals 55 years and older in the user population |  |
| Number of individuals 65 years and older in the user population |  |
| Number of individuals 75 and older in the user population |  |
| Number of veterans 65 and older in the user population |  |

**\*The IHS User Population Definition:**

* Must have been seen at least once in the three years prior to end of the Report Period, regardless of the clinic type, and the visit must be either ambulatory (including day surgery or observation) or a hospitalization; the rest of the service categories are excluded.
* Must be alive on the last day of the Report Period.
* Must be AI/AN.
* Must reside in a community specified in the site’s GPRA community taxonomy, defined as all communities of residence in the defined PRC catchment area.

**\*See recommended dementia diagnostic codes on next page**

**Recommended Dementia Diagnostic Codes**

International Classification of Diseases 9th Revision Clinical Modification (ICD-9-CM) and ICD-10-CM codes used to define Alzheimer’s disease and Related Diseases and Dementias

*Note: this is a limited set of diagnostic codes that can be expected to capture most cases of dementia.*

|  |  |  |
| --- | --- | --- |
| **Disease Category** | **ICD-9-CM** | **ICD-10-CM** |
| Alzheimer’s Disease  Early Onset  Late Onset | 331.0 | G30.8, G30.9  G30.0  G30.1 |
| Dementia  Presenile Dementia  Senile Dementia | 290.40, 290.41, 290.42, 290.43,  294.10, 294.11, 294.20, 294.21  290.10, 290.11, 290.12, 290.13  290.0, 290.20, 290.21, 290.3 | F01.50, F01.51, F02.80, F02.81,  F03.90, F03.91  G31.1 |
| Related Diseases | 331.11, 331.19, 331.2, 331.7,  294.0, 294.8, 797 | F04, G13.8, F05, F06.1, F06.8, G31.2,  G31.01, G31.09, G94, R41.81 |

## 

## BUDGET AND BUDGET NARRATIVE (5 page limit)

**You are welcome to use your own budget and budget narrative format.**

| BUDGET CATEGORY | BUDGET DETAILS | YEAR 1 AMOUNT REQUESTED | YEAR 2 AMOUNT REQUESTED | TOTAL PROJECT COSTS | JUSTIFICATION |
| --- | --- | --- | --- | --- | --- |
| **Personnel (Not including contract staff – see below)**  Include budget details for each staff position | | | |  |  |
| Name, Position Title | * % FTE |  |  |  | E.g., Project coordinator will provide day-to-day management all of project activities and serve as primary point of contact and clinic champion. |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
| **TOTAL PERSONNEL COSTS** | |  |  |  |  |
| **Fringe Benefits** |  |  |  |  |  |
| **TOTAL FRINGE COSTS** | |  |  |  |  |
| **Travel** | | | |  |  |
| E.g., Staff attendance @ for IHS meeting | * 2 staff x 3 hotel nights @ $X per night; 2 staff x $airfare; 2 staff x $ transportation; 2 staff x $per diem |  |  |  | E.g., Travel for two people to attend one IHS meeting annually |
| E.g., Provider training in x intervention | * 2 staff x 3 hotel nights @ $X per night; 2 staff x $airfare; 2 staff x $ transportation; 2 staff x $per diem |  |  |  | E.g., Travel for two people to attend training on x evidence-based intervention |
| **TOTAL TRAVEL COSTS** | |  |  |  |  |
| **Equipment**  *Moveable equipment that cost $5,000 or more and with a useful life of one year or more* | | | |  |  |
|  |  |  |  |  |  |
| **TOTAL EQUIPMENT COSTS** | |  |  |  |  |
| **Supplies**  *Equipment items that cost less than $5,000 each and other supplies* | | | |  |  |
| E.g., Printing costs | * $X.XX per brochure x 4 brochures x X copies |  |  |  | E.g., Patient and caregiver educational materials post-diagnosis |
| E.g., Medical or community health supplies | * $X.XX per visit x XXX visits |  |  |  |  |
| **TOTAL SUPPLIES COSTS** | |  |  |  |  |
| **Contractual**  *Include detailed justification* | | | |  |  |
| E.g., Pharmacy Services | * Contractor name, SOW, $x per contract |  |  |  |  |
| E.g., Training consultant/ contract | * Contractor name, SOW, $x per contract |  |  |  |  |
| **TOTAL CONTRACTUAL COSTS** | |  |  |  |  |
| **Other** | | | |  |  |
| E.g., Intervention licensing costs | * XX license x $X per license * Rationale: |  |  |  |  |
| **TOTAL OTHER COSTS** | |  |  |  |  |
| Indirect Charges |  |  |  |  |  |
| **TOTAL INDIRECT COSTS** | |  |  |  |  |

### Budget Summary Table

| CATEGORY | YEAR 1 | YEAR 2 | TOTAL PROJECT COSTS |
| --- | --- | --- | --- |
| **Personnel** |  |  |  |
| **Fringe** |  |  |  |
| **Travel** |  |  |  |
| **Equipment** |  |  |  |
| **Supplies** |  |  |  |
| **Contractual** |  |  |  |
| **Other** |  |  |  |
| **Total Direct Charges** |  |  |  |
| **Indirect Charges** |  |  |  |
| **TOTAL** |  |  |  |

### Year 2 Budget Justification and Summary of Anticipated Changes