NEW MEXICO DEPARTMENT OF HEALTH AND NEW MEXICO FINANCE AUTHORITY

APPLICATION FOR FINANCIAL ASSISTANCE

I. GENERAL INFORMATION

A. Applicant: ______________________________ Application Date: ______________

Contact-Person: ________________________ Title: ____________________________

Mailing Address: ____

Telephone#: ____________________ Fax#: ________________________________

Bond/Legal Counsel: __________________________ Telephone #: ________________

Applicant's Bank: ___________________________ Bank Account #: ______________
(For Wire Transfer)

B. Is there a consulting professional contributing to the project: 9 Yes 9 No

Engineer/Architect: _________________________________ Telephone #: ____________

Address: ____

Other: _____________________________________ Telephone #: ________________

Address: ____

II. PROJECT SUMMARY

Project Description: The Public Health Division (Division) of the New Mexico Department of Health (DOH) and the New Mexico Finance Authority (NMFA) require the following to determine eligibility and to formulate appropriate lending instruments for Primary Care Capital Fund (PCCF) projects. Please complete the following information, using additional paper if necessary. Include any additional documents that may be useful in reviewing this project, i.e. architectural designs, survey plats, etc. The applicant shall respond in the order given, with the information requested, below. **Applicants shall submit one original including all required program data and attachments and 4 (four) clipped/bound copies of a completed application. The original application with original signatures should be labeled "original". Incomplete applications may be rejected as unacceptable.**

Submit application to:

New Mexico Department of Health
Office of Primary Care and Rural Health
Primary Care Capital Fund Program
300 San Mateo Blvd, NE Suite 900
Albuquerque, New Mexico 87108

A. DESCRIPTION OF THE PROJECT:

1. Stage of Capital Project Development

   a) Has a preliminary architectural design for the proposed capital project been completed? 9 Yes 9 No

   If yes, please attach a copy of the design documents to this application.

   b) Has a preliminary cost estimate for the proposed capital project been completed?

   If yes, please attach a copy of the cost estimate documents to this application.

   c) Has a site been acquired and developed for the proposed capital project?

   If yes, please provide a site plan and additional site description information.

   If no, please attach a complete site acquisition and development plan.

   d) Have final construction plans been completed?

   If yes, please attach a copy of these plans.

2. Project Action Plan: Present in detail all elements of the project. Include all items that have been completed and estimated time frame for completion of remaining items.

3. Describe the purpose of the project and provide a complete description of how the proposed project will be used. Include what services will be provided, levels of each service, staffing and anticipated organizational changes resulting from the project.

4. Describe the rural area or Health Care Underserved Area (HCUA) which the capital project will serve. Include key demographic and economic data, describe any special health needs of the area. Define the boundaries of the area using census tract data and geographic reference. Include the most current population data for the HCUA.

5. Describe how the proposed capital project meets the needs of the community and the priorities of the Department:

   a) Facility Need: describe whether the project will require renovation, repair, or replacement of existing facilities, expansion of existing facilities, or construction of new facilities. Give a justification for the approach taken. Describe how the facility will be used; age of existing facility, if appropriate; and assurances for in-kind support.

   b) Community Need: indicate the distance to other health services, and the relationship of the services housed at the proposed project with other providers and agencies (including but not limited to citizens groups, health and human service agencies, government, health care planning groups, emergency medical services, specialty medical services, dental services, home health services and hospital services).

6. Estimated Capital Project Start Date: ______________ Completion Date: ______________

7. Estimated useful life of the PCCF project, giving the source of funds to operate and maintain the capital

project over its useful life.

8. Describe how the applicant budgets for future capital purchases. Provide a five-year capital replacement / acquisition plan.

9. Does the applicant request assistance in the form of a contract to provide primary care services to the sick and medically indigent to offset all or part of the loan repayment: 9 Yes 9 No
If the answer is Yes, please answer the following:

a) Describe what adjustment to the loan repayment is being requested.
b) Complete the attached chart indicating the current and proposed levels of service to the sick and medically indigent:

		Last Completed Fiscal Year	**Current Fiscal Year [Projected]**	**Projected Year 1**	**Projected Year 2**	**Projected Year 3**
Encounters	Total Medical/Dental					
	Medicaid					
	Medicare					
	Sliding Fee					
Users	Total Medical/Dental					
	Medicaid					
	Medicare					
	Sliding Fee					
Staffing (FTEs)	Physician					
	Non-Physician Provider					
	Dentist					
	Dental Hygienist					
	Clinical Support					
	Administrative					
Financial Data	Total Revenue					

		Last Completed Fiscal Year	Current Fiscal Year [Projected]	Projected Year 1	Projected Year 2	Projected Year 3
	Total Unadjusted Primary Care Charges					
	Sliding Fee Adjustments					
Financial Data (con’t)	Bad Debt Write-off					
	Medicaid Revenue					
	Medicare Revenue					
	Sliding Fee Revenue					

B. TOTAL PROJECT COST AND SOURCES OF FUNDS:

1. Infrastructure Activities

Infrastructure	PCCF Loan Requested	Other Public Funds*	Private Funds	TOTAL
Land acquisition, clearance	$	$	$	$
Utilities (electricity, gas, water, etc.)				
Engineering				
Architectural				
Contingencies				
Project Administration				
Legal Fees				
Other (Specify)				
Infrastructure Total				

2. Construction Activities

Activities	PCCF Loan Requested	Other Public Funds*	Private Funds	TOTAL
Planning	$	$	$	$
Design				
Construction				
Equipment: fixtures				
Furniture				
Construction Total				
Construction and Infrastructure TOTAL				

3. *Other Public Funds, Amounts and Terms of these Funds (i.e., FmHA, CDBG, EPA, etc.)

Fund	Amount	Term
	$	

C. APPLICANT ORGANIZATIONAL INFORMATION

The following documents will be used by both the Division and the NMFA to determine the eligibility of the applicant and **must** be included:

1. Certification provided in Section IV (Page 8), certifying compliance with all applicable federal, state, and local laws and regulations, and that the applicant meets the definitions of a primary care clinic and/or hospice contained in the Act;

2. A letter certifying that the capital project or projects were duly authorized and approved by the applicant's governing body with any applicable hearing notice, minutes of the hearing, minutes of the meeting at which submission of this application was approved, and approving resolution;

3. Written assurance, signed by an attorney, that the applicant has proper title, easements, leases, and rights of way to the property upon which any facility proposed for funding is constructed or improved with copies of any existing title insurance policies, title abstracts or searches of the real property owned by the applicant. If any portion of the site or facility will not be owned by the applicant, describe that ownership;

4. Copy of plats, architectural drawings and specifications and construction plans, as appropriate. List of all required permits and licenses necessary to complete this project. Detail the status of each completed item, a plan of action for incomplete items, and time frame for acquiring incomplete permits and licenses. Also provide a copy of all permits and licenses obtained for this project;

5. Describe the funding source(s) to be pledged to repay the PCCF loan;

6. (a) Current year budget and current year unaudited financial statements that show receipts of the revenue stream to be pledged as security for the PCCF financing.
(b) Cash flow projections for your next fiscal year.
(c) Three (3) years of audited financial statements ending with the last full fiscal year.

7. A letter for each Non-PCCF loan source certifying approval, or explaining any exceptions;

8. Organizational Chart showing the structure and responsibility of each organizational unit noting any proposed changes as a result of the project;

9. Proof of current facility licenses and certifications (for proposed facility repair, renovation or expansion projects);

10. Biographical data and professional credentials for key staff members;

11. By-Laws with an indication of when it was last updated and approved by the Board of Directors; and/or applicant's enabling charter as amended;

12 IRS tax status letter and registration with NM Dept. of Taxation and Revenue;

13. Current Governing Board, and local Advisory Board if applicable, using the form provided in Appendix A;

14. Billing policies and procedures which maximize patient collections, assure that no person will be denied services because of the inability to pay, a sliding fee discount schedule, and address medically indigent persons between 100% and 200% of poverty without third party coverage;

15. W-9 Form provided in Appendix B;

16. Articles of Incorporation.

III. ADDITIONAL DEBT INFORMATION

A. Has the applicant ever defaulted on a debt? If so, provide a complete summary of all circumstances relative to the default.

B. Is there litigation pending which would have a bearing on this project or applicant? Please provide a complete record of insurance claims, lawsuits, etc. for the last five years.

C. Is there an alternative revenue source which will be pledged to pay debt service in the event that the primary pledged revenue is unavailable or insufficient? Explain.

D. Is there any additional outstanding debt that pledges the revenues that will be used for repayment of a PCCF loan? If so, provide copies of all outstanding debt documentation.

IV. CERTIFICATION

As the duly authorized representative of the applicant, I certify that the applicant:

A. Is a community based nonprofit primary care clinic or hospice that operates in a rural or other health care underserved area of the State and that has assets totaling less than ten million dollars ($10,000,000.00) and is a 501 (c)(3) nonprofit corporation for federal income tax purposes.

B. Has a local or regional primary care Governing or Advisory Board that is generally representative of the rural area or HCUA. Will comply with the guidelines for Governing and/or Advisory Board members to be residents of the area served and representative of the social, economic, linguistic, ethnic, and racial target population and shall include consumers of the applicants services.

C. Will abide by all Federal and State Laws, Rules, Regulations, and Executive Orders of the Governor of the State of New Mexico pertaining to equal opportunity. The applicant assures the Department of Health that no person in the State of New Mexico shall on the grounds of race, color, national origin, gender, sexual orientation, age, handicap or disability, or religion be excluded from employment with or the participation in, be denied the benefit of or be otherwise subjected to discrimination under any program or activity performed under a contract(s) entered into pursuant to this Application.

D. Will give the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standards.

E. Will comply with the provisions of federal certification regarding lobbying.

F. Will comply with the provisions of the Federal Assurance of Compliance Section with Section 504 of the Rehabilitation Act of 1973, as amended, and the Americans with Disabilities Act of 1990.

G. Will comply with the provisions of Title VI of the Civil Rights Act of 1964.

H. Will comply with the provisions of federal certification regarding debarment and suspension.

I. Will comply with the provisions of federal certification regarding drug-free workplace requirements.

J. Will comply with all other applicable state and federal regulations and requirements.

K. Has the authority to request and incur the debt described in this application and upon award, will enter into a contract for the repayment of any PCCF loans and/or bonds.

L. To the best of my knowledge all information contained in this application is valid and accurate and the submission of this application has been authorized by the governing body of the undersigned jurisdiction.

Signature:____ Date: _______________________

Printed Name of Certifying Official: ____

Title:___________________________________ Organization: _____________________________________

APPENDIX A
BOARD ROSTER FORMS

New Mexico Department of Health **Offeror Name**___________________
Public Health Division **Date**___________________

CURRENT GOVERNING BOARD, AND LOCAL ADVISORY BOARD COMPOSITION AND MEMBER CHARACTERISTICS

NAME	BOARD OFFICE	MALE/ FEMALE	RACE/ ETHNICITY	OCCUPATION/ EXPERTISE	Live (L) Work (W) in Service Area	BOARD TERM EXPIRES	Years Continuous Board Service	Consumer of Clinic Services Yes/ No

New Mexico Department of Health **Offeror Name**___________________
Public Health Division **Date**___________________

APPENDIX B
W-9 FORM

Print or Type

DO NOT SEND TO IRS
RETURN TO ADDRESS BELOW

State of New Mexico
DFA CONTROLLERS OFFICE
P.O. BOX 25116
SANTA FE, NM 87504-5116
PHONE (505) 827-5071
FAX (505) 827-3692

BUSINESS NAME ____

dba NAME ____

ADDRESS ____

CITY ____________________________ STATE __________ ZIP _________

BELOW PLEASE PLACE AN "X" BESIDE THE TYPE OF DESIGNATION WITH WHICH YOU CONDUCT BUSINESS WITH THE STATE. ENTER YOUR TAXPAYER IDENTIFICATION NUMBER (TIN) AT THE RIGHT.

INDIVIDUAL ORGANIZATION	TYPE OF TAXPAYER IDENTIFICATION REQUIRED	9 DIGIT TAXPAYER IDENTIFICATION NUMBER
____ INDIVIDUAL	INDIVIDUAL'S SSN (SEE REVERSE)	___ ___ ___ - ___ ___ - ___ ___ ___ ___
____ SOLE PROPRIETORSHIP	OWNER'S SSN OR FEIN (SEE REVERSE)	___ ___ ___ - ___ ___ - ___ ___ ___ ___
____ PARTNERSHIP	PARTNERSHIP'S FEIN	___ ___ - ___ ___ ___ ___ ___ ___ ___
____ ESTATE/TRUST	LEGAL ENTITY'S FEIN	___ ___ - ___ ___ ___ ___ ___ ___ ___
____ CORPORATION	CORPORATION'S FEIN	___ ___ - ___ ___ ___ ___ ___ ___ ___
____ TAX EXEMPT INCLUDING MEDICAL SERVICES UNDER SEC.501 (e) (3)	ORGANIZATION'S FEIN	___ ___ - ___ ___ ___ ___ ___ ___ ___
____ GOVERNMENTAL	GOVERNMENT ENTITY'S FEIN	___ ___ - ___ ___ ___ ___ ___ ___ ___
____ PROFESSIONAL CORPORATION PROVIDING A MEDICAL SERVICES	PROFESSIONAL CORPORATION'S FEIN	___ ___ - ___ ___ ___ ___ ___ ___ ___

____________ CHECK HERE IF TIN APPLIED FOR   LICENSE REALTOR YES________NO ________

UNDER PENALTIES OF PERJURY, I CERTIFY THAT:
(1)THE NUMBER SHOWN ON THIS FORM IS MY CORRECT TAXPAYER IDENTIFICATION NUMBER (OR I AM WAITING FOR A NUMBER TO BE ISSUED TO ME)
AND
(2) I AM NOT SUBJECT TO BACKUP HOLDING BECAUSE (a) I AM EXEMPT FROM BACKUP HOLDING, OR (b) I HAVE BEEN NOTIFIED BY THE INTERNAL REVENUE SERVICES (IRS) THAT I AM SUBJECT TO BACKUP WITHHOLDING AS A RESULT OF A FAILURE TO REPORT ALL INTERESTED OR DIVIDENDS OR (c) THE IRS HAS NOTIFIED ME THAT I AM NO LONGER SUBJECT TO BACKUP WITHHOLDING (DOES NOT APPLY TO REAL ESTATE TRANSACTIONS, MORTGAGE INTEREST PAID, THE ACQUISITION OR ABANDONMENT OF SECURED PROPERTY, CONTRIBUTED TO AN INDIVIDUAL RETIREMENT ACCOUNT (IRA) AND PAYMENT OTHER THAN INTEREST AND DIVIDENDS CERTIFICATION INSTRUCTIONS..
YOU MUST CROSS OUT ITEM (2) ABOVE YOU HAVE BEEN NOTIFIED BY IRS THAT YOU ARE CURRENTLY SUBJECT TO BACKUP WITHHOLDING BECAUSE OF UNDERREPORTING INTEREST OR DIVIDENDS ON YOUR TAX RETURN (ALSO SEE SIGNING THE CERTIFICATION ON THE REVERSE OF FORM)

NAME (Print or Type) ____ TITLE (Print or Type) _________________________________

SIGNATURE ____ DATE _____________________ TELEPHONE (_____)________________

DO NOT WRITE BELOW THIS LINE

DFA USE ONLY

AGENCY NAME _____________________________________

SENT BY: ______________________________________   VEND ADDITIONS_____________CHANGE____________

DIVISION/BUREAU _____________________________________   1099 Y_____________ N___________

OFFICE LOCATION ______________________________________   ACTION COMPLETED BY: ______________DATE______________