

**Developmental Disabilities (DD) APPLICATION**

**North Dakota Home and Community Based Services**

**Agency Development Grant**

The grant application and supporting documentation should be submitted by email to [NDARPA@mslc.com](mailto:NDARPA@mslc.com)

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| **ABOUT THE ORGANIZATION** | |
| **Applicant Medicaid ID or Tax ID:** | |
| **Agency/Applicant Name:** | |
| **Primary Contact Name:** | **Mailing Address:** |
| **Phone:** | **Email Address:** |
| **Your agency’s work with Medicaid-funded HCBS**  *Work completed in the past twelve months and planning to expand or establish.*   |  |  |  |  | | --- | --- | --- | --- | |  |  |  |  | | **Provider Type** | Are you an existing provider? *(yes/no)* | If yes –  are you planning to expand?  *(yes/no)* | If no – are you establishing a new approved agency?  *(yes/no)* | | **HCBS waiver** |  |  |  | | **Developmental Disability waiver** |  |  |  | | **Autism Spectrum Disorder waiver** |  |  |  | | **1915(i) State Plan Amendment** |  |  |  |   For the purposes of this grant, a DD HCBS Agency is defined as a new organization who intends to offer one or more of the approved DD 1915(c) services, or an existing DD agency who intends to expand into new DD 1915(c) services or geographies where HCBS eligible individuals have a need for services.  Entities can apply for these funds by submitting the ND DD HCBS Agency Development Grant Application that outlines the services they intend to provide, the counties they intend to serve, and a project budget utilizing the Grant Application. The budget should outline how they will utilize the funds to create and operate as a DD HCBS Agency or expand services to HCBS eligible individuals.  Preference will be given to proposals received from applicants who will provide:  Services designed to serve youth with significant behavioral needs; or  Services that address behavioral health needs for children and adults; or  Expansion of opportunities for competitive employment | |
| **Applicant’s Current Organization Type:** (select all that apply)  Not-for-Profit business  For-Profit business  Sole proprietor (individual)  Private human service provider  Public human service provider (Human Service Zone)  Hospital  Long Term Care Facility  Home Health Agency  Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| **Expectations of Grantee**  Meet with DHS representatives before the grant period begins to review the business plan, which must include the budget and timeline. The business plan must identify the following:   * Date the DD Agency will complete the licensing/enrollment process, if applicable (must be within 6 months of grant approval) * Date the DD Agency will begin marketing efforts to promote agency and/or expand services. * Anticipated date new HCB Services will begin * 3-month service delivery milestone * 6-month service delivery milestone * Grant close-out (final expenses submitted and project report complete)   If Grantee fails to fulfill the expectation to become a DD HCBS Agency or begin delivering services to the expanded population within six months of grant award, all grant funds must be returned. Likewise, if grantee fails to maintain its status as an active provider of DD HCBS services for at least 6 months after receiving required approval to do so, all grant funds must be returned. | |

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| **GRANT PROJECT** **DETAIL**  *Please note:**You can choose to include your responses as an attachment or within the space provided on the application form. If you are using a separate document to provide information, please note with “See Attached”.* |
| **Project Title:** |
| **Amount of Grant Request:   $**  *(maximum $50,000)* |
| **Agency/Business mission statement/value proposition:** |
| **Why you are applying for the grant funds (explain need for funds)?** |
| **Current county or counties being served:** |
| **For expansion strategy, which county or counties do you plan to provide services to:** |

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| **DD PROJECT IMPLEMENTATION** | |
| **What services do you plan to provide?** | |
| **How do you plan to obtain the necessary training / credentialing to deliver the service(s) with a high level of quality?** | |
| **Anticipated number of employees in the DD HCBS Agency (new and existing).** | |
| **Given your business plan, how many clients do you anticipate being able to serve? Please delineate by service if providing more than one service.** | |
| **Who will be responsible for the project implementation? Briefly describe their experience/background.** | |
| **What types of support (e.g., technical assistance, information, resources) do you anticipate needing to carry out your project successfully?** | |
| **How will these grant funds help you successfully implement your project?** | |
| **Signature:** | **Date:** |