Cover Page for NC Farmworker Health Program Funding

Track III: Behavioral Health Services Support

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| --- |
| **Contractor Name (Agency)** Click or tap here to enter text. |
| **Contractor Tax ID#** Click or tap here to enter text. **Contractor DUNS#** Click or tap here to enter text. |
| **Contractor Street Address** Click or tap here to enter text.**City** Click or tap here to enter text. **State** Choose an item. **ZIP** Click or tap here to enter text. |
| **Contractor P.O. Address** *(if applicable)* Click or tap here to enter text. |
| **City** Click or tap here to enter text.  **State** Choose an item.  **ZIP** Click or tap here to enter text. |
| **Contractor Fax Number** Click or tap here to enter text. |
| **Contract Administrator’s Name** Click or tap here to enter text. **Title** Click or tap here to enter text. |
| **Contract Administrator’s Phone Number:**Click or tap here to enter text. **Email** Click or tap here to enter text. |
| **Contractor Signatory’s Info** *(if different from Contract Administrator)* **Name** Click or tap here to enter text. |
| **Title** Click or tap here to enter text. **Phone Number** Click or tap here to enter text. **Email** Click or tap here to enter text. |

**Agency’s fiscal year:** Choose an item. **through**  Choose an item.

**Agency’s Electronic Health Record** Yes [ ]  No [ ]

If yes, please provide name of EHR. Click or tap here to enter text.

|  |
| --- |
| **Contact person for this application:** Click or tap here to enter text. |
| Phone: Click or tap here to enter text.  | Email: Click or tap here to enter text. |
| **Select the type of agency from the drop-down menu:** Choose an item.**If other, please describe**: Click or tap here to enter text. |

Application for NC Farmworker Health Program Funding

Track III: Behavioral Health Services Support

**Section I: Service Delivery Model**

1. **Briefly describe your agency’s proposed approach to providing behavioral health services, including how this approach enhances access to quality services for farmworker patients of NCFHP Service Delivery Sites.** *(limit 200 words)*

Click or tap here to enter text.

1. **Describe your agency’s approach and experience providing behavioral health services that are linguistically and culturally relevant for the majority of NC’s farmworker population.** *(limit 200 words)*

Click or tap here to enter text.

1. **Please list the NCFHP Service Delivery Sites and counties where your agency plans to provide behavioral health services during the 2022-2023 contract year.**

Click or tap here to enter text.

1. **Please describe your proposed partnership with NCFHP Service Delivery Sites, including how you plan to submit documentation of patient encounters, communicate about provider schedules, and coordinate any needed case management.** *(limit 200 words)*

Click or tap here to enter text.

1. ***Currently funded agencies only*: Describe any achievements or successes associated with this initiative during the last year.** *(limit 300 words)*

Click or tap here to enter text.

1. ***Currently funded agencies only:* Describe any challenges you encountered with this initiative during the last year and your plans to respond to these challenges.** *(limit 200 words)*

 Click or tap here to enter text.

1. **Please describe what clinical patient outcomes you will monitor, how you will measure them, and how you will use the findings for quality improvement.** *(limit 150 words)*

Click or tap here to enter text.

1. **Please describe how your agency plans to incorporate patient feedback in program planning and quality improvement activities.** *(limit 150 words)*

Click or tap here to enter text.

**Section II: Access to Health Services**

Please complete the following table with your hours of operation. Please specify what evening or weekend hours will be available for farmworkers to help ensure access, especially during peak agricultural season.

|  |  |
| --- | --- |
| **Regular service hours:** | **List NCFHP Service Delivery Sites whose patients can access these hours of operation:** |
| Day:       | Time:       | Click or tap here to enter text. |
| **Evening hours available to farmworkers:** ***Example:****Day****: Thursday*** *Time:* ***6-10 pm*** *Months:* ***April-October*** |  |
| Day:       | Time:       | Months:       | Click or tap here to enter text. |
| Day:       | Time:       | Months:       | Click or tap here to enter text. |
| Day:       | Time:       | Months:       | Click or tap here to enter text. |

**Section III. 2021 Performance**

***Currently funded applicants only***

Please report on outcomes for calendar year 2021 (January 1, 2021-December 31, 2021) in the table below.

|  |  |  |  |
| --- | --- | --- | --- |
| **Measure** | **2021** **Goal** | **2021****Actual** | **If you did not meet your goal, what challenges did you face? If you met your goal, what contributed to your success?** |
| Unduplicated patients | Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. |
| Behavioral health encounters | Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. |

**Section IV. 2022 Goals**

Please complete the following table with your goals for the 2022 calendar year (January 1, 2022-December 31, 2022).

|  |
| --- |
| **2022 Goals** |
| Total Patients | Click or tap here to enter text. |
| Total Encounters | Click or tap here to enter text. |

**Section V: Contacts**

**key staff contact information**

**Clinical Supervisor of NCFHP funded provider(s):**

|  |  |
| --- | --- |
| **Name:** | Click or tap here to enter text. |
| **Phone:** | Click or tap here to enter text. |
| **Email:** | Click or tap here to enter text. |

**Farmworker Health Telemedicine Program Manager:**

|  |  |
| --- | --- |
| **Name:** | Click or tap here to enter text. |
| **Phone:** | Click or tap here to enter text. |
| **Email:** | Click or tap here to enter text. |

**Fiscal Manager for Farmworker Health Grant:**

|  |  |
| --- | --- |
| **Name:** | Click or tap here to enter text. |
| **Phone:** | Click or tap here to enter text. |
| **Email:** | Click or tap here to enter text. |

**Medical Director:**

|  |  |
| --- | --- |
| **Name:** | Click or tap here to enter text. |
| **Phone:** | Click or tap here to enter text. |
| **Email:** | Click or tap here to enter text. |

**HIPAA Contact:**

|  |  |
| --- | --- |
| **Name:** | Click or tap here to enter text. |
| **Phone:** | Click or tap here to enter text. |
| **Email:** | Click or tap here to enter text. |

**Contact for Provider Credentialing:**

|  |  |
| --- | --- |
| **Name:** | Click or tap here to enter text. |
| **Phone:** | Click or tap here to enter text. |
| **Email:** | Click or tap here to enter text. |