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| **DEPARTMENT OF HEALTH SERVICES**Division of Quality AssuranceF-00176 (08/2017) | **STATE OF WISCONSIN**Page 1 of 4 |
| **CIVIL MONEY PENALTY FUNDS PROJECT PROPOSAL** |
| **For Stakeholders of Federally Certified Nursing Facilities and Skilled Nursing Facilities****Applying for Use of Civil Money Penalty Funds** |
| **INTRODUCTION**This project proposal form is an application for grant monies derived from Civil Money Penalty (CMP) funds. Grants are available for projects or programs that are provided through various stakeholders, e.g., federally-certified skilled nursing facilities (SNFs) and nursing facilities (NFs), consumer groups, professional nursing home associations, advocacy groups, quality improvement organizations.**Note: These grants are not available to state-licensed only nursing facilities or stakeholders.**The Quality Assurance and Improvement Committee (QAIC) reviews all proposals. The QAIC is the sole judge as to compliance with the requirements contained in this form. The QAIC retains the right to accept or reject any or all proposals or to accept or reject any part of a proposal. Proposals which do not comply with instructions or are unable to comply with specifications mandated by the QAIC may be rejected.The QAIC may request reports regarding the financial stability of an applicant and, if financial stability is not substantiated, may reject the proposal. Recipients of awards will be required to make project reports to the QAIC at least every three months unless, based upon the nature of the project, the QAIC decides otherwise.For more information regarding these grants and the QAIC, see DQA publication P-00422, *Quality Assurance and Improvement Committee, and* visit <https://dhs.wisconsin.gov/regulations/qai/introduction.htm> .Questions may be addressed to the **Division of Quality Assurance**at **608-266-8481.** |
| **FUND RESTRICTIONS**Below is a list of restrictions received from the Centers for Medicare and Medicaid Services:1. **Lodging (Allowable)**

Lodging to attend a training or conference is allowable, as long as the attendee lives at least 50 miles away and the conference is longer than one day.1. **Travel (Allowable)**
2. Travel for a contractor to visit multiple facilities to conduct training
3. Travel reimbursement for nursing home staff to attend training or a conference
4. Travel of nursing home staff who have become “Train the Trainers” to travel to other sites and conduct training
5. **Food – Per diem (Not Allowable)**
6. Food is an expense that is not allowable under the CMP Use Program.
7. Per diem must be broken down so that travel, lodging, and food are separated and food can be excluded.
8. **University Health and Human Services Rate Agreements**

If a proposal is submitted by a university and includes fringe benefits and facility and administrative costs for university staff, the university must include a copy of their department of health and human services rate agreement. |
| **SUBMISSION INSTRUCTIONS**1. Requests will **NOT** be accepted via facsimile or mail. All requests must be submitted electronically to: **dhswebmaildqa@wisconsin.gov**

 In “Subject” line, enter: **ATTN: Quality Assurance and Improvement Committee**1. All applicants must submit their request using DQA form **F-00176, *Civil Money Penalty Funds Project Proposal.***

3. Requests shall include a cover letter addressed to the Quality Assurance and Improvement Committee.4. The font for all CMP requests is Times New Roman, 12 point. The entity name, project title, and page numbers must be present on all documents.5. Request should be limited to no more than 10 pages, including appendices and the actual request form (DQA form F-00176, *CMP Funds Project Proposal*). Pages should not include color background, photos, or illustrations (as are often found in PowerPoint presentations).6. When CMP funds are requested for educational purposes, the applicant must also include:* Anticipated number of attendees
* Target audience
* Accrediting authorities
* Time-line for implementation
* Plan for sustainability
* Letters of support

Representatives from any group requesting funding or representatives who are in situations where a conflict of interest exists, must disqualify themselves from making recommendations.*(Continued on page 3)* |
| **GENERAL INFORMATION**  |
| Title – Project       |
| Name – Applicant *(Submitting Organization)*      | Tax ID No. (FEIN)      |
| Mailing Address – Street Address or P.O. Box      | City      | County      | State   | Zip Code      |
| Name – Project Contact      | Title – Project Contact      |
| Telephone No.      | Email Address      | Date Submitted *(MM/dd/yyyy)*      |
| **SIGNATURE** – Project Originator | Date Signed *(MM/dd/yyyy)*      |
| **PROJECT DETAILS** |
| The following items are expandable. |
| 1. **Summary of the Project and its Purpose.** Provide a summary of the project. List the (a) problem or gap this project is aiming to address, (b) goals and/or objectives, and (c) a plan to implement the project to include a timeline. |
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| 2. **Unique / Innovative.** Briefly describe how your proposal is unique and innovative and how it is relevant to the improvement of quality of care / life for residents in Wisconsin nursing homes. Append any supportive research or literature. |
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| 3. **Expected Outcomes.** Describe the intended outcomes and sustainability of the project. |
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| 4. **Deliverables.** Provide a detailed, numbered list of the project deliverables. Include all components of the project, such as planning, implementation, and evaluation. |
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| 5. **Scope of Work.** Provide a detailed, numbered list of the intended scope of work. Include all components of the project, such as planning, implementation, and evaluation. |
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| 6. **Documentation of Results.** Explain how the information from the results of your proposal will be gathered and evaluated. |
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| 7. **Results Measurement.** Describe the methods by which the project results will be assessed. Include specific measures. |
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| 8. **Non-Supplanting.**  Describe the manner in which the project will not supplant existing responsibilities of the facility to meet current Medicare/Medicaid requirements or other statutory and regulatory requirements. |
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| 9. **Qualifications.** Describe how your organization is qualified to carry out the proposal. |
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| 10. **Consumer and Other Stakeholder Involvement.** Describe how the facility community, including resident and/or family councils and direct care staff, will be involved in the development of the project.  |
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| 11. **Involved Organizations.** List all organizations (names and addresses) that will receive funds through this project. Also, list sub-contractors and organizations that are expected to execute and bear responsibility for components of the project.  |
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| 12. **Other Funding Sources.** If other funding sources have been applied for and/or granted for this proposal or project, explain and identify sources and amounts. |
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| 13. **Funding.** Provide the specific amount of CMP funds requested, an itemized budget to be used for this project, and an estimate of any non-CMP funds that the State or other entity are expected to contribute to the project.  |
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| 14. **Time Period.** Provide the time period of the project. |
| No. of Years:  |    | Specific Dates Proposed for the Project – From:  |       | To: |       |
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| **ATTESTATION** |
| The applicant attests that all statements made and information provided on the Civil Money Penalty Funds Project Proposal are true and correct. |
| **SIGNATURE** – Applicant | Name – Applicant *(Print or type.)*      | Date Signed      |