Community Capacity Grants-Application Questions

For reference only.

This PDF is provided so you can preview the application questions and prepare your responses in advance. All responses must be submitted through the official online application, which opens October 1. Please do not complete or return this PDF, as it will not be accepted.

To be eligible to apply for and receive Community Capacity Grants, organizations must meet the following eligibility criteria.

Please attest that your organization meets each of the following criteria:

#1: Your organization is enrolled in or intends to enroll in the HOKU system as an eligible HRSN provider type.

☐I Attest

#2: If your organization is not yet enrolled in the HOKU system, your organization does not appear on applicable federal or state exclusion lists, including:

- Hawaii Provider Exclusions/Reinstatement List
- U.S. Department of the Treasury Office of Foreign Assets Control (OFAC) Sanctions Lists
- Social Security Administration Death Master File (SSADMF)
- System of Award Management (SAM) Exclusions Database
- U.S. Department of Health and Human Services Office of Inspector General (HHS-OIG) List of Excluded Individuals and Entities (LEIE)

☐ I Attest

#3: Your organization intends to serve as an HRSN provider for at least one HRSN service

☐ I Attest

#4: Your organization has demonstrated capability to provide one or more HRSN services delivered to Medicaid beneficiaries in Hawaii. For the purposes of this requirement, capability is defined as having either:

- One (1) or more years of relevant experience providing HRSN, similar, or related services in Hawaiʻi; *OR*

- Demonstrated experience operating in Hawai‘i for at least one (1) or more years and capacity to participate in the delivery of one (1) or more HRSN services.

☐ I Attest

#5: Your organization has demonstrated capacity to deliver culturally and linguistically appropriate services by:

- Demonstrating a willingness and ability to draw on community-based values, traditions, and customs to devise strategies to better meet culturally diverse member needs, and to work with knowledgeable people of and from the community in developing focused interactions, communications, and other supports.
- Demonstrating a willingness to provide services to people of all cultures, races, ethnic backgrounds, and religions, including those with limited English proficiency and/or disabilities, and regardless of gender, sexual orientation, or gender identity, in a manner that recognizes, affirms, and respects the worth of the individual member and protects and preserves the dignity of each.

☐ I Attest

#6: Your organization is financially stable with a current external audit indicating no material weakness or significant deficiencies that would impede responsible management of public funds.

☐ I Attest

#7: If awarded, Community Capacity Grant funding will not duplicate other federal, state, and local funding for the same purpose.

☐ I Attest

#8: If awarded, your organization will participate in federal and state required reporting, monitoring, and external evaluation activities.

☐ I Attest

PART 1: GENERAL AGENCY INFORMATION

1. Organization Name
2. Mailing Address
3. Authorized Contact
    a. First Name
    b. Last Name
    c. Phone
    d. Email
    e. Title
4. Point of Contact
    a. First Name
    b. Last Name
    c. Phone
    d. Email
    e. Title

5. Is your organization currently enrolled in HOKU?
    a. Yes/No

6. If Yes, please provide your Medquest Provider ID

7. If No, will you be enrolled in HOKU by the time of the grant award period?
    a. Yes/No

8. Select Organization Type
    a. Community-based Nonprofit
    b. Healthcare Provider Organization
    c. FQHC
    d. Behavioral Health Provider
    e. Social Service Provider
    f. Housing Provider
    g. Food/Nutrition Provider
    h. Faith-based Organization
    i. Educational Institution
    j. For-profit Organization
    k. Other

9. Funding Amount Requested (per year, up to two years)
    a. *Recommended range is between $100,000-$1,000,000 per year*

10. What is the length of the program?
    a. 1 year
    b. 2 years
    c. 3 years

Organizational Background

11. Which types of HRSN services does your organization currently deliver or plan to deliver to Medicaid beneficiaries in Hawaii? Select all that apply.
    a. Nutrition Supports Providers
    b. Community Integration Services Plus (CIS+) Providers
    c. Medical Respite Providers

12. Please describe your organization's experience providing HRSN or similar services.

13. How many Hawaii-based staff does your organization currently employ?

14. Which island(s) is your organization currently serving? Select all that apply
    a. Hawai'i (Big Island)
    b. Kaua'i
    c. Lānaʻi
    d. Maui
    e. Molokaʻi
    f. O'ahu
    g. All Islands

15. What region(s) will you be serving on Hawaiʻi Island as an enrolled HRSN provider? Select all that apply
    a. Hawaiʻi Island
        i. Hilo (East Hawaiʻi)
        ii. Puna
        iii. Kaʻū
        iv. Kona (North & South Kona)
        v. Kohala (North & South Kohala)

vi. Hāmākua
vii. Waimea

b. Maui
    i. West Maui
    ii. South Maui (Kīhei/Wailea area)
    iii. Central Maui (Kahului/Wailuku)
    iv. Upcountry (Kula, Makawao, Haʻikū area)
    v. East Maui (Hāna)

c. Oʻahu
    i. Honolulu (urban core)
    ii. Windward Oʻahu (Kāneʻohe, Kailua)
    iii. Leeward Oʻahu (Waiʻanae Coast)
    iv. ʻEwa (Kapolei, ʻEwa Beach, Makakilo, Kunia)
    v. North Shore (Mokulēʻia, Haleʻiwa, Pūpūkea)
    vi. Koʻolauloa (Kahaluʻu, Kaʻaʻawa, Kualoa, Hauʻula, Lāʻie, and Kahuku)
    vii. Central Oʻahu (Wahiawā, Mililani, Pearl City, Waipahu, ʻAiea)
    viii. East Oʻahu (Hawaiʻi Kai, Waimānalo)

d. Kauaʻi
    i. North Shore (Hanalei, Princeville)
    ii. East Side (Kapaʻa, Wailua)
    iii. South Shore (Poʻipū, Kōloa)
    iv. West Side (Waimea, Hanapēpē)

e. Molokaʻi
    i. East Molokaʻi (Kaunakakai)
    ii. West Molokaʻi
    iii. Kalaupapa

f. Lānaʻi
    i. Lānaʻi City
    ii. Windward side
    iii. Leeward side (Mānele/Hulopoʻe)

16. Please describe your organization's role in the community and experience providing services in a culturally and linguistically appropriate manner.

17. Please identify any other federal, state, local, or private funding sources currently supporting, or expected to support, the same or similar activities included in this application.

18. Please select focus area(s) of the application. Select all that apply
    a. Business and Operational Practices
    b. Technology Investments
    c. Workforce Development
    d. Education and Outreach

19. For providers not yet enrolled in HOKU, please describe how funds will support readiness for participation in Medicaid HRSN program activities and your plans for HOKU enrollment.

20. Describe how the expenditures and activities listed in your budget will help develop your organization's capacity to implement and continue to deliver HRSN services.

21. If awarded funding, what is your anticipated timeline for fund expenditure?

22. Are you applying jointly with other eligible organizations (up to 3 other organizations)?
    a. Yes/No

23. If applying jointly with other eligible organizations, please provide the following information for each organization on whose behalf you are applying as the lead applicant. You may include up to three (3) co-applicants.
    a. Co-Applicant Organization Name
    b. Co-Applicant Organization Type
        i. Community-based Nonprofit
        ii. Healthcare Provider Organization
        iii. FQHC
        iv. Behavioral Health Provider
        v. Social Service Provider
        vi. Housing Provider
        vii. Food/Nutrition Provider
        viii. Faith-based Organization
        ix. Educational Institution
        x. For-profit Organization
        xi. Other
    c. Co-Applicant Address

d. Co-Applicant Name
e. Co-Applicant Phone
f. Co-Applicant Email
g. Co-Applicant Title
h. Please briefly describe how the requested funding will be utilized and shared among all co-applicants and how activities will be coordinated between the partner organizations

☐Do you attest that each organization listed meets all the eligibility requirements?

Upload Supporting Documentation

The following documents are **required**:

- Completed Budget Template
- Organizational Chart
- Viable Financial Plan (as applicable)
- Documentation for co-applicants (as applicable)
- Most recent audit
- Proof of demonstrated capability

Please attach any documents that support your request.

Applicant Signature

☐By checking this box and providing your name below, you attest that you are authorized to submit this application and that the information provided is true and accurate to the best of your knowledge.