TITLE XVI HEALTH CENTER LOAN GUARANTEE PROGRAM APPLICATION

Please answer all questions as completely and accurately as possible and provide all requested attachments.
Only shaded/starred items are required for pre-application.

*I. BACKGROUND

Legal Name of Borrower: CHC Name
Current Address:
Address of Project:
Executive Director:

Contact Name (if different):
Title:
Telephone:
Fax:

Legal Counsel (Firm):
Address:
Telephone:
Fax:

Attorney's Name:
Telephone:
Fax:
Email:

Borrower's Accountant:
Address:

II. BOARD OF DIRECTORS AND MANAGEMENT

A) ***Attachment 1:*** Please provide a complete list of your Board of Directors and officers, including names, addresses, employer and position.

B) ***Attachment 2:*** Please provide a list of all Senior Management personnel and resumes.

III. BUSINESS ORGANIZATION AND CORPORATE RELATIONSHIPS

A) Are you corporately integrated with (e.g., a subsidiary of) any other organization? Yes / No

If yes, please indicate name, address, type of legal relationship, and nature of integration.

B) Are you involved in any joint ventures? Yes / No

If yes, please indicate names, addresses, and types of legal relationships.

C) Is there a developing or operating Health Center managed care network in your marketplace? Yes / No

If yes, is your health center involved? Yes / No

D) How is the health center collaborating with other entities to integrate service delivery?

*IV. PROGRAM INFORMATION

*A)	(Note: For the following program information, please note any projected changes due to the facility project. Mission of Borrower:
*B)	Please circle each of the medical/dental services offered: Adult Medicine Ambulatory Surgery Dental Home Care Laboratory Mental Health Occupational Health Pediatrics Pharmacy Substance abuse Urgent Care Vision Elder care Family Planning Nutrition OB/GYN Podiatry Radiology Care Other medical/dental services offered (please list):
*C)	Description of any other programs offered:
*D)	Geographic Service Area: (please name census tracts/counties/towns served)
*E)	Population of Service Area:
*F)	In the table below, please indicate the daily hours of operation of the health center.

Hours of Operation	**Sun.**	**Mon.**	**Tues.**	**Wed.**	**Thurs.**	**Fri.**	**Sat.***	**Total:**
Existing								
Planned								

G) What percentage of users fall: below 100% of poverty between 100% and 200% of poverty between 200% and 400% of poverty?

Income Category	**Percent**
Below 100% of Federal Poverty Level	
Between 100% and 200% of Federal Poverty Level	
Over 200% of Federal Poverty Level	

*V. PROJECT INFORMATION

*A) Purpose of loan (circle all that apply):

- Facility Acquisition
- New Construction
- Renovation
- Land Acquisition
- Equipment Purchase
- Refinance Existing Debt
- Modernization

*B) Permanent financing will be needed: From to

Construction financing will be needed: From to

*C) The facility housing the project to be financed is: Owned / To Be Purchased. If you currently own, is your facility mortgaged? Yes / No

*D) Site Control:

If you do not presently own the site, please describe the status of your plans to purchase the site (i.e. what needs to be done for you to control the site). Indicate the estimated acquisition price for the proposed site.

*E) Site Location:

Describe what presently exists on the site as well as in the immediate surrounding area (empty lot, vacant/occupied buildings, residential/commercial uses). Describe whether the location of planned facility is conducive to successfully providing primary care, in terms of its access to public transportation and other transportation routes, commercial activity and residential concentrations.

*F) Facility Square Footage:

In the table below, please indicate the total square footage of your current facility and the projected total square footage following the project.

Description of Area	Current Site (Sq. ft.)	Projected Site (Sq. ft.)
Medical		
Dental		
Laboratory		
Administrative		
Other (specify)		
Common Area		
Total Sq. Footage		

*G) Will any other organization occupy space at this facility? Yes / No

If yes, list organizations, amount of space to be occupied, and terms of lease.

*H) In the table below, please indicate the total number of existing and new examination rooms.

Description of Area	Current	Projected
Medical Exam Rooms		
Dental Operatories		

*I) Please provide the following pieces of project information:

**Attachment 3:* Description of capital project .

**Attachment 4:* Please provide a detailed capital project budget.

**Attachment 5:* Please complete Attachment 5 to detail the sources and uses of project funding.

**Attachment 6:* Business Plan or a financial/operational justification for the project. This statement should include the following types of information:

Project Justification: Discuss the need for services in your targeted service area. What unmet public health needs will the project help to meet? How will this project help you address changes in the health care environment in your area? Why is this project important to your health center? How will this project influence your ability to serve patients?

Demand: Provide an analysis of current demand for primary care services in the target community, and how the planned project will respond to that demand. If a formal demand analysis has been conducted for this site, include that analysis as an attachment. Is the health center's patient population growing or changing in composition? What effect will those changes have on the health center's services or volume? Include information on the location and capacity of competing health care providers.

Financial Feasibility: Discuss your organization's ability to assume the debt involved in financing the planned facility. How will the project affect annual operating revenues and expenses? How will you fund initial operating deficits, working capital needs, and start-up costs, if any? How does your organization plan to meet the equity needs of the project?

Market and Staffing : What plans do you have to market your services? How will you reach your target markets? Please discuss your recruitment and retention plan for the clinical staffing of the proposed facility. Describe your capacity for achieving this objective (e.g. your past record of recruitment and retention, linkages to medical institutions that will assist, participation in special programs, etc.)

**Attachment 7:* Consistent with your stated plan (detailed in Attachment 6), please provide budget projections to cover the period from the present through completion of construction, plus three additional years after occupancy. Include those assumptions and projections covered in the following three attachments (8, 9, & 10), as well as the operational and financial changes created by the new building project.

VI. UTILIZATION AND REIMBURSEMENT INFORMATION

Attachment 8: Please complete Attachment 8 detailing utilization and reimbursement information. Please include any changes created by the facility project.

VII. GRANTS AND CONTRACTS INFORMATION

Attachment 9: Please complete Attachment 9 detailing grants and contract information for the health center. Please include any changes created by the facility project.

VIII. EMPLOYMENT INFORMATION

Attachment 10: Please complete Attachment 10 detailing employment information for the health center. Please indicate any changes created by the facility project.

IX. OTHER ATTACHMENTS

Please include the following as attachments to this application:

*Audited financial statements for your last three fiscal years, including Management Letters.

*Year-to-date internal financial statements with comparisons to the same period in the previous fiscal year. Budget (income and expense projections) for the current fiscal year. If your health center is in the final quarter of its current fiscal year, also include the budget for the next fiscal year.

Your most recent annual report. If you do not have an annual report, please provide a brief history and description of your organization.

Bank letter stating preliminary terms and conditions.

Building plans and materials specifications (or at least at a 30% design review phase of development).

X. FINANCIAL INFORMATION

A) Please provide the following information on any outstanding debt:

Date of Loan:	Original Amount:
Lender:	Amount Outstanding:
Interest Rate:	Expiration:
Fixed / Floating?	Amortization:
Purpose of Loan:	Collateral:

Please attach additional pages with above information for any additional debt.

B) Does your health center have a working capital line of credit? Yes / No

If yes, what is the maximum amount of credit availability under your line? $

What is the current amount outstanding under the line of credit? $

What is used to secure the line of credit?

Is the line extendable to at least 1 year after receipt of loan guarantee?

C) Has the health center ever defaulted on a loan or filed for bankruptcy or protection against creditors? Yes / No

XI. LITIGATION

Are you aware of any litigation pending against the health center that might materially affect the health center's ability to borrow funds or to repay them? Yes / No

XII. CERTIFICATION

The undersigned hereby represents and certifies to the best of his/her knowledge and belief that the information contained in this application and exhibits or attachments hereto is true and complete and accurately describes the nature of the health center and the proposed project, and agrees to promptly inform the Health Resources and Services Administration's Bureau of Primary Health Care of any relevant changes in the proposed/actual project or the information contained herein.

Applicant: Name of CHC

Signature: ____

Title: Name and title of Director

Date: ____

APPLICATION ATTACHMENTS AND CHECKLIST

These attachments are a required part of the application. ***Items in bold are required for the pre-application****. If an item is not available, please so indicate and note plans for obtaining the item. Please attach the following and mark the first page of each with its corresponding number:*

- A complete list of your Board of Directors and officers, including addresses, employer & position.
- Resumes of all senior management personnel.
- **Description of capital project(s) to be funded by this loan. If refinancing, describe project that was originally financed.**
- **Detailed capital project budget. Include a timetable, cost estimates, itemized equipment list, and architectural drawings or plans, if available.**
- **Detailed sources and uses (see attached chart).**
- **Business plan or a financial/operational justification for the project.**
- **Budget projections to cover the period from present through completion of construction, plus three additional years after occupancy. The budget projections should include the operational and financial changes created by the building project and the projections included in Attachments 8, 9, & 10.**
- Utilization and Reimbursement information (see attached chart).
- Historical and Projected Grant / Contract Revenue (see attached chart).
- Employment information (see attached chart).
- Information on any loan defaults, if applicable.
- Litigation pending against the health center, if applicable.
- **Audited financial statements for your last three fiscal years, including Management Letters.**
- **Year-to-date internal financial statements with comparisons to the same period in the previous fiscal year.**
- **Budget (income and expense projections) for the current fiscal year. If your health center is in the final quarter of its current fiscal year, also include the budget for the next fiscal year.**
- Your most recent annual report. If you do not have an annual report, please provide a brief history and description of your organization.
- Bank letter stating preliminary terms and conditions
- Building plans and materials specifications (or at least at a 30% design review phase of development).

ATTACHMENT FORMS (Excel version of attachments also available at http://caplink.org/FreePubs2.html)

Attachment 4 - Proposed Capital Budget

Please use the following format as a guide for developing a detailed budget for your capital project.

(Total Sq. Footage)		
	Costs	**Cost/ Sq.Foot**
Hard Costs:		
Real Estate Acquisition:		
Land (acres)		
Site Preparation		
Existing Building (sq.ft.)		
Construction/Renovation:		
Construction of New Building (sq.ft.)		
Rehab of Existing Building (sq.ft.)		
Addition to Existing Bldg. (sq.ft.)		
Construction Contingency		
Interest Costs during Construction		
Total Hard Costs:		
Equipment Costs:		
Furniture		
Medical Equipment		
Telephone		
Computers		
Artwork/Plants		
Security Systems		
Signage		
Installation Costs		
Total Equipment Costs:		
Soft Costs:		
Architectural		
Engineering		
Geotechnical		
Environmental		

Civil
Structural
Plumbing and Fire Protection
Electrical
Bonding
Surveying
Owner's Representative
Construction Testing
Insurance
Permits and Fees
Legal - Health Center Attorney
Legal - Financing Entity Attorney
Legal - Title Insurance
Financing Fees
Appraisal
Moving
Rent
Soft Costs Contingency
Total Soft Costs:
TOTAL PROJECT COSTS

Attachment 5 – Sources and Uses of Project Funds Summary

USES: Total Hard Costs (See hard costs total, Attachment 4): Equipment Acquisition (See equipment total, Attachment 4): Total Soft Costs (See soft costs total, Attachment 4): Refinancing Existing Debt : Other Project Costs (please list) : **TOTAL USES OF FUNDS:**	 **$ ______**
SOURCES: Cash reserves for this purpose: $ Capital campaign contributions: 1) Cash received to date: 2) Capital campaign pledges (pledges that have a firm commitment): a) Cash from existing pledges to be received within 1 year: b) Cash from existing pledges to be received within 2 years: c) Cash from existing pledges to be received within 3 years: d) Other pledges receivable: Total pledge amount: 3) Additional amounts to be raised / expected to be raised: Total capital campaign amounts: Grants not included in section above (please list): Other amounts (please describe) Amount of this loan request: **TOTAL SOURCES OF FUNDS**	 **$ ______**

(Total Uses of Funds should equal Total Sources of Funds.)

Attachment 8 - Utilization and Reimbursement Information
(historical and projected)

	FY2007			FY2008			FY2009			FY2010			FY2011			FY2012		
Payor	Users	Enctrs	Net Revenue	Users	Enctrs	Net Revenue	Users	Enctrs	Net Revenue	Users	Enctrs	Net Revenue	Users	Enctrs	Net Revenue	Users	Enctrs	Net Revenue
Medicaid																		
Medicare																		
Self Pay																		
Free Care																		
(UCC reimburse)																		
Commercial																		
FFS (Name):																		
BCBS																		
Capitation (Name):																		
Medicaid																		
Other Payors:																		
Total:																		

Attachment 9 - Grants and Contracts
(historical and projected)

Please list major sources and dollar amounts of grant and contract revenue for three previous and three projected years.

Grant / Contract Revenue Type	FY2007	FY2008	FY2009	FY2010 (Projected)	FY2011 (Projected)	FY2012 (Projected)

Attachment 10 – Employment Information
(historical and projected)

Please list the following staffing information for the health center during the past three fiscal years and project staffing needs for next three fiscal years.

	FY2007		FY2008		FY2009		FY2010 (Projected)		FY2011 (Projected)		FY2012 (Projected)	
Service Provider	*FTEs*	*Salaries*	*FTEs*	*Salaries*	*FTEs*	*Salaries*	*FTEs*	*Salaries*	*FTEs*	*Salaries*	*FTEs*	*Salaries*
Physicians												
Midlevels (PA, NP)												
Nurses (RN, LPN)												
Mental Health Providers												
Substance Abuse Providers												
Dental Providers												
Provider Support*												
Administration												
Other												
TOTAL												

**Provider support - Clinical support staff, outreach workers, etc.*