



HEALTHCARE INFRASTRUCTURE DEVELOPMENT MATCHING GRANT APPLICATION

1) **APPLICANT COUNTY:** _____

2) **PROJECT TITLE:** _____

3) **REQUESTED CMSP GRANT AMOUNT:** _____

4) **APPLICANT COUNTY CONTACT**

Name / Title	
Address	
Phone	
Email	County Tax ID

5) **APPLICANT COUNTY DEPARTMENT/AGENCY**

Specify the county department/agency submitting the application. In addition, if the county's application is being made on behalf of a partner organization under contract with the county for the delivery of health care and/or behavioral health services, specify the partner organization.

☐ County department/agency

☐ Health Department

☐ Public Health Department

☐ Behavioral Health Department

☐ Health & Human Services Agency

☐ Partner organization* (when applicable):

Organization Name	Entity Type <input type="checkbox"/> For Profit <input type="checkbox"/> Non-Profit
Contact Name / Title	
Address	
Email	Phone

*If a partner organization is present, an MOU must be submitted as an attachment to this application.

6) TARGET POPULATIONS

Identify the target population(s) that will receive health and/or behavioral health services at the new or expanded facility made possible by the CMSP Infrastructure Matching Grant.

- ☐ CMSP Beneficiaries
- ☐ Uninsured Adults
- ☐ Uninsured Children
- ☐ Medi-Cal Members
- ☐ Medicare Members
- ☐ Covered California Members
- ☐ Privately Insured Populations

7) SERVICES TO BE PROVIDED AT NEW/EXPANDED FACILITY

Identify the types of healthcare services that will be provided at the new or expanded facility made possible by the CMSP Infrastructure Matching Grant.

- ☐ Healthcare Services
- ☐ Public Health Services
- ☐ Mental Health Services
- ☐ Alcohol/Drug Treatment Services

8) DESCRIPTION OF THE INFRASTRUCTURE PROJECT

A. Federal, state or other grant that will serve as the primary funding for the infrastructure project:
B. Funding amount requested from federal, state or other grant:
C. Website link to federal, state or other grant:
D. Required amount of local matching funds for receipt of the federal, state or other grant:
E. Summary description of the new or expanded healthcare facility to be built with CMSP Healthcare Infrastructure Grant funds (limit 1,500 characters):

F. Square feet to be constructed at new or expanded facility:
G. Location of the new or expanded facility:
H. CMSP County or Counties to be serve by the new or expanded facility:
I. Expected facility construction completion date:
J. Beginning date for delivery of health and/or behavioral health care services at the new or expanded facility:

9) LETTER OF COMMITMENT FROM COUNTY BOARD OF SUPERVISORS

The County Board of Supervisors (or Boards of Supervisors in joint-county applications) must provide a Letter of Commitment that commits the County to assuring that the healthcare infrastructure funded by the CMSP Healthcare Infrastructure Grant shall be used for this intended purpose for the entire period required under the federal, state or other grant received by the county or a non-profit under contract with the county. *Failure to include the Letter of Commitment as an attachment will disqualify the application from funding consideration.*

10) AUTHORIZED SIGNATURE

Name / Title of Official
County Department/Agency
Signature
Date