

Appropriations Project Request - Fiscal Year 2020-21

For projects meeting the Definition of House Rule 5.14

1. Title of Project: Marion County Hospital District - Beacon Point Treatment Campus
2. Date of Submission: 09/04/2019
3. House Member Sponsor: Stan McClain
Members Copied: Brett Hage, Charlie Stone

4. DETAILS OF AMOUNT REQUESTED:

- a. Has funding been provided in a previous state budget for this activity? No
If answer to 4a is "No" skip 4b and 4c and proceed to 4d, Col. E
- b. What is the most recent fiscal year the project was funded?
- c. Were the funds provided in the most recent fiscal year subsequently vetoed?
- d. Complete the following Project Request Worksheet to develop your request:

FY:	Input Prior Year Appropriation for this project for FY 2019-20 <i>(If appropriated in 2019-20 enter the appropriated amount, even if vetoed.)</i>			Develop New Funds Request for FY 2020-21 <i>(Requests for additional RECURRING funds are prohibited.)</i>		
Column:	A	B	C	D	E	F
Funds Description:	Prior Year Recurring Funds	Prior Year Nonrecurring Funds	Total Funds Appropriated <i>(Recurring plus Nonrecurring: column A + column B)</i>	Recurring Base Budget <i>(Will equal non-vetoed amounts provided in Column A)</i>	Additional Nonrecurring Request	TOTAL Nonrecurring plus Recurring Base Funds <i>(Will equal the amount from the Recurring base in Column D plus the Additional Nonrecurring Request in Column E.)</i>
Input Amounts:					400,000	400,000

5. Are funds for this issue requested in a state agency's Legislative Budget Request submitted for FY 2020-21? No
 - 5a. If yes, which state agency?
 - 5b. If no, which is the most appropriate state agency to place an appropriation for the issue being requested? Department of Children and Families
 - 5c. Has the appropriate state agency for administering the funding, if the request were appropriated, been contacted? Yes
 - 5d. Describe penalties for failing to meet deliverables or performance measures which the agency should provide in its contract to administer the funding if appropriated.

A 20% reduction in funding if we do not meet 90% of our stated goals. The reduction in funding could be assessed quarterly, or at the end of the year (as a direct penalty payment).

6. Requester:

- a. Name: Curt Bromund
- b. Organization: Marion County Hospital District
- c. Email: curt@mchdt.org
- d. Phone #: (352)622-3662

7. Contact for questions about specific technical or financial details about the project:

- a. Name: Curt Bromund
- b. Organization: Marion County Hospital District
- c. Email: curt@mchdt.org
- d. Phone #: (352)622-3662

8. Is there a registered lobbyist working to secure funding for this project?

- a. Name: None
- b. Firm: None
- c. Email:
- d. Phone #:

9. Organization or Name of entity receiving funds:

- a. Name: Marion County Hospital District
- b. County (County where funds are to be expended): Marion
- c. Service Area (Counties being served by the service(s) provided with funding): Marion

10. What type of organization is the entity that will receive the funds? (Select one)

- For Profit
- Non Profit 501(c) (3)
- Non Profit 501(c) (4)
- Local Government
- University or College

Ⓒ Other (Please describe) Dependent Special District

11. What is the specific purpose or goal that will be achieved by the funds being requested?

To provide outpatient mental health and substance use treatment to uninsured, poor and homeless citizens of Marion County. The requested funds will be used as supplemental or braided funding (with at least \$1M from the Marion County Hospital District) to provide outpatient treatment and stabilization services at Beacon Point. Services include outpatient counseling, navigation, peer support, assessments, treatment plans, medication assisted treatment, case management and life stabilization.

12. Provide specific details on how funds will be spent. (Select all that apply)

Spending Category	Description	Nonrecurring (Should equal 4d, Col. E) Enter "0" if request is zero for the category
Administrative Costs:		
<input type="checkbox"/> a. Executive Director/Project Head Salary and Benefits		
<input type="checkbox"/> b. Other Salary and Benefits		
<input type="checkbox"/> c. Expense/Equipment/Travel/Supplies/Other		
<input type="checkbox"/> d. Consultants/Contracted Services/Study		
Operational Costs:		
<input type="checkbox"/> e. Salaries and Benefits		
<input type="checkbox"/> f. Expenses/Equipment/Travel/Supplies/Other		
<input checked="" type="checkbox"/> g. Consultants/Contracted Services/Study	Contracted services to provide increased capacity for case management, social work, mental health and substance use treatment, labs, stabilization/maintenance medication and medication assisted treatment (MAT) and life stabilization services	400,000

Fixed Capital Construction/Major Renovation:		
<input type="checkbox"/> h. Construction/Renovation/Land/Planning Engineering		
TOTAL		400,000

13. For the Fixed Capital Costs requested with this issue (In Question 12, category “h. Fixed Capital Outlay” was selected), what type of ownership will the facility be under when complete? (Select one correct option)

- For Profit
- Non Profit 501(c) (3)
- Non Profit 501(c) (4)
- Local Government (e.g., police, fire or local government buildings, local roads, etc.)
- State agency owned facility (For example: college or university facility, buildings for public schools, roads in the state transportation system, etc.)
- Other (Please describe)

14. Is the project request an information technology project?

No

15. Is there any documented show of support for the requested project in the community including public hearings, letters of support, major organizational backing, or other expressions of support?

Yes

15a. Please Describe:

Support from the Marion County Legislative Delegation Members- presented 9/10/2019 before them during public hearing portion of the delegation meeting.

16. Has the need for the funds been documented by a study, completed by an independent 3rd party, for the area to be served?

Yes

16a. Please Describe:

2019 Community Health Assessment (CHA) and Community Health Improvement Program (CHIP).

17. Will the requested funds be used directly for services to citizens?

Yes

17a. What are the activities and services that will be provided to meet the purpose of the funds?

Mental health and behavioral health assessments, individual counseling, group therapy, peer support counseling, case management, educational attainment services, job skills and job attainment, self-sufficiency and life stabilization services.

17b. Describe the direct services to be provided to the citizens by the funding requested.

Mental health and behavioral health assessments, individual counseling, group therapy, peer support counseling, case management, educational attainment services, job skills and job attainment, self-sufficiency and life stabilization services.

17c. Describe the target population to be served (i.e., "the majority of the funds requested will serve these target populations or groups.").

Select all that apply to the target population:

- Elderly persons
- Persons with poor mental health
- Persons with poor physical health
- Jobless persons
- Economically disadvantaged persons
- At-risk youth
- Homeless
- Developmentally disabled
- Physically disabled
- Drug users (in health services)
- Preschool students
- Grade school students
- High school students
- University/college students
- Currently or formerly incarcerated persons
- Drug offenders (in criminal Justice)
- Victims of crime
- General (The majority of the funds will benefit no specific group)
- Other (Please describe)

17d. How many in the target population are expected to be served?

- < 25
- 25-50
- 51-100

- 101-200
- 201-400
- 401-800
- Ⓞ>800

18. What benefits or outcomes will be realized by the expenditure of funds requested? (Select each Benefit/Outcome that applies)

Benefit or Outcome	Provide a specific measure of the benefit or outcome	Describe the method for measuring level of benefit
<input type="checkbox"/> Improve physical health		
<input checked="" type="checkbox"/> Improve mental health	Stabilization based on each client's treatment plan	Treatment measures and notes input into the database will help counselors determine improvement or regression towards stabilization (family, behavioral, educational, job stability, socialization progress).
<input type="checkbox"/> Enrich cultural experience		
<input type="checkbox"/> Improve agricultural production/promotion/education		
<input type="checkbox"/> Improve quality of education		
<input type="checkbox"/> Enhance/preserve/improve environmental or fish and wildlife quality		
<input type="checkbox"/> Protect the general public from harm (environmental, criminal, etc.)		
<input type="checkbox"/> Improve transportation conditions		
<input type="checkbox"/> Increase or improve economic activity		
<input type="checkbox"/> Increase tourism		
<input type="checkbox"/> Create specific immediate job opportunities		

<input type="checkbox"/> Enhance specific individual's economic self sufficiency		
<input type="checkbox"/> Reduce recidivism		
<input checked="" type="checkbox"/> Reduce substance abuse	Documented improvement based on an individual's Reduction In Harm progress report, and adherence to the client's treatment plan.	All treatment data is collected and input into a Reduction in Harm scoring model, which indicated if a client is making progress or regressing.
<input type="checkbox"/> Divert from Criminal/Juvenile justice system		
<input type="checkbox"/> Improve wastewater management		
<input type="checkbox"/> Improve stormwater management		
<input type="checkbox"/> Improve groundwater quality		
<input type="checkbox"/> Improve drinking water quality		
<input type="checkbox"/> Improve surface water quality		
<input type="checkbox"/> Other (Please describe):		

19. Provide the total cost of the project for FY 2020-21 from all sources of funding (Enter "0" if amount is zero):

Type of Funding	Amount	Percent of Total	Are the other sources of funds guaranteed in writing?
1. Amount Requested from the State in this Appropriations Project Request:	400,000	26.7%	N/A
2. Federal:	0	0.0%	No
3. State: (Excluding the requested Total Amount in #4d, Column F)	0	0.0%	No
4. Local:	1,100,000	73.3%	Yes

5. Other:	0	0.0%	No
TOTAL	1,500,000	100%	

20. Is this a multi-year project requiring funding from the state for more than one year?

Yes

20a. How much state funding would be requested after 2020-21 over the next 5 years?

- <1M
- 1-3M
- >3-10M
- >10M

20b. How many additional years of state support do you expect to need for this project?

- 1 year
- 2 years
- 3 years
- 4 years
- >= 5 years

20c. What is the total project cost for all years including all federal, local, state, and any other funds? Select the single answer which best describes the total project cost. If funds requested are for ongoing services or for recurring activities, select "ongoing activity".

- Ongoing activity – no total cost
- <1M
- 1-3M
- >3-10M
- >10M