

**Financial Assessment/Revenue Cycle Award**

**2020-2021**

**Application Form**

**Award Description**

The Financial Assessment/Revenue Cycle Award is available to critical access hospitals interested in conducting a financial evaluation/analysis of a current or potentially new hospital service(s). The intent of this award is to provide funding for hospitals to improve financial and/or operational improvement activities based on hospital need.

**Award Project Suggestions:**

* Revenue Cycle Analysis
* Chargemaster Review
* Coding Audits
* Interim Cost Report
* Cost Management Analysis
* Financial Tracking and/or Reporting Software
* Service Line Evaluation
* Price Estimator
* Financial Assessment

**Project Period: September 1, 2020 – June 30, 2021**

**Amount: $ 7,500 maximum for each recipient. There are approximately 10 awards available.**

**Application Deadline: December 7, 2020**

**Contact:**

**Laura S. Fischer, Flex Grant Project Manager**

**Illinois Critical Access Hospital Network**

**Phone: (815) 875-2999**

[**Lfischer@icahn.org**](mailto:Lfischer@icahn.org)

**Application Instructions**

All application fields/sections must be completed. Applications with blank fields/sections will be considered non-responsive and will not be considered for award. Applicants must be in compliance with all previous awards in order to be eligible. Only one application per hospital per category will be accepted.

Please send completed application to Laura Fischer [lfischer@icahn.org](mailto:lfischer@icahn.org) no later than Monday, December 7, 2020. Blank applications can be accessed electronically at [Flex Grant Info](https://icahn.org/flex-grant/). Applications are to be submitted in as a Word document or PDF. **Handwritten applications are no longer accepted**. Fields may be expanded to suit the space requirements of the response; however, all fields must be included, i.e., do not delete any fields or fail to respond to information sought in each field.



**Financial Assessment/Revenue Cycle Award**

**2020-2021**

**Application Form**

*Due back to the Illinois Critical Access Hospital Network by December 7, 2020*

|  |  |
| --- | --- |
| ***Hospital Name*** | ***Date*** |
| ***Address*** | ***Contact Person*** |
| ***Phone Number*** | ***Email Address*** |
| ***FEIN (Federal Employee Identification Number)*** | ***IDHR # (Illinois Department of Human Rights)*** |

*\*Blank fields may result in application being considered non-responsive.*

***Hospital Ownership (please mark one):***

**[ ] For Profit; [ ] Not for Profit; [ ] Government**

**Authorized Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**PROGRAM NARRATIVE**

|  |
| --- |
| Please respond to each question. Question fields left blank will result in application being considered non-responsive. Each question area should be expanded so sufficient detail can be provided. |

**1. What do you plan to use the funds for? Please check one (1) or more areas this Award program/project will address:**

* Revenue Cycle Analysis
* Chargemaster Review
* Coding Audits
* Interim Cost Report
* Cost Management Analysis
* Financial Tracking and/or Reporting Software
* Service Line Evaluation
* Price Estimator
* Financial Assessment
* Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Baseline Award Information**

What is your Medicare Cost to Charge ratio? \_\_\_\_\_\_\_\_\_\_\_\_\_\_

What is your Days Cash on Hand? \_\_\_\_\_\_\_\_\_\_\_\_

What is your Days in Accounts Receivable? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**2. Describe the proposed program/project and the impact this project will have to strengthen existing services, improve operations, or add new services to the facility.** **Please include information on the proposed consultant and explanation of expertise for project area.**

**3. Describe your hospital’s current efforts in the identified program/project and how successful it has been.**

**4.** **Define the problem or issue you would like to address and how it relates to the overall goal of the Award. What is not being accomplished and why is it not being accomplished?**

**5.** **Identify the desired outcomes you would like to achieve (examples: decrease accounts receivables, increase revenue, decrease claims denied).**

|  |  |
| --- | --- |
| **Short term outcomes (less than 6 months)** | **Long term outcomes (6 months or greater)** |
| **1.** | **1.** |
| **2.** | **2.** |
| **3.** | **3.** |

**How will these outcomes be achieved? How will these outcomes be sustained after the Award period is complete?**

**6.** **Describe the planning process, education and implementation timetable for this program/project. (Who is involved, and who is responsible for the project?)**

**7. How will the program/project improve the overall operations of your hospital? Identify factors (external/environmental) that may impact your outcomes, including sustainability.**

**8.** **Describe how you will measure/evaluate the value and effectiveness of the program/project for the hospital and community (example: claims denied before project/claims denied after project) and list the current values for the measures chosen.**

|  |  |
| --- | --- |
| **Measure 1** |  |
| **Measure 2** |  |
| **Measure 3** |  |
| **Measure 4** |  |

**What indicators will be used to evaluate the program/project and what milestones have you identified as being important?**

**Do you anticipate that this project will impact the following?**

**Medicare Cost to Charge ratio?  Yes  No**

**Days Cash on Hand?  Yes  No**

**Days in Accounts Receivable?  Yes  No**

**If no to all three, what financial indicator will this project address in the facility?**

|  |  |  |  |
| --- | --- | --- | --- |
| **2020-2021 Proposed Award Budget—$7,500** | | | |
| **Category** | **Award Funds** | **Matching Funds** | **Total Funds** |
| Consultant’s Fees |  |  |  |
| Contracted Services |  |  |  |
| Communications/Marketing |  |  |  |
| Education/Training |  |  |  |
| Equipment/Supplies |  |  |  |
| Hardware/Software |  |  |  |
| **Total** |  |  |  |

**Budget Narrative** Provide detail of the amounts listed in budget section above**.** You may include additional materials to further support this Award Application. If documentation is not provided to explain expenses listed in each category your application will not be eligible for an award. Include consultant qualifications and level of expertise for the project. Please only include allowable expenses as identified in the state cost principles as part of uniform guidance.

Consultant’s Fees

Contracted Services

Communications/Marketing

Education/Training

Equipment/Supplies

Hardware/Software

**Review Criteria – Application Hints**

This Award Application will be reviewed by outside award reviewers and assigned awarding scores based on the following criteria:

1. Was all hospital information completed (including Federal Employee Identification Number, Illinois Department of Human Rights Number, and Hospital Ownership)?

2. How well did the applicant explain the problem/issue and how they were planning on addressing it?

3. Is the program/project clearly described?

4. Is information provided which supports the idea that the program/project will meet the identified outcomes?

5. Is the method of evaluating the effectiveness of the program/project reasonable?

6. Does the applicant provide enough budgetary detail to assess the likely success of the program/project?

7. Is the budget reasonable for this type of program/project?

8. Is there an indication that this program/project will continue in the future?

9. Does the program/project make sense? Is it valuable to the community? Does it improve the hospital? Is there community involvement?