

**Financial Assessment/Revenue Cycle Award**

**2021-2022**

**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. Due to the funding source, this award is available to Critical Access Hospitals ONLY.

**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, 2021 – June 30, 2022**

**Amount: $ $7,500 maximum for each recipient. There are approximately 12 awards available.**

**Application Deadline: End of business on Friday, November 12th, 2021**

**Contact:**

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

**Illinois Critical Access Hospital Network**

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

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**Financial Assessment/Revenue Cycle Award**

**2021-2022**

**Application Form**

*Due back to the Illinois Critical Access Hospital Network by November 12th, 2021*

|  |  |
| --- | --- |
| ***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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**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). Applications are to be submitted as a Word document or PDF. **Handwritten applications are not 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

**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. |

**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? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. **Describe the proposed program/project and the impact the project will have to improve finance operations or revenue cycle workflow at the hospital. If the project will be ongoing, describe how that work will be funded or how the improvement will be maintained over time.**

**3. Describe your hospital’s current efforts in the identified project area and any challenges or successes the hospital has had.**

**4. Define the need for this project and how it relates to the overall goal of improving the hospital’s financial position or improve revenue cycle. Use data to support the need for this project.**

5. Project Goals—Creation of **SMART** Goals

**List 2 goals for your project. Be as SPECIFIC as possible.**

**How will you MEASURE if each of the goals listed above is achieved? What are the metrics and milestones that need to be met for this project to be a success?**

**What other resources will you need to ACHIEVE your goal and for this project to be a success? These may include such things as: additional funding support from the hospital or if outside consultants are needed—describe their qualifications and experience.**

**If key hospital personnel will be needed to manage the project and ACHIEVE your goals—describe their qualifications, experience, and the amount of time they will be able to dedicate to the project.**

**How will the proposed project RELEVANT to strengthening the financial health and/or revenue cycle of the hospital?**

**Detail the major steps in your work plan. What is needed for project completion and the projected TIMELINE for the proposed project. (Included major steps from planning to implementation to final measurement)**

1. **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(s) will this project address in the facility?

|  |  |  |  |
| --- | --- | --- | --- |
| **2021-2022 Proposed Award Budget—$7,500** | | | |
| **Category** | **Award Funds** | **Hospital Matching Funds** | **Total Funds Spent** |
| Consultant’s Fees |  |  |  |
| Contracted Services |  |  |  |
| Communications/Marketing |  |  |  |
| Education/Training |  |  |  |
| Equipment/Supplies |  |  |  |
| Hardware/Software |  |  |  |
| Employee Salaries |  |  |  |
| **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. Only include allowable expenses as identified in the state cost principles as part of uniform guidance (No direct patient care, purchase of vehicles, purchase food or use of funds to purchase or improve real property).

Consultant’s Fees

Contracted Services

Communications/Marketing

Education/Training

Equipment/Supplies

Hardware/Software

Employee salaries

**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?