DEPARTMENT OF HEALTH
OFFICE OF RURAL HEALTH AND PRIMARY CARE

2021 Dental Safety Net Grant

Step 1 GRANT APPLICATION FORM

1. Applicant Organization (This information will be used in drafting the grant contract. Sub-applicants must complete this form as well.)

Legal Name_____

Doing Business As (if different than above):_____

Address_____City:_____State:_____ZIP:_____

County:_____

Phone_____

Federal ID Number _____ State Tax ID Number _____

Swift ID Number_____ Swift Location Code: _____

Remit Address (If different than above):

Address: _____City:_____State:_____Zip:_____

County: _____

2. Applicant Organization -CEO/Authorized Organization Representative

Name/Title_____Name/Title_____

Address _____City: _____

State: _____ Zip: _____

Phone _____

Email address:_____

3. Fiscal Management Officer of Organization

Name/Title_____Name/Title_____

Address _____ Address _____

Phone _____ Phone _____

Email address: _____ Email address: _____

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5. Primary Contact for Project Administration

Name/Title _____

Address _____

Phone _____ Email address: _____

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7. Total number of dental patient <u>encounters</u> in the clinic from July 1, 2019 to June 30, 2020: _____

8. Number of dental patient encounters between July 1, 2019 and June 30, 2020 with patients who were uninsured or covered by Medical Assistance or MinnesotaCare: _____

(The numbers in Question #7 and Question #8 will be used to determine eligibility for the grant program. The number from #8 must be at least 80 percent of the number from #7 in order to be eligible for the grant program. Separate documentation must be included with the application.)

9. Total number of uninsured dental patients under the age of 21 served by the applicant from July 1, 2019 to June 30, 2020: _____

(The number from Question #9 will be used to calculate the grant award. Separate documentation must be included with the application.)

I certify that the information contained herein is true and accurate to the best of my knowledge, that no changes were made in the organization's accounting and record-keeping practices or policies for providing free or reduced-cost care to uninsured patients for the purpose of creating eligibility or increasing the organization's allocation, and that I submit this application on behalf of the applicant organization.

Signature of Authorized Official	Print Name	Title	Date