

**Denali Commission  
BUSINESS PLAN TEMPLATE:  
BEHAVIORAL HEALTH FACILITY**

**Applicant Name**

**Communities Served**

**Submittal/Revision Date**

Denali Commission program information and general policies can be found at [www.denali.gov](http://www.denali.gov).

**Send an original plus 4 copies to:**

**Health Facilities Program Manager  
Denali Commission  
510 "L" Street Suite 410  
Anchorage, Alaska 99501**

**Phone: 907-271-1414  
Fax: 907-271-1415**

**This document is not an application for funding. Business Plans will not be accepted for review without Technical Assistance Advisor approval.**



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**\*These sections must directly provide narrative summary to the Excel spreadsheets with this title.**

## **Introduction**

### **Purpose of the Business Plan**

This document is a requirement for receipt of Denali Commission funding; however this is not an application for funding. The Business Plan document is a tool for use in the conceptual planning phase of facility development, which the Commission and other funders recognize as a critical process in facility development to occur prior to design or construction. Organizations are invited to participate in the Business Plan process by submitting a Letter of Interest (LOI) or they may be a targeted organization based on an initiative underway by the Denali Commission through its many partners (e.g. Bring The Kids Home, etc.)

Denali Commission funding is generally unknown for the year in which construction funding may be needed for a project in the conceptual planning phase. By assisting potential Applicants in planning for their facility, once funding availability is known, projects are ready to advance if they have completed the Business Plan. Participants in this process should be advised that because funding amounts are unknown, all funding possibilities should be explored and a backup plan for funding should always be in mind in the event Commission funding is not available.

### **Potential Outcomes of Conceptual Planning**

There are two possible outcomes in this process. First, if a project is sustainable, meets all requirements, demonstrates need and necessary cost share match, a recommendation for inclusion in the next funding cycle may be made, assuming appropriations are available. The second possible outcome is that a project is either not eligible or not ready, is not sustainable or may not demonstrate existing need. In this scenario, by assisting in the conceptual planning process, organizations are better positioned to make knowledgeable decisions about investing in a capital project.

### **The Business Plan has 2 parts that support one another:**

- 1) This Microsoft Word document contains text boxes that will expand as you type your answers. Many of the questions in the Word document provide narrative explanations to the accompanying Excel spreadsheets.
- 2) The Excel spreadsheets present the framework for a proposed Service Delivery Model and Financial Sustainability of the services, the facility and the capital budget.

**Important Note:** Applicant's failure to provide supporting narrative and Excel data will result in resubmission.

### **Technical Assistance Advisors**

Technical Assistance (TA) Advisors serve as resources for Applicants. TA Advisors do not participate in the review process for those Applicants they have assisted in the Business Plan preparation. Additionally the TA advisors will not write the Business Plan for Applicants or produce any of the necessary work for completing its requirements. The TA is an independent resource to answer questions and review documents for their preparedness for submission.

**Important Note:** The TA must review all documents and provide a positive recommendation of a Business Plan prior to their submission to the Denali Commission. Contact the Health Facilities Program Manager for questions about your TA.

## Section 1 – Organization Information and Executive Summary

<b>Applicant Information</b>	
<b>Name of Organization</b>	
<b>DUNS Number Dun and Bradstreet (D&amp;B) Data Universal Numbering System</b>	
<b>TIN# (Taxpayer Identification Number)</b>	
<b>Community(ies) to be served:</b>	
<b>Type of Project</b>	
<b>Applicant Contacts</b>	
<b>*Signatures serve as notification that the following Applicant contacts have reviewed the Service Delivery Model and Business Plan.</b>	
<b>Primary Contact Person Name: Phone and Fax : E-mail address: Mailing address:</b>	<b>(The person who filled out the Business Plan and can answer questions about it)</b>
<b>Behavioral Health Program Representative Name: Phone and Fax : E-mail address:</b>	<b>(The representative of the organization that is administratively responsible for clinical services provided)</b>
<b>*Behavioral Health Program Rep Signature:</b>	<b>Date:</b>
<b>Facility Representative Name: Phone and Fax : E-mail address:</b>	<b>(The person responsible for facility operations &amp; maintenance)</b>
<b>*Facility Rep Signature:</b>	<b>Date:</b>
<b>Applicant Representative Name: Phone and Fax : E-mail address: Mailing Address:</b>	<b>(Authorized to conduct business on behalf of the Applicant—the Chief Executive Officer or other)</b>
<b>*Applicant Rep Signature:</b>	<b>Date:</b>

**Internal Processing (Applicant to leave this section blank)**

Business Plans must be reviewed by the DHSS prior to Denali Commission submission. Upon review, this page will be signed by the DHSS Commissioner or their designated representative signifying adherence to the proposed service delivery model.

**\*Signatures serve as notification that the Service Delivery Model is consistent with statewide models for service delivery. (Business Plan review is a separate process).**

<b>Alaska Department of Health and Social Services – Commissioner or designee</b>		
<b>* Name, Title and Signature:</b>		<b>Date:</b>
<b><u>Contingencies:</u> All contingencies must be addressed prior to Denali Commission submission. Significant unresolved issues may result in DHSS foregoing signature until resolution occurs.</b>	<b>DHSS: State all contingencies below.</b>	

## **Executive Summary**

Please include a 1-2 page Executive Summary. (Tip: complete this section last)

Describe:

1. Your organization
2. Those involved in the development of this proposal
3. Support from community members, behavioral health care providers and other health care providers, and facility owners
4. When will the project will be construction-ready (including design completion and having secured the required community cost-share match funding)
5. Project tasks completed
6. What remains to be done

**Note: All boxes will expand with text**

## **Section 2 - Service Delivery Model: Service Lines (Excel page 1), Target Population (Excel page 2) and Staffing Expenses (Excel pages 3-5).**

IMPORTANT: Please include narrative directly supporting the applicable section of the Excel spreadsheet document. Business Plans that do not provide explanations to the Excel document will not be approved.

The following section requires Applicants to submit narrative to support the coinciding data in the Excel spreadsheet to include Service Line, Target Population and Staffing documentation. Projections for the next 5 years are required.

### **Service Line(s)-Excel page 1**

Provide a brief description of the organization and program philosophy and design. You must address the following areas in your description:

1. Indicate whether your organization is publicly or privately owned.
2. Articulate the target population that the program is designed to treat and as appropriate describe the admission criteria.
3. Describe the screening, intake and assessment process.
4. Describe the treatment planning and service delivery process that includes individualized treatment services that include cultural awareness/ sensitivity, and trauma informed care.
5. Describe discharge criteria, and processes that facilitate the transition youth into their community of origin.
6. Describe ancillary services to include psychiatric services medications, medical services, psychological/neuropsychological services, occupational/physical therapy, dental, social and recreational activities.
7. As appropriate describe programming that addresses integrated treatment for the family of parental custody youth, and custody youth when clinically indicated.
8. Describe the philosophy, program capacity and history to achieve successful completion of treatment recipients.

9. Describe the program philosophy and capacity to successfully maintain the client's current level of care.
10. Describe the philosophy and program capacity for outcomes driven services, including assessment and reporting, and follow up.

This information should narrate each service line selected in the drop down menu of Page 1 of the Excel document. Please answer the above questions addressing each selected service line, as appropriate in the space below.

**Please space as necessary to address the requested information. All boxes will expand.**

If another organization is involved, describe the relationship between the Applicant and the Organization that is responsible for programs and services (salaries, supplies, equipment). Discuss changes that will occur with the new facility.

If another Organization is involved, describe the relationship between the Applicant and the Organization that is responsible for facility (building related) expenses and maintenance. Discuss changes that will occur with the new facility.

Do any of the providers limit access to their services, (e.g., serve only IHS beneficiaries, serve only those who are insured or have the ability to pay, do not accept Medicaid, or are open part-time, etc.)?

Does a board or advisory council oversee the facility or various programs to be contained in the proposed facility? If yes, include a list of appropriate Board Members. Label as **ATTACHMENT "A"**.

Name of Board/Council \_\_\_\_\_

Programs and Services Board? \_\_\_\_\_

Facility Operations & Maintenance Board? \_\_\_\_\_

**Accreditation**

Please provide an explanation of compliance with applicable national accreditation for your program and/or compliance with State grant/quality assurance obligations.

Name of applicable accreditation and/or State grant obligations	Explanation of status

**Needs Assessment**

If your organization has conducted a needs assessment as a part of a local behavioral health care planning process (within the last 2 or 3 years), or for this current project, please provide a copy of that needs assessment. Label as **ATTACHMENT “B”**.

**Applicant Resolution**

The Applicant organization must provide confirmation of approval and support of the proposal and acceptance of responsibility for the duties assigned in the proposal.

The resolution also establishes signatory authority for an appropriate individual who is authorized by the organization to conduct normal and usual business regarding this project. The suggested format for the resolution may be adapted to the particular circumstances of the Applicant, provided the new format correctly identifies the responsible participants and documents their commitment to the project.

Please provide a signed original resolution adopted by the Applicant organization. Label as **ATTACHMENT “C”**. A sample resolution is provided after the Checklist of Application Materials of this Business Plan.

**External Relationships**

Describe the relationships among the partners responsible for the facility including: the facility owner, local oversight or advisory body, and any other organizations involved in running the facility. Discuss anticipated changes with the new facility. Provide applicable documentation and label as **ATTACHMENT “D”**.

Name of Partner	Relationship to the BH Provider

**Integration/Joint Occupancy**

Will your facility include multiple services beyond behavioral health? If no, skip this section. If yes, please reflect square footage associated with each service below. Provide copies of applicable Memorandums Of Understanding (MOU), etc. and label as **ATTACHMENT “E”**.

Other service provider	Relationship to service delivery model and Square Footage

Please describe program interaction of above services. Describe key advantages of joint occupancy. Please indicate relationship with Regional Program Specialist at this stage in the project:

--

**Collaboration with Local and Home Schools (As applicable to your program)**

Some behavioral health programs need to work directly with schools. Indicate below the any collaboration with schools and/or districts.

Name of School/District(s) and representative(s).	Reference existing Memorandums of Of Understanding) (MOUs) that apply to the proposed services and provide copies ( <b>ATTACHMENT “E”</b> ).

**Target Population (Excel Page 2)**

Please provide narrative regarding the existing and projected target population and the associated level of service reflected on the Excel spreadsheet, Page 2: Target Population. Please reference sources cited for projected service population and describe existing model as well as basis for projecting reflected numbers for the next five (5) years. Provide attachments of cited needs assessments or studies that apply and label as **ATTACHMENT “F”**.

**Community Planning**

Describe how this proposal reflects the service delivery needs identified as a part of the community planning process. Provide Attachment(s) of applicable document(s).

Are there minutes or any documentation of the community planning process?

Yes  No

If yes, label as **ATTACHMENT “G”**

**Staff Expenses (Excel Pages 3-5)**

Please provide narrative regarding the Staffing reflected on the Excel spreadsheet: Page 3: Staff Expenses. Please include services to be delivered; qualified staff to deliver services, the amount of time spent delivering services and the billable revenue for these activities. Both current and projected 5 years is required.

Describe the appropriate level of clinical supervision to staff (structure, frequency, etc.) and identify specifically the staff that will provide this supervision. (This must support Excel spreadsheet: Pages 3-5).

Do you routinely or currently have unfilled positions for periods of 3 - 6 months or more?  
 Yes       No

Identify any staffing issues, (e.g., difficulty in recruiting and retaining personnel) and steps taken to resolve these problems. Include issues specific to your community.

**Organizational Chart**

Please provide an organizational chart showing current clinical, dental and administrative staff and lines of supervision. If two or more organizations are involved in the clinic, provide a chart from each organization. Indicate any changes in staffing patterns or supervision that will occur with this project. Label as **ATTACHMENT "H"**.

Please provide narrative regarding the organizational chart, including identification of specific staff on the organizational chart that are reflected in the Excel spreadsheet for this program. Staff that are not dedicated to the proposed program(s) should not be reflected on the spreadsheet. Any shared staff with other programs and how that will be managed should be explained.

**Section 3 – Facility (Excel Pages 7 and 12) and Financial Feasibility (Excel Pages 1-15)**

The following sections require Applicants to explain the financial projections reflected in the expenses and revenue sections of the business plan, as well as address any project specific issues or cost share issues. Please note, Business Plans that do not provide narrative supporting the spreadsheet will not be approved.

In the following narrative section, please identify for reviewers specific page numbers to reference in the attached operating budget that relate to the information cited in Page 7 of the Excel spreadsheet.

**Facility Expenses-Excel Page 7**

Please outline how the facility maintenance plan will be implemented as reflected in Page 4 of the Excel spreadsheet: Facility Expenses.

**Increasing energy costs:**

Explain how your plan takes into consideration escalating energy costs.

Is there fire and liability insurance for the proposed facility?     Yes     No

If yes, label proof of insurance as **ATTACHMENT “I”**.

If no, please explain.

The amount of coverage for facility replacement is: \$\_\_\_\_\_

(Note: the cost of this coverage should be included in the Facility Expense budget)

**Additional Expenses-Excel Page 8**

Please describe any additional expenses that have not yet been reflected in the staffing expenses or facility expenses. These should be reflected on the spreadsheet, Page 5: Additional Expenses. In addition, these should be supported by a submitting a separate operating budget as an attachment. Label as **ATTACHMENT “J”**.

In this narrative, please identify for reviewers specific page numbers to reference in the operating budget that relate to the information cited in Page 5 of the Excel spreadsheet.

**Client Revenue-Excel Pages 9-11**

Information reflected in the Excel spreadsheet must be explained in this section. Please describe the client revenue as reflected in Page 6: Client Revenue:

**Non-client Revenue-Excel Page 12**

Information reflected in the Excel spreadsheet must be explained in this section. Please describe the non-client revenue as reflected on Page 7: Non-Client Revenue:

**Other Financial Documentation**

The Denali Commission will file “DOCUMENTS OF RECORD” for Applicants so that common documents will not have to be filed with individual Business Plan applications.

The documents currently accepted include:

- Audited Financial Statements – must be supplied annually
- Regional Health Corporation Organizational Charts – must be supplied annually, or upon update
- Community Plans – must be supplied upon update

**Current Year Financial Reports**

Provide a copy of the most recent year-end financial statements for the organization that will be paying for delivery of services (salary, supplies, etc). Audited statements are preferred; however municipal certified statements from the State of Alaska are allowable. Include the financial statements as **ATTACHMENT “K”**.

Attached  On File

**Current Year Financial Reports - Facility Operations & Maintenance**

Provide a copy of the most recent year-end financial statements for the organization that will be paying the facility related expenses. Audited statements are preferred. Reports from QuickBooks or copies of bank statements may be accepted if financial statements are not available. Include the financial statements as **ATTACHMENT “L”**.

Attached  On File

**Financial Support Resolution**

If the budget includes revenues not directly generated by or specifically received for the facility, a resolution of financial support is required. Include as **ATTACHMENT “M”**.

For example, if an organization such as a Regional Health Corporation (RHC) receives grant funding or contract healthcare funding, and allocates funds to individual programs or facilities within its system, then those revenues will need to be shown either by the RHC, if it is an Applicant and receives grants, or by local villages receiving grant funds from the RHC.

**Project Cost-Excel Page 13**

Please explain the cost estimates reflected in the Excel spreadsheet. Final cost estimates for a designed facility should be based on 100% stamped drawings. An independent cost estimate may be required. For property acquisition projects, fair market value of property

will be based on a current appraisal. All applicable information about project cost should be attached. Label documentation of project cost as **ATTACHMENT "N"**.

Please describe the status of the design as reflected on Page 13: Project Cost. Consult with design firm or TA if necessary (% of design completed is required).

**Current Facility Condition (includes existing facility if applicable)**

If a Code and Conditions survey was NOT completed for your facility, describe your current facility—its condition, adequacy, suitability for continued use, and other pertinent information in the space below. Include third-party documentation, (e.g., engineering studies, State Fire Marshall Report, etc.) if available. Label documentation of current facility condition (including Code and Condition) as **ATTACHMENT "O"**.

**Site Selection**

Have you selected a preferred site for the new facility?  Yes  No  
If NO, skip ahead to \*\* (status of your progress).

If your site has been selected or narrowed down to a few alternatives, please explain below, the process by which the selection was made. Also describe the general location (not the legal description) of your new facility and the major factors involved in selecting the site.

Why is the site you selected the best for the project? What factors were considered in site selection?

\*\*Indicate the status of your progress on the Site Plan Checklist:

- 1) Site Plan Checklist not started
- 2) Site Plan Checklist underway but not complete
- 3) Site Plan Checklist complete and submitted

\_\_\_ 4) Site Plan Checklist approved (include as **ATTACHMENT “P”**)

**Appropriateness of Size, Design, & Cost**

Discuss the appropriateness of the size, design, and cost of your proposed project for the service area you have identified. Include information that shows that the proposed project is the most appropriate and cost-effective approach to address the identified need(s). Include any documentation to support “Space Programming” and provide as **ATTACHMENT “Q”**.

Design contract was competitively procured (required if Commission funds are requested for design costs): Yes \_\_\_\_\_ No \_\_\_\_\_

Construction firm must be competitively procured. Please outline the process by which firm (if already hired) was procured or the planned procurement process.

Estimates take into consideration Davis Bacon Act wage rates (required): Yes \_\_\_ No \_\_\_

**Cost Share-Excel Page 14**

Denali Commission funding by statute requires cost share match in the amount of 50% for non-distressed communities and 20% for distressed communities. Please describe the status of cost share match as reflected on Page 9: Cost Share. Include documents verifying cost share match as **ATTACHMENT “R”**. In special circumstances, site work or certain predevelopment activities may be acceptable. Please explain the status of all cost share match including timelines, etc.

**Summary-Excel Page 15**

Please address any issues reflected on Excel Page 15: Summary.

## Checklist of application materials

Check all attachments that are included. If not applicable, mark as "N/A"

_____	Completed Business Plan document
_____	ATTACHMENT A List of Board Members
_____	ATTACHMENT B Community Needs Assessment Documents
_____	ATTACHMENT C Applicant Resolution
_____	ATTACHMENT D Documentation of External Partners and Community Planning Regarding Proposed Facility
_____	ATTACHMENT E MOU with Ext. Relationships/Schools/Joint Occupancy
_____	ATTACHMENT F Sources to Support "Target Population"
_____	ATTACHMENT G Documentation of Community Planning Process
_____	ATTACHMENT H Staffing Organizational Chart
_____	ATTACHMENT I Fire and Liability Insurance Documentation
_____	ATTACHMENT J Operating Budget to Support "Additional Expenses"
_____	ATTACHMENT K Recent Audited YE Financial Statements – Programs
_____	ATTACHMENT L Recent Audited YE Financial Statements – Facility O/M
_____	ATTACHMENT M Resolution of Financial Support
_____	ATTACHMENT N Documentation of Project Cost Estimate
_____	ATTACHMENT O Documentation of Current Facility Condition
_____	ATTACHMENT P Site Plan Checklist
_____	ATTACHMENT Q Space Program Document
_____	ATTACHMENT R Documents Verifying Cost Share