

The Application Outline is intended to be used as a planning tool and is not the final approved format for applying for CITED funds. Applicants are still required to apply for CITED Round 4 via the application link on the [PATH CITED website](#), which will open on **January 6, 2025.**

Introduction

Thank you for your interest in the Capacity and Infrastructure Transition, Expansion and Development (CITED) Initiative. Before beginning this application, please review the eligibility criteria, allowable uses and not allowable uses for funds, and other important information available on the [PATH CITED website](#). It is highly recommended that all applicants read the guidance document and attend an informational session or virtual office hour before beginning this application to prepare all materials required for submission and ensure that the submitted funding request meets the minimum eligibility requirements.

The CITED Round 4 application period will be open for 60 days after the release of the application in **early January**.

To request CITED funding, eligible entities must complete the online application in its entirety, submit all required attachments, and provide the necessary signatures by March 7, 2025. Applications will be accepted online only at [LINK].

Please Note: the CITED Application must be electronically signed by each applicant organization's authorized signatory to be considered complete.

For technical assistance with this application, please contact:

By Email: cited@ca-path.com (With the subject line including "CITED Round 4")

By Phone: (866) 529-7550

What information is needed and required to complete the application?

The application will collect the following information from applicants, at a minimum:

- Organizational information, including organization size, populations served, and relevant **experience** providing or supporting the delivery of Enhanced Care Management (ECM) and/or Community Supports (See LINK for additional details);
- **Clear and detailed funding request** that describes the intended uses of CITED funds (See LINK for additional details);
- Detailed explanation of **why funds are needed** to help with the transition, expansion, development, and improvement of ECM and/or Community Supports services (See LINK for additional details);
- Description of **approach to sustaining items/activities/staff** funded via CITED after CITED funding ends (See LINK for additional details);
- Explain how the applicant will work with MCPs and other stakeholders to ensure coordination and prevent funding overlap, including whether the applicant previously sought IPP, CITED, DxF, TA Marketplace, or other CalAIM related funds (See LINK for additional details);
- Description of how funding request will align with various goals, including, but not limited to, CalAIM goals, filling gaps in infrastructure identified by DHCS, needs identified through the collaborative planning and implementation (CPI) initiative. (See LINK for additional details), and;
- Copy(ies) of all executed contract(s) in the State of California for the provision of ECM and/or Community Supports. Contract(s) should align with the county and services the Applicant proposes to serve using CITED Round 4 funding. A current list of MCPs by county can be found here [LINK].
 - If the applicant is in the process of being contracted, a copy(ies) of a signed letter from the MCP, their authorized subcontractor, or another authorized entity must confirm their intent to contract with the applicant in a timely manner for the provision of ECM/Community Supports (See LINK for additional details).
 - If awarded, applicants will need to provide executed contract(s), or updates on contracting with MCPs in their quarterly progress reports.
 - Signed contracts and / or letters should include at a minimum:
 - Identification of ECM and populations of focus served and / or Community Supports provided that would be supported with CITED funds;
 - Identification of the counties where the service(s) will be offered;

- Completed signature page (Contracts must be signed by both the MCP and the applicant);
- A date demonstrating the contract is current.
 - Contracts and/or addendums are considered current if they have an effective start date of no earlier than January 1, 2022
 - Attestation Letters, demonstrating intent to contract, must be from within the past 24 months

Applicant Information

The purpose of this section is to collect general information about the applicant organization. Please complete all the information requested below (See LINK for additional details).

Organization Name (Please enter the organization's full legal name):

Primary Organization Type (Please select **one** of the following)

See [LINK] for definitions and examples of the organization types below. Please select the organization type that best fits the applicant organization, based on the Organization Type Definitions.

- ☐ Community-Based Organization (CBO)
- ☐ County, City, or Local Government Agency
- ☐ Federally Qualified Health Center (FQHC) or FQHC Look-Alike
- ☐ Rural Health Clinic
- ☐ Community Clinics/Free Clinics
- ☐ Indian Health Clinic (Also known as Indian Health Care Providers or IHCPs)
- ☐ Tribal FQHC
- ☐ Primary Care, Specialist Physician, or Physician Group
- ☐ Physician Group
- ☐ Hospital or Hospital-Based Clinic
- ☐ Public Hospital/Hospital System or District/Municipal Public Hospital/Hospital System
- ☐ Tribe, Indian Health Program, or Urban Indian Organization
- ☐ Adult Day Health Center
- ☐ Food and Nutrition Services
- ☐ Home Health Agency

- ☐ Recuperative Care and/or Medical Respite Provider

Secondary Organization Type (Please select **all** that apply)

See [LINK] for definitions and examples of the organization types below.

- ☐ Community-Based Organization (CBO)
- ☐ County, City, or Local Government Agency
- ☐ Federally Qualified Health Center (FQHC) or FQHC Look-Alike
- ☐ Rural Health Clinic
- ☐ Community Clinics/Free Clinics
- ☐ Indian Health Clinic (Also known as Indian Health Care Providers or IHCPs)
- ☐ Primary Care, Specialist Physician, or Physician Group
- ☐ Physician Group
- ☐ Hospital or Hospital-Based Clinic
- ☐ Public Hospital/Hospital System or District/Municipal Public Hospital/Hospital System
- ☐ Tribe, Indian Health Program, or Urban Indian Organization
- ☐ Adult Day Health Center
- ☐ Food and Nutrition Services
- ☐ Home Health Agency
- ☐ Recuperative Care and/or Medical Respite Provider
- ☐ Local Health Jurisdictions (LHJ)
- ☐ County Behavioral Health Department
- ☐ Behavioral Health Facility
- ☐ Community Mental Health Center
- ☐ Substance Use Disorder Treatment Provider
- ☐ Housing and/or Homelessness Services Entity
- ☐ Tribal FQHC
- ☐ Entity Serving Justice-Involved Individuals
- ☐ Hub Organization

Organizations Applying as a Hub Entity

Is this organization applying for CITED funds as a hub, or hub-like entity, on behalf of other provider(s) or CBO(s)?

- ☒ Yes ☐ No

If you selected “Yes”, please provide the following:

- Please describe your approach to sharing CITED funds with subcontracted providers.
- Please describe how you will ensure that subcontracted providers are not receiving duplicative funding.
- Please describe how you will ensure your organization is not retaining funds for administrative activities beyond what is allowable as described in the PATH CITED Guidance.
- How many subcontracted provider organizations do you intend to support using CITED funds?
- For each subcontracted provider, please provide the following:
 - Subcontractor Name
 - Primary Organization Type
 - Counties Served with CITED Funds
 - CITED Round # and Funding Amount Awarded if applicable. (Please indicate applying organization if funds were received through subcontract with a CITED Awardee)
 - ECM Population(s) of Focus (POFs) and/or Community Supports to be provided with CITED Funds
 - Contracting Status (Documentation of Subcontract with Applying Organization Must be Provided)

Document Upload

Organizations applying as a Hub must submit at least two (2) letters of support from contracting providers, in addition to a current MCP contract demonstrating the organization’s authority to subcontract with providers of ECM and/or Community Supports. Hub organizations are encouraged to submit any other relevant documentation to support the CITED funding request.

Please note: Files must be JPEG, JPG, PNG, or PDF with maximum size of file for upload is 10MB.

Organization Contact

Enter Employer Identification Number (EIN): _____ - _____

Enter National Provider Identifier (NPI): _____

Organization

Website: _____

Organization Street

Address: _____

City: _____

County: _____

State: _____

Zip: _____

Please select your entity type: (See LINK for additional details)

- ☐ Nonprofit (public or private organization with a 501(c)(3) status or a fiscally sponsored entity of a 501(c)(3) non-profit organization)
- ☐ Government Entity
- ☐ Other (includes, but is not limited to, For-profits and any Non-Tax-Exempt entities)

[If Government Entity is selected, the following populates]

If you are not selected for CITED funding in this round, are you interested in receiving Intragovernmental transfer (IGT) application review to potentially receive funds from this source? By selecting that you are interested in exploring the opportunity to receive IGT funds you are not obligated to participate if selected.

- ☐ Yes
- ☐ No

Primary Contact

The below information represents the Authorized Representative of the applying Organization.

First Name: _____

Last Name: _____

Title: _____

Phone Number: _____

Email: _____

Is the Primary Contact's address the same as the Organization's address?

- ☐ Yes
- ☐ No

[If No is selected, then the following populates]

Primary Contact Street

Address: _____

City: _____

State: _____

Zip: _____

Third Party Representative

Is the primary contact a third party entity completing the application on behalf of the organization (e.g., a grant writer that is external to the applicant's organization)?

- ☐ Yes
- ☐ No

[If Yes is selected, the following populates]

Please provide the following details for the third-party entity completing the application.

Third Party Representative Organization Name: _____

Describe the relationship to the applying organization.

(Text entry of 100 words or less)

About This Organization

How long has this organization been in operation in California?

- ☐ My organization is looking to expand to California.
- ☐ Less than 1 year
- ☐ 1-5 years
- ☐ 6-10 years
- ☐ 11 or more years

Is your organization based/headquartered in California? (See LINK for additional details)

- ☐ Yes
- ☐ No

Does your organization operate outside of California? (See LINK for additional details)

- Yes
- No

What is this organization's average annual operating budget?

Please note that the information provided in this question will not impact an applicant's overall score and is for informational purposes only.

- Under \$1 million
- \$1 million to \$4.99 million
- \$5 million to \$9.99 million
- \$10 million to \$24.99 million
- \$25 million to \$49.99 million
- \$50 million or more

CITED Eligibility

Applicants must upload signed contract(s) or signed attestation letter(s) from a Managed Care Plan(s) (MCP), or an MCP's authorized subcontractor(s) / network provider(s), demonstrating the applicant's intent to become an ECM / Community Supports provider for every ECM POF or Community Support that would be supported by the requested CITED funding. Documentation must clearly indicate the counties where the service will be offered. A memorandum of understanding (MOU) may be accepted if the applicant is a Tribe, Indian Health Organization or Urban Indian Organization.

Signed contracts and / or letters should include at a minimum:

- Identification of ECM and Populations of Focus served and / or Community Supports provided that would be supported with CITED funds;
- Identification of the counties where the service(s) will be offered;
- Completed signature page (contracts must be signed by both parties, letters must be signed by the MCP);
- The effective date of the contract to demonstrate the contract is current.

Documentation of contract status is required for all MCPs you are contracted or intending to contract with to provide the services included in your CITED request.

[Please click here to view the managed care plans by county as of 2023 and 2024.](#)

What is your current contracting status for ECM and / or Community Support services you plan to provide and / or develop with CITED funds?

- Fully contracted with at least 1 MCP
- Not Contracted

[If Not Contracted is selected, then the following populates]

If your organization is not currently contracted and does not have an active MOU, but is intending to contract or establish an MOU with one or more MCPs, please describe the status. An attestation letter signed by the MCP(s) must be included.

(Text entry of 100 words or less)

How many MCPs does your organization intend to contract with, currently contract with, or have an MOU with (if applicant is a Tribe, Indian Health Organization, or Urban Indian Organization) for ECM and / or Community Support services you plan to provide and / or develop with CITED funds?

Select the amount from a numerical drop-down list (values: 0-24)

[If 0 is selected, then the following populates]

If your organization is not currently contracted (or does not have an active MOU) and does NOT intend to contract or establish an MOU with one or more MCPs, please describe the status.

(Text entry of 100 words or less)

[If 1 or more is selected, then the following populates]

For each identified ECM Population of Focus or Community Support that would be supported through your requested CITED funding, select all the MCPs you contract with or have a letter of intent to contract with (or MOU/other documentation for Tribes, Indian Health Programs, or Urban Indian Organizations).

If the plan that you contract with operates in multiple counties, please ensure you provide the contract that represents all the counties in which you plan to utilize CITED funds.

If you have a subcontract with an MCP's authorized subcontractor, please see [link] for additional details.

Please select all that apply.

- ☐ I have a subcontract with an MCP's authorized hub or network provider.
- ☐ AIDS Healthcare Foundation
- ☐ Alameda Alliance for Health
- ☐ Anthem Blue Cross Partnership Plan
- ☐ Blue Shield of California Promise Health Plan
- ☐ CalOptima Health

- ☐ CalViva Health
- ☐ CenCal Health
- ☐ Central California Alliance for Health
- ☐ Community Health Group Partnership Plan
- ☐ Community Health Plan of Imperial Valley
- ☐ Contra Costa Health Plan
- ☐ Gold Coast Health Plan
- ☐ Health Net Community Solutions, Inc. (including former California Health and Wellness)
- ☐ Health Plan of San Joaquin
- ☐ Health Plan of San Mateo
- ☐ Inland Empire Health Plan
- ☐ Kaiser Permanente
- ☐ Kern Health Systems/Kern Family Health Care
- ☐ L.A. Care Health Plan
- ☐ Molina Healthcare of California
- ☐ Partnership Health Plan of California
- ☐ San Francisco Health Plan
- ☐ Santa Clara Family Health Plan
- ☐ SCAN Health Plan
- ☐ Other (please specify) _____

[For each MCP checked (except "I have a subcontract", the following populates]

Please select the type of supporting documentation uploaded for the selected MCP:

- ☐ Signed ECM Contract with MCP
- ☐ Signed Community Supports Contract with MCP
- ☐ Signed ECM and Community Supports Contract with MCP
- ☐ Signed Medi-Cal Contract with MCP, not specific to ECM and / or Community Supports (note this is **NOT** sufficient for CITED Eligibility)
- ☐ Signed ECM Sub-Contract with Organization contracted with MCP to provide ECM
- ☐ Signed Community Supports Sub-Contract with Organization contracted with MCP to provide Community Supports

- Signed ECM and Community Supports Contract with Organization contracted with MCP to provide ECM and Community Supports
- Signed Attestation Letter from MCP
- Signed Technical Assistance Marketplace (TAM) Attestation Letter from MCP
- Memorandum of Understanding (MOU)
- Other: _____

[If “I have a subcontract with an MCP’s authorized hub or network provider” is selected, then the following populates]

Please note that if you are subcontracted with another organization that is directly contracted with an MCP to provide ECM and / or Community Support Services, then you must upload the MCP contract for that organization and your subcontract with the main organization. Please see [link] for additional details.

Please select the type of supporting documentation uploaded for the selected MCP:

- Signed ECM Contract with MCP
- Signed Community Supports Contract with MCP
- Signed ECM and Community Supports Contract with MCP
- Signed Medi-Cal Contract with MCP, not specific to ECM and / or Community Supports (note this is **NOT** sufficient for CITED Eligibility)
- Signed ECM Sub-Contract with Organization contracted with MCP to provide ECM
- Signed Community Supports Sub-Contract with Organization contracted with MCP to provide Community Supports
- Signed ECM and Community Supports Contract with Organization contracted with MCP to provide ECM and Community Supports
- Signed Attestation Letter from MCP
- Signed Technical Assistance Marketplace (TAM) Attestation Letter from MCP
- Memorandum of Understanding (MOU)
- Other: _____

Name of organization you are sub-contracted with:

NPI of the organization you are sub-contracted with:

What MCP(s) is this organization contracted with?

- MCP(s): _____

In what county(ies) is this organization contracted to provide ECM and / or Community Supports?

- County(ies): _____

Is this organization a nonprofit? (Public or private organization with a 501(c)(3) status)

- Yes
- No

Document Upload

Please upload the appropriate documentation to demonstrate current contracted status. All documentation provided should include, at minimum:

- completed signature page including Applicant and MCP names (must be signed by both parties);
- identification of populations of focus receiving ECM and / or which Community Supports will be supported with CITED funds;
- identification of the counties where the service(s) will be offered
- a date demonstrating the contract is current.

Please note: Files must be JPEG, JPG, PNG, or PDF with maximum size of file for upload is 10MB.

Additional Funding Considerations

Applications, and accompanying funding requests, should consider (1) needs identified in local MCP Needs Assessment and [Gap Filling Plans](#) (developed as part of the Incentive Payment Program [IPP]), (2) needs identified in local homelessness plans (developed as part of the Housing and Homelessness Incentive Program), and (3) needs identified in the PATH Collaborative Planning and Implementation (CPI) initiative.

Applications should include strategies to avoid duplication and supplantation of other funding sources (e.g., IPP or other federal, state, local funds) as well as services paid for by Medi-Cal. Applicants are encouraged to coordinate requirements with local MCPs (including those entering the county starting in 2024) or the authorized subcontractor or network provider that they contract with or strongly intend to contract with to provide ECM/Community Support services. Applicants are strongly encouraged to seek [IPP funding](#) for their request from MCPs, apply for Technical Assistance (TA) offered in the [TA Marketplace](#), and explore funding opportunities related to the [Data Exchange Framework](#) before seeking PATH funding from CITED.

Please note that other Federal, state, or local funding sources and programs that are complementary to or enhance PATH funds will not be considered supplanted by PATH funds or duplicate reimbursement. If applicable, applicants must describe how similar or

related services and activities supported by other Federal, state, or local funding sources are complemented or enhanced by efforts funded by PATH. For example, if other funding 1) does not fully reimburse activities, 2) may allow additional/different populations to be served or 3) may allow additional/different services to be provided beyond those funded by PATH. To the extent that otherwise allowable PATH activities are reimbursed by other Federal, state, or local programs, PATH funding must not duplicate such reimbursement.

Please indicate if this organization participated in the following programs and the amounts awarded if applicable.

Program	Amount Awarded
Incentive Payment Program (IPP)	
PATH CITED Round 1	
PATH CITED Round 2	
PATH CITED Round 2 IGT	
PATH CITED Round 3	
PATH CITED Round 3 IGT	
PATH CITED-Clinics	
Whole Person Care (WPC) pilot	
Data Exchange Framework (DxF) Grant Program	
PATH Technical Assistance (TA) Marketplace	
Other funding source	

Please describe how you will ensure there is no duplication or supplanting of funding between this request and any other funding source, including those sources listed above or any other local, state, or federal funding source.

(Text entry of 250 words or less)

Have you requested the same budget items included in this application via any other pending funding sources for which you have not yet received your award or denial notification? If yes, please describe which budget items are duplicative of outstanding requests from other sources.

It is the responsibility of the applicant to notify the Third-Party Administrator (TPA) at cited@ca-path.com as soon as possible once you learn of the status of the pending funding sources. Failure to notify the TPA in a timely manner may affect the review of your application. See [LINK] for additional details.

(Text entry of 150 words or less)

Enhanced Care Management (ECM) and Community Support Services

As a key part of CalAIM, [Enhanced Care Management \(ECM\)](#) is a statewide Medi-Cal benefit available to select [Populations of Focus](#) that will address clinical and non-clinical needs of the highest-need Members through intensive coordination of health and health-related services.

Please only select the [ECM populations of focus](#) which are currently served or will be served by this organization using CITED funds. If this organization does not provide ECM, please select Not applicable.

- ☐ Not applicable
- ☐ Adult individuals and families experiencing homelessness
- ☐ Adults at risk for avoidable hospital or emergency department (ED) utilization (formerly high utilizers)
- ☐ Adults with Serious Mental Illness (SMI) and/or Substance Use Disorder (SUD) Needs
- ☐ Adult individuals transitioning from incarceration
- ☐ Adults living in the community and at risk for long-term care (LTC) institutionalization
- ☐ Adult nursing facility residents transitioning to the community
- ☐ Adult Birth Equity Population of Focus
- ☐ Children/Youth experiencing homelessness
- ☐ Children/Youth at risk for avoidable hospital or emergency department (ED) utilization (formerly high utilizers)
- ☐ Children/Youth with Serious Mental Illness (SMI) and/or Substance Use Disorder (SUD) Needs
- ☐ Children/Youth enrolled in California Children's Services (CCS) / CCS Whole Child Model (WCM) with additional needs beyond the CCS qualifying condition
- ☐ Children/Youth involved in, or with a history of involvement in, child welfare (including foster care up to age 26)
- ☐ Children/Youth transitioning from incarceration
- ☐ Youth Birth Equity Population of Focus

Community Supports are services provided by Medi-Cal managed care plans (MCPs) to address Medi-Cal Members' health-related social needs, help them live healthier lives, and avoid costlier levels of care.

Please only select the Community Supports which are currently provided or will be provided by this organization using CITED funds. If this organization does not provide Community Supports, please select Not applicable.

- ☐ Not applicable
- ☐ Housing Transition Navigation Services
- ☐ Housing Deposits
- ☐ Housing Tenancy and Sustaining Services
- ☐ Short-Term Post-Hospitalization Housing
- ☐ Recuperative Care (Medical Respite)
- ☐ Day Habilitation Programs
- ☐ Caregiver Respite Services
- ☐ Nursing Facility Transition/Diversion to Assisted Living Facilities
- ☐ Community Transition Services / Nursing Facility Transition to a Home
- ☐ Personal Care and Homemaker Services
- ☐ Environmental Accessibility Adaptations (Home Modifications)
- ☐ Medically Tailored Meals / Medically Supportive Food
- ☐ Sobering Centers
- ☐ Asthma Remediation
- ☐ Transitional Rent

Please enter the estimated percentage of the funding request that will be allocated to each ECM Population of Focus (POF) or Community Support Service. If you are requesting funding for one ECM POF or Community Support, enter 100% in the corresponding field. If you are requesting funding for multiple ECM POFs or Community Supports, enter the percentage dedicated to each. The total percentage across all POFs or Community Supports must equal 100%.

ECM POFs and Community Support Services	Percent of Funding (Total must equal 100%)
Adult individuals and families experiencing homelessness	
Adults at risk for avoidable hospital or emergency department (ED) utilization (formerly high utilizers)	

Adults with Serious Mental Illness (SMI) and/or Substance Use Disorder (SUD) Needs	
Adult individuals transitioning from incarceration	
Adults living in the community and at risk for long-term care (LTC) institutionalization	
Adult nursing facility residents transitioning to the community	
Adult Birth Equity	
Children/Youth experiencing homelessness	
Children/Youth at risk for avoidable hospital or emergency department (ED) utilization (formerly high utilizers)	
Children/Youth with Serious Mental Illness (SMI) and/or Substance Use Disorder (SUD) Needs	
Children/Youth enrolled in California Children's Services (CCS) / CCS Whole Child Model (WCM) with additional needs beyond the CCS qualifying condition	
Children/Youth involved in, or with a history of involvement in, child welfare (including foster care up to age 26)	
Children/Youth transitioning from incarceration	
Youth Birth Equity	
Housing Transition Navigation Services	
Housing Deposits	
Housing Tenancy and Sustaining Services	
Short-Term Post-Hospitalization Housing	
Recuperative Care (Medical Respite)	
Day Habilitation Programs	
Caregiver Respite Services	
Nursing Facility Transition / Diversion to Assisted Living Facilities	
Community Transition Services / Nursing Facility Transition to a Home	
Personal Care and Homemaker Services	
Environmental Accessibility Adaptations (Home Modifications)	

Medically Tailored Meals / Medically Supportive Food	
Sobering Centers	
Asthma Remediation	
Transitional Rent	

For each ECM POF and Community Support, please enter the number of Medi-Cal Members your organization currently serves per year, and the number of additional Medi-Cal Members your organization intends to serve per year with CITED funding.

Service Type	# of Current Members	# of Additional Members
Adult ECM POFs		
Child/Youth ECM POFs		
Community Supports Services		

Project Description and Justification

To request CITED funding, eligible entities must complete all sections of this application and submit all necessary attachments.

The purpose of this section is to gather information about the overall goals of your project, the services that will be provided by the applicant organization, and the applicant's approach to sustainability.

Please indicate whether the funding requested in this application will be spent in one county or multiple counties. If the funding will be spent in multiple counties, please estimate the percentage of total funding requested that will be spent in each county.

For example, if an applicant is requesting to hire one Community Health Worker who will be based at a facility in Alameda County and two Community Health Workers who will be based at a facility in Contra Costa County, they may estimate 35% of their requested funding will be spent in Alameda County and 65% will be spent in Contra Costa County.

If an applicant operates in San Bernardino and Riverside Counties and is seeking to connect to a health information exchange organization in both regions, then they may report that funding will be spent equally across these two counties. Alternatively, the applicant may also report that the funding will be unevenly distributed across participating counties if that is more appropriate.

We recognize that there may be instances where it is difficult to determine the percentage of funding that will be spent in a particular county, but applicants should provide the best estimate that they can based on the anticipated funding uses.

Please enter the estimated percentage of the funding request that will be used in each county in California. If you are requesting funding for one county, enter 100% in

the corresponding field. If you are requesting funding for multiple counties, enter the percentage dedicated to each. The total percentage across all counties must equal 100%.

Alameda County		Orange County	
Alpine County		Placer County	
Amador County		Plumas County	
Butte County		Riverside County	
Calaveras County		Sacramento County	
Colusa County		San Benito County	
Contra Costa County		San Bernardino County	
Del Norte County		San Diego County	
El Dorado County		San Francisco	
Fresno County		San Joaquin County	
Glenn County		San Luis Obispo County	
Humboldt County		San Mateo County	
Imperial County		Santa Barbara County	
Inyo County		Santa Clara County	
Kern County		Santa Cruz County	
Kings County		Shasta County	
Lake County		Sierra County	
Lassen County		Siskiyou County	
Los Angeles County		Solano County	
Madera County		Sonoma County	
Marin County		Stanislaus County	
Mariposa County		Sutter County	
Mendocino County		Tehama County	
Merced County		Trinity County	
Modoc County		Tulare County	
Mono County		Tuolumne County	
Monterey County		Ventura County	
Napa County		Yolo County	
Nevada County		Yuba County	

Please briefly describe your project and its overall goals in relation to your requested budget should you receive CITED funding.

(Text entry of 250 words or less)

Please describe how your organization is prepared to complete the proposed project and spend down all funds within the 1-year award period.

(Text entry of 500 words or less)

Please describe how CITED funding will help your organization to close gaps in the delivery of Enhanced Care Management (ECM) and expand the capacity and impact of the organization's delivery of ECM. Please enter n/a if your organization does not plan to provide ECM with CITED funding.

(Text entry of 250 words or less)

Please describe how CITED funding will help your organization to close gaps in the delivery of Community Supports and expand the capacity and impact of the organization's delivery of Community Supports. Please enter n/a if your organization does not plan to provide Community Supports with CITED funding.

(Text entry of 500 words or less)

Please describe, in detail, your approach to sustaining approved activities after CITED funding ends.

(Text entry of 250 words or less)

Please describe your organization's history working in the communities you intend to serve through this CITED funding request.

(Text entry of 250 words or less)

Please select all PATH-funded Collaborative Planning and Implementation (CPI) groups your organization currently participates in. *If your organization is not participating in a CPI group, please select Not applicable.*

- ☐ Not applicable
- ☐ Alameda Collaborative
- ☐ Central Collaborative
- ☐ Central Valley Collaborative
- ☐ Coastal Collaborative
- ☐ Contra Costa Collaborative
- ☐ Gold Country Collaborative
- ☐ Imperial Collaborative
- ☐ Indian Health Collaborative
- ☐ Inland Collaborative
- ☐ Kern Collaborative
- ☐ Los Angeles Collaborative
- ☐ Merced Collaborative
- ☐ NorCal Collaborative
- ☐ Northeast Collaborative
- ☐ Northwest Collaborative
- ☐ Orange Collaborative
- ☐ Sacramento Collaborative
- ☐ San Diego Collaborative
- ☐ San Francisco Collaborative
- ☐ San Joaquin/Stanislaus Collaborative
- ☐ Santa Cruz County Collaborative
- ☐ South Bay Collaborative
- ☐ Southeast Collaborative
- ☐ Southwest Collaborative
- ☐ Tri-Counties Collaborative
- ☐ Tulare Collaborative

Please select all populations served by the organization:

- ☐ LGBTQ+ individuals and families

- ☐ Seniors participating in Supplemental Social Security Program
- ☐ Persons with intellectual and developmental disabilities
- ☐ People with physical disabilities
- ☐ Survivors of domestic violence
- ☐ Indigenous People
- ☐ Veterans
- ☐ Persons with low educational status
- ☐ Persons whose primary language is not English / Non-English speaking individuals
- ☐ People who are geographically hard to reach
- ☐ Other (please describe): _____

Funding Request

Purpose

The purpose of this section is to collect information about: (1) the activities and personnel included in your funding request; (2) funding need and justification; and (3) how funding will be utilized and disbursed.

Budgets

- **Download the CITED Round 4 Funding Request Excel Workbook and enter your detailed funding request.**
- To request CITED funding, you will be required to submit a budget that comprises your total funding request. For this application, budget items should be the purchase of an item, the completion of an activity, or the salary support for staff related to ECM and/or Community Supports. CITED funding may be requested for up to 12 months (4 quarters) in Round 4. Specific restrictions on salary requests are described in more detail in the CITED Round 4 Guidance.
- Organizations who are awarded CITED funding will be required to submit a Progress Report (at minimum) every 3 months with milestones based on their approved budget. Progress Reports will be used to demonstrate proof of completed project milestones or to request up-front funds prior to funds being disbursed.
- Please ensure your requested budget items are reasonable. You can see reasonableness guidelines here [\[LINK\]](#).
- Sample budgets are also available here [\[LINK\]](#). There are several different examples provided to demonstrate different types of projects based on different services provided, organization types, etc.

- Funding requests for retroactive funding will each be recorded the same as other funding requests in the Funding Request Workbook. You will have the option of marking each activity as retroactive, if applicable, in the designated column.
- Please note that requests for retroactive funding must be accompanied by receipts, invoices, or other documentation for the historical investments. Appropriate documentation must be uploaded to this CITED application.
- Documentation requirements for retroactive funding requests are discussed in more detail in the CITED Round 4 Guidance here [LINK]. DHCS reserves the right to deny retroactive funding requests or approve retroactive requests at a lesser amount than your entity is requesting.

Allowable Use Categories

The following categories have been identified as “allowable” for CITED funding requests. You will be directed to select from these categories as you complete your CITED Round 4 Funding Request Excel Workbook later in this section of the application. These allowable use categories apply to retroactive and all other CITED funding requests and are subject to change at the discretion of DHCS.

Allowable Use Categories- Approved Uses of Funding
Training and Recruitment
Modifying, purchasing and/or developing the necessary referral, billing, data reporting or other infrastructure and IT systems, to support integration into CalAIM.
Evaluating and monitoring ECM and Community Supports service capacity to assess gaps and identifying strategies to address gaps.
Developing a plan to conduct outreach to populations who have traditionally been under-resourced and/or underserved to engage them in care.

Please note that funding for salaries must meet the requirements in the PATH CITED guidance document under “i. Funding to Support Staff Salaries.” Parameters include:

- CITED funding may only be used to support salaries for new positions or existing positions with new responsibilities where at least 60% of the FTE is directly related to supporting delivery or administration of ECM or Community Supports.
- Funding for salary support may only be requested for the portion of FTE that is directly related to supporting delivery or administration of ECM or Community Supports. For example, an applicant may not request funding for 100% FTE for a position where only 75% of the FTE is related to delivery or administration of ECM or Community Supports.
- CITED funding for salary support is capped at 12 months in duration for new positions or existing positions with new responsibilities.
- Indirect rates are capped at 5%.
- CITED funding for direct salary support may include costs associated fringe benefits, up to 40% of the salary costs, subject to guardrails enumerated above.

Requests for salary support must be reasonable relative to salaries for similar positions within the region.

How many months are you requesting funding for CITED Round 4? Applicants may request funding for up to 12 months.

Select the number of months from the drop-down list:

What is the total amount of funding you are requesting in CITED Round 4? Please enter the Total CITED Round 4 Funding Request Amount from *Tab 4. Summary: Column B, Row 5* of the completed CITED Round 4 Funding Request Excel Workbook:

\$

[If total requested funding is greater than \$3,000,000, then the following populates]

If you are requesting a large amount of CITED funding (greater than \$3,000,000), please explain if there are any specific factors that are driving the large size of your request. Please describe any special considerations related to the size of the request that you think may impact your project's success.

(Text entry of 250 words or less)

Please note that the total amount of funding requested in this application must be equal to the amount requested in your CITED Round 4 Funding Request Excel Workbook. If these amounts do not match, or do not represent the amount of funds you are requesting, please return to the CITED Round 4 Funding Request Excel Workbook to correct your amounts and re-enter them into the online application. Once your application is submitted, you will be unable to modify funding requests unless requested by the TPA or DHCS.

Document Upload

Please upload your completed CITED Round 4 Funding Request Excel Workbook and any other supporting documentation related to your funding request.

Please note: Files must be JPEG, JPG, PNG, or PDF with maximum size of file for upload is 10MB.

Attestations and Certifications

As an authorized representative of the applicant, the applicant attests as follows and agrees to the following conditions:

- The funding received through the CITED initiative will not duplicate or supplant¹ reimbursement received through other programs/initiatives (e.g., the Incentive Payment Program).
- The funding received through the CITED initiative will not duplicate or supplant⁴ reimbursement or activities covered under Medi-Cal.
- Funding received for the CITED initiative will only be spent on allowable uses as stated above, or that the applicant has received express DHCS approval for.
- Funding received for the CITED initiative will not be spent on unallowable uses as stated (add an attachment below or in the terms and conditions for them to sign).
 - Failure to comply will result in termination of CITED funding.
- The applicant will submit progress reports on CITED funding in a manner and on a period specified by the TPA and/or DHCS.
- The applicant will respond to general inquiries from the TPA and/or DHCS within one business day of receipt, and provide requested information within three business days, unless an alternate timeline is approved or determined necessary by the TPA and/or DHCS.
- The applicant understands that the TPA and/or DHCS may suspend or terminate CITED funding if persistent poor performance is identified.
- The applicant will alert DHCS if circumstances prevent it from carrying out activities described in the program application. In such cases, the applicant may be required to return unused funds to DHCS contingent upon the circumstances.

As the authorized representative of the applicant, I attest that all information provided in this application is true and accurate to the best of my knowledge.

Please note that an authorized signatory is a person with permission to act on behalf of the organization and make legal and financial decisions for the organization.

Signature

¹ Other Federal, state or local funding sources and programs that are complementary to or enhance PATH funds will not be considered supplanted by PATH funds or duplicate reimbursement. If applicable, applicants must describe how similar or related services and activities supported by other Federal, State, or local funding sources are complemented or enhanced by efforts funded by PATH. For example, if other funding 1) does not fully reimburse activities, 2) may allow additional/different populations to be served or 3) may allow additional/different services to be provided beyond those funded by PATH. To the extent otherwise allowable PATH activities are reimbursed by other Federal, state or local programs, PATH funding must not duplicate such reimbursement.

Print Name, Title

Date
