



# The Florida Senate

## Local Funding Initiative Request

### Fiscal Year 2019-2020

LFIR#: 1602

1. **Title of Project:** Florida Donated Dental Services Program
2. **Senate Sponsor:** Anitere Flores
3. **Date of Submission:** 02/06/2019
4. **Project/Program Description:**  
Florida Donated Dental Services Program.
5. **State Agency to receive requested funds :** Department of Health  
State Agency Contacted? Yes
6. **Amount of the Nonrecurring Request for Fiscal Year 2019-2020**

| Type of Funding                    | Amount         |
|------------------------------------|----------------|
| Operations                         | 180,000        |
| Fixed Capital Outlay               |                |
| <b>Total State Funds Requested</b> | <b>180,000</b> |

7. **Total Project Cost for Fiscal Year 2019-2020 (including matching funds available for this project)**

| Type of Funding                                      | Amount         | Percent       |
|--|----------------|---------------|
| Total State Funds Requested (from question #6)       | 180,000        | 100.00%       |
| Federal  | 0              | 0.00%         |
| State (excluding the amount of this request)         | 0              | 0.00%         |
| Local  | 0              | 0.00%         |
| Other  | 0              | 0.00%         |
| <b>Total Project Costs for Fiscal Year 2019-2020</b> | <b>180,000</b> | <b>100.0%</b> |

8. **Has this project previously received state funding? Yes**

| Fiscal Year<br>(yyyy-yy) | Amount    |              | Specific<br>Appropriation # | Vetoed |
|--------------------------|-----------|--------------|-----------------------------|--------|
|                          | Recurring | NonRecurring |                             |        |
| 2017-18                  |           | 100,000      | 447                         | No     |

9. **Is future-year funding likely to be requested? Yes**
  - a. **If yes, indicate non-recurring amount per year. \$180,000**

10. **Details on how the requested state funds will be expended**

| Spending Category                                   | Description | Amount |
|---|-------------|--------|
| <b>Administrative Costs:</b>                        |             |        |
| Executive Director/Project Head Salary and Benefits |             |        |



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|  |  |                |
|--|--|----------------|
| Other Salary and Benefits  | T & A for payroll, A/P, A/R, Budget, and Reports.                            | 22,000         |
| Expense/Equipment/Travel/Supplies/Other                                |  |                |
| Consultants/Contracted Services/Study                                  |  |                |
| <b>Operational Costs:</b>  |  |                |
| Salary and Benefits  | Coordinators/Supervisors.  | 130,498        |
| Expense/Equipment/Travel/Supplies/Other                                | Expenses, equipment, travel, phone, postage, print, insurance, and training. | 25,102         |
| Consultants/Contracted Services/Study                                  | Audit and lab reimbursements.  | 2,400          |
| <b>Fixed Capital Construction/Major Renovation:</b>                    |  |                |
| Construction/Renovation/Land/Planning Engineering                      |  |                |
| <b>Total State Funds Requested (must equal total from question #6)</b> |  | <b>180,000</b> |

**11. Program Performance:**

**a. What is the specific purpose or goal that will be achieved by the funds requested?**

Funding is for two full-time coordinators and operating expenses for the Florida Donated Dental Services (DDS) Program through the Dental Lifeline Network.

**b. What are the activities and services that will be provided to meet the intended purpose of these funds?**

The coordinators will facilitate appointments for the comprehensive dental treatment between those indigent Floridians who are disabled, elderly, and/or medically compromised.

**c. What are the direct services to be provided to citizens by the appropriations project?**

Those in the Donated Dental Services Program will receive much needed and sometimes life saving comprehensive dental care.

**d. Who is the target population served by this project? How many individuals are expected to be served?**

Citizens who are disabled, elderly, and/or medically compromised. Statewide.

**e. What is the expected benefit or outcome of this project? What is the methodology by which this outcome will be measured?**

Aside from the coordination of dental care for those that are some of the most needy, the program will help reduce costs in emergency room settings, which is typically where these individuals end up if they can't get access to a dentist. A program summary report and financial report for the fiscal year will be created to document performance data for the project.

**f. What are the suggested penalties that the contracting agency may consider in addition to its standard penalties for failing to meet deliverables or performance measures provided for in the contract?**

None.

**12. The owner(s) of the facility to receive, directly or indirectly, any fixed capital outlay funding. Include the relationship between the owner(s) of the facility and the entity.**



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N/A

#### 13. Requestor Contact Information:

- a. **Name:** Joe Anne Hart
- b. **Organization:** Florida Dental Association
- c. **E-mail Address:** jahart@floridadental.org
- d. **Phone Number:** (850)224-1089

#### 14. Recipient Contact Information:

- a. **Organization:** Dental Lifeline Network
- b. **County:** Statewide
- c. **Organization Type:**
  - For Profit
  - Non Profit 501(c) (3)
  - Non Profit 501(c) (4)
  - Local Entity
  - University or College
  - Other (Please specify)
- d. **Contact Name:** Hollie Stevenson
- e. **E-mail Address:** hstevenson@dentallifeline.org
- f. **Phone Number:** (720)287-6185

#### 15. Lobbyist Contact Information

- a. **Name:** Joe Anne Hart
- b. **Firm Name:** Florida Dental Association
- c. **E-mail Address:** jahart@floridadental.org
- d. **Phone Number:** (850)224-1089