



The Florida Senate

Local Funding Initiative Request

Fiscal Year 2024-2025

LFIR # 1367

1. Project Title

2. Senate Sponsor

3. Date of Request

4. Project/Program Description

To provide care coordination for uninsured and underinsured patients high risk/high utilizers of acute care services including emergency department, observation and/or inpatient admissions with the goal of reducing unnecessary hospital utilization, by linking patients to community services and close care gaps related to social determinants of health. Providing uninsured clinic patients with imaging, lab, medical which allows our providers address care needs to avoid unnecessary ER and inpatient hospitalizations - recently underfunded by North Lake County Tax District and impacts our clinic patients.

5. State Agency to receive requested funds

State Agency contacted?

6. Amount of the Nonrecurring Request for Fiscal Year 2024-2025

Type of Funding	Amount
Operations	300,000
Fixed Capital Outlay	0
Total State Funds Requested	300,000

7. Total Project Cost for Fiscal Year 2024-2025 (including matching funds available for this project)

Type of Funding	Amount	Percentage
Total State Funds Requested (from question #6)	300,000	100%
Matching Funds		
Federal	0	0%
State (excluding the amount of this request)	0	0%
Local	0	0%
Other	0	0%
Total Project Costs for Fiscal Year 2024-2025	300,000	100%

8. Has this project previously received state funding?

Fiscal Year (yyyy-yy)	Amount		Specific Appropriation #	Vetoed
	Recurring	Nonrecurring		
2023-24	0	200,000	458	No

9. Is future funding likely to be requested?

a. If yes, indicate nonrecurring amount per year.

b. Describe the source of funding that can be used in lieu of state funding.

10. Has the entity requesting this project received any federal assistance related to the COVID-19 pandemic?



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If yes, indicate the amount of funds received and what the funds were used for.

Complete questions 11 and 12 for Fixed Capital Outlay Projects

11. Status of Construction

a. What is the current phase of the project?

- Planning
 Design
 Construction
 N/A

b. Is the project "shovel ready" (i.e permitted)?

c. What is the estimated start date of construction?

d. What is the estimated completion date of construction?

12. List the owners of the facility to receive, directly or indirectly, any fixed capital outlay funding. Include the relationship between the owners of the facility and the entity.

13. Details on how the requested state funds will be expended

Spending Category	Description	Amount
Administrative Costs:		
Executive Director/Project Head Salary and Benefits	Medical Director	9,000
Other Salary and Benefits		0
Expense/Equipment/Travel/Supplies/Other		0
Consultants/Contracted Services/Study		0
Operational Costs: Other		
Salary and Benefits	RN, LCSW/Salary and Benefits	180,000
Expense/Equipment/Travel/Supplies/Other	Equipment, supplies, travel, phone, lab, imaging, OP Medical	111,000
Consultants/Contracted Services/Study		0
Fixed Capital Construction/Major Renovation:		
Construction/Renovation/Land/Planning Engineering		0
Total State Funds Requested (must equal total from question #6)		300,000

14. Program Performance

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

To provide care coordination for uninsured and underinsured patients high risk/high utilizers of acute care services including emergency department, observation and/or inpatient admissions with the goal of reducing unnecessary hospital utilization, by linking patients to community services and close care gaps related to social determinants of health. Providing uninsured clinic patients with imaging, lab, medical which allows our providers address care needs to avoid unnecessary ER and inpatient hospitalizations - recently underfunded by North Lake County Tax District and impacts our clinic patients.



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

Uninsured and underinsured population seen will be provided with care coordination services by an RN and LCSW. The goal is to find patients appropriate medical provider home and reduce unnecessary hospital utilization, while linking patients to community services. This will allow to close care gaps related to social determinants of health. Uninsured clinic patients would be provided labs, imaging, medical that assist providers to support unnecessary hospital visits to Emergency room or inpatient hospitalization.

c. What direct services will be provided to citizens by the appropriation project?

Outreach will be provided by an RN and LCSW to uninsured and underinsured population of Lake County seen at AdventHealth Waterman to encourage admission to a community care program that best meets their needs. The program would connect patients with appropriate resources, support, and follow up to ensure patients continue to receive appropriate care. Uninsured patients would be provided labs, imaging, medical that assist providers to support unnecessary ER visits or inpatient hospitalization.

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

Underinsured patients to include. Persons with poor mental and physical health, jobless persons, economically disadvantaged persons, homeless, physically disabled, drug users, drug offenders. WE expect to serve close to 800 patients.

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

Improve physical and mental health. These will be measured by volume of patients served and emergency department volume reduction.

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 the contract?

Unused funds will be returned.

15. Requester Contact Information

a. First Name **Last Name**

b. Organization

c. E-mail Address

d. Phone Number **Ext.**

16. Recipient Contact Information

a. Organization

b. Municipality and County

c. Organization Type

- For Profit Entity
- Non Profit 501(c)(3)
- Non Profit 501(c)(4)
- Local Entity
- University or College



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Other (please specify)

d. First Name **Last Name**

e. E-mail Address

f. Phone Number

17. Lobbyist Contact Information

a. Name

b. Firm Name

c. E-mail Address

d. Phone Number