The Florida Senate

Local Funding Initiative Request - Fiscal Year 2018-2019

1. **Title of Project:** 47 Million Reasons Healthcare Movement
2. **Senate Sponsor:** Daphne Campbell
3. **Date of Submission:** 12/01/2017
4. **Project/Program Description:**

   The Optimum Care Center

5. **State Agency Contacted?** No

   a. If yes, which state agency?

   b. If no, which is the most appropriate state agency to place an appropriation for the issue being requested? Department of Health

6. **Amount of Non-recurring Requested for fiscal year 2018-19:**

Amount Requested for Operations	Amount Requested for Fixed Capital Outlay	Total Amount of Requested State Funds
1,000,000	1,000,000	2,000,000

7. **Type, amount and percent of matching funds available for this project for fiscal year 2018-19:**

Type	Amount	Percent
Federal	0	0.0%
State (excluding the amount of this request)	0	0.0%
Local	0	0.0%
Other	0	0.0%
TOTAL	0	0.0 %

8. **Total Project Cost for fiscal year 2018-19 (including the Total Amount of Requested State Funds):** 2,000,000

9. **Previous Year Funding Details:**

   a. Has funding been provided in a previous state budget for this activity? No
   b. In the previous 5 fiscal years, how many years was funding provided? (Optional)
   c. What is the most recent fiscal year the project was funded?
   d. Were the funds provided in the most recent fiscal year subsequently vetoed?
   e. Complete the following Worksheet.

FY:	Input Prior FY Appropriation for this project for FY 2017-18 (If appropriated in FY 2017-18 enter the appropriated amount, even if vetoed.)		
Column:	**A**	**B**	**C**
Funds Description:	**Prior Year Recurring Funds ***	**Prior Year Nonrecurring Funds ***	**Total Funds Appropriated (Column A + Column B)**
Input Amounts:			

10. Is future-year funding likely to be requested?

Yes

a. If yes, indicate non-recurring amount per year.

$1,000,000

11. Program Performance:

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

Open community health and wellness facilities

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

Focus on prevention care, patient-directed care

c. How will the funds be expended?

Spending Category	Description	Amount
Administrative Costs		
☑Executive Director/Project Head Salary and Benefits	Physician (3)	350,000
☑Other Salary and Benefits	Staff	250,000
☑Expense/Equipment/Travel/Supplies/Other	Medical	250,000
☑Consultants/Contracted Services/Study	Study	150,000
Operational Costs		
☐Salary and Benefits		

☐Expense/Equipment/Travel/Supplies/Other		
☐Consultants/Contracted Services/Study		
Fixed Capital Construction/Major Renovation		
☑Construction/Renovation/Land/Planning Engineering	$200 sq ft	1,000,000
TOTAL		2,000,000

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

Preventative Care, patient-directed treatment, monitoring

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

25,000 Community members (general)

f. What is the expected benefit or outcome of this project? What is the methodology by which this outcome will be measured?
Screen Test, Evaluate, Patient-Directed Treatment

g. 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?
No additional penalties are recommended.

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.
Facility is owned by Physician, staff, community members, non profit

13. Requestor Contact Information:

a. Name: George Soria
b. Organization: Optimum Care Center/ 47 Million Reasons Healthcare Movement
c. Email: GLS@47MR.org
d. Phone Number: (561)703-5087

14. Recipient Contact Information:

a. Organization: 47 Million Reasons Healthcare Movement
b. County: Palm Beach
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: George Soria
e. E-mail Address: gls@47mr.org
f. Phone Number: (561)703-5087

15. If there is a registered lobbyist, fill out the lobbyist information below.

a. Name: None
b. Firm: None
c. Email:
d. Phone Number:

16. Have you applied for alternative state funding?

☐Wastewater Revolving Loan

☐Drinking Water Revolving Loan

☐Small Community Wastewater Treatment Grant

☐Other (Please describe)

☐N/A

17. What is the population economic status?

☐Financially Disadvantaged Community (ch. 62-552, F.A.C)

☐Financially Disadvantaged Municipality (ch. 62-552, F.A.C)

☐Rural Area of Economic Concern

☐Rural Area of Opportunity (s. 288-0656, Florida Statutes)

☐N/A

18. What is the status of construction?

19. What percentage of construction has been completed?

20. What is the estimated completion date of construction?