



The Florida Senate

Local Funding Initiative Request

Fiscal Year 2025-2026

LFIR # 1861

1. Project Title

2. Senate Sponsor

3. Date of Request

4. Project/Program Description

Provide care coordination for uninsured/underinsured patients high risk utilizers of acute care services including emergency dept., obs and/or inpatient admissions with 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 - recently underfunded by N. Lake Tax District impacting clinic patients.

5. State Agency to receive requested funds

State Agency contacted?

6. Amount of the Nonrecurring Request for Fiscal Year 2025-2026

Type of Funding	Amount
Operating	400,000
Fixed Capital Outlay	0
Total State Funds Requested	400,000

7. Total Project Cost for Fiscal Year 2025-2026 (including matching funds available for this project)

Type of Funding	Amount	Percentage
Total State Funds Requested (from question #6)	400,000	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 2025-2026	400,000	100%

8. Has this project previously received state funding?

If yes, provide the most recent instance:

Fiscal Year (YYYY-YY)	Amount		Specific Appropriation #	Vetoed
	Recurring	Nonrecurring		
2024-25	0	300,000	1367	No

9. Is future-year 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.

Public Private Partnerships.

Complete questions 10 and 11 for Fixed Capital Outlay Projects



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10. 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?

e. What funding stream will be used for ongoing operations and maintenance of the project?

11. 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.

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

Spending Category	Description	Amount
Administrative Costs:		
Executive Director/Project Head Salary and Benefits	Medical Doctor	9,000
Other Salary and Benefits		0
Expense/Equipment/Travel/Supplies/Other		0
Consultants/Contracted Services/Study		0
Operational Costs		
Salary and Benefits	Equipment, supplies, travel, phone, lab imaging, OP Medical	206,000
Expense/Equipment/Travel/Supplies/Other	Equipment, supplies, travel, phone, lab, imaging, OP Medical	185,000
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)		400,000

13. Program Performance

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

Provide care coordination for uninsured/underinsured patients high risk utilizers of acute care services including emergency dept., OBS and/or inpatient admissions with 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-recently underfunded by N. Lake Tax District impacting clinic patients.

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



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

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

Uninsured and Underinsured patients to include persons with poor mental and physical health, jobless persons, economically disadvantaged persons, homeless, physically disabled, drug users and 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?

Increase in patients establishing themselves at a community clinic, or other community program that meets their care needs. Decrease in ER utilization due to healthcare needs being met at primary care office. Volume of patients served, and Emergency Department Volume Reduction will be methodology to measure.

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?

Return the funding.

14. Is this project related to mitigation, response, or recovery from a natural disaster? No

a. If Yes, what phase best describes the project?

- Mitigation (reducing or eliminating potential loss of life or property)
- Response (addressing the immediate and short-term effects of a natural disaster)
- Recovery (assisting communities return to normal operations, including rebuilding damaged infrastructure)

b. Name of the natural disaster (or Executive Order # for events not under a federal declaration):

15. Has the entity applied for or received federal assistance for this project?

- Yes, Applied
- Yes, Received
- No
- No, but intends to apply

a. If yes, provide the FEMA project worksheet ID#:

b. Provide the total project cost listed on the FEMA project worksheet:



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16. Has the entity applied for or received state assistance for this project (other than this request)?

- Yes, Applied
- Yes, Received
- No
- No, but intends to apply

a. If yes, specify the program and state agency (ex. Local Government Emergency Bridge Loan, Department of Commerce):

17. Requester Contact Information

a. First Name **Last Name**

b. Organization

c. E-mail Address

d. Phone Number **Ext.**

18. 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
- Other (please specify)

d. First Name **Last Name**

e. E-mail Address

f. Phone Number **Ext.**

19. Lobbyist Contact Information

a. Name

b. Firm Name



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c. E-mail Address

d. Phone Number

The information provided will be posted to the Florida Senate website for public viewing if sponsored by a Senator.