Print Form

Letter of Support Request Form

Submit by Email

As New York State's Primary Care Association, CHCANYS strengthens the delivery of health care to the underserved and reinforces health centers' central role in New York's primary care safety net. CHCANYS' strength and effectiveness as your PCA depends not only on our staying continuously apprised of regulatory and policy developments but also on our having access to up-to-date, detailed information about the state's health centers and the communities they serve. Information from our members and other stakeholders allows us to provide the highest quality technical assistance as well as to compellingly and successfully advocate for those measures that strengthen New York's community health care system.

In considering your request to CHCANYS for a letter of support, therefore, we will also ask that you commit to providing us with certain specific information about your project and your organization. Further, organizations requesting a letter of support will be required to meet certain criteria to demonstrate the strength of their projects.

Before submitting your request, please read CHCANYS' Letter of Support Policy.

Primary Contact:

First Name: _____ Last Name: _____

Job Title: _____ Email Address: _____

☐ I have read and agree to comply with CHCANYS' Letter of Support Policy.

Organization Information:

Name of Organization: _____

CEO/ED Name: _____

Address: _____

City: _____

Zip Code: _____

Phone: _____

Organization Web Site: _____

☐ I am an existing 330

☐ I am an existing Look-Alike

☐ I am an existing Article 28

☐ I am an existing Diagnostic Treatment Center

Organization County: _____

Congressional District: _____

NYS Senate District: _____

NYS Assembly District: _____

Letter of Support Narrative Information

To assist CHCANYS in developing a letter of support that highlights the strengths of your project, provide a brief paragraph on your project and your center. (In drafting this paragraph, you should consider the following: What makes the project for which you are seeking funding valuable to the community it will serve? If you could choose one thing to highlight about your center, its history, or its past service to its patients, what would it be? What will be the impact on the community if your project is *not* funded? Is there anything about your center that makes it particularly well-qualified to carry out this project?)

Grant Information:

Name of grant for which you are applying:

Grant number: Grant due date:

Amount of funding requested:

Check one. This is a:

☐ new application ☐ renewal application

Check all that apply. This is a:

☐ 330i ☐ 330c ☐ 330h ☐ LAL

Project Address:

If your project address is different from your organization address please enter the addresses of all the sites included in the project:
(If there are more than two (2) sites in your project, please email an additional sheet to LOS@chcanys.org)

Site 1:

Address: Congressional District:

City: NYS Senate District:

Zip Code: NYS Assembly District:

Phone:

Site 2:

Address: Congressional District:

City: NYS Senate District:

Zip Code: NYS Assembly District:

Phone:

Review Criteria:
Please check all that apply

- ☐ Consumer Board Members currently constitute 51% of our Governing Board.
- ☐ This project includes adding Consumer Board Members to our Board.
- ☐ We currently serve patients at our proposed grant project site.
- ☐ Our grant project site is/will be open to all residents regardless of their ability to pay, race, religion, color, gender, age, sexual orientation, national origin or disability.
- ☐ We have done a needs assessment of the community to determine community need for this grant project.
- ☐ Our Governing Board has approved a sliding fee schedule and updates the fee and discount schedule on a regular basis.
- ☐ We have posted signs announcing the availability of a sliding fee scale in a prominent and accessible location in our health center.
- ☐ We provide access to all services without regard for a person's ability to pay.

List all FQHCs, Look-Alikes, Rural Health Clinics and Critical Access Hospitals in the proposed service area:	
List all FQHCs, Look-Alikes, Rural Health Clinics and Critical Access Hospitals contiguous to the proposed service area:	

** **FOR NAP APPLICANTS ONLY**:

Please email copies of the letters of support you have obtained from FQHCs and LALs operating within or contiguous to the proposed service area, or a written explanation of why those letters are unavailable, to LOS@chcanys.org.

Project Abstract

Copy and paste the Project Abstract from your application here:
(If you are unable to copy and paste onto the grid, please email your Project Abstract to LOS@chcanys.org.)

As applicable, please list zip codes in the proposed service area and your current service area.
Only list one zip code per cell.

Organization/Project	NAP/EMC Service Area Zip Codes	Current Service Area Zip Codes

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Have you included the following:

- [ ] Letter of support narrative information
- [ ] Project Abstract
- [ ] Checked all relevant review criteria boxes
- [ ] Emailed letters of support obtained to LOS@chcanys.org if applicable