



The Florida Senate

Local Funding Initiative Request - Fiscal Year 2018-2019

1. **Title of Project:** Agape Mobile Dental Program

2. **Senate Sponsor:** Audrey Gibson

3. **Date of Submission:** 12/07/2017

4. **Project/Program Description:**

Dental services for adults and children

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
500,000		500,000

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

Type	Amount	Percent
Federal	100,000	13.3%
State (excluding the amount of this request)	0	0.0%
Local	150,000	20.0%
Other	0	0.0%
TOTAL	250,000	33.3 %

8. **Total Project Cost for fiscal year 2018-19 (including the Total Amount of Requested State Funds):** 750,000

9. **Previous Year Funding Details:**

a. Has funding been provided in a previous state budget for this activity? Yes

b. In the previous 5 fiscal years, how many years was funding provided? (Optional) 1

c. What is the most recent fiscal year the project was funded? 2017-18

d. Were the funds provided in the most recent fiscal year subsequently vetoed? Yes

e. Complete the following Worksheet.



The Florida Senate

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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:		500,000	500,000

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

Yes

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

\$500,000.00

11. Program Performance:

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

Salaries to staff of dental unit

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

Allocation of this funding will result in the filling of a void that has been in existence since funding was last provided. Adults in Jacksonville who are unemployed, uninsured or underinsured are continuously flooding our emergency rooms resulting in millions of dollars being spent on preventative conditions such as cavities.

c. How will the funds be expended?

Spending Category	Description	Amount
Administrative Costs		
<input type="checkbox"/> Executive Director/Project Head Salary and Benefits		
<input type="checkbox"/> Other Salary and Benefits		
<input type="checkbox"/> Expense/Equipment/Travel/Supplies/Other		
<input type="checkbox"/> Consultants/Contracted Services/Study		
Operational Costs		



The Florida Senate

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<input checked="" type="checkbox"/> Salary and Benefits	Salaries for Dental Unit	500,000
<input type="checkbox"/> Expense/Equipment/Travel/Supplies/Other		
<input type="checkbox"/> Consultants/Contracted Services/Study		
Fixed Capital Construction/Major Renovation		
<input type="checkbox"/> Construction/Renovation/Land/Planning Engineering		
TOTAL		500,000

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

Dental services for citizens in need.

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

Adults in Jacksonville who are unemployed, uninsured or underinsured. This is approximately 122,343 people.

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

Reduce ER visits by unemployed or under employed who need dental care.

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?

10% reduction in next year's budget.

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.

N/A

13. Requestor Contact Information:

- a. **Name:** Mia L. Jones
- b. **Organization:** Agape Community Health Center, Inc.
- c. **Email:** mia.jones@agapefamilyhealth.org
- d. **Phone Number:** (904)703-0165

14. Recipient Contact Information:

- a. **Organization:** Agape Community Health Center, Inc.
- b. **County:** Duval
- c. **Organization Type:**
 - For Profit
 - Non Profit 501(c) (3)



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- Non Profit 501(c) (4)
- Local Entity
- University or College
- Other (Please specify)

d. Contact Name: Mia L. Jones

e. E-mail Address: mia.jones@agapefamilyhealth.org

f. Phone Number: (904)703-0165

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

a. Name: None

b. Firm: None

c. Email:

d. Phone Number: