STATE OF WISCONSIN
DEPARTMENT OF ADMINISTRATION
DIVISION OF ENTERPRISE OPERATIONS
01/2023

101 EAST WILSON STREET, 6TH FLOOR
PO BOX 7867
MADISON, WI 53707-7867
https://doa.wi.gov/pages/healthcareinfrastructure.aspx

HEALTHCARE INFRASTRUCTURE GRANT PROGRAM

Closeout Report Form

The Healthcare Infrastructure Grant Program ("Program") is administered by the Wisconsin Department of Administration (DOA) and supported by up to $100,235,854 in American Rescue Plan Act of 2021 (ARPA) federal funding. The Program provided grants for investments in healthcare infrastructure necessary to reduce disparities in healthcare services provided to individuals living in Qualified Census Tracts or to other populations disproportionately affected by the COVID-19 pandemic.

INSTRUCTIONS: Program Grantees shall use this form to submit a Final Report describing activities and eligible expenses under the Program. Eligible expenses include construction of new or upgraded facility spaces to enable additional capacity for care, and other operating expenses that are reasonable and consistent with program intent.

Program Grantees are not considered "subrecipients" under guidance from the Department of Treasury and are therefore not subject to the Uniform Guidance procurement requirements (under 2 CFR Part 200, Subpart D) or cost principles (under 2 CFR 200, Subpart E) and are not required to include the grant award funds in an audit of federal awards (under 2 CFR part 200, Subpart F) or the State Single Audit Guidelines issued by DOA.

Section 1. **GRANTEE CONTACT INFORMATION**			
Grantee Name			
Date		Project ID *(ARPA-HCI-###)*	
Contact Person Name			
Contact Person Title			
Contact Person Phone			
Contact Person Email			

CONVENIENCE COPY

Section 2. **REPORTING AND NARRATIVE DESCRIPTION OF ACTIVITIES**

1. Total number of individuals served during the Performance Period_____

   ☐ Check if grantee did not collect this data during the reporting period.

2. Total number of individuals served during the Performance Period enrolled in Medicaid and/or Medicare, uninsured and underserved populations living in and/or working in qualified census tracts*, or populations disproportionately impacted by COVID-19_____

   ☐ Check if grantee did not collect this data during the reporting period.

   *Definition: https://www.huduser.gov/portal/datasets/qct.html

3. Did grant funds lead to the retention or creation of jobs for your organization? If so, how many?
   ☐ Check if not applicable or you did not collect this data during the reporting period.

   a. _____ Jobs retained
   b. _____ Jobs created

4. Are all capital projects funded under this grant agreement completed?
   ☐ Yes
   ☐ No, project will be completed by _____
   ☐ N/A

5. Did your organization expend all award funds received under this grant?
   ☐ Yes
   ☐ No, our organization must return $_____ to DOA per terms of the grant agreement.

   Please send a check made out to the Wisconsin Department of Administration to:

   WI Department of Administration
   BFM AR (Floor 6)
   PO BOX 7869
   Madison WI 53707-7869

   In the memo line, please include your project ID (example: ARPA-HCI-###) that is included at the top of your Grant Agreement and on Semi-Annual Reimbursement and Payment Request forms.

CONVENIENCE COPY

Accomplishments

6. In the space provided, describe the activities performed (goals, outcomes, and accomplishments, services provided and community impact) or capital projects completed, and how these compare to the objectives described in your approved Scope of Work during the Performance Period. *(4000-character limit)*

CONVENIENCE COPY

COVID Recovery Impact

7. In the space provided, describe how the funds helped your organization build additional capacity for care, increase access to healthcare for underserved communities, or increase the ability to respond to future public health emergencies. Please share specific examples that demonstrate the impact the funds have had and where possible include quantitative metrics to illustrate outcomes (e.g., increase in the number of underserved individuals served, etc.). *(4000-character limit).*

CONVENIENCE COPY

Challenges

8. Please describe any barriers or difficulties you experienced in achieving the objectives of your Scope of Work, Timeline or Budget (e.g., cost overruns, staffing, supply change disruptions, etc.). Offer specific examples where applicable *(4000-character limit)*

CONVENIENCE COPY

Success Stories (optional but encouraged)

9. Do you have specific examples of successes you want to share? Please describe, or attach an example in the space provided below (e.g., anecdotes from individuals served, or capacity building efforts of your organization and its resilience) *(4000-character limit).*

CONVENIENCE COPY

Attach photos, press releases, or other documentation supporting the narrative.

Section 3. **CERTIFICATION AND ATTESTATIONS**

Check all that apply. Accepting all attestations is required.

☐ I, the undersigned, attest that the information contained in the ARPA Healthcare Infrastructure Grant Program Final Report Form is complete and accurate to the best of my knowledge and belief, and

☐ I, the undersigned, attest that all expenses were incurred by the organization that received payment, and

☐ I, the undersigned, attest that all expenses were incurred during the allowable expense performance period, as specified in Article 3 of the amended grant agreement and

☐ I, the undersigned, attest that all expenses are compliant with applicable state and federal laws, regulations, and the terms and conditions of the grant agreement, and will remit any unencumbered funds to the DOA per the terms and conditions of the grant agreement, and

☐ I, the undersigned, attest that I understand that real property bought in whole or in part with grant funds may not be sold, encumbered, or otherwise disposed of without the consent of the Department and that, to the best of my knowledge and belief, this has not occurred, and

☐ I, the undersigned, attest that the organization will maintain records sufficient to demonstrate that the expenses were compliant with applicable American Rescue Plan Act of 2021 (ARPA) requirements for at least five (5) years, and

☐ I, the undersigned, am authorized to submit this final report form and am authorized to certify compliance with the terms and conditions of the grant agreement, and

☐ I, the undersigned, irrevocably authorize the State of Wisconsin, Department of Administration (DOA), to use any information I provide, including any images, for the purposes of advertising related to DOA's administration of federal funds under the American Rescue Plan Act of 2021 and waive any and all claims for invasion of privacy or violation of rights of publicity arising from such authorized use. I further confirm that the provision of any and all information was done in compliance with all applicable laws.

CONVENIENCE COPY

Applicant Authorized Representative

By signing below, I certify that the above attestations are true and accurate and that I have the authority to make the above attestations, the intent, and legal authorization to agree to them on the organization's behalf.

Authorized Representative Signature	
Print Name	
Title	
Date	
Email	

OFFICE USE ONLY	Date Received:	Date Reviewed:
Performance Period		
☐Approved ☐Denied Comments:		

CONVENIENCE COPY