



NASSAU COUNTY
BOARD OF COUNTY COMMISSIONERS
P.O. Box 1010
Fernandina Beach, Florida 32034

Jim B. Higginbotham	Dist. No. 1 Fernandina Beach
Hazel Jones	Dist. No. 2 Fernandina Beach
Tom Branan	Dist. No. 3 Yulee
James E. Testone	Dist. No. 4 Hilliard
Jimmy L. Higginbotham	Dist. No. 5 Callahan

T.J. "Jerry" GREESON
Ex-Officio Clerk

MICHAEL S. MULLIN
County Attorney

January 26, 1989

CERTIFIED MAIL
RETURN RECEIPT REQUESTED

Mr. Allen Ream
Department of Banking & Finance
Bureau of Local Government Finance
The Capitol, Room 1001
Tallahassee, FL 32399-0350

Re: Shared County and State Health Care Program
Proposed County Allocation

Dear Mr. Ream:

Enclosed please find Nassau County's original application for the above-mentioned program.

If any additional information is needed regarding same, please do not hesitate in contacting this office.

Sincerely,

T. J. "Jerry" Greeson
Ex-Officio Clerk

TJG/mja

Enclosure

xc: Dr. David Page
Nassau County Health Dept.



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County Attorney

January 26, 1989

Mr. Bill Little
Medicaid Program Integrity
1317 Winewood Boulevard
Building 6, Room 271
Tallahassee, FL 32399-0700

Re: Shared County and State Health Care Program
Proposed County Allocation

Dear Mr. Little:

Enclosed please find a copy of Nassau County's original application for the above-mentioned program.

If any additional information is needed regarding same, please do not hesitate in contacting this office.

Sincerely,

T. J. "Jerry" Greeson
Ex-Officio Clerk

TJG/mja

Enclosure

xc: Dr. David Page
Nassau County Health Dept.



Shared County and State Health Care Program
Proposed County Allocation

County Nassau

- o Available state funds for your county for inpatient hospital care are \$35,530, assuming all counties participate.
- o Your county must provide up to \$19,132 in matching funds if:
 - a. the county funded inpatient hospital care prior to July 1, 1988;
 - b. the county has not reached the maximum ad valorem millage; and
 - c. the county has other revenue sources to fund the program, including unrestricted reserves, that can be used statutorily to fund the program.
- o The total amount available for inpatient hospital care for this program, if your county participates at the full 35 percent is \$54,662.
- o The state share will be available when a county provides less than 35 percent funding if the county:
 - a. did not fund inpatient hospital services prior to July 1, 1988;
 - b. has reached the maximum ad valorem millage; and
 - c. has no other revenue sources or has revenue sources that will meet part but not all of the county share.
- o The level of financial participation shall be determined by the Department of Banking and Finance based on completion of the application in Attachment 2.

Formula for Determining County Allocation

$$(a) \quad \frac{\text{State Appropriation}}{\text{Number of Indigents - Number of Medicaid in State} - \text{Eligibles in State}} = \text{Amount per Capita}$$

$$(b) \quad \left(\frac{\text{Number of Indigents - Number of Medicaid}}{\text{in County} - \text{Eligibles in County}} \right) \times \text{Amount per Capita} = \text{County's Allocation}$$

Source data is from: (a) Florida Consensus Estimating Conference; (b) 1987 Florida Statistical Abstract; and (c) Assistant Secretary for Medicaid, Department of Health and Rehabilitative Services.

**County Participation Application for
Shared County and State Health Care Program
and
Health Care Responsibility Act**

County: Nassau

Contact Person Name: T.J. "Jerry" Greeson Phone # 904-261-6127

Address: P.O. Box 456 -
Fernandina Beach, Florida 32034

A. Shared County and State Health Care Program (SCSHCP)

Please complete this section regarding your county's participation in the SCSHCP.

1. Do you desire to participate in the Shared County and State Program during the optional period? Yes No

If yes, please continue to Question 2.

If no, please go to Section B, regarding the Health Care Responsibility Act.

2. a) Did your county fund inpatient hospital services for those who would be eligible for the program on or before July 1, 1988? Yes No

If yes, how much was spent in fiscal year 1987-88? \$29,167

b) What is your 1988/89 fiscal year budget for eligible inpatient hospital services? \$50,000.00

3. What is your ad valorem millage rate? 7.3984
(use work sheet on page 4)

4. a) Does your county have other sources of revenue or funding that are statutorily available to fund this program, including unrestricted reserves? Yes No

b) If yes, please identify sources and provide estimates for the fiscal year ending Septemer 30, 1989 and estimates for the fiscal year beginning October 1, 1989 and ending September 30, 1990.

	<u>Source</u>	<u>Amount</u>		<u>Source</u>	<u>Amount</u>
FY 89	_____	_____	FY 90	_____	_____
	_____	_____		_____	_____
	_____	_____		_____	_____
	_____	_____		_____	_____

5. If additional funds become available because a county does not participate during the optional period, would your county be interested in providing additional funds in order to receive a share of unsubscribed state funds?

Yes X (This does not obligate the county to participate if additional funds are available.)

No (The county will not be contacted if additional funds become available.)

6. Eligibility Determination Responsibilities for the Shared County State Health Care Program.

For those counties that contribute 20 percent or more to the program the department shall conduct eligibility determinations only when the county demonstrates that staff are not available or are inadequate to conduct the determinations or in those situations where eligibility can be conducted concurrently with another application process. (Section 409.2673(8)(a), F.S.)

For those counties that contribute less than 20 percent to fund the program, the department shall determine eligibility. (Section 409.2673(8)(a), F.S.)

At this time, levels of financial participation have not been established, however, if your county participates at a funding level of 20 percent or greater will the county conduct the eligibility determination for the Shared County and State Health Care Program?

Yes X No

B. Health Care Responsibility Act

The county is required to participate in funding services under the Health Care Responsibility Act.

The county has the responsibility to conduct eligibility determinations unless the county demonstrates that the staff are not available or are inadequate to conduct the determination or in those situations where the department can conduct eligibility concurrently with another application process. (Section 154.306, F.S.)

Will the county conduct the eligibility determination for Health Care Responsibility Act.

Yes X No

We, the undersigned, do HEREBY CERTIFY, to the best of our knowledge, information, and belief, that the information reported herein is as correct and complete as possible.


Signature of Chief Financial Officer
or Designated Budget Officer

Date: January 24, 1989

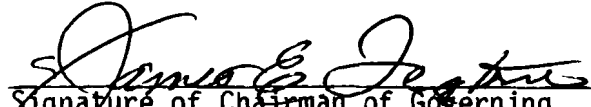
T.J. "Jerry" Greeson
Name (Please Print or Type)

Chief Financial Officer

Title
P.O. Box 456

Address
Fernandina Beach, Florida 32034

(904) 261-6127
Telephone


Signature of Chairman of Governing
Board or Mayor

Date: January 24, 1989

James E. Testone
Name (Please Print or Type)

Chairman

Title
P.O. Box 1010

Address
Fernandina Beach, Florida 32034

(904) 261-6127
Telephone

Note: Participation in the SCSHCP in the optional year is conditional on receipt by February 1, 1989. Failure to timely return will be considered a decision not to participate.

Return the original to:
Mr. Allen Ream
Department of Banking & Finance
Bureau of Local Government Finance
The Capitol, Room 1001
Tallahassee, Florida 32399-0350
(904) 488-4098

Return a copy to:
Mr. Bill Little
Medicaid Program Integrity
1317 Winewood Boulevard
Bldg. 6, Room 271
Tallahassee, Florida 32399-0700
(904) 487-2355

Worksheet for
Determination of Ad Valorem Millage
(Section A, Question 3)

1. General county millage.	<u>7.3984</u>
2. Dependent district millages county-wide.	<u>0</u>
3. Dependent district millages less than county-wide.	<u>0</u>
4. Total highest possible millage levied by county in any taxing district (1+2+3).	<u>7.3984</u>

Directions

1. "General county millage" is the millage levied excluding any dependent districts.
2. "Dependent districts county-wide millages" is the sum of all county-wide dependent millages levied.
3. "Dependent district less than county-wide millage" is the sum of all dependent less than county-wide millages levied within any one taxing district.
4. The total of 1, 2, and 3 gives the highest possible millage levied by the county for any one taxing district.
5. Enter the total at Section A, Question 3 of the application.

This worksheet was prepared by the Department of Revenue. For questions contact:

Norman McMillan
Bureau of Ad Valorem Taxes
Department of Revenue
(904) 488-3338 or
Suncom 278-3338

Please return the worksheet with the application.



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T.J. "Jerry" GREESON
Ex-Officio Clerk

MICHAEL S. MULLIN
County Attorney

April 12, 1989

Mr. William L. Little
Health Care Access Section, Administrator
Medicaid Program Development
Bldg. 6, Room 240
1317 Winewood Blvd.
Tallahassee, Florida 32399-0700

Dear Mr. Little:

The Board of County Commissioners instructed this office to return to you the signed agreement and information regarding the Shared County and State Health Care Program, which was approved in their meeting of April 11, 1989.

Should you need further information please do not hesitate in contacting my office.

Sincerely,

J. J. Greeson, by J. Greeson

T.J. "Jerry" Greeson
Ex-Officio Clerk



STATE OF FLORIDA
DEPARTMENT OF HEALTH AND REHABILITATIVE SERVICES

BOARD MEETING

DATE: 4-11

1989

March 22, 1989

ACTION: 3

**Certified Mail
Return Receipt Requested**

INFO: _____

Mr. Jerry Greeson
Nassau Clerk of the Court
P.O. Box 456
Fernandina Beach, Florida 32034

Dear Mr. Greeson:

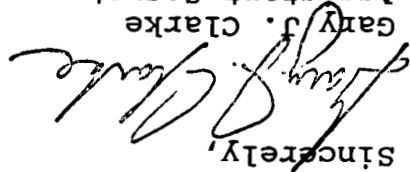
Your county has previously notified my office of its intent to participate in the optional period of the Shared County and State Health Care (SCS) program. Our letter of December 30, 1988 notified you of the potential SCS program allocation figures of \$35,530 in state funding and \$19,132 in required county matching funds. These figures were based on the assumption that all counties would participate in the optional period at the 35 percent matching rate.

These December 1988 figures will constitute your county's initial allocation amount for fiscal year 1988/89. You must provide us with a written confirmation of your acceptance of participation in the SCS program at the above funding level. Please utilize the attached "Participation and Funding Agreement" letter for this required confirmation. With your acceptance of participation, you must establish either a special SCS trust fund or a separate account in a multi-purpose trust fund and deposit the initial 25 percent of the county's match amount. Please use the attached information form to notify us that this accounting requirement has been completed. As soon as we are notified, we will request the Office of the Comptroller to issue to your county the initial 25 percent state allocation.

With 30 of the 67 counties participating in the optional period of the program, there is additional state funding available to your county under this program. For Nassau County, there is currently an additional amount of up to \$18,070.59 in state funds available. In order to receive this additional funding, the county would be required to provide an additional matching amount of \$9,729.85. Please notify us on the attached information form as to whether you want this funding made available to your county.

There may be further reallocations of SCS program funds during this fiscal year. Therefore, we are requesting that you provide us with a maximum amount the county is able and willing to allocate in order to receive state matching funds under this program for the current fiscal year. With this

attachments

Sincerely,

Gary J. Clarke
Assistant Secretary
for Medicaid

Please contact David Royce of my staff at (904) 487-2355 if you have any questions.

Mr. William L. Little
Health Care Access Section, Administrator
Medicaid Program Development
Bldg. 6, Room 240
1317 Winwood Blvd.
Tallahassee, Florida 32399-0700

We are requesting that you complete the attached agreement letter and information form and return it to the address below by no later than **April 17, 1989**.

amount identified on the attached information form, we will be able to notify you of any future funding that you would be eligible to receive.

Page 2
Mr. Jerry Gresson



STATE OF FLORIDA
DEPARTMENT OF HEALTH AND REHABILITATIVE SERVICES

BOARD MEETING

DATE: 4-11

1989

March 22, 1989

ACTION: 3

**Certified Mail
Return Receipt Requested**

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Mr. Jerry Greeson
Nassau Clerk of the Court
P.O. Box 456
Fernandina Beach, Florida 32034

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Mr. Jerry Greeson

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Health Care Access Section, Administrator
Medicaid Program Development
Bldg. 6, Room 240
1317 Winewood Blvd.
Tallahassee, Florida 32399-0700

Please contact David Royce of my staff at (904) 487-2355 if you have any questions.

Sincerely,



Gary J. Clarke
Assistant Secretary
for Medicaid

attachments

**INFORMATION FORM
INITIAL SCS PROGRAM IMPLEMENTATION
Nassau COUNTY**

A special trust fund or a separate account in a multi-purpose trust fund has been established. The twenty-five percent county share of \$4,783.00 has been deposited in this fund.

The county (requests)/(does not request) that additional SCS state funds be made available to the county in the amount of \$18,070.59. The county agrees to provide matching funds in the amount of \$9,729.85 in order to receive this additional state allocation amount.

The county (will)/(~~will not~~) provide additional funds to match state funds that may become available. The maximum amount the county will make available for any such funds will be \$ 50,000.00.

Which hospital(s) does the county anticipate it will be negotiating an agreement with for participation in the SCS program:

Nassau General 1700 East Lime St. Fernandina Beach, Fl.

University Hospital 655 West 8th St. Jacksonville, Fl

The contact person where the state allocation warrant can be sent:

Name: Mr. T.J. "Jerry" Greeson

Title: Ex-Officio Clerk

Address: P.O. Box 1010
Fernandina Beach, Florida 32034

Phone: (904) 261-6127

