

Demonstration Grant
Technical Assistance
2016-2017

OHIO COMMISSION ON
MINORITY HEALTH



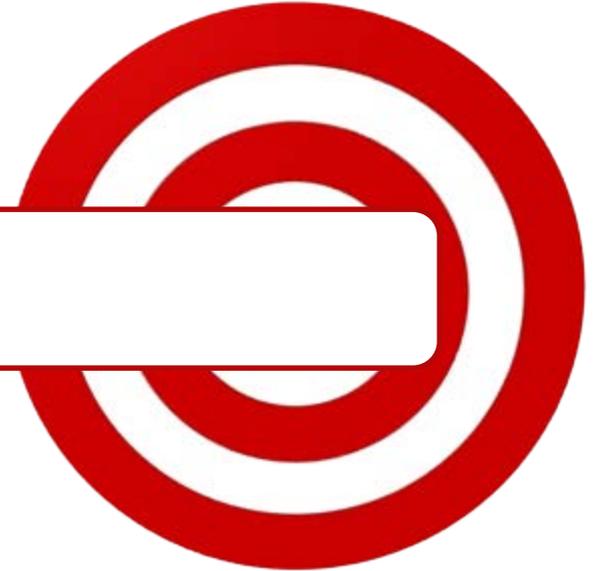
Overview of Presentation

-  Background- Overview of OCMH
-  Applicant Eligibility
-  Critical Elements
-  Funding
-  Compliance Guidelines
-  Proposal Preparation
-  Evaluation
-  Budget
-  Request for Proposal
-  Application Requirements/Contact Information





BACKGROUND

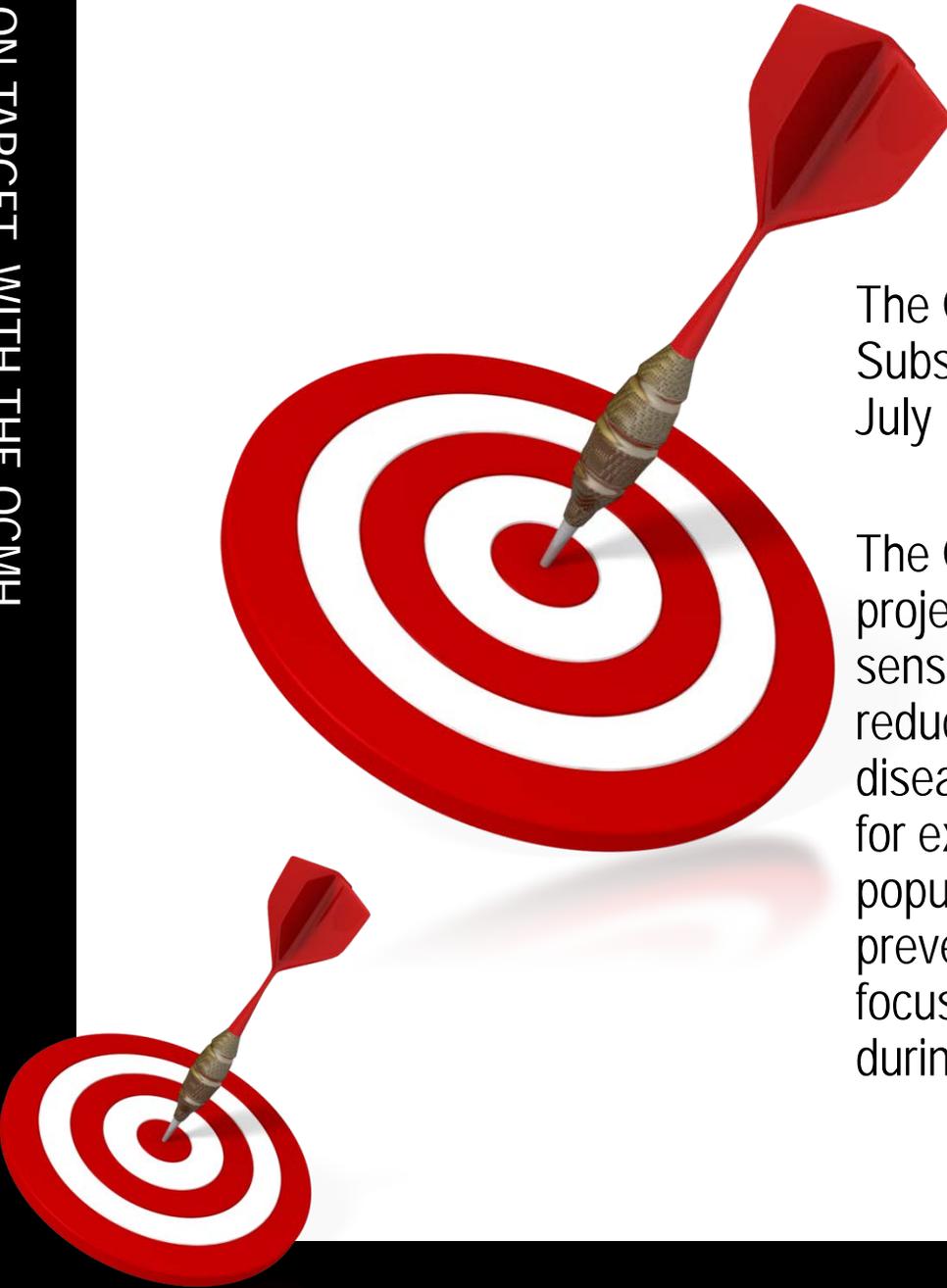


Background

In February 1986 the Governor's Task Force on Black and Minority Health was appointed to determine the reasons why a disparity existed between the health status of minority and non-minority Ohioans and to recommend methods to remediate the disparity.



Background



The Commission was established by Amended Substitute House Bill 171 and commenced on July 1, 1987.

The Commission was interested in funding projects which were innovative, culturally sensitive and specific in their approach toward reduction of the incidence and severity of those diseases or conditions which are responsible for excess morbidity and mortality in minority populations. Health promotion and disease prevention activities will constitute the primary focus of projects funded by the Commission during FY 2016-2017.



APPLICANT ELIGIBILITY



ELIGIBILITY

Priority will be given to grant applicants who develop services in accordance with the mission of the Commission. To receive consideration for funding, applicants must:

Demonstrate that at least 20% of project funds are received from sources other than grants awarded by the Commission on Minority.

Be a public or private organization which has a 501 (c) (3).

Grantee must meet all licensure and certification requirements of the State of Ohio.

Submit a complete application and budget.

Develop and establish a management board for the administration of the grant.

Provide services in close proximity to minority communities or include minority communities in their stated service area.

Answer all questions listed on the Administrative Compliance form.

Also, be in **GOOD STANDING** with the State of Ohio Auditor's office (www.auditor.state.oh.us)



INELIGIBILITY

➤ Individuals

➤ National organizations: local chapters or affiliates may be eligible if they meet the definition of a community-based health group.

➤ Organizations applying for the sole purpose of acquiring funds to supplement existing programs without any plan for enlarging their scope of work.

➤ Organizations in the process of creating or starting a “community-based health group” for the sole purpose of applying for grants from the Commission.



APPLICANT ELIGIBILITY

Terms of Grant

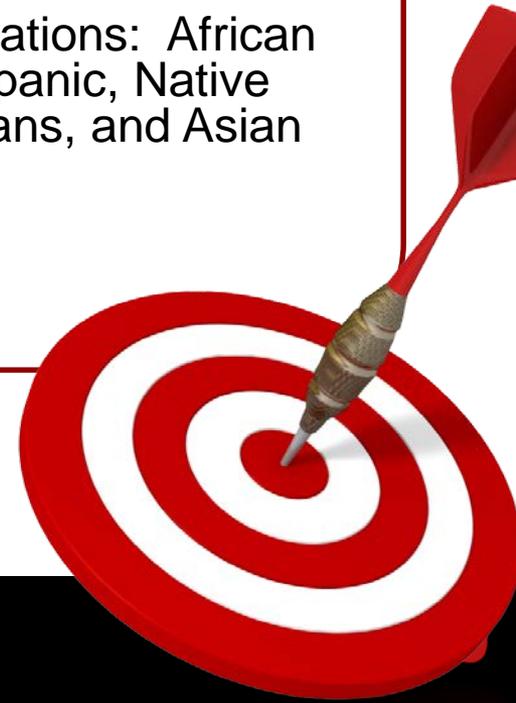
➤ Competitively bid statewide.

➤ Award will not exceed \$140,000 (up to \$70,000.00 per year) for a two year funding cycle.

➤ Mandatory participation in Minority Health Month Expo in Columbus (MHM 2016).

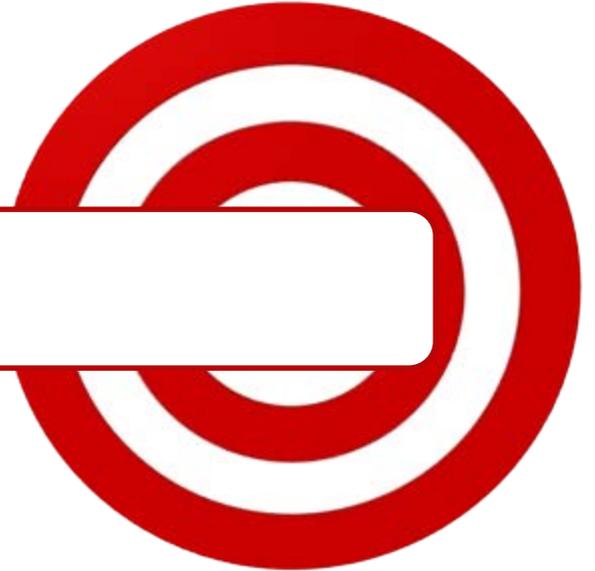
➤ Amended Substitute House Bill 171 established Commission grants for the purpose of health promotion and prevention of diseases among minority Ohioans who are economically disadvantaged.

➤ Target Populations: African American, Hispanic, Native American Indians, and Asian Americans.





CRITICAL ELEMENTS



CRITICAL ELEMENTS



➤ Culturally relevant health promotion and disease prevention constitute the focus for this grant program

➤ Funding priorities set by the Commission will be considered for grants designed to:

- ❖ Prevent Type 2 diabetes
- ❖ Prevent Infant Mortality

Consideration will be given to quality grants targeting heart disease, certain preventable cancers (breast, lung, mouth, throat and prostate), cardiovascular disease, substance abuse, or violence. All grants must contain a lifestyle modification component to include diet, exercise, and mandatory clinical measures and screenings .



CRITICAL ELEMENTS CONTINUED



➤ Grants that rely heavily on screening services exclusive of interventions for measurable behavior change will not receive a high priority.

➤ **Applicant must comprehensively address reduction/elimination of known risk factors in the program design.**

➤ In all cases, primary prevention activities will be given a higher priority than secondary or tertiary plans.



CRITICAL ELEMENTS CONTINUED



- Methods of Implementation must comprehensively address reduction/elimination of known risk factors in program design.
- Attention should be paid to the section under Proposal Preparation in the application.



CRITICAL ELEMENTS CONTINUED



IMPORTANT



➤ The Commission is interested in new, innovative, culturally relevant program models.

➤ Existing projects that seek funds to continue service delivery are not appropriate.

➤ Should not supplement agency or other systems.



CRITICAL ELEMENTS CONTINUED

- School based programs **must be budgeted and programmed for the entire 24 months** of the grant and cannot be limited to the school year.
- The Commission requires grants that propose service delivery in a school setting to also contain a community component involving all or some of the family unit of the school participants based on established criteria for inclusion.
- The Commission requires full pre/post evaluations of summer portions of a school based program to include mandatory clinical measures.



CRITICAL ELEMENTS CONTINUED



➤ Attention should be paid to *Method of Implementation* section of application.

➤ Applicants should clearly delineate and explain the methodology that will be used to demonstrate measurable health outcome behavioral changes.

Goal of funded projects:

➤ Behavior Change = Improved Health Status

➤ Improvements in required Clinical Measures

➤ Improvements in A1C levels, BP, BMI, and birth weight depending on program focus

➤ Improvements in knowledge, awareness and skills



CRITICAL ELEMENTS CONTINUED

- **THIS DEMONSTRATION GRANT REQUIRES THE IMPLEMENTATION OF CLINICAL MEASURES PER THE EVALUATION GUIDANCE.**
- **This is not optional and must be a part of the evaluation section. Organizations must demonstrate the ability to implement quarterly clinical and non-clinical measures to evaluate program effectiveness.**
- **Grantees targeting minor participants (children) must describe a thorough process to obtain parental consent for mandatory invasive and non-invasive clinical measures such as A1C and blood pressure measures. As well as non-clinical measures such as knowledge, awareness and attitudes.**



- **Minor program participants must have parental permission to participate in all areas of the program to include mandatory clinical measures and non-invasive clinical measures.**
- **The projected numbers for evaluation purposes must be based on those who both participate in educational programming as well as non-clinical and clinical measures.**



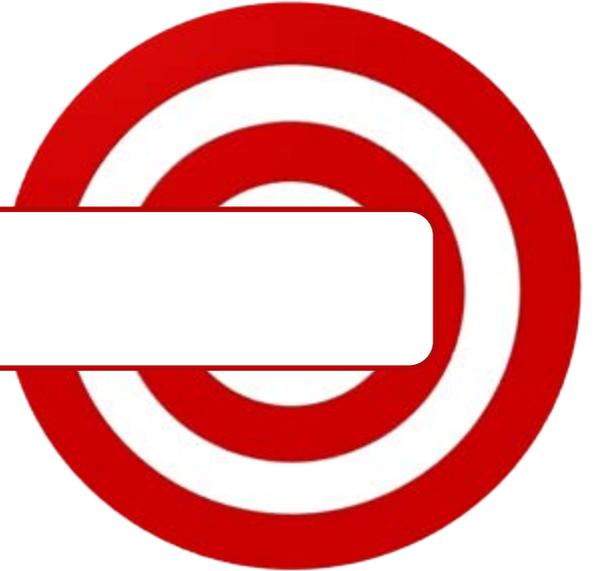
Institutional Review Board (IRB)

- If you are working with an academic institution, your evaluator may be involved in a review process with the college or university's Institutional Review Board. It is important to keep in mind that the IRB process generally takes several weeks to complete and may add time to the start-up of the project.
- *The OCMH expects grantees to perform direct service within the first quarter of project funding.*
- Therefore, it is recommended that you simultaneously apply for an IRB, when you apply for OCMH funding. If it is later determined that you will not use the IRB there will be no detriment to the OCMH funded project.





FUNDING



FUNDING



Only one application will be accepted per agency

Funding period:
July 1, 2016 –
June 30, 2017

Award notification
by May 2015
with an
immediate
startup required



Performance based
grant – second year
contingent on
measured outcomes
during first year



FUNDING INELIGIBILITY

Will not be considered for...

- Support of residential services.
- Treatment as the primary direct service.
- Construction or renovation.
- Conducting research and/or studies independent of service delivery.
- Projects legislatively mandated/funded by other public dollars.
- Exclusively conducting conferences or workshops.





COMPLIANCE GUIDELINES



COMPLIANCE GUIDELINES



➤ All compliance forms must be original, completed, and signed by authorized agency representative in blue ink.

- ❖ Rehabilitation Act
- ❖ Civil Rights Act
- ❖ IRS
- ❖ W-9 (use the IRS form Dec 2011)
- ❖ Receipt of Acceptance
 - Segregation of Duties
 - No PO Boxes
 - No Personal Home Address/Telephone

Attach a copy of agency IRS 501(c)(3) letter





PROPOSAL PREPARATION



PROPOSAL PREPARATION



IMPORTANT



- 30 page limit.
- Complete the Receipt of Acceptance, assurances, and compliance forms.
- Include copy of 501(c)(3) status.
- Most recent audit report.
- Board resolution (not included in the page count).
- Agency must provide statement from Board giving approval to apply.
- Utilize RFP Checklist provided.



IMPORTANT INFORMATION



Responses to this RFP should be prepared following the application format described.

Proposals that do not provide all of the requested information, or do not meet all the requirements specified in the RFP **WILL** be determined incomplete and will be disqualified.

PROPOSAL PREPARATION



➤ **Proposal Narrative – Sections**

- ❖ Description of Applicant Agency
- ❖ Problem Need Statement
- ❖ Project Abstract
- ❖ Project Action Plan
- ❖ Method of Implementation
- ❖ Evaluation
- ❖ Year Two Project Summary



PROPOSAL PREPARATION

Description of Applicant Agency



➤ Agency mission and mandate

➤ Previous involvement with minority populations



➤ Agency accomplishments

➤ Enhancement of agency service delivery

➤ Agency description



➤ Facility where service delivery will be conducted - days/hours of operation

➤ Technical accuracy of the health component will be assured through mandatory clinical screens



PROPOSAL PREPARATION

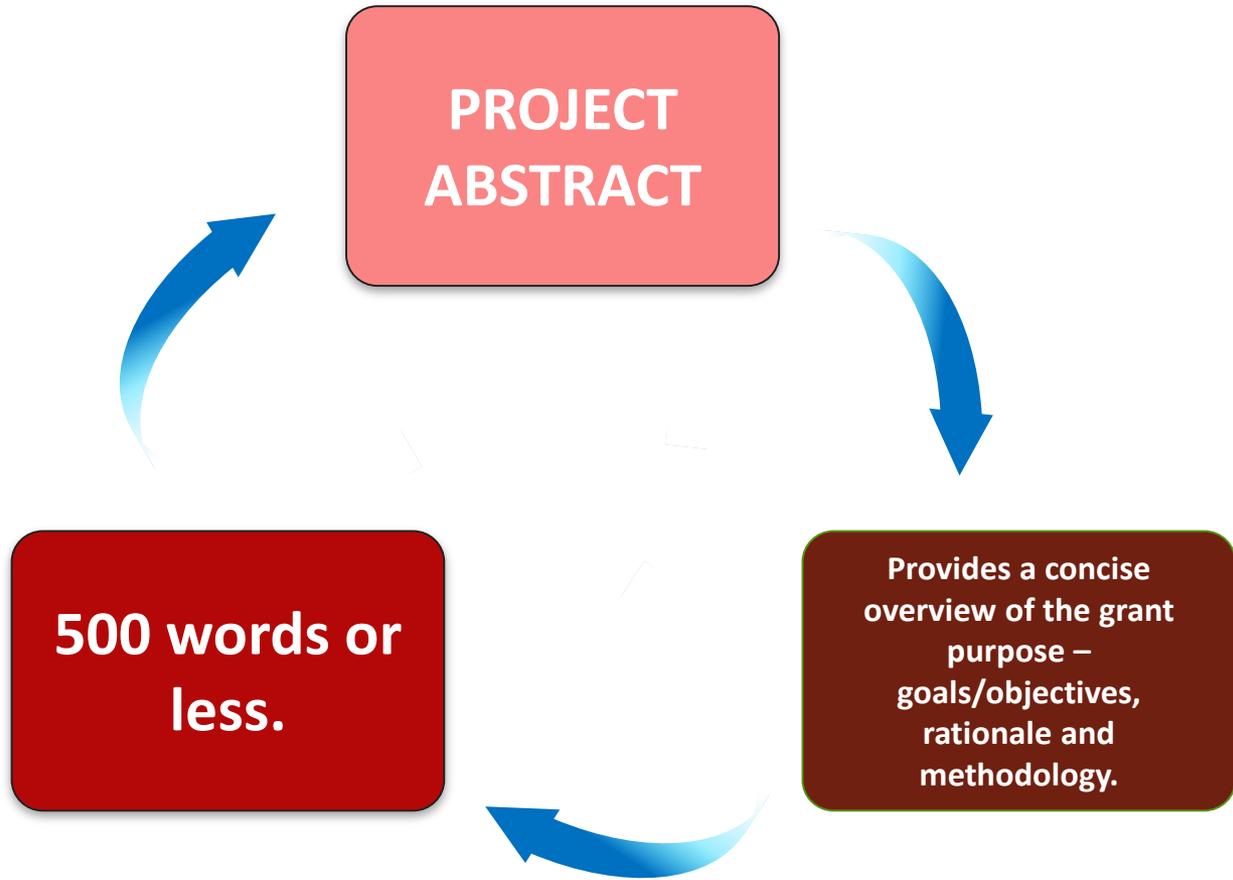


➤ **Problem Need Statement**

- ❖ Specific Target Area
- ❖ Describe problem and needs to be addressed
- ❖ Provide statistics, research findings or other pertinent documentation
- ❖ Target population – race, age, gender, and number to be served and geographical area
- ❖ Letters of Support – must outline specific activities or services proposed by each partner and should not be generalized.



PROPOSAL PREPARATION



PROPOSAL PREPARATION

Proposal Action Plan



- Use attached form
- PDF or Word



- Timeframe conforms with funding period

- Major tasks and activities should be indicated for each objective



- Clearly define and measurable goals and objectives

- Do not include hiring personnel as a measurable objective

Note: You must list goals and objectives with the projected number of participants to be served and objectives must be clearly defined and measurable in process and client behavior outcome changes. Utilize numbers NOT percent's.



PROPOSAL PREPARATION

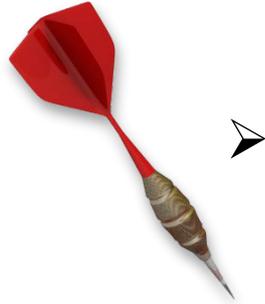


Method of Implementation

- ❖ Detail description of services provided.
- ❖ Demonstrate and verification that the proposed services/activity are medically and technically accurate.
- ❖ Include the proposed days, hours of operation, and location of activities.
- ❖ Explain how the target populations will be involved in the administration and execution of the grant.



PROPOSAL PREPARATION



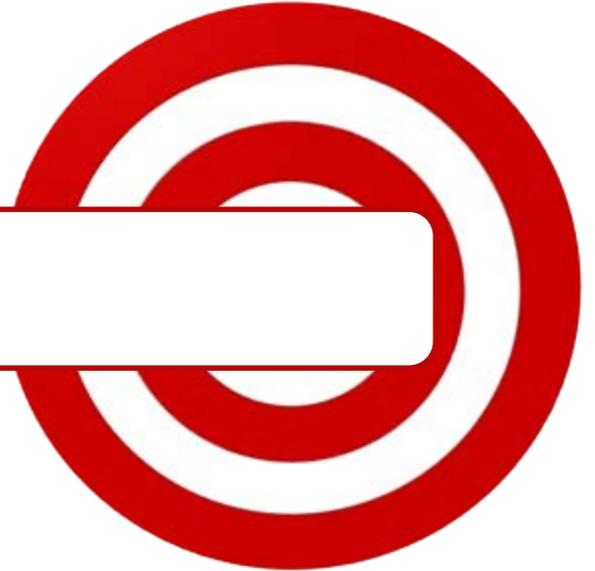
Method of Implementation

- ❖ Describe the linkages between the program design, goals, and objectives the program intends to achieve.
- ❖ Describe culturally-specific components that reflect the target populations attitudes, values, and beliefs.
- ❖ Describe the role of the REEP evaluator in the program design, implementation and goal attainment.





EVALUATION



PROPOSAL PREPARATION

Evaluation (Section of External Evaluator)



- Required to work with the Research and Evaluation Enhancement Program (REEP)



- Evaluator must be selected from an approved list of REEP evaluators
- Evaluator should be engaged from the beginning through the life of project



- Provide on-site review of program delivery
- Assist with client assessment forms
- Meet with REEP Panel member



PROPOSAL PREPARATION

Evaluation (Section of External Evaluator Continued)



- Evaluation procedures are quantitative and incorporate required clinical and non-clinical measures.

- Evaluation of objectives must occur on a quarterly basis.



- Valid time-lined outcomes and effectiveness.

- Do not state in percentages, use actual numbers.

- All grantees must refer to the Evaluation Guidance Packet in preparing the proposed evaluation plan and the required areas that must be measured.



- Detailed method to determine how established goals with a total to be served for the year and objectives will be met and outcomes are achieved

- The evaluation Guidance Packet can be found on the Commission's website at www.mih.ohio.gov.

PROPOSAL PREPARATION



- **Grant Implementation Requirements (If funded)**
 - Return signed Acknowledgement of Terms
 - Satisfactory response to the Program and Fiscal Special conditions if assigned
 - Submission of Program, Evaluation and Fiscal Quarterly Reports (on Commission forms)
 - Submit year end Program and Evaluation Reports



PROPOSAL PREPARATION



- Grant Implementation Requirements (If funded) Continued.
- Responsible for Annual and Biennial Program Reporting.
- Submit year end fiscal audit due October 30, 2017.



PROPOSAL PREPARATION

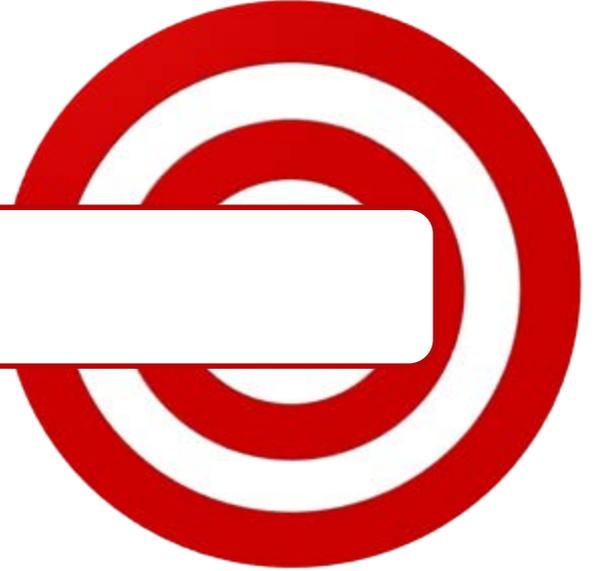


- **Year II Project Summary**
 - Brief Narrative
 - Describe the major tasks and activities for Year II including required clinical measures
 - Define how they will be accomplished.





BUDGET



BUDGET FORMS

Personnel and Fringe Benefits - Section I

➤ Do not list contractual or consultants in this section.

➤ Include agency staff only.

➤ Attach job description and written narrative justification,

➤ **Column I** – provide the yearly salary budgeted for each position listed.

➤ **Column II** – Provide the total number of months of employment projected per position for this grant.

➤ **Column III** – Calculate the percent of time the employee will devote exclusively to the project.



BUDGET FORMS



Personnel and Fringe Benefits

- ❖ **Column IV** - provide the amount of the employee's salary that will be funded by the Commission.
 - **Example:** An employee works an annual salary of \$15,000.00, works 12 months at 50% of his/her time would earn \$7,500.00 and request that amount from Commission funds).



BUDGET

Personnel and Fringe Benefits



➤ Only employees who implement services detailed in the project proposal may charge their time to this grant



➤ **Column V** - List the fringe benefits for all positions listed in the budget.

➤ **Column VI** - List the percentage of employee fringe benefits



➤ **Column VII** - Other sources of Support: Applicant will identify line items that have other sources of support

➤ Include job descriptions for assigned staff and resumes if available.



BUDGET FORMS

- Section I of the Personnel and Fringe Benefit page must be signed in **blue ink** by the Chief Executive Director/Officer and the agency Fiscal Officer.



BUDGET FORMS



Travel

- ❖ Provide an estimate of number of miles that will be traveled and the rate at which payment would be made, not to exceed the State rate of \$.52 cents per mile. If you have an internal policy that was approved by your board as a resolution, you can charge your agency's rate. (NOTE: The agency's policy/resolution must be submitted with the grant application).
- ❖ Lodging rate per day/per person may not exceed the state rate of \$106.00 plus room tax (if applicable).



BUDGET FORMS



Meals expenses are allowable for dinner and breakfast when on an approved overnight stay not to exceed \$27.00 per day with receipts for full day days travel preceded and followed by overnight stays.



Out-of-state travel is non-allowable cost under this grant.



BUDGET FORMS

- Fees for conference/training sessions, when determining to be related to specific job-duties and/or responsibilities, are reimbursable or allowable. Projected number of such sessions and costs should be stated.
- Only employees who implement services detailed in the project proposal may be reimbursed for actual travel expenses.



BUDGET FORMS

Minority Health Month: All funded grantees are required to allot funds to support.

At least two (2) events during the month of April 2016 and 2017.

Travel costs (mileage, meals, hotel accommodations to attend the Health Expo scheduled for March 2016 and 2017.



BUDGET FORMS

- Equipment may not be purchased with Commission funds.
- Leasing/rental of equipment may be considered.
- Provide the rate per month and the number of months for leasing/rental of equipment.



BUDGET FORMS



Each supply line item must include the cost per unit on the budget narrative justification form

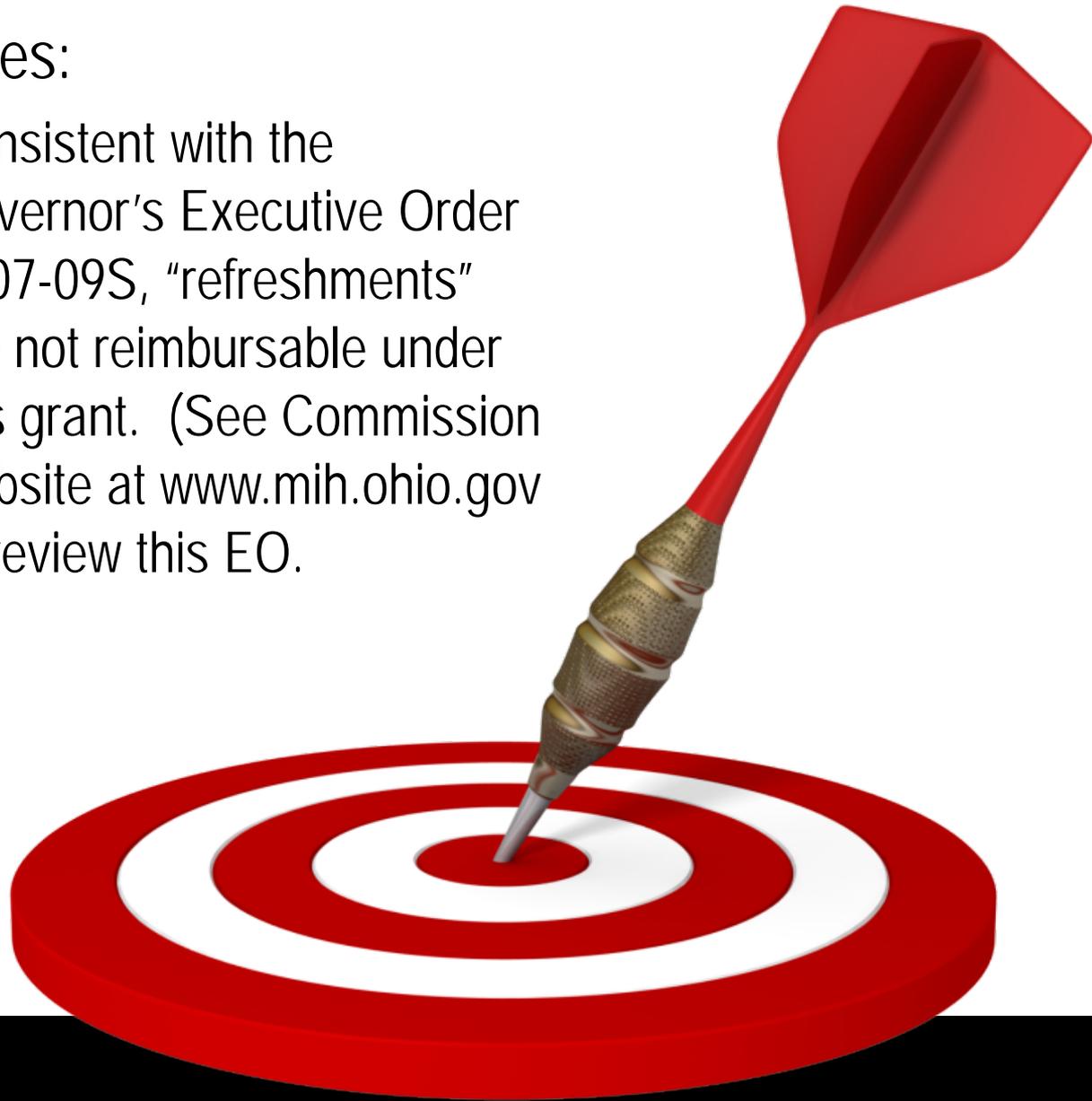
- ❖ Supplies consist of expendable items which have a useful product life of one year or less.
- ❖ Supplies include all tangible and expendable property.
- ❖ Items priced less than \$100.00 (e.g. staples, scissors, wastebaskets, paper, pens) are considered office supplies.



BUDGET FORMS

➤ Supplies:

- ❖ Consistent with the Governor's Executive Order 2007-09S, "refreshments" are not reimbursable under this grant. (See Commission website at www.mih.ohio.gov to review this EO.



BUDGET FORMS

➤ Printing:

- ❖ Costs may include typesetting, actual printing or photocopying of the materials which is completed by a commercial printing company. Included also are costs for pamphlets, brochures, and flyers. Provide the cost per unit (ex: 100 brochures X \$.01 = \$1.00).



BUDGET

Contracts

- Agreements for all sub-contracts must be submitted with the following being addressed: scope of service, deliverables, beginning/ending date, hourly rate, total number of contract hours, and include a termination clause.
- Consultant expenses may not exceed 10% of the total award.
- Interpreters hourly rates may not exceed \$35.00 per hour and may not be a part of the agency personnel.



BUDGET FORMS



- Advertising:
 - Specify the media and cost of advertisement (ex. 3 ads at \$50.00 per ad = \$150.00)
- Evaluator:
 - ❖ As indicated in the Proposal Preparation section, the external evaluator must be selected from the approved list of REEP evaluators.



BUDGET FORMS



- Non-Personnel
 - Administrative/Indirect Costs
 - Total administrative cost may not exceed 15% of the total grant award. The following may be charged as indirect costs/services and must be itemized.
 - Administrative charges: salaries of support staff (administrators, secretaries, accountants). Provide the percentage of time on the project per line item.



BUDGET FORMS

Administrative/Indirect Costs

ON TARGET WITH THE OCMH



- Rental/space leasing: space rental is an allowable cost. Space for which rental fees will be paid must meet the following requirements:
 - ❖ The number of months and the rate at which payment will be made should be stated;
When rent is shared among several programs, the amount charged to the Commission must not exceed the Commission's fair share.



➤ Rental Space/Leasing:

- ❖ The agency must submit documentation of how the Commission's fair share was determined (e.g., if Commission-funded project uses 20% of the space, the Commission may be charged no more than 20 percent of the total rent.
- ❖ Submit a copy of the lease which includes the building's owners name, location of the building, square footage, total amount of rent paid, terms of agreement, termination clause, signatures of lessee and lessor;

BUDGET FORMS

Rental Space and Leasing

- Approved rent is non-transferable from the original site to a new or relocated site.
- Rent will not be approved for:
 - ❖ Space which is paid for by another state/federal or private grant;
 - ❖ Space in buildings purchased with federal funds;
 - ❖ Space donated to the applicant agency; and
 - ❖ Utilities, heat, water, electricity, etc.



BUDGET FORMS

➤ Budget Justification/Narrative

- ❖ This page is mandatory and must be completed in order for the application to be considered complete. All line items need to be itemized and include a cost per unit.
- ❖ The budget and budget narrative must total the same.

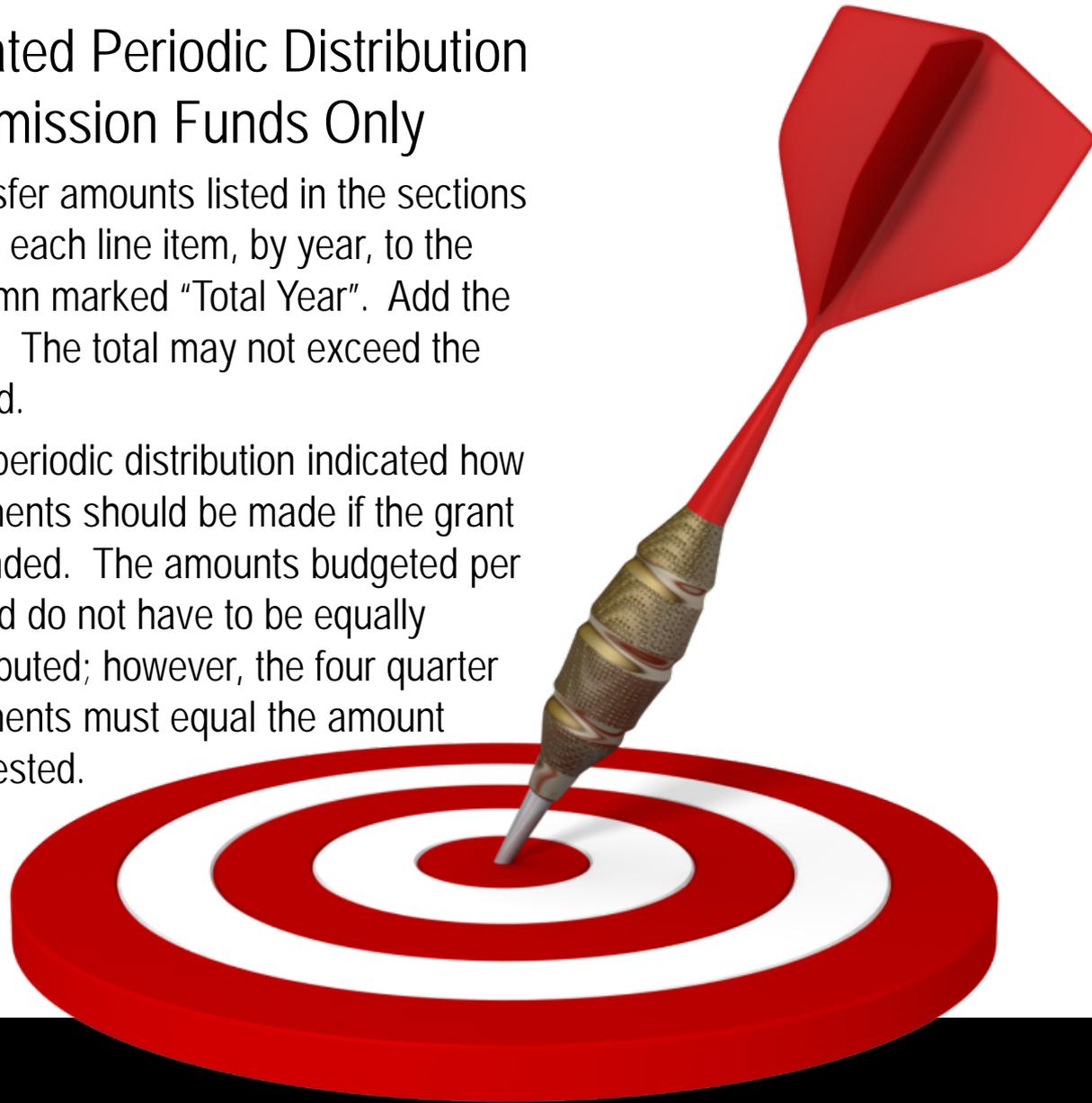
➤ Contracts

- ❖ Internal capacity is an essential requirement of Commission grants. Please address the impact of all contract services in the budget justification.



BUDGET FORMS

- Anticipated Periodic Distribution of Commission Funds Only
 - Transfer amounts listed in the sections III for each line item, by year, to the Column marked "Total Year". Add the lines. The total may not exceed the award.
 - The periodic distribution indicated how payments should be made if the grant is funded. The amounts budgeted per period do not have to be equally distributed; however, the four quarter payments must equal the amount requested.



BUDGET Administrative Compliance

- This section is mandatory. Failure to completely respond to all questions will deem this grant application and incomplete and will be disqualified.
- In completing the Administrative Compliance Form add additional pages if needed.





REQUEST FOR PROPOSAL



REQUEST FOR PROPOSAL



Letter from the Director



ON TARGET WITH THE OCMH

<p>John R. Kasich GOVERNOR</p> <p>Gregory L. Hall, MD CHAIRPERSON</p>		<p>COMMISSION ON MINORITY HEALTH</p> <p>77 South High Street, 18th Floor, Columbus, Ohio 43215 Phone: (614) 466-4000 Fax: (614) 752-9049 Website: http://www.mh.ohio.gov E-mail: mnhealth@cmh.state.oh.us</p>
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November 24, 2014

Dear Colleagues:

The 2016/2017 State of Ohio Biennial Budget Guidance required state agencies to project a 10% budget reduction. This projected reduction will impact the level of grant funding available for distribution.

In light of that, the Ohio Commission on Minority Health announces the availability of funds up to \$280,000 for fiscal year 2016 to support demonstration grants with a priority focus on the prevention of **Type 2 diabetes or infant mortality**. Quality grants targeting heart disease, certain cancers (breast, lung, mouth, throat and prostate), substance abuse and/or violence will receive consideration. Grant funds will not exceed \$70,000 per applicant agency per year. The Commission will fund up to four Demonstration Grants. **This is a competitive-bid process.**

Please note, this grant requires the implementation of clinical measures which are not optional to demonstrate projected outcomes. Organization must demonstrate the ability to implement quarterly clinical measures and evaluate program effectiveness.

Enclosed is the Request for Proposal that provides detailed submission guidance and criteria for funding. An electronic version of this packet is located on our website at www.mh.ohio.gov. Please remember to include your agency's 501(c)(3) determination letter with the application.

I strongly encourage you to thoroughly read the application and to attend the Technical Assistance session (TA) via webinar. The Technical Assistance session will discuss the grant application process and provide information to assist you in the development of your proposal. The schedule for TA sessions will be available on our website. The sessions will be conducted on **Monday, December 15, 2014 at 10:00 am and on Wednesday, December 17, 2014 at 2:00 pm**. Please note that we will not be able to accommodate individual requests to provide this information.

Remember that an original and five copies of your grant application must be received in the Commission office at 77 S. High Street, 18th Floor, Columbus, Ohio 43215, no later than **5:00 p.m. on Friday, January 30, 2016**.

You have our best wishes as you prepare your application.

Sincerely,

Angela C. Dawson
Angela C. Dawson
Executive Director

REQUEST FOR PROPOSAL



Background, Introduction & Eligibility



Ohio Commission on Minority Health Request for Proposals Fiscal Years 2016-17 Demonstration Grant

BACKGROUND

In February 1986, the Governor's Task Force on Black and Minority Health was appointed to determine the reasons why a disparity existed between the health status of minority and non-minority Ohioans and to recommend methods to remediate the disparity. In April 1987, the Task Force issued a final report including 12 recommendations. The twelfth recommendation called for the establishment of a Commission on Minority Health to implement the Task Force recommendations.

The Commission was established by Amended Substitute House Bill 171 and commenced operation on July 1, 1987. The Commission is interested in funding projects which are innovative, culturally sensitive and specific in their approach toward reduction of the incidence and severity of those diseases or conditions which are responsible for excess morbidity and mortality in minority populations. Health promotion and disease prevention activities will constitute the primary focus of projects funded by the Commission during FY 2016-17.

INTRODUCTION

The Ohio Commission on Minority Health announces the availability of funds for grants not to exceed \$140,000 (up to \$70,000 per year) per applicant agency over a two-year funding cycle. Amended Substitute House Bill 171 established Commission grants for the purpose of health promotion and prevention of disease among minority Ohioans who are economically disadvantaged. Minority groups are defined as African Americans, Hispanics, Native American Indians and Asians. Grants will be awarded on a competitive bid basis to 501 (c) (3), community-based agencies or organizations.

This Request for Proposal solicits grant applications meeting the requirements set forth in Chapter 3704 of the Ohio Administrative Code. Applications will be accepted exclusively from agencies or institutions meeting the eligibility criteria established by the Commission on Minority Health.

ELIGIBILITY

Priority shall be given to grant applicants who develop services in accordance with the mission of the Commission. To receive consideration for funding, applicants must:

- Demonstrate that at least 20% of project funds are received from sources other than grants awarded by the Commission on Minority Health;
- Be a public or private organization which has a 501 (c)(3);
- Develop and establish a management board for the administration of the grant, composed of proportionate representation of the population to be served and submit the Board Composition form with the grant application;
- Provide services in close proximity to minority communities or include minority communities in their stated service area;
- Grantees must meet all licensure and certification requirements of the State of Ohio;
- Answer all questions listed on the Administrative Compliance form, and
- Grantees must comply with all current and applicable laws, regulations, rules, and administrative guidelines of the Ohio Commission on Minority Health.

ON TARGET WITH THE OCMH

REQUEST FOR PROPOSAL



Eligibility, Public Notice and Critical Elements



ON TARGET WITH THE OCMH

The following are ineligible for funding consideration:

- Individuals.
- National organizations: local chapters or affiliates of national organizations may be eligible if they meet the definition of a "community-based health group."
- Organizations applying for the sole purpose of acquiring funds to supplement existing programs without any plan for enlarging their scope of work.
- Organizations in the process of creating or starting a "community-based health group" for the sole purpose of applying for grants from the Commission.

Ohio Revised Code (O.R.C.) Section 9.24 prohibits the State from awarding a contract to any offeror(s) against whom the Auditor of the State has issued a finding for recovery if the finding for recovery is "unresolved" at the time of the award. By submitting a proposal, offeror warrants that it is not now, and will not become a subject of an "unresolved" finding for recovery under O.R.C. 9.24, prior to the award of any contract arising out of this RFP, without notifying the Commission of such finding.

PUBLIC RECORD NOTICE

It is expressly understood by the parties the **Ohio Commission on Minority Health (OCMH)** is a public office and is subject to the Ohio Public Records Act, O.R.C. 149.43, et. seq. Upon receipt of a public records request, **OCMH** is required to provide prompt inspection or copies within a reasonable period of time of responsive records that **OCMH** determines, in its sole discretion, are public records subject to release.

If your organization chooses to not have what is considered a proprietary trade secret they must complete the following statement and submit to the Ohio Commission on Minority Health on your agency letterhead.

OCMH agrees not to disclose, without giving prior notice, any specific information that **(organization)** has previously identified as a proprietary trade secret. In the event that a person seeks that information through a public records request, **OCMH** will notify **(organization)** in the course of **OCMH's** legal review to give **(organization)** an opportunity to establish to the satisfaction of **OCMH** that the information constitutes a proprietary trade secret that is exempt from disclosure under the Public Records Act. If **OCMH** does not find that the information constitutes a proprietary trade secret, **OCMH** will notify **(organization)** of its intention to disclose the information in accordance with law. **(Organization)** may choose to seek appropriate legal action, including injunctive relief, to prevent disclosure of the information at issue.

CRITICAL ELEMENTS OF ACTIVITIES

Culturally relevant health promotion and disease prevention constitute the focus for this grant program. For state biennium 2016-17 the Commission has determined that grants designed to prevent Type 2 diabetes and infant mortality will be considered for 2016/17 funding priorities. Behavior change resulting in improved health status and outcomes is the goal of Commission funded projects. Therefore, grants that rely heavily on screening services exclusive of interventions for measurable behavior change will not receive high priority. **Applicants must comprehensively address reduction/elimination of known risk factors in program design.**

In most cases primary prevention activities will be given higher priority than secondary or tertiary plans.

Quality grants targeting heart disease, certain preventable cancers (breast, lung, mouth, throat and prostate), cardiovascular disease, substance abuse, or violence will receive consideration. All grants must contain a lifestyle modification component to include diet, exercise, and screenings .

REQUEST FOR PROPOSAL



Critical Elements, Minority Health Month and Funding



ON TARGET WITH THE OCMH

Attention should be paid to the Method of Implementation section under Proposal Preparation on Page 5 of the application. Applicants should clearly delineate and explain the methodology that will be used to demonstrate measurable behavior change.

- **Priority will be given to grantees who are able to provide services to a proportionate number of individuals per fiscal year based on funding request.**
- In designing the proposal it is important to note that the Commission is interested in new, innovative, culturally relevant program models.
- This program should not be viewed as a supplement to the agency or other systems.
- School based programs **must be budgeted and programmed for the entire 24 months** of the grant and cannot be limited to the school year.
- The Commission requires grants that propose service delivery in a school setting to also contain a community component involving all or some of the family unit of the school participants based on established criteria for inclusion.
- The Commission requires full pre/post evaluations of summer portions of a school based program to include mandatory clinical measures.

MINORITY HEALTH MONTH PROGRAMMING REQUIREMENT

All funded grantees must:

- Participate in the OCMH Kick-Off activities for 2016/ 2017.
- Conduct a minimum of two Minority Health Month events during April of 2016/2017.

FUNDING

The Request for Proposals has a maximum funding ceiling of \$140,000 (up to \$70,000 per year) per applicant agency for State Fiscal Years 2016-17. **ONLY ONE APPLICATION WILL BE ACCEPTED PER AGENCY.** July 1, 2015 through June 30, 2016, constitutes the first funding period covered by this RFP. Notification of funding will be in early June 2015. As with all grants, funding is contingent on the approval of the State Budget and the availability of funds. Grants will be effective July 2015, **with an immediate startup required: this must be reflected in the recruiting, hiring of staff, in the first month and the immediate implementation of program activities no later than the 2nd month of the 1st Quarter of funding.**

IMPORTANT: This is a performance-based grant. The 2017 year of funding is non-competitive, but is contingent on a change achieving a proportionate level of projected outcomes during the first year of funding and the availability of funds. The Commission reserves the right to terminate the grant prior to the second funding cycle if the project does not perform in accordance with stated measurable outcomes. For the second year, program activities must continue without gaps in services by providing program activities beginning July 2016 –June 2017.

The Commission **will not** consider funding for proposals:

- Which seek funding to support residential services;
- When treatment constitutes the primary service;
- Which request funds for the purpose of construction or renovation;
- To conduct research and/or studies independent of service delivery;

REQUEST FOR PROPOSAL



Funding, Proposal Format, and Technical Assistance Sessions

- Which are legislatively mandated and funded by other public dollars;
- Exclusively designed to conduct conferences or workshops; or
- Agencies, previously funded by the Commission on a fiscal year or biennial grant award using the same model to continue service delivery.
- Agencies, previously funded by the Commission on a fiscal year or biennial grant award, with a modified model that did not obtain at least 75% of cash funding of the original award from an external source.

APPLICATION DEADLINE/PROPOSAL PREPARATION

Applicants must provide an original and five copies of the complete proposal.

PROPOSAL FORMAT

- Applications must be submitted on 8 ½ by 11 WHITE paper only. No colored paper will be accepted.
- Application must be submitted single side of paper. No double-sided pages allowed.
- Applications must be typed in Times New Roman or similar font and must be 12 point in size.
- Applications must clearly indicate ORIGINAL and COPIES and must be stapled or attached with paper clips.
- All signatures must be signed in BLUE INK.
- No binders or separation tabs permitted.

All applications must be received in our offices by **5:00 p.m., January 30, 2015.** Any application or supporting documentation received after that date and time will be returned without review. **The proposal must be typed on Commission forms. FAXED, EMAILED AND HANDWRITTEN APPLICATIONS WILL NOT BE ACCEPTED.**

Ohio Commission on Minority Health
77 S. High Street, 18th Floor
Columbus, Ohio 43215

PLEASE NOTE: ALLOT SUFFICIENT TIME TO DELIVER THE PACKAGE, AND CLEAR BUILDING SECURITY.

Technical Assistance Session:

Register now!

Demonstration Webinar

Join us for a webinar on Dec 15, 2014 at 10:00 AM EST.

<https://attendee.gotowebinar.com/register/4108449804730951938>

Join us for a webinar on Dec 17, 2014 at 2:00 PM EST.

<https://attendee.gotowebinar.com/register/1086865407765318658>

ON TARGET WITH THE OCMH



REQUEST FOR PROPOSAL



Proposal Preparation and Proposal Narrative Guidelines



ON TARGET WITH THE OCMH

PROPOSAL PREPARATION

The Commission strongly encourages you to thoroughly read the application and to attend Technical Assistance (TA) Webinar sessions that can be accessed through the Ohio Commission on Minority Health Website: www.mih.ohio.gov. The technical assistance session will review the grant application and provide information to assist in the development of your proposal. Please note that we will not be able to accommodate individual requests to provide this information.

The demonstration grant sessions will be conducted on **Monday, December 15, 2014 at 10:00 am and on Wednesday, December 17, 2014 at 2:00 pm**. Please note that we will not be able to accommodate individual requests to provide this information.

Responses to this RFP should be prepared following the format described below. Proposals that do not provide all of the requested information, or do not meet all the requirements specified in the RFP, will be determined incomplete and will be disqualified.

We anticipate a higher than usual response to this grant solicitation. Please allow ample time to write your response and fully develop your application. Do not provide brief items of information assuming that your agency is known to the Commission. We use external reviewers so it is important that you use concise, but comprehensive responses. **Please remember to submit the agency's 501 (c)(3) IRS Letters with the grant application.**

Complete the Receipt of Acceptance, assurances and compliance forms, W-9, and Vendor Forms. All forms must have original signature in blue ink. Include a copy of 501(c)(3) status, most recent audit report and board resolution. Agency must include a board resolution on agency letterhead approving the submission of the application. The resolution must be signed in blue ink. (Not included in the page count).

I. Proposal Narrative

A. Description of Applicant Agency

Describe the agency's mission and mandate. Also describe successful and previous involvement with minority populations. Include accomplishments and indicate how this project will enhance the agency's service delivery capacity. Describe the facility where activity will be provided including days and hours of operation. Describe how the technical accuracy of the project's health component will be assured. Staff Description: Include job description, contracts of staff assigned, and resumes of staff assigned to the grant. Describe agency's plan to ensure that assigned program staff are culturally/linguistically competent. Describe agency plan to ensure that assigned program staff are culturally /linguistically competent.

B. Problem Need Statement

Define the specific target area, including a description of the problems, and needs to be addressed by the proposed project. Support the problem and needs statement with statistics, research findings, or other documentation pertinent to your community/target population.

Identify and include narrative information about the targeted population (identify such factors as race or ethnicity, age, sex, number of clients to be served, etc.), geographical area(s), or similarly disadvantaged area(s) to be served and sources of community support.

REQUEST FOR PROPOSAL



Proposal Narrative Continued



ON TARGET WITH THE OCMH

Submit letters of support from appropriate organizations. Their letters must outline the activities or services they will provide to the project and generally describe how this project will impact/improve the identified problem. The originals must be signed in blue ink.

C. Project Abstract

During the review process, the abstract is separated from the grant for the reviewer to have a summary of the proposed project. Therefore provide goals and objectives with a concise overview of the purpose, rationale and methodology to be utilized by the project. *(Limit = 500 words or less)*

D. Project Action Plan – (use attached form)

The Project Action Plan must list goals and objectives with the projected number of participants to be served for the year of the project that are clearly defined and measurable in process and client behavior outcomes. Project time frames must conform to the funding period. Although certain tasks such as advertising for positions, hiring staff or identifying dates when advisory committees meet, are important steps in the project's evolution, these items need not appear as goals and objectives. Major tasks and activities should be indicated for each objective.

Emphasis should be placed on developing measurable outcome objectives, which are focused on client outcomes rather than process outcomes (recruitment, hiring staff, etc.). Outcome focused objectives are designed to create measurable behavioral changes.

E. Method of Implementation

Provide a comprehensive narrative describing the proposed activities that will be provided under this grant. The explanation should include:

- A detailed description of services to be provided;
- Demonstration and verification that the proposed services/activities are medically and technically accurate;
- Proposed days and hours of operation and location(s) of activities date/month;
- How the target population(s) will be involved in the administration and execution of the grant;
- The linkages between the program design and the goals and objectives the program intends to achieve;
- The culturally-specific components that reflect the target population's attitudes, values and beliefs;
- A description of the aspects of the proposal that make it a demonstration grant, and
- A description of the role of the evaluator in the program's design, implementation and goal attainment.

F. Evaluation

NOTE: All Commission funded grantees are required to work with the Research and Evaluation Enhancement Program (REEP) of Wright State University in implementation of the evaluation of the project.

- **The evaluator must be selected from an approved list of REEP evaluators**

All grantees must refer to the Evaluation Guidance Packet in preparing the proposed evaluation plan and required areas that must be measured.

- **Visit our website for a complete list of approved evaluators and the guidance packet.**
- Grantees must comply with all clinical measures by disease/condition per evaluation guidance.

REQUEST FOR PROPOSAL



Proposal Narrative and Institutional Review Board Guidance

ON TARGET WITH THE OCMH

- Grantees targeting minor participants (children) must describe a thorough process to obtain parental consent for mandatory invasive and non-invasive clinical measures such as A1C and blood pressure measures. As well as non-clinical measures such as knowledge, awareness and attitudes.
- Minor program participants must have parental permission to participate in all areas of the program to include mandatory clinical measures and non-invasive clinical measures.
- The projected numbers for evaluation purposes must be based on those who both participate in educational programming as well as non-clinical and clinical measures.

Describe, in detail, the method(s) that will be used to determine whether the established goals and objectives are being met and whether the expected outcomes are being achieved. **Do not state in percentages.** Limiting your response to a statement such as, "we will hire an evaluator", will be considered non-responsive.

The proposal should offer valid time-lined outcomes and effectiveness of the project.

THIS DEMONSTRATION GRANT REQUIRES THE IMPLEMENTATION OF CLINICAL MEASURES PER THE EVALUATION GUIDANCE. This is not optional and must be a part of the evaluation section. Organizations must demonstrate the ability to implement quarterly clinical and non-clinical measures to evaluate program effectiveness.

PLEASE NOTE: Upon the establishment of the baseline measures, evaluation of objectives must occur on a quarterly basis. Please ensure that you build into your plan the collection of required participant data (clinical measures, feedback) on a quarterly basis to allow for the reporting of behavioral outcomes.

Evaluation procedures are quantitative, document intervention, and assess the degree to which intended objectives are achieved by clients or the agency. Therefore, it is necessary for the agency to engage an evaluator from the beginning of the project through the end of the life of the project. An evaluator should be included in the project to assist the program director in designing client assessment forms in order to retrieve demographics and baseline information and to measure behavioral changes. Applicants are strongly encouraged to contact an evaluator when developing the proposal.

Institutional Review Board (IRB)

- *For Grantees pursuing IRB approval, if you are working with an academic institution, your evaluator may be involved in a review process with the college or university's Institutional Review Board (IRB). It is important to keep in mind that the IRB process generally takes several weeks to complete and may add time to the start-up of the project.*
- *The OCMH expects grantees to perform direct service within the first quarter of project funding. Therefore, it is recommended that you simultaneously apply for an IRB, when you apply for OCMH funding. If it is later determined that you will not use the IRB there will be no detriment to the OCMH funded project.*

G. Year Two Project Summary

Provide a brief narrative that describes the major tasks and activities planned for year 2 and how they will be accomplished. Make sure program activities will start in July 2016 and are ongoing without gaps in services.



REQUEST FOR PROPOSAL



Budget Forms, Proposal Review and Proposal Scoring



II. Budget Forms

Use the attached budget pages to provide cost associated with developing and implementing your proposed demonstration grant. Instructions are included for each form as appropriate.

Consistent with the Governor's Executive Order 2007-09S, "refreshments" are not reimbursable under this grant. (See Commission website at www.mh.ohio.gov to review this EO). **If holding cooking demonstrations they must be educational and participatory. A registered licensed Dietician is required to oversee the cooking demonstration.**

Internal capacity is an essential requirement of Commission grants. Please address the impact of all contracted services the budget justification.

Please attach a budget narrative describing unit cost and itemization of each line item.

PROPOSAL REVIEW / SELECTION

Responses to this RFP, which are determined to be complete and in compliance with the requirements of the Commission will be reviewed by teams following the general criteria listed below.

A weighted system will be applied to the proposal criteria. The weighed system will not be shared with applicants.

The final selection process will involve a ranking system based on the weighted score, reflecting compliance with the proposal criteria. Grants will be awarded to the highest ranking applicants who represent a combination of geographic, demographic, service delivery/program activity mix, targeted to ethnic/racial groups, and diseases and conditions identified by the Commission as identified in this RFP.

Proposal Scoring

(Items which are considered during the review of grant applications):

I. Service Area Design

- There is clear documentation of an access problem for health care or identification of a disproportionately at-risk population.
- Programs are directed at a clearly defined target population consistent with the Commission's definition of economically disadvantaged minority (ies).
- The need for the program is well documented.

II. Innovation and Impact

- The project is designed specifically for the proposed target population and includes measures to determine the acceptability of services to the community.
- The project will result in some measurable impact on the identified population.
- The applicant states expected health behavior outcome changes as a result of proposed interventions.

III. Program Design

- The applicant has demonstrated that cultural beliefs, attitudes and practices have been considered and included designing the program.
- Barriers to service; i.e., availability, acceptability, language and cost have been considered, and appropriate recourse is included in the approach to the project.

ON TARGET WITH THE OCMH

REQUEST FOR PROPOSAL



Evaluation and Budget Appropriateness



- The problems to be addressed are clearly stated in specific rather than general terms, can be reasonably addressed during the grant period, and can be accomplished with the dollars available for the project.
- Program design should describe the clinical and non-clinical measure procedures that ensure data collection and reporting procedures.

IV. Evaluation

- The applicant has a plan to measure required areas per the evaluation guidance.
- The applicant has plans to establish baseline data and collect and report participant data on a quarterly basis to determine behavior outcomes.

V. Budget Appropriateness and Reasonableness

- Administrative Code 3704-2-02 states: "*That at least twenty percent of applicant funds and/or resources are received from sources other than grants awarded by the Commission on Minority Health*". In other words, the Commission cannot be the sole funding source of an agency. This 20% should not be perceived as matching funds.
- Specified line item costs are appropriate and reasonable/justifiable.
- Costs support direct client activities.
- All line items must be itemized and list unit cost for each requested expenditure.

NOTE: Please double-check your grant proposal for accuracy. Original signatures in blue ink and completion. Missing pages, omitted sections, forms, signatures, and mathematical errors **WILL** impact your overall score and may disqualify your application.

ON TARGET WITH THE OCMH

REQUEST FOR PROPOSAL

Grant Reporting & Participation Requirements

Grant Reporting/Participation Requirements

Prior to submitting this proposal, please be aware that there are grant reporting mechanisms and evaluation reports that are required to be submitted to the Commission on a quarterly basis if funded. Grants management is required by your agency to be responsible for submission of or participating in the following:

- Signed Acknowledgement of Terms and responses to the Program and Fiscal Special Conditions, if any are given.
- Submission of Program and Fiscal quarterly reports (on appropriate Commission forms) along with the Program Evaluation Report.
- Ensure Program Evaluator Reports are reviewed by assigned REEP Panel Members prior to submission to the Commission.
- Participation in the MHM Kickoff Expo sponsored by the Commission on the last Thursday in March each funding year. In an effort to raise awareness OCMH funded program grantees are required to set up a display table at the annual health expo.
- The Program Director and REEP Evaluator will participate face to face, by Webinar, and/or conference call with the REEP Panel.
- Year end Program Evaluation Report by the required deadline.
- A Biennial Program Report by the required deadline.



ON TARGET WITH THE OCMH



REQUEST FOR PROPOSAL



Receipt of Acceptance



ON TARGET WITH THE OCMH

	COMMISSION ON MINORITY HEALTH 77 South High Street, 18th Floor, Columbus, Ohio 43215 Phone: (614) 466-4000 Fax: (614) 752-9049 Web site: http://www.mnh.ohio.gov E mail: mnhealth@ocmh.state.oh.us
John R. Kasich GOVERNOR Gregory L. Hall, MD CHAIRPERSON	

RECEIPT OF ACCEPTANCE
(Grant Application Cover Page)

This receipt confirms that the following grant proposal has been received by the application deadline and accepted for consideration. This does not confirm that the grant application has been determined to be complete.

TO BE COMPLETED BY APPLICANT:

Project Name: _____

Applicant Agency/Organization: _____

Complete Mailing Address: _____
(No P.O. Boxes) _____

County of Agency: _____ Federal Tax I.D. Number: _____
(Attach a copy of 501(C)(3) letter)

Total year one amount you are requesting: _____

Executive Director: _____ Phone: () _____
E-mail: _____ Fax: () _____

Project Director: _____ Phone: () _____
E-mail: _____ Fax: () _____

Fiscal Officer: _____ Phone: () _____
E-mail: _____ Fax: () _____

DO NOT WRITE BELOW THIS LINE

Date Received: _____ Received by: _____

The above-named grant application has been assigned the following identification number. Please use this number to refer to your grant in any correspondence or inquiry:

GRANT I.D. NUMBER: MIH 2016/17-_____

ENCLOSE WITH ORIGINAL APPLICATION AND FIVE COPIES.

REQUEST FOR PROPOSAL



Receipt of Acceptance Instructions



INSTRUCTIONS FOR COMPLETION OF RECEIPT OF ACCEPTANCE- USE AS COVER PAGE

Applicant Agency/Organization:	The legal name of the agency. Include D.B.A., A.K.A., etc. The name <u>must</u> match the name on the 501 (c) (3) letter.
Complete Mailing Address:	This is the address of the administrative office of the agency and will be utilized for official notice and payment if the grant is awarded. Include street number, suite number, street name, city, state, and zip code. P.O. Boxes are <u>not</u> acceptable.
Executive Director:	Chief Executive Officer of the applicant agency and title. Include area code and telephone number.
County of Agency:	List Resident County of administrative office.
Federal Tax I.D.:	A nine digit number issued by the U.S. Internal Revenue Service.
Amount Requested:	Self-explanatory.
Project Name:	The name assigned to this activity or service. The project name can not be used for other funding sources.
Project Director:	The person who has the authority to make operational decisions for the project. Include telephone number.
Date Received:	Upon receipt, the Commission will verify the date.
Received By:	The signature of the Commission staff person who received the application.
Grant I.D. Number:	Leave this space blank. The <u>Commission</u> will assign a number to the application which should be referenced on all correspondence. A copy of the Receipt of Acceptance will be returned to the applicant to verify that the grant as received before the deadline. This <u>does not</u> confirm that the grant application has been determined to be complete.

ON TARGET WITH THE OCMH

REQUEST FOR PROPOSAL



Project Application – page 1 of 2



ON TARGET WITH THE OCMH

PROJECT APPLICATION

NOTE: Where applicable, instructions have been included.

Do **NOT** write in this space. For Commission use only.

MIH 2016/17 - _____

1. Applicant Agency Information:

Name of Director: _____ Title _____

Agency Name: _____

Address: _____

City: _____, OHIO Zip: _____ County: _____

Telephone #: (____) _____ Fax #: (____) _____

2. Federal Tax I.D.: _____

3. Project Title: _____

4. Project Director (Only if different from agency director)

Name: _____ Phone (____) _____

Mailing Address: _____

City: _____, OHIO Zip: _____

5. Name of Fiscal Officer: _____ Phone (____) _____

6. Project Period: July 1, 2015 through June 30, 2016

Budget Period: July 1, 2015 through June 30, 2016

7. **CERTIFICATION:** The applicant understands and agrees to the following conditions:

- a. That funds granted as a result of this application are to be used for the purposes set forth therein and administered in compliance with the "Commission's Administrative Rules" and other applicable terms and conditions established by the Commission on Minority Health.
- b. That the project budget contained herein includes grant funds requested, applicant funds and in-kind contributions obligated to support the project and any anticipated income to be generated by the grant funds and applicant support. That any expenditure of grant funds, obligated applicant support and project income will be included in the project budget or subsequent budget revisions will have prior written authorization from the Commission and will have separate accountability with supportive documentation.
- c. That project funds are exclusive of any unauthorized federal funds and will not be used as matching requirements for federal grants.
- d. That all project records will be made available to State agents upon request for review or audit and will not be disposed of without written authorization from the Commission, and that a copy of all audits of project funds will be submitted to the Commission.
- e. That the balances of any unspent grant funds and project income, and any expenditure of project funds not authorized by the Commission will be transferred to the Commission within thirty (30) days after termination of funding.

AGENCY NAME _____

REQUEST FOR PROPOSAL



Project Application – Page 2 of 2 (Sign in Blue Ink)



f. That all equipment purchased in whole or in part with project funds (as defined in 7b, above) be tagged or otherwise identified as property of the Commission. No disposition of such property may be made without written authorization from the Commission. Such equipment will be used only to continue the project upon termination of grant funding and will be transferred to the Commission upon request.

g. That the applicant agency is in compliance with:

(1) Title VI of the Civil Rights Act of 1964.

____ Statement of compliance submitted herewith

(2) Section 504 of the Rehabilitation Act of 1973.

____ Statement of compliance submitted herewith

1. We certify to the best of our knowledge and believe that the information contained in this application is true and correct, that the document has been duly authorized by the governing body of the applicant and that the applicant will comply with the conditions contained in part seven (7) above. We understand that the use of grant funds provided by the Commission constitutes acceptance of the terms and conditions contained herein and in the notice of award.

(A) _____
Signature of Agency Director (Blue Ink) Date

(B) _____
Signature of Auditor or Fiscal Officer (Blue Ink) Date

AGENCY NAME _____

ON TARGET WITH THE OCMH

REQUEST FOR PROPOSAL



Project Application Instructions



PROJECT APPLICATION – INSTRUCTIONS

- Project name as indicated on the Receipt of Acceptance.
- Federal Tax I.D. Number of the applicant agency.
- Provide the name and telephone number for the fiscal officer who can answer specific questions about this application.
- Read assurances of compliance with the terms of the grant application.
- A. Original signature of the Chief Executive Officer of the applicant agency (Executive Director, Senior Pastor, Health Commissioner, etc.), and date.
- B. Original signature of the applicant agency Fiscal Officer and date.

NOTE: Every page of the application must bear the applicant agency name.

ON TARGET WITH THE OCMH

REQUEST FOR PROPOSAL



Civil Rights
Act of 1964
(Sign in Blue
Ink)



ON TARGET WITH THE OCMH

**ASSURANCE OF COMPLIANCE WITH THE DEPARTMENT OF
HEALTH AND HUMAN SERVICES REGULATION UNDER
TITLE VI OF THE CIVIL RIGHTS ACT OF 1964**

(hereinafter called the "Applicant")
Name of Applicant (type or print)

HEREBY AGREES THAT it will comply with Title VI of the Civil Rights Act of 1964 (P.L. 88-352) and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 80) issued pursuant to that title, to the end that, in accordance with Title VI of the Act and the Regulation, no person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department; and HEREBY GIVE ASSURANCE THAT it will take any measures necessary to effectuate this agreement.

If any real property or structure thereon is provided or improved with the aid of Federal financial assistance extended to the Applicant by the Department, this Assurance shall obligate the Applicant, or in the case of any transfer of such property, any transferee, for the period during which the real property or structure is used for a purpose for which the Federal financial assistance is extended or for another purpose involving the provision of similar services or benefits. If any personal property is so provided, this Assurance shall obligate the Applicant for the period during which it retains ownership or possession of the property. In all other cases, this Assurance shall obligate the Applicant for the period during which the Federal financial assistance is extended to it by the Department.

THIS ASSURANCE is given in consideration of and for the purpose of obtaining any and all Federal grants, loans, contracts, property, discounts or other Federal financial assistance extended after the date hereof to the Applicant by the Department, including installment payments after such date on account of applications for Federal financial assistance which were approved before such date. The Applicant recognizes and agrees that such Federal financial assistance will be extended in reliance on the representations and agreements made in this Assurance, and that the United States shall have the right to seek judicial enforcement of this Assurance. This Assurance is binding on the Applicant, its successors, transferees, and assignees, and the person or persons whose signatures appear below and authorized to sign this Assurance on behalf of the Applicant.

Date _____
(Applicant type or print)

Signature and Title of Authorized Official (Blue Ink)

Applicant's mailing address

NOTE: If this form is not returned with the application for financial assistance, return it to DHHS, Office for Civil Rights, 330 Independence Ave., S.W., Washington, D.C. 20201

HHS-441 (Rev. 12/82) AGENCY NAME _____

REQUEST FOR PROPOSAL



Rehabilitation Act of 1973 (Sign in Blue Ink)



ON TARGET WITH THE OCMH

DEPARTMENT OF HEALTH AND HUMAN SERVICES
ASSURANCE OF COMPLIANCE WITH SECTION 504 OF THE
REHABILITATION ACT OF 1973, AS AMENDED

The undersigned (hereinafter called the "recipient") HEREBY AGREES THAT it will comply with Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. 794), all requirements imposed by the applicable HHS regulation (45 C.F.R. Part 84), and all guidelines and interpretations issued pursuant thereto.

Pursuant to §84.5 (a) of the regulation [45 C.F.R. 84.5 (a)], the recipient gives this Assurance in consideration of an for the purpose of obtaining any and all Federal grants, loans, contracts (except procurement contracts and contracts of insurance guaranty), property, discounts, or other Federal financial assistance extended by the Department of Health and Human Services after the date of this Assurance, including payments or other assistance made after such date on applications for Federal financial assistance that were approved before such date. The recipient recognizes and agrees that such Federal financial assistance will be extended in reliance on the representations and agreements made in this Assurance and that the United States will have the right to enforce this Assurance through lawful means. This Assurance is binding on the recipient, its successors, transferees, and assignees, and the person or persons whose signatures appear below are authorized to sign this Assurance on behalf of the recipient.

This Assurance obligates the recipient for the period during which Federal financial assistance is extended to it by the Department of Health and Human Services or, where the assistance is in the form of real or personal property, for the period provided for in §84.5 (b) of the regulation [45 C.F.R. 84.5 (b)].

The recipient: [Check (a) or (b)]

- a. employs fewer than fifteen persons
- b. employs fifteen or more persons and, pursuant to §84.7 (a) of the regulation [45 C.F.R. 84.7 (a)], has designated the following person(s) to coordinate its efforts to comply with the HHS regulations.

Name of Designee(s) (Type or Print)

Name of Recipient (Type or Print)

Street Address or P.O. Box

(IRS) Employer Identification Number

City

State

Zip

I certify that the above information is complete and correct to the best of my knowledge.

Date

Signature and Title of Authorized Official (Blue Ink)

If there has been a change in name or ownership within the last year, please PRINT the former name below:

**NOTE: If this form is not returned with the application for financial assistance, return it to the DHHS, Office for Civil Rights,
330 Independence Avenue, S.W., Washington, D.C. 20201.**

REQUEST FOR PROPOSAL



Project Action Plan



PROJECT ACTION PLAN – FY 2016

Agency Name: _____

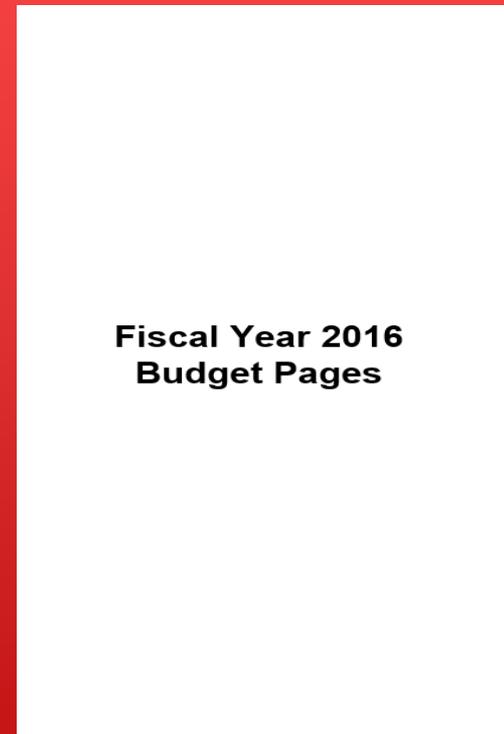
Goals/Objectives	Approach	Activities	Evaluation	Responsibilities	Timeline
<ul style="list-style-type: none">Project how many participants you plan to serve, in whole numbers.Project how many participants will participate in the frequency of your program activity designed.Project how many participants will show quarterly health outcome behavior changes.	<ul style="list-style-type: none">How will you do it?	<ul style="list-style-type: none">What will take place?	<ul style="list-style-type: none">What results do you expect?How will you measure it?Refer to the Evaluation Guidance Packet for required areas.What are your plans to collect participant data quarterly?	<ul style="list-style-type: none">Who will be responsible?	<ul style="list-style-type: none">What will happen by the end of the first quarter an ongoing on a quarterly basis?

ON TARGET WITH THE OCMH

REQUEST FOR PROPOSAL



Budget Pages



ON TARGET WITH THE OCMH

REQUEST FOR PROPOSAL



Personnel and Fringe Benefits



ON TARGET WITH THE OCMH

SECTION I: PERSONNEL AND FRINGE BENEFITS **FY 2016**

(Do not list contractual personnel or consultants in this section, agency staff only. Attach job description and written narrative justification.)

Agency Name: _____ Grant #: MIH 2016-_____

SALARIES AND WAGES	I	II	III	IV	V	VI	VII
POSITION NAME	ANNUAL SALARY	MONTHS ON PROJECT	% OF TIME ON PROJECT	AMOUNT REQUESTED FROM COMMISSION	FRINGE BENEFITS	% OF FRINGE BENEFITS	OTHER SOURCES OF SUPPORT (AGENCY FUNDS AND FRINGE BENEFITS)
SUBTOTAL							
TOTAL PERSONNEL = SALARIES + FRINGE BENEFITS (Columns IV & V)							

Executive Director (Blue Ink) _____ Date _____

Fiscal Officer (Blue Ink) _____ Date _____

Commission Approval:

Angela C. Dawson, Executive Director _____ Date _____

[] Approved as submitted [] Disapproved
 [] Approved with condition

Condition (s):

REQUEST FOR PROPOSAL



Personnel and Fringe Benefits Instructions



SECTION I: PERSONNEL AND FRINGE BENEFITS – INSTRUCTIONS

Only those positions which provide direct client services are to be listed. Do not list contractual personnel or consultants in this section. Administrative costs are to be listed in Section II - Non-Personnel. Any personnel listed in this section must be employed by applicant agency.

Column I: Provide the yearly salary budgeted for each position listed. The amount should be consistent with similar positions in the agency based on Full-Time Equivalency (FTE).

Column II: The total number of months of employment projected per position for this grant.

Column III: Calculate the percent of time the employee will devoted exclusively to the project under this grant; for example, a 40-hour per week agency employee who provides 20 hours of service on this project would be listed as 50%.

Column IV: Amount of the employee's salary that will be funded by the Commission based on annual salary (Column I), number of months on the project (Column II) and the percentage of time on the project (Column III).

- a. Example: 1) An employee with an annual salary of \$15,000 who works 12 months at 50% of his/her time would earn \$7,500 from Commission funds; 2) An employee with an annual salary of \$20,000 who works nine months at 25% of his/her time on the project would earn \$3,750 from the Commission.
- b. If the agency pays one rate during a probationary period with an increase after probation, state budget assumptions on separate lines for each category and provide a narrative explanation.
- c. Only employees who implement services detailed in the project proposal may charge their time to the grant.

Column V: List the fringe benefits for all positions listed in the budget.

Column VI: List the percentage of employee fringe benefits.

Column VII: Where appropriate, match must be identified for each line item.



Section I Personnel and Fringe Benefits page must be signed by the Executive Director and the agency Fiscal Officer.

ON TARGET WITH THE OCMH

REQUEST FOR PROPOSAL



Supplies & Contracts



(C) SUPPLIES, CONTRACTS, ETC. <small>(Denote and attach written narrative justification for each item)</small>	I. Total Budget	II. Amount Requested From Commission
REEP EVALUATOR PROGRAM AUDIT AUDIT YEAR II ONLY		
<small>SUBTOTAL</small>		
(D) MINORITY HEALTH MONTH EVENTS <small>(Denote and attach written narrative justification for each item SEE INSTRUCTIONS)</small>		
<small>SUBTOTAL</small>		

ON TARGET WITH THE OCMH

REQUEST FOR PROPOSAL



Non- Personnel Instructions



ON TARGET WITH THE OCMH

SECTION II: NON-PERSONNEL – INSTRUCTIONS

A. Travel

- i. State estimated number of miles that will be traveled and the rate at which payment would be made, not to exceed the federal rate of \$.52 cents per mile. Example: 2,000 miles at \$.52 cents = \$1,040.00
- ii. Projected number of overnight lodgings, number of people involved and the rate per day/per person should be stated. Lodging rate per day/per person may not exceed the state rate of \$80.00 plus room tax (if applicable).
- iii. Meal expenses are allowable for dinner and breakfast when on an approved overnight stay, not to exceed \$27.00 per day with receipts for full days of travel preceded and followed by overnight stays.
- iv. Out-of-state travel is a non-allowable cost under this grant.
- v. Fees for conferences/training sessions, when determined to be related to specific job-duties and/or responsibilities, are reimbursable or allowable. Projected number of such sessions and costs should be stated.
- vi. Only employees who implement services detailed in the project proposal may be reimbursed for actual travel expenses.
- vii. Travel cost (mileage, meals, and hotel accommodations) to attend the Awards Ceremony and Health Expo scheduled for March 2015.

B. Equipment

Equipment is any tangible item having a useful life of one year or more which is purchased in whole or in part with Commission funds. Non-allowable costs include, but are not limited to, the following under this grant:

- | | |
|---|---|
| ▪ VCRs/accessories | ▪ Vehicle purchases |
| ▪ Portable cameras | ▪ Reflotron machines |
| ▪ Television | ▪ Copiers |
| ▪ Computers | ▪ Refrigerators |
| ▪ Ink Cartridges | ▪ Baby/infant seats, cribs, clothing, shoes |
| ▪ Typewriters | ▪ Wii and other high priced computer games |
| ▪ Furniture (<i>will provide state/federal salvage applications to successful grantees</i>) | |

Leasing/rental of any of this equipment may be considered. The rate per month and the number of months for leasing/rental should be stated.

C. Supplies (Each item must have a cost per unit stated)

For purposes of Commission funds, supplies consist of expendable property items which have a useful product life of one year or less. Supplies include all tangible, expendable property other than equipment purchased with Commission funds. Equipment priced less than \$100 (e.g., staples, scissors, wastebaskets, paper, pens) is considered office supplies.

Consistent with the Governor's Executive Order 2007-09S, "refreshments" are not reimbursable under this grant. (See Commission website at www.mih.ohio.gov to review this EO.)

Printing: Costs may include typesetting, actual printing or photocopying of the material which is completed by a commercial printing company. Included also are costs for pamphlets, brochures and flyers. Provide the unit cost.

Contracts: Agreements for all sub-contracts must be submitted with the following being addressed: scope of service, beginning/ending date, hourly rate and total number of contract hours.

Advertising: Specify the media and cost of advertisement (e.g. 3 ads at \$50.00 per ad).

Evaluator: As indicated in the Proposal Preparation section, the internal evaluator must be selected from the approved list of REEP evaluators. A list of these evaluators is located on our website at www.mih.ohio.gov (**need actual area listed**).

Program Audit: If funded for Year II, agencies must include the cost for a program audit.

D. Minority Health Month:

All funded grantees are required to allot funds to support:

- At least two (2) events during the month April of each funded year.
- Detailed information about these two events will be discussed at the Technical Assistance Session.

REQUEST FOR PROPOSAL



Non-
Personnel
Continued



SECTION II: NON-PERSONNEL FY 2016 [] ADDITIONAL SHEET ATTACHED

(E) ADMINISTRATIVE COSTS <small>(Itemize and attach written narrative justification for each item)</small>	I. Total Budget	II. Amount Requested From Commission
SUBTOTAL		
SUBTOTAL - Non-personnel (Section II)		
TOTAL (Section I and II)		



The attached budget narrative must be completed and submitted in order for this application to be considered complete.

AGENCY NAME _____

ON TARGET WITH THE OCMH

REQUEST FOR PROPOSAL



Non-Personnel Instructions Continued



SECTION II: NON-PERSONNEL - INSTRUCTIONS

(E) **Administrative/Indirect costs:** Total cost **must not** exceed 15% of the amount requested.

The following may be charged as indirect costs/services and **must be itemized**:

- 1) Administrative charges: salaries of support staff (administrators, secretaries, accountants). Provide the percentage of time on the project per line item;
- 2) Rental/space leasing: space rental is an allowable cost. Space for which rental fees will be paid must meet the following requirements:
 - a. The number of months and the rate at which payment will be made should be stated;
 - b. When rent is shared among several programs, the amount charged to the Commission must not exceed the Commission's fair share. The agency must submit documentation of how the Commission's fair share was determined (e.g., if Commission-funded project uses 20% of the space, the Commission may be charged no more than 20% of the total rent);
 - c. Submit a copy of the lease which includes the building owner's name, location of the building, square footage, total amount of rent paid, terms of agreement, termination
 - d. Clause, signatures of lessee and lessor;
 - e. Approved rent is non-transferable from the original site to a new or relocated site.
- 3) Rent will not be approved for:
 - a. Space which is paid for by another state/federal program or private grant;
 - b. Space in buildings purchased with federal funds;
 - c. Space donated to the applicant agency.
 - d. Utilities: heat, water, electricity, etc.

ON TARGET WITH THE OCMH

REQUEST FOR PROPOSAL



Budget Justification and Narrative



BUDGET JUSTIFICATION/NARRATIVE – FY 2016

ADDITIONAL SHEET ATTACHED

(This page is mandatory and must be completed in order for the application to be considered complete. All line items need to be itemized and list unit costs.)

Agency Name: _____ Grant Number: MIH 2014 - _____

SECTION I: PERSONNEL AND FRINGE BENEFITS:

SECTION II: NON PERSONNEL:

A. Travel:

B. Equipment: (Rental Only)

C. Supplies, Contracts, Etc. (Consultant expenses may not exceed 10% of the total award).

D. Minority Health Month:

E. Administrative Costs:

AGENCY NAME _____

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REQUEST FOR PROPOSAL



Anticipated
Periodic
Distribution
(Sign in Blue Ink)



ON TARGET WITH THE OCMH

SECTION III: ANTICIPATED PERIODIC DISTRIBUTION OF COMMISSION FUNDS ONLY
SFY 2016

BUDGET CATEGORY	Total Year	1 st Quarter	2 nd Quarter	3 rd Quarter	4 th Quarter
A. Personnel (<i>salaries and fringes</i>)					
B. Travel					
C. Equipment					
D. Supplies, Contracts & Other					
E. Minority Health Month					
F. Administrative Costs					
Total Project Cost <small>(Total of all budget categories)</small>	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____

SOURCE OF AGENCY SUPPORT

LIST ALL SOURCES OF AGENCY SUPPORT AMOUNTS WHICH WILL BE USED FOR THIS PROJECT.
Fundraising is prohibited under this grant.
All services are free of charge and open to the public as well as the target population.

<u>SOURCE</u>	<u>AMOUNT</u>
1. Local Appropriations	\$ _____
2. Gifts and Contributions	\$ _____
3. In-kind Contributions (<i>Itemize</i>)	\$ _____
4. State	\$ _____
5. Federal	\$ _____
6. Other	\$ _____
TOTAL AMOUNT OF APPLICANT AGENCY SUPPORT	\$ _____
TOTAL AMOUNT REQUESTED FROM COMMISSION	\$ _____

Executive Director (Blue Ink) _____ Date _____

Fiscal Officer (Blue Ink) _____ Date _____

 **This page must be signed by the Executive Director and the agency Fiscal Officer.**

REQUEST FOR PROPOSAL



Anticipated Periodic Distribution Instructions



SECTION III: ANTICIPATED PERIODIC DISTRIBUTION – INSTRUCTIONS

Transfer the amounts listed in Sections I and II for each line item, by year, to the column marked "TOTAL YEAR". Add the lines. The total should not exceed award.

The periodic distribution indicates how payments should be made if the grant is funded. The amounts budgeted per period do not have to be equally distributed (anticipate start-up delays e.g. due to advertising for staff); however, the four quarterly payments must equal the amount requested.

ON TARGET WITH THE OCMH

REQUEST FOR PROPOSAL



Administrative Compliance



This Form is mandatory. Failure to respond to all questions will deem this grant application incomplete and the applicant will be disqualified. If information is cut off in electronic format, use additional pages.

SECTION IV: ADMINISTRATIVE COMPLIANCE

The Commission uses the information on this form to understand the applicant agency's internal policies and method of conducting business.

1. List all sources of agency funds.
2. List all sources of third-party funding.
3. Does the project's budget include documentation of 20% operational costs from sources other than the Commission?
 YES NO

If project income IS NOT maintained in a separate account, enter plans and timetable for doing so. If project income IS maintained in a separate account, describe how project income is identified or allocated to the project.

What actions will be taken if actual income is less than anticipated? (Explain where funds will be sought to replace deficit or which expenditures will be cut should no replacement funds be available.)

If actual income is greater than anticipated, it is desired to:

- Re-budget additional funds to expand the project.
- Return the funds to the Commission within 30 days of the end of the project period.
- Other (explain)

4. Describe check or warrant processing system when paying employee salaries, employee travel reimbursement, vendors or contractors, and include the titles of agency personnel involved in the process, the role of the project director and the forms used. These forms will become source documentation for accounting records.

REQUEST FOR PROPOSAL



Administrative Compliance



5. Are controls used to assure that expenditures of project funds do not exceed budgeted line-item amounts? YES NO (If YES, please explain system. If no controls exist, explain controls to be implemented and include timetables.)
6. Is a separate project account maintained to identify expenditures of project funds (consisting of grant funds and project income)? YES NO
- Please explain project accounting system. If a separate accountability of project expenditures is not maintained, enter plans to change present system in order to provide separate accountability and include timetables. Include explanation of accounting for in-kind applicant support.
- Does the present accounting system provide current and accurate fiscal information to assure that expenditure reports will be submitted when due? YES NO
- If answer is "No," please explain changes to be made in the system to comply and include timetables.
- Does the present accounting system provide for the project to return to the Commission on Minority Health the balance of unspent, unobligated grant funds and project income? YES NO
- If answer is "No," please explain changes to be made to the system to comply and include timetables.
7. Project expenditures are reported on (check one): a cash basis an accrual basis a modified accrual basis.
- If a modified accrual system is used, please explain system.
- If an accrual or modified accrual system is used, please explain agency's system for encumbering or obligating funds. (Describe forms used, flow of paper, and authorizing authorities.)
8. Are time/activity records maintained for project personnel to account for time spent on the project? YES NO
- If not, describe how personnel costs are allocated to the project. (Include controls to avoid charges to various Federal and State projects.)

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REQUEST FOR PROPOSAL



Administrative Compliance



ON TARGET WITH THE OCMH

9. Are fringe benefits for this project the same as those for other agency employees? YES NO (If NO, please explain.)

10. Are there any agency non-personnel costs that are shared by project and non-project activities? YES NO

If yes, list them and explain how they are allocated to the project. If no, go to **Question #11**.

11. (A) Does the agency have an in-house billing system when providing goods and services to the project? YES NO

If yes, explain the intra-agency billing system detailing titles of individuals involved and forms used. If no, go to **Question #12**.

(B) Does an appointed project representative periodically review charges set by central stores to assure that charges to the project do not exceed cost of goods plus a reasonable amount to cover the costs of maintaining and operating a central stores organization? YES NO

If yes, please explain the review procedures, review frequency and documentation of such reviews that will be made available to the Ohio Commission on Minority Health. If the answer is no, please explain changes to be made to the system for compliance and include timetables.

12. Does the project incur travel costs? YES NO

If yes, describe the procedure used to determine the project travel costs incurred when using agency vehicles (include most recent costs when available) and briefly describe project accounting system for such expenses (include a description of forms or form numbers used). If no, go to **Question #13**.

If a rate has been established for reimbursing employees when using their own vehicles, is the rate the same as that allowed for other agency employees? YES NO

If per diem is paid to employees on travel status, enter agency's per diem policy. Include amounts authorized for lodging, subsistence and related travel items, and describe accounting system and forms used for expenditures. **(NOTE: The rates and amounts listed for travel and per diem can not exceed those allowed by the agency for non-grant activities. Any rates or amounts in excess of the amount authorized by the State for Commission employees will not be approved from grant funds.)**

REQUEST FOR PROPOSAL



Administrative Compliance



13. Are project funds budgeted for equipment, supplies and contracts? YES NO (If No, please go to **Question #14**)
- If yes, please explain agency's procurement policies and procedures for equipment, supplies, and contractual goods and services. Detail provisions that assure free competition among suppliers, that prevent agency officers or personnel having a personal interest in the selection from influencing the procurement, that encourages procurement from minority-owned and/or operated organizations, and that assures compliance with the Copeland "Anti-Kick-Back Act" (18 USC as supplemented in the Department of Labor Regulations 41 CFR Part 60).
14. Is the project entering into any contracts for the procurement of goods and services? YES NO (If No, go to **Question #15**).
- If YES, do contracts meet the following conditions:
- a. Definition of a sound and complete agreement YES NO
 - b. Administrative remedies for violations YES NO
 - c. Termination provisions YES NO
15. Has an audit of the agency's funds been conducted during the past year? YES NO
- If yes, please attach one (1) copy with the original of this application.
- Is an audit of the agency anticipated during the coming year? YES NO
- If yes, what individual(s) or organization is scheduled to perform the audit and what is the approximate date of completion?
16. If the applicant is a non-governmental agency, does it carry adequate fidelity bond coverage as indemnification against losses resulting from the fraud or lack of integrity, honesty or fidelity of one or more employees, officers, or other persons holding a position of trust? YES NO
- If yes, attach a copy of the bonding agreement. If no, explain actions that will be taken to comply.

ON TARGET WITH THE OCMH

REQUEST FOR PROPOSAL



Applicant Checklist



APPLICANT CHECKLIST

(Do **not** return this form to Commission)

- Specify the name of your agency on the bottom of all sheets.
- Receipt of Acceptance attached to the top of each application (*copy & original signed in blue ink*).
- Review the application to assure that all sections have been answered completely.
- Check to assure that appropriate signatures have been entered and dated.
- Check all figures for typing errors and to assure that all calculations are correct. (*Does budget match budget narrative?*)
- Attach a copy of 501 (c)(3) letter from the Internal Revenue Service (*The 501(c)(3) letter must be attached even if the agency was funded by the Commission in previous years*).
- Attach statement for Rehabilitation Act of 1976; original is signed in blue ink.
- Attach statement for Civil Rights Act of 1964; original is signed in blue ink.
- Attach completed W-9 Form signed in blue ink (*you must use the attached form; forms before the November 2005 revision date are not acceptable.*)
- Board Resolution approving agency to apply for funding on letterhead and signed in blue ink.
- Include copies of all contracts and job descriptions funded by this grant.
- Complete and attach the "Program Narrative" portion of the grant application.
- Number all pages of the grant application.
- Include a copy of agency's most recent audit.
- The original with original signatures and five (5) copies are submitted.
- Sign in Blue Ink.
- The Administrative Compliance form and a copy of the agency audit must be included in the original grant application, but need not be included in the copies.

ON TARGET WITH THE OCMH

REQUEST FOR PROPOSAL



Applicant Checklist - Continued



- Vendor Forms – (Do not send to Ohio Shared Services – include with your grant application).

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REQUEST FOR PROPOSAL



**IRS W-9 Form
(Sign in Blue
Ink)**



Insert a signed
blue ink original
W-9 form for
your
organization
here.

Go to link for the
Internal Revenue
Services web site for
form, if needed.

ON TARGET WITH THE OCMH

REQUEST FOR PROPOSAL



IRS W-9 Form (Sign in Blue Ink)



ON TARGET WITH THE OCMH

Form W-9 (Rev. December 2011) Department of the Treasury Internal Revenue Service		Request for Taxpayer Identification Number and Certification		Give Form to the requester. Do not send to the IRS.
Print or type See Specific Instructions on page 2.	Name (as shown on your income tax return)			
	Business name/disregarded entity name, if different from above			
	Check appropriate box for federal tax classification: <input type="checkbox"/> Individual/sole proprietor <input type="checkbox"/> C Corporation <input type="checkbox"/> S Corporation <input type="checkbox"/> Partnership <input type="checkbox"/> Trust/est ate <input type="checkbox"/> Limited liability company. Enter the tax classification (C=C corporation, S=S corporation, P=partnership)* <input type="checkbox"/> Exempt payee <input type="checkbox"/> Other (see instructions)*			
	Address (number, street, and apt. or suite no.)		Requester's name and address (optional)	
	City, state, and ZIP code		List account number(s) here (optional)	
Part I Taxpayer Identification Number (TIN) Enter your TIN in the appropriate box. The TIN provided must match the name given on the "Name" line to avoid backup withholding. For individuals, this is your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the Part I instructions on page 3. For other entities, it is your employer identification number (EIN). If you do not have a number, see <i>How to get a TIN</i> on page 3.				
		Social security number		
		Employer identification number		
Part II Certification Under penalties of perjury, I certify that:				
1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), and 2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding, and 3. I am a U.S. citizen or other U.S. person (defined below).				
Certification instructions: You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the certification, but you must provide your correct TIN. See the instructions on page 4.				
Sign Here	Signature of U.S. person*	Date*		
General Instructions Section references are to the Internal Revenue Code unless otherwise noted.				
Purpose of Form A person who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) to report, for example, income paid to you, real estate transactions, mortgage interest you paid, acquisition or abandonment of secured property, cancellation of debt, or contributions you made to an IRA. Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN to the person requesting it (the requester) and, when applicable, to: 1. Certify that the TIN you are giving is correct (or you are waiting for a number to be issued), 2. Certify that you are not subject to backup withholding, or 3. Claim exemption from backup withholding if you are a U.S. exempt payee. If applicable, you are also certifying that as a U.S. person, your allocable share of any partnership income from a U.S. trade or business is not subject to the withholding tax on foreign partners' share of effectively connected income.				
		Note. If a requester gives you a form other than Form W-9 to request your TIN, you must use the requester's form if it is substantially similar to this Form W-9. Definition of a U.S. person. For federal tax purposes, you are considered a U.S. person if you are: • An individual who is a U.S. citizen or U.S. resident alien. • A partnership, corporation, company, or association created or organized in the United States or under the laws of the United States. • An estate (other than a foreign estate), or • A domestic trust (as defined in Regulations section 301.7701-7). Special rules for partnerships. Partnerships that conduct a trade or business in the United States are generally required to pay a withholding tax on any foreign partners' share of income from such business. Further, in certain cases where a Form W-9 has not been received, a partnership is required to presume that a partner is a foreign person, and pay the withholding tax. Therefore, if you are a U.S. person that is a partner in a partnership conducting a trade or business in the United States, provide Form W-9 to the partnership to establish your U.S. status and avoid withholding on your share of partnership income.		
		Cat. No. 10231X Form W-9 (Rev. 12-2011)		

REQUEST FOR PROPOSAL



Vendor Forms



**Insert an original Vendor Information Form (OBM-5657)
signed in blue ink, here.**

To obtain the form, go to the Ohio Shared Services link below:

http://media.obm.ohio.gov/oss/documents/New+Vendor+Information+Form_11+05+2014.pdf

ON TARGET WITH THE OCMH

REQUEST FOR PROPOSAL



Vendor Forms



ON TARGET WITH THE OCMH



Re: Potential State of Ohio Vendor Registration

Please complete the following forms in order to register as a vendor and do business with the State of Ohio.

Vendor Information Form (OBM-5657-Rev.11/1/2011) - Please complete the Vendor Information Form in order to assure an accurate, up-to-date record of company information. Please verify that all fields are complete and the form has been signed. Electronic signatures are not accepted at this time. Additionally, please verify that information contained on the W-9 form matches that provided on the Vendor Information Form. Specifically, legal business name, taxpayer ID # (TIN), and business type/business entity.

IRS Form W-9 Request for Taxpayer Identification Number & Certification - Enclosed is IRS Form W-9, revised January 2011. Please complete all applicable sections of the document including taxpayer type, a valid tax identification number, and your signature. Electronic signatures are not accepted at this time. The information you provide must match how you are registered with the IRS. Instructions for completing the form are enclosed. Should you require additional assistance in completing the W-9 form, please contact the IRS at 1-800-829-1040.

Authorization Agreement for Direct Deposit of EFT Payments (OBM-4310-Rev.11/1/2011) - The preferred method of payment for the State of Ohio is EFT (Electronic Funds Transfer); please complete the Authorization Agreement for Direct Deposit of EFT Payments and include a current voided check or bank letter. Instructions are provided with the Agreement form.

Send the completed forms to:

Vendor Maintenance
Ohio Shared Services
P.O. Box 182880
Columbus, Ohio 43218-2880

Fax: 614-485-1052
Email: vendor@ohio.gov

We appreciate your assistance in this matter. If you have any questions, please contact Ohio Shared Services at 1 (877) OHIO - SS1 (1-877-644-6771) or 1 (614) 338-4781 or via our contact page at <http://www.ohiosharedservices.ohio.gov/ContactUs.aspx>.

OBM -

DO NOT SUBMIT THESE FORMS TO OHIO SHARED SERVICES. ALL FORMS ARE TO BE TURNED IN TOGETHER TO OCMH.

Rev. 11/1/11

REQUEST FOR PROPOSAL



Vendor Forms



VENDOR INFORMATION FORM

All parts of the form must be completed by the vendor. Incomplete forms will be returned. The information must be legible. Ensure this is the latest version of the form at www.ohiosharedservices.ohio.gov.

SECTION 1 – PLEASE SPECIFY TYPE OF ACTION

- NEW (W-9 OR W-9ECI FORM ATTACHED) CHANGE OF CONTACT PERSON/INFORMATON
- ADDITIONAL ADDRESS – (A COPY OF AN INVOICE OR A LETTER INCLUDING THE ADDRESS IS REQUIRED)
- CHANGE OF ADDRESS – (PLEASE PROVIDE OLD ADDRESS BELOW OR ATTACH LETTER)

ADDRESS TO BE REPLACED:

- CHANGE OF TIN (W-9 & LETTER OF CLARIFICATION OF CHANGE, WHICH INCLUDES NEW & OLD TIN IS REQUIRED)
- CHANGE OF NAME (W-9 & LETTER OF CLARIFICATION OF CHANGE, MUST INCLUDES NEW & OLD NAME IS REQUIRED)
- CHANGE OF PAY TERMS CHANGE OF PO DISPATCH METHOD OTHER _____

SECTION 2 – PLEASE PROVIDE VENDOR INFORMATION

LEGAL BUSINESS OR INDIVIDUAL NAME: (MUST MATCH W-9 OR W-9ECI FORM)

BUSINESS NAME, TRADE NAME, DOING BUSINESS AS: (IF DIFFERENT THAN ABOVE)

FEDERAL EMPLOYER ID (EIN) OR SOCIAL SECURITY NUMBER (SSN):

--	--	--	--	--	--	--	--	--	--

SECTION 3 – PLEASE PROVIDE COMPLETE ADDRESS

ADDRESS:		COUNTY:
CITY:	STATE:	ZIP CODE:

SECTION 4 – ADDITIONAL ADDRESS (IF MORE THAN 2 ADDRESSES, PLEASE INCLUDE A SEPARATE SHEET)

ADDRESS:		COUNTY:
CITY:	STATE:	ZIP CODE:

ON TARGET WITH THE OCMH

REQUEST FOR PROPOSAL



Vendor Forms

Submit these forms to
OCMH only

(Do not submit to OSS)

(Sign in Blue Ink)



SECTION 5 – CONTACT INFORMATION & PERSON TO RECEIVE PURCHASE ORDER	
NAME:	
WEBSITE:	
PHONE:	FAX:
EMAIL:	
PREFERRED METHOD OF BEING CONTACTED: (CHECK ONE) <input type="checkbox"/> PHONE <input type="checkbox"/> EMAIL	
SECTION 6 – INDIVIDUAL TO RECEIVE EMAIL NOTICE OF BID EVENTS - A USER ID & PASSWORD WILL BE SENT TO THE EMAIL ADDRESS BELOW	
NAME:	
EMAIL:	PHONE:
TO ADD AN ADDITIONAL OR REPLACE A STRATEGIC SOURCING CONTACT PERSON	
ADDITIONAL CONTACT PERSON REPLACE CONTACT PERSON (WILL BE MARKED INACTIVE)	
NAME:	
EMAIL:	PHONE:
SECTION 7 – PAYMENT TERMS (PLEASE CHECK ONE – IF NONE IS SELECTED THEN NET 30 WILL APPLY)	
<input type="checkbox"/> 2/10 NET 30 <input type="checkbox"/> NET 30 <input type="checkbox"/> NET 45 <input type="checkbox"/> NET 60 <input type="checkbox"/> NET 90	
SECTION 8 – PURCHASE ORDER DISTRIBUTION – OTHER THAN USPS MAIL	
EMAIL OR FAX:	
SECTION 9 – PLEASE SIGN & DATE	
PRINT NAME:	
SIGNATURE: (DIGITAL SIGNATURES NOT ACCEPTED AT THIS TIME)	DATE:
SECTION 10 – STATE OF OHIO AGENCY CONTACT PERSON (AGENCY RECEIVING PAYMENTS FROM)	
AGENCY CONTACT NAME/EMAIL/PHONE:	
COMMENTS:	
Note: This document contains sensitive information. Sending via non-secure channels, including e-mail and fax can be a potential security risk.	
SUBMIT FORM TO:	QUESTIONS? PLEASE CONTACT:
Mail: Ohio Shared Services Attn: Vendor Maintenance P.O. Box 182880 Cols., OH 43218-2880	Phone: 1 (877) OHIO - SS1 (1-877-644-6771) 1 (614) 338-4781
Email: vendor@ohio.gov	Website: www.ohiosharedservices.ohio.gov/
Fax: 1 (614) 485-1052	Email: vendor@ohio.gov

REQUEST FOR PROPOSAL



Vendor Forms



ON TARGET WITH THE OCMH

Form W-9 (Rev. December 2011) Department of the Treasury Internal Revenue Service	Request for Taxpayer Identification Number and Certification	Give Form to the requester. Do not send to the IRS.
Name (as shown on your income tax return)		
Business name/disregarded entity name, if different from above		
Print or type See Specific Instructions on page 2.	Check appropriate box for federal tax classification:	
	<input type="checkbox"/> Individual/sole proprietor <input type="checkbox"/> C Corporation <input type="checkbox"/> S Corporation <input type="checkbox"/> Partnership <input type="checkbox"/> Trust/estate	
	<input type="checkbox"/> Limited liability company. Enter the tax classification (C=C corporation, S=S corporation, P=partnership) *	
	<input type="checkbox"/> Other (see instructions) *	
		<input type="checkbox"/> Exempt payee
Address (number, street, and apt. or suite no.)		Requester's name and address (optional)
City, state, and ZIP code		
List account number(s) here (optional)		
Part I Taxpayer Identification Number (TIN)		
Enter your TIN in the appropriate box. The TIN provided must match the name given on the "Name" line to avoid backup withholding. For individuals, this is your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the Part I instructions on page 3. For other entities, it is your employer identification number (EIN). If you do not have a number, see <i>How to get a TIN</i> on page 3.		
		Social security number
		Employer identification number
Part II Certification		
Under penalties of perjury, I certify that:		
1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), and		
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding, and		
3. I am a U.S. citizen or other U.S. person (defined below).		
Certification instructions: You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the certification, but you must provide your correct TIN. See the instructions on page 4.		
Sign Here	Signature of U.S. person *	Date *
General Instructions		
Section references are to the Internal Revenue Code unless otherwise noted.		
Purpose of Form		
A person who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) to report, for example, income paid to you, real estate transactions, mortgage interest you paid, acquisition or abandonment of secured property, cancellation of debt, or contributions you made to an IRA.		
Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN to the person requesting it (the requester) and, when applicable, to:		
1. Certify that the TIN you are giving is correct (or you are waiting for a number to be issued).		
2. Certify that you are not subject to backup withholding, or		
3. Claim exemption from backup withholding if you are a U.S. exempt payee. If applicable, you are also certifying that as a U.S. person, your allocable share of any partnership income from a U.S. trade or business is not subject to the withholding tax on foreign partners' share of effectively connected income.		
Note. If a requester gives you a form other than Form W-9 to request your TIN, you must use the requester's form if it is substantially similar to this Form W-9.		
Definition of a U.S. person. For federal tax purposes, you are considered a U.S. person if you are:		
• An individual who is a U.S. citizen or U.S. resident alien.		
• A partnership, corporation, company, or association created or organized in the United States or under the laws of the United States.		
• An estate (other than a foreign estate), or		
• A domestic trust (as defined in Regulations section 301.7701-7).		
Special rules for partnerships. Partnerships that conduct a trade or business in the United States are generally required to pay a withholding tax on any foreign partners' share of income from such business. Further, in certain cases where a Form W-9 has not been received, a partnership is required to presume that a partner is a foreign person, and pay the withholding tax. Therefore, if you are a U.S. person that is a partner in a partnership conducting a trade or business in the United States, provide Form W-9 to the partnership to establish your U.S. status and avoid withholding on your share of partnership income.		

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The person who gives Form W-9 to the partnership for purposes of establishing its U.S. status and avoiding withholding on its allocable share of net income from the partnership conducting a trade or business in the United States is in the following cases:

- The U.S. owner of a disregarded entity and not the entity, and
- The U.S. grantor or other owner of a grantor trust and not the trust, and
- The U.S. trust (other than a grantor trust) and not the beneficiaries of the trust.

Foreign person. If you are a foreign person, do not use Form W-9. Instead, use the appropriate Form W-8 (see Publication 515, *Withholding of Tax on Nonresident Aliens and Foreign Entities*).

Nonresident alien who becomes a resident alien. Generally, only a nonresident alien individual may use the terms of a tax treaty to reduce or eliminate U.S. tax on certain types of income. However, most tax treaties contain a provision known as a "saving clause." Exceptions specified in the saving clause may permit an exemption from tax to continue for certain types of income even after the payee has otherwise become a U.S. resident alien for tax purposes.

If you are a U.S. resident alien who is relying on an exception contained in the saving clause of a tax treaty to claim an exemption from U.S. tax on certain types of income, you must attach a statement to Form W-9 that specifies the following five items:

1. The treaty country. Generally, this must be the same treaty under which you claimed exemption from tax as a nonresident alien.
2. The treaty article addressing the income.
3. The article number (or location) in the tax treaty that contains the saving clause and its exceptions.
4. The type and amount of income that qualifies for the exemption from tax.
5. Sufficient facts to justify the exemption from tax under the terms of the treaty article.

Example. Article 20 of the U.S.-China income tax treaty allows an exemption from tax for scholarship income received by a Chinese student temporarily present in the United States. Under U.S. law, this student will become a resident alien for tax purposes if his or her stay in the United States exceeds 5 calendar years. However, paragraph 2 of the first Protocol to the U.S.-China treaty (dated April 30, 1984) allows the provisions of Article 20 to continue to apply even after the Chinese student becomes a resident alien of the United States. A Chinese student who qualifies for this exception (under paragraph 2 of the first protocol) and is relying on this exception to claim an exemption from tax on his or her scholarship or fellowship income would attach to Form W-9 a statement that includes the information described above to support that exemption.

If you are a nonresident alien or a foreign entity not subject to backup withholding, give the requester the appropriate completed Form W-8. **What is backup withholding?** Persons making certain payments to you must under certain conditions withhold and pay to the IRS a percentage of such payments. This is called "backup withholding." Payments that may be subject to backup withholding include interest, tax-exempt interest, dividends, broker and barter exchange transactions, rents, royalties, nonemployee pay, and certain payments from fishing boat operators. Real estate transactions are not subject to backup withholding.

You will not be subject to backup withholding on payments you receive if you give the requester your correct TIN, make the proper certifications, and report all your taxable interest and dividends on your tax return.

Payments you receive will be subject to backup withholding if:

1. You do not furnish your TIN to the requester,
2. You do not certify your TIN when required (see the Part II instructions on page 3 for details),
3. The IRS tells the requester that you furnished an incorrect TIN,
4. The IRS tells you that you are subject to backup withholding because you did not report all your interest and dividends on your tax return (for reportable interest and dividends only), or
5. You do not certify to the requester that you are not subject to backup withholding under 4 above (for reportable interest and dividend accounts opened after 1983 only).

Certain payees and payments are exempt from backup withholding. See the instructions below and the separate instructions for the Requester of Form W-9.

Also see *Special rules for partnerships* on page 1.

Updating Your Information

You must provide updated information to any person to whom you claimed to be an exempt payee if you are no longer an exempt payee and anticipate receiving reportable payments in the future from this person. For example, you may need to provide updated information if you are a C corporation that elects to be an S corporation, or if you no longer are tax exempt. In addition, you must furnish a new Form W-9 if the name or TIN changes for the account, for example, if the grantor of a grantor trust dies.

Penalties

Failure to furnish TIN. If you fail to furnish your correct TIN to a requester, you are subject to a penalty of \$50 for each such failure unless your failure is due to reasonable cause and not to willful neglect. **Civil penalty for false information with respect to withholding.** If you make a false statement with no reasonable basis that results in no backup withholding, you are subject to a \$500 penalty.

Criminal penalty for falsifying information. Willfully falsifying certifications or affirmations may subject you to criminal penalties including fines and/or imprisonment.

Misuse of TINs. If the requester discloses or uses TINs in violation of federal law, the requester may be subject to civil and criminal penalties.

Specific Instructions

Name

If you are an individual, you must generally enter the name shown on your income tax return. However, if you have changed your last name, for instance, due to marriage without informing the Social Security Administration of the name change, enter your first name, the last name shown on your social security card, and your new last name.

If the account is in joint names, list first, and then circle, the name of the person or entity whose number you entered in Part I of the form. **Sole proprietor.** Enter your individual name as shown on your income tax return on the "Name" line. You may enter your business, trade, or "doing business as (DBA)" name on the "Business name/disregarded entity name" line.

Partnership, C Corporation, or S Corporation. Enter the entity's name on the "Name" line and any business, trade, or "doing business as (DBA)" name on the "Business name/disregarded entity name" line. **Disregarded entity.** Enter the owner's name on the "Name" line. The name of the entity entered on the "Name" line should never be a disregarded entity. The name on the "Name" line must be the name shown on the income tax return on which the income will be reported. For example, if a foreign LLC that is treated as a disregarded entity for U.S. federal tax purposes has a domestic owner, the domestic owner's name is required to be provided on the "Name" line. If the direct owner of the entity is also a disregarded entity, enter the first owner that is not disregarded for federal tax purposes. Enter the disregarded entity's name on the "Business name/disregarded entity name" line. If the owner of the disregarded entity is a foreign person, you must complete an appropriate Form W-8.

Note. Check the appropriate box for the federal tax classification of the person whose name is entered on the "Name" line (Individual/sole proprietor, Partnership, C Corporation, S Corporation, Trust/estate).

Limited Liability Company (LLC). If the person identified on the "Name" line is an LLC, check the "limited liability company" box only and enter the appropriate code for the tax classification in the space provided. If you are an LLC that is treated as a partnership for federal tax purposes, enter "P" for partnership. If you are an LLC that has filed a Form 8832 or a Form 2553 to be taxed as a corporation, enter "C" for C corporation or "S" for S corporation. If you are an LLC that is disregarded as an entity separate from its owner under Regulation section 301.7701-3 (except for employment and excise tax), do not check the LLC box unless the owner of the LLC (required to be identified on the "Name" line) is another LLC that is not disregarded for federal tax purposes. If the LLC is disregarded as an entity separate from its owner, enter the appropriate tax classification of the owner identified on the "Name" line.

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Other entities. Enter your business name as shown on required federal tax documents on the "Name" line. This name should match the name shown on the charter or other legal document creating the entity. You may enter any business, trade, or DBA name on the "Business name/disregarded entity name" line.

Exempt Payee

If you are exempt from backup withholding, enter your name as described above and check the appropriate box for your status, then check the "Exempt payee" box in the line following the "Business name/disregarded entity name," sign and date the form.

Generally, individuals (including sole proprietors) are not exempt from backup withholding. Corporations are exempt from backup withholding for certain payments, such as interest and dividends.

Note. If you are exempt from backup withholding, you should still complete this form to avoid possible erroneous backup withholding.

The following payees are exempt from backup withholding:

1. An organization exempt from tax under section 501(c), any IRA, or a custodial account under section 403(b)(7) if the account satisfies the requirements of section 401(f)(2).
 2. The United States or any of its agencies or instrumentalities.
 3. A state, the District of Columbia, a possession of the United States, or any of their political subdivisions or instrumentalities.
 4. A foreign government or any of its political subdivisions, agencies, or instrumentalities, or
 5. An international organization or any of its agencies or instrumentalities.
- Other payees that may be exempt from backup withholding include:
6. A corporation.
 7. A foreign central bank of issue.
 8. A dealer in securities or commodities required to register in the United States, the District of Columbia, or a possession of the United States.
 9. A futures commission merchant registered with the Commodity Futures Trading Commission.
 10. A real estate investment trust.
 11. An entity registered at all times during the tax year under the Investment Company Act of 1940.
 12. A common trust fund operated by a bank under section 584(a).
 13. A financial institution.
 14. A middleman known in the investment community as a nominee or custodian, or
 15. A trust exempt from tax under section 664 or described in section 4647.

The following chart shows types of payments that may be exempt from backup withholding. The chart applies to the exempt payees listed above, 1 through 15.

IF the payment is for . . .	THEN the payment is exempt for . . .
Interest and dividend payments	All exempt payees except for 9
Broker transactions	Exempt payees 1 through 5 and 7 through 13. Also, C corporations.
Barter exchange transactions and patronage dividends	Exempt payees 1 through 5
Payments over \$800 required to be reported and direct sales over \$5,000 ¹	Generally, exempt payees 1 through 7 ²

¹ See Form 1099-MISC, Miscellaneous Income, and its instructions.

² However, the following payments made to a corporation and reportable on Form 1099-MISC are not exempt from backup withholding: medical and health care payments, attorneys' fees, gross proceeds paid to an attorney, and payments for services paid by a federal executive agency.

Part I. Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. If you are a resident alien and you do not have and are not eligible to get an SSN, your TIN is your IRS individual taxpayer identification number (ITIN). Enter it in the social security number box. If you do not have an ITIN, see How to get a TIN below.

If you are a sole proprietor and you have an EIN, you may enter either your SSN or EIN. However, the IRS prefers that you use your SSN.

If you are a single-member LLC that is disregarded as an entity separate from its owner (see Limited Liability Company (LLC) on page 2), enter the owner's SSN (or EIN, if the owner has one). Do not enter the disregarded entity's EIN. If the LLC is classified as a corporation or partnership, enter the entity's EIN.

Note. See the chart on page 4 for further clarification of name and TIN combinations.

How to get a TIN. If you do not have a TIN, apply for one immediately. To apply for an SSN, get Form SS-5, Application for a Social Security Card, from your local Social Security Administration office or get this form online at www.ssa.gov. You may also get this form by calling 1-800-772-1213. Use Form W-7, Application for IRS Individual Taxpayer Identification Number, to apply for an ITIN, or Form SS-4, Application for Employer Identification Number, to apply for an EIN. You can apply for an EIN online by accessing the IRS website at www.irs.gov/businesses and clicking on Employer Identification Number (EIN) under Starting a Business. You can get Forms W-7 and SS-4 from the IRS by visiting IRS.gov or by calling 1-800-TAX-FORM (1-800-529-3678).

If you are asked to complete Form W-9 but do not have a TIN, write "Applied For" in the space for the TIN, sign and date the form, and give it to the requester. For interest and dividend payments, and certain payments made with respect to readily tradable instruments, generally you will have 60 days to get a TIN and give it to the requester before you are subject to backup withholding on payments. The 60-day rule does not apply to other types of payments. You will be subject to backup withholding on all such payments until you provide your TIN to the requester.

Note. Entering "Applied For" means that you have already applied for a TIN or that you intend to apply for one soon.

Caution: A disregarded domestic entity that has a foreign owner must use the appropriate Form W-8.

Part II. Certification

To establish to the withholding agent that you are a U.S. person, or resident alien, sign Form W-9. You may be requested to sign by the withholding agent even if item 1, below, and items 4 and 5 on page 4 indicate otherwise.

For a joint account, only the person whose TIN is shown in Part I should sign (when required). In the case of a disregarded entity, the person identified on the "Name" line must sign. Exempt payees, see *Exempt Payee* on page 3.

Signature requirements. Complete the certification as indicated in items 1 through 3, below, and items 4 and 5 on page 4.

1. Interest, dividend, and barter exchange accounts opened before 1984 and broker accounts considered active during 1983. You must give your correct TIN, but you do not have to sign the certification.

2. Interest, dividend, broker, and barter exchange accounts opened after 1983 and broker accounts considered inactive during 1983. You must sign the certification or backup withholding will apply. If you are subject to backup withholding and you are merely providing your correct TIN to the requester, you must cross out item 2 in the certification before signing the form.

3. Real estate transactions. You must sign the certification. You may cross out item 2 of the certification.

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Vendor Forms



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4. **Other payments.** You must give your correct TIN, but you do not have to sign the certification unless you have been notified that you have previously given an incorrect TIN. "Other payments" include payments made in the course of the requester's trade or business for rents, royalties, goods (other than bills for merchandise), medical and health care services (including payments to corporations), payments to a nonemployee for services, payments to certain fishing boat crew members and fishermen, and gross proceeds paid to attorneys (including payments to corporations).
5. **Mortgage interest paid by you, acquisition or abandonment of secured property, cancellation of debt, qualified tuition program payments (under section 529), IRA, Coverdell ESA, Archer MSA or HSA contributions or distributions, and pension distributions.** You must give your correct TIN, but you do not have to sign the certification.

Note. If no name is circled when more than one name is listed, the number will be considered to be that of the first name listed.

Secure Your Tax Records from Identity Theft

Identity theft occurs when someone uses your personal information such as your name, social security number (SSN), or other identifying information, without your permission, to commit fraud or other crimes. An identity thief may use your SSN to get a job or may file a tax return using your SSN to receive a refund.

To reduce your risk:

- Protect your SSN.
- Ensure your employer is protecting your SSN, and
- Be careful when choosing a tax preparer.

If your tax records are affected by identity theft and you receive a notice from the IRS, respond right away to the name and phone number printed on the IRS notice or letter.

If your tax records are not currently affected by identity theft but you think you are at risk due to a lost or stolen purse or wallet, questionable credit card activity or credit report, contact the IRS Identity Theft Hotline at 1-800-908-4460 or submit Form 14039.

For more information, see Publication 4535, Identity Theft Prevention and Victim Assistance.

Victims of identity theft who are experiencing economic harm or a system problem, or are seeking help in resolving tax problems that have not been resolved through normal channels, may be eligible for Taxpayer Advocate Service (TAS) assistance. You can reach TAS by calling the TAS toll-free case intake line at 1-877-777-4778 or TTY/TDD 1-800-828-4056.

Protect yourself from suspicious emails or phishing schemes. Phishing is the creation and use of email and websites designed to mimic legitimate business emails and websites. The most common act is sending an email to a user falsely claiming to be an established legitimate enterprise in an attempt to scam the user into surrendering private information that will be used for identity theft.

The IRS does not initiate contacts with taxpayers via emails. Also, the IRS does not request personal detailed information through email or ask taxpayers for the PIN numbers, passwords, or similar secret access information for their credit card, bank, or other financial accounts.

If you receive an unsolicited email claiming to be from the IRS, forward this message to phishing@irs.gov. You may also report misuse of the IRS name, logo, or other IRS property to the Treasury Inspector General for Tax Administration at 1-800-366-4484. You can forward suspicious emails to the Federal Trade Commission at: spam@uce.gov or contact them at www.ftc.gov/idtheft or 1-877-IDTHEFT (1-877-432-4333).

Visit IRS.gov to learn more about identity theft and how to reduce your risk.

What Name and Number To Give the Requester

For this type of account:	Give name and SSN of:
1. Individual	The individual
2. Two or more individuals (joint account)	The actual owner of the account or, if combined funds, the first in possession of the account.
3. Custodian account of a minor (Uniform Gift to Minors Act)	The minor.
4. a. The usual revocable savings trust (grantor is also trustee) b. So-called trust account that is not a legal or valid trust under state law	The grantor-trustee. The actual owner.
5. Sole proprietorship or disregarded entity owned by an individual	The owner.
6. Grantor trust filing under Optional Form 1099 Filing Method 1 (see Regulation section 1.671-4(b)(2)(ii)(A))	The grantor.
For this type of account:	Give name and EIN of:
7. Disregarded entity not owned by an individual	The owner.
8. A valid trust, estate, or pension trust	Legal entity.
9. Corporation or LLC electing corporate status on Form 9932 or Form 2553	The corporation.
10. Association, club, religious, charitable, educational, or other tax-exempt organization	The organization.
11. Partnership or multi-member LLC	The partnership.
12. A broker or registered nominee	The broker or nominee.
13. Account with the Department of Agriculture in the name of a public entity (such as a state or local government, school district, or prison) that receives agricultural program payments	The public entity.
14. Grantor trust filing under the Form 1041 Filing Method or the Optional Form 1099 Filing Method 2 (see Regulation section 1.671-4(b)(2)(ii)(B))	The trust.

¹List first and circle the name or the person whose number you furnish, if only one person on a joint account has an SSN, that person's number must be furnished.

²Circle the minor's name and furnish the minor's SSN.

³You must show your individual name and you may also enter your business or "d/b/a" name on the "Business name (disregarded entity) name line." You may use either your SSN or EIN (if you have one), but the IRS encourages you to use your SSN.

⁴List first and circle the name or the trust, estate, or pension trust. (Do not furnish the EIN of the personal representative or trustee unless the legal entity itself is not designated in the account title.) Also see Special rules for partnerships on page 1.

⁵Note. Grantor also must provide a Form V-9 to trustee of trust.

Privacy Act Notice

Section 6109 of the Internal Revenue Code requires you to provide your correct TIN to persons (including federal agencies) who are required to file information returns with the IRS to report interest, dividends, or certain other income paid to you, mortgage interest you paid, the acquisition or abandonment of secured property, the cancellation of debt, or contributions you made to an IRA, Archer MSA, or HSA. The person collecting this form uses the information on the form to file information returns with the IRS, reporting the above information. Routine uses of this information include giving it to the Department of Justice for civil and criminal litigation and to cities, states, the District of Columbia, and U.S. possessions for use in administering their laws. The information also may be disclosed to other countries under a treaty, to federal and state agencies to enforce civil and criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism. You must provide your TIN whether or not you are required to file a tax return. Under section 3405, payers must generally withhold a percentage of taxable interest, dividend, and certain other payments to a payee who does not give a TIN to the payer. Certain penalties may also apply for providing false or fraudulent information.

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Vendor Forms- EFT
Payments
Submit to OCMH
Do not submit to OSS
(Sign in Blue Ink)



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SECTION 4 – READ THE AGREEMENT, SIGN, & DATE - DIGITAL SIGNATURES ARE NOT ACCEPTED AT THIS TIME

- > Account changes must be reported to Ohio Shared Services thirty (30) days prior to the effective date.
- > All EFT accounts are tied to an address in our system, a form is required for each address (if needed).

ATTENTION ODJFS PROVIDERS: It is the provider's responsibility to keep ODJFS **AND** Ohio Shared Services informed of any changes in order to receive important information regarding benefits and to remain qualified for payments. Information provided must match the information on file with Medicaid or your form will be returned. If you are uncertain, please contact Provider Enrollment at (800) 686-1516 or verify/ update the information in the MITS Medicaid Web Portal located at <https://ssopro.mits.odjfs.state.oh.us/prosecure/authiam/login?HOSTNAME=ssopro.mits.odjfs.state.oh.us>.

- The entity listed hereby authorizes the Ohio Office of Budget and Management (OBM) to initiate credit entries to its account in the financial institution identified above. Additionally, this form provides OBM the authority to debit any erroneous credit or transfers to the account in the amount of the transfer.
- This authority is to remain in effect until revoked by us in writing to Ohio Shared Services, a division of OBM.

I have attached a copy of a current voided check or included a bank letter.

ODJFS PROVIDERS – I have ensured the Name, Address, TIN, & Provider Number matches the information in the MITS Medicaid Web Portal.

Preferred method of being contacted: (circle one) PHONE EMAIL

PRINT NAME _____

SIGNATURE (DIGITAL SIGNATURE NOT ACCEPTED AT THIS TIME) DATE _____

Attach a voided check here using tape or include a bank letter signed by a bank representative.

NOTE:

- The bank letter must include the Name on the Account, Routing Number, Account Number and Type of Account. This letter must be typed, not handwritten, on bank letterhead, and signed by a bank representative. Exceptions will be made for Prepaid Cards.
- All information on the current voided check must be imprinted; this includes the name, address, account and routing numbers. No information can be handwritten.
- We are unable to accept starter checks, deposit slips, or bank statements.
- The name and address on the form and the check/bank letter must match the information in our current vendor records &/or MITS.

Please note: This record is subject to public records requests under the laws of the State of Ohio. If you are a business entity that provides a social security number in place of a Federal Tax ID number, you are waiving any expectation of privacy and this record may be subject to disclosure.

SUBMIT FORM TO:	QUESTIONS? PLEASE CONTACT:
Mail: Ohio Shared Services Attn: Vendor Maintenance P.O. Box 182880 Cols., OH 43218-2880	Phone: 1 (877) OHIO - SS1 (1-877-644-6771) 1 (614) 338-4781
E-mail: vendor@ohio.gov	Website: www.ohiosharedservices.ohio.gov
Fax: 1 (614) 485-1052	E-mail: vendor@ohio.gov

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INSTRUCTIONS FOR COMPLETING THE AUTHORIZATION AGREEMENT FOR DIRECT DEPOSIT OF EFT PAYMENTS

SECTION 1

- Place a check mark to indicate the type of transaction.
- Enter the complete name and address of the company or individual participating in the EFT program.

Enter your phone number & email address. When your email address is provided, you will receive an automated email notification stating your banking information has been added or updated in our system.

- Enter your Employer Identification Number or your Social Security Number (required).
- Please enter your OAKS Vendor Id Number (if known).
 - Check all that applies. If you are an ODJFS or DODD provider please check mark to indicate & add Provider Id Number or please specify, if you are a RSC-PCA, Lottery Winner, or All Other.

SECTION 2 (New Information)

- Please enter the new name and phone number of the financial institution authorized to conduct transactions, as it should be updated in our system.
- Please place a check mark to indicate the type of account to which funds are to be deposited.
- Enter the Account Number to which the EFT Transactions are to be deposited.
- Enter the financial institution's Transit Routing/ABA number in the spaces provided. This is a nine digit number that is shown on your check or bank letter.

SECTION 3 (Old/Prior Information) **Required if a CHANGE/UPDATE**

- Please enter the name and phone number of the previous financial institution authorized to conduct your transaction. This should be the last EFT account information that was submitted to the state and is currently in our system.
- Enter the OLD/Prior Account Number to which the EFT Transactions were deposited.
- Enter the OLD/Prior financial institution's Transit Routing/ABA number in the spaces provided.

SECTION 4

- Please read all of the information listed in Section 4. Read & check mark the boxes to verify you have acknowledged the information. Then print your name, sign your name, and provide the date.
- Please attach a current voided check or bank letter (required).



GUIDELINES & OCMH INFO



GUIDELINES

Proposal Format

- Applications must be submitted on 8 ½ by 11 WHITE paper only. No colored paper will be accepted.
- **One sided documents only**, no two-sided documents allowed
- Applications must be typed in Times New Roman or similar font and must be 12 point in size.
- Applications must clearly indicate ORIGINAL and COPIES and must be stapled or attached with paper clips.
- No binders or separation tabs permitted.
- **ALL DOCUMENTS MUST BE SIGNED IN BLUE INK**



GUIDELINES

Proposal Format

All applications must be typewritten.

Handwritten applications or those submitted by fax will not be accepted.



GUIDELINES

Proposal Format

The **original** and **five copies** of the grant application must be received in the Commission office by

5:00 p.m. on Friday, January 30, 2014

Applications and other materials received after this deadline will be returned without review.

If hand delivering, please remember to account for time for parking and getting to the Commission Office.



CONTACT INFORMATION

OHIO COMMISSION ON MINORITY HEALTH



77 S. High Street, 18th Floor
Columbus, Ohio 43215

Telephone: (614) 466-4000
Fax: (614) 752-9048
Website: www.mih.ohio.gov



QUESTIONS

