COMMISSION ON MINORITY HEALTH

John R. Kasich
GOVERNOR

Gregory L. Hall, MD
CHAIRPERSON

77 South High Street, 18th Floor, Columbus, Ohio 43215
Phone: (614) 466-4000
Fax: (614) 752-9049
Website: http://www.mih.ohio.gov
Email: minhealth@mih.ohio.gov

June 14, 2014

Re: Minority Health Month (MHM) 2015

Dear Colleagues:

The Ohio Commission on Minority Health announces the availability of funds to support Minority Health Month grants. Grant funds will not exceed $2,500 per applicant agency.

It is with great pleasure that we provide the grant application packet for Minority Health Month (MHM) 2015. Created in Ohio in 1989, Minority Health Month has been replicated as a national celebration since 2000. While we believe that the phenomenal participation over the years exemplifies the continued importance of this 30 day campaign we are concerned about some aspects of planning and implementation including but not limited to:

- Assuring that while MHM is developed to reach minority communities, it serves all Ohioans;
- The requirement for two separate (different days) activities per agency;
- Notifying the public of any changes in dates, locations of activities etc., after the closing date for the calendar of events is the sole responsibility the grantee; and
- Budgetary shifts without approval (budget revision) resulting in nonpayment.
- New Requirement: Satisfaction Survey

We suggest that you thoroughly read the application prior to preparing your application and that the person who will be responsible for implementing the program participate in a webinar (schedule included). This suggestion applies to new applicants and previous applicants of MHM.

You have our sincere appreciation for the services you provide to improve the health status of Ohioans. We look forward to your participation for Minority Health Month 2015.

Please note that regardless of the type of event and whether there are other sponsors, the Commission's interest is promotion of good health. Therefore, food selection, activities, etc., whether funded with State dollars or not, must support this goal. The Commission will accept only **ONE** application per 501 (C) (3) agency.

The original grant application and three (3) copies must be received in the Commission office located at 77 S. High Street, 18th floor, no later than 5:00 pm on Monday, July 28, 2014.

Sincerely,

Angela C. Dawson

Angela C. Dawson
Executive Director

Minority Health Month 2015 Webinar

The Commission will conduct two (2) webinars:

Monday, June 23th at 9:00 am
Tuesday, June 24th at 1:00 pm

The Link to register for the Webinar is:

Monday, June 23th at 9:00 am
https://www4.gotomeeting.com/register/146031807

Tuesday, June 24th at 1:00 pm
https://www4.gotomeeting.com/register/193174839

The webinar link will also be available on our website at www.mih.ohio.gov before June 23, 2014

For questions regarding the Webinar session contact Sheronda Whitner at (614) 466-4000 or email Sheronda.whitner@mih.ohio.gov

Questions and answers from the Webinar will be posted on our website www.mih.ohio.gov within 48 hours following the session.

DO NOT SUBMIT THIS PAGE WITH APPLICATION

APPLICANT CHECKLIST

Failure to submit the completed items will deem your application ineligible and it will be returned without review.

- ☐ Please double check your proposal to ensure you have included all required information Receipt of Acceptance attached to the top of each application *(copy & originals)*.
- ☐ Review 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. This must be a letter from the IRS.
- ☐ Attach statement for Rehabilitation Act of 1973.
- ☐ Attach statement for Civil Rights Act of 1964.
- ☐ Attach completed W-9 Form (*you must use the attached form; forms before the November 2005 revision date are not acceptable*.)
- ☐ Include the completed State of Ohio Vendor Forms. The information should match information listed on the W-9 Form. The Commission OCMH will process this form with Shared Services.
- ☐ Complete and attach the "Project Description" portion of the grant application.
- ☐ Number all pages of the grant application.
- ☐ Specify the name of your agency on the bottom of all sheets.
- ☐ The fiscal budget and budget narrative page must be signed by the Executive Director and Fiscal Officer (this cannot be the same person or a relative or spouse).
- ☐ Proposed Activities Form for at least two events on two separate dates with original signatures
- ☐ Invasive Procedure Form, if providing invasive health screenings (must be completed and signed).
- ☐ Proof of Liability Insurance (if performing invasive screenings).
- ☐ Budget Justification/Narrative explaining program activities- with original signatures.
- ☐ If available, include copies of all resume for speakers and consultant contracts funded by this grant.
- ☐ The original grant application and three (3) copies, including all additional forms must be received in the Commission office located at 77 S. High Street, 18th floor, no later than 5:00 pm on Monday, July 29, 2014.

_____ _____

Signed Date

John R. Kasich
Governor

Gregory L. Hall, MD
Chairperson

COMMISSION ON MINORITY HEALTH

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REQUEST FOR PROPOSALS
Minority Health Month SFY 2015

BACKGROUND

In 1989, the Ohio Commission on Minority Health developed the concept of a high-visibility campaign designed to focus on health awareness and disease prevention. In 2000 Minority Health Month became a national celebration. This 30-day campaign, held in April, consists of numerous activities designed to solicit the interest and participation of minorities or providers of health services to minority populations. The minority population is defined as **economically disadvantaged*:***

- **African-Americans**
- **Asian American/Pacific Islanders**
- **Hispanics**
- **Native American Indians**

While the month was designed to reach minority Ohioans, services are provided to anyone who presents for appropriate services.

Demonstration of a positive impact on health knowledge, attitudes and/or practices is an expected outcome of all funded activities.

Minority Health Month (MHM), established annually by gubernatorial proclamation, focuses attention on the health of Ohio's minority populations. The purposes of the month are to:

- Promote healthy lifestyles;
- Provide crucial information to allow individuals to practice disease prevention;
- Showcase the resources for, and providers of, grass-roots health care and information;
- Highlight the resolution of the disparate health conditions between Ohio's minority and non-minority populations;
- Gain additional support for the on-going efforts to improve minority health year-round; and
- Increase the opportunity to collaborate with other community resources locally.

Do not submit this page with the grant application

CRITICAL ELEMENTS FOR MHM ACTIVITIES

The following sections outline critical elements of all Minority Health Month activities. The Commission reserves the right to reduce the requested funding level if the applicant is determined to be non-responsive to the criteria set forth in this Request for Proposal.

Diseases/Conditions

Priority will be given to applications that address one or more of the six diseases/conditions that constitute areas of concern for economically disadvantaged minority populations:

- Cancer;
- Cardiovascular diseases, primarily hypertension;
- Diabetes;
- Infant mortality;
- Substance abuse; and
- Violence.

For Minority Health Month only, the Commission will consider funding projects that address other diseases and conditions that disproportionately affect minorities in Ohio based on documented need.

Target Population

The Commission is interested in funding projects that are culturally sensitive and target economically disadvantaged African-Americans, Asians, Hispanics, or Native American Indians. Some activities may target a specific segment of the minority population (e.g. men, women, children, teens, senior citizens). Additional targeting may include those at greatest risk for a specific disease or condition. Therefore, age, gender, occupational, environmental and/or geographic needs may be critical planning elements.

Performance Standards

All proposals must satisfy the following minimum performance standards. Please provide detailed information in your proposal addressing how each standard will be met.

- A minimum of two separate events is required per applicant. **Separate means events are provided on different days**. Events should be participatory or interactive in nature and be designed to teach or transfer skills or knowledge through an experientially-based, “hands-on” approach.
- Provide an alternative plan that addresses issues such as weather, speaker cancellations, date change, no show or low attendance.
- All events should be age and culturally appropriate, and linguistically specific (i.e. language accessible to the target group).
- Events must be held in a healthy environment.

- Grantee must complete a final report which is due on May 15, 2015.

- Events should be educational, focused on **health awareness** and **disease prevention.**
- Events where **early detection and disease identification** activities are provided must incorporate appropriate protocols (pre-screening and /or referrals). Activities of this nature must also:
  - Be medically and technically accurate;
  - Be conducted in a clinically safe environment utilizing standard/universally (acceptable) precautions;
  - Include a referral and follow-up process for persons with abnormal readings;
  - Include self-help instruction;
  - If performing mammography screening activities, grantees must following Commission guidelines for mammography screening activities. Mammography guidelines are available on the Commission website under the Minority Health Month tab.
  - Show costs based on the number of persons screened; and
  - If invasive procedures will be provided the applicant must:
    a) Provide evidence of compliance with licensure standards for the State of Ohio; and
    b) Provide documentation of appropriate liability insurance coverage. Failure to do so may result in non-approval/payment for services.

Transportation

- Public transportation is reimbursable (i.e. bus passes, taxis, etc.) for program participants.
- Mileage for agency vehicles is reimbursable.

Incentives

- No cash incentives or awards are allowable.
- No gas cards are allowable.
- Gift cards must restrict the purchase of alcohol and tobacco.
- Gift cards may not be used to reimburse speakers.

Food

- **Refreshments, sit-down meals, or catering services ARE NOT reimbursable under this grant.** Only events that contain food demonstrations are reimbursable under this grant.
- Events that include **food demonstrations** must be accompanied by transference of knowledge (i.e., handouts, recipe cards, cookbooks, etc.) and client participation. A Registered Dietician/Licensed Dietitian (not a caterer) must approve and supervise such events.

Other Guidelines

- Please note that retail sales of products are prohibited at events.

- Events that are defined as **workshops, training sessions**, etc. must verify and document that the content is age, gender, culturally and linguistically appropriate for the target population. Documentation must be included in proposals to verify the qualifications of speakers.

- All Minority Health Month activities must be conducted during the month of April 2015.
- Ensure that the dates you choose are realistic and check the availability of space before you submit your proposal. This will help you avoid scheduling problems during Minority Health Month.

- Minority Health Month events must occur at times appropriate for the target population. For example, agencies should not schedule activities for families between 8 a.m. – 5 p.m., Monday through Friday, when many family members are at work or in school.

- Proposed activities should be appropriate to the time constraints of Minority Health Month. For example, a tobacco cessation program may be unrealistic for this campaign with recruitment, retention and outcome issues.

- It is our preference that anticipated participants not be limited to membership of a church, organization, etc., and should be open to the public unless there is a defensible justification for an exclusively internal event.

ELIGIBILITY

Priority shall be given to grant applicants who develop services in accordance with the mission of the Commission. All applicants must meet the following eligibility criteria in order to be considered for Commission funding:

- 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) at the time of application (this excludes applications which are pending).

- Each application must include a copy of the 501 (C)(3) status letter from the IRS. **Please Note: prior submission of a 501 (C)(3) document in a previous grant application will not be acceptable.**

- Provide services in close proximity to economically disadvantaged minority communities or include economically disadvantaged communities in their service area.

- Provide a street address and office phone number. Organizations with a post office box as their only address and/or a personal phone number are not eligible.

- Only one application per agency will be accepted.

- The 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 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 “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. Additionally, it is the policy of the Commission not to award a grant or contract to any offeror that is subject to unresolved findings, debts or monies owed to any other State or Federal governmental entity. By submitting a proposal, offeror warrants that it is now, and will not become, subject to unresolved findings, debts or monies owed to any State or Federal governmental entity, without notifying the Commission of such finding. Failure to comply with this requirement will be considered a violation of the terms and conditions of the grant or contract.

The following are <u>ineligible</u> 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;
- Minority Health Month dollars cannot be used to replicate activities currently funded by the Ohio Commission on Minority Health or other funding sources; and
- Any agencies currently receiving a Demonstration Grant from the Commission (July 1, 2014 - June 30, 2015).

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.

Do not submit this page with the grant application

***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.*

ADDITIONAL REQUIREMENTS

The following are additional programmatic and fiscal requirements to consider when preparing your proposal.

- The grantee must provide all required documents. The Commission will not obtain documents on behalf of the grantee, or utilize documents from previous funded Commission grants.
- The Ohio Commission on Minority Health will not pay for medical services and/or personnel that can be covered by third party payers or other resources.
- Grantees that are membership organizations cannot charge cost differentials between members and the public for Commission funded events.
- The Commission requires full disclosure (itemized) of registration fees or other costs to the public at the time of application.
- Community Development Corporations that plan to rent space from an affiliated faith-based organization must submit verification that line items constitute reasonable and customary costs; and the facility is adequately equipped compared to other venues, including costs for audio visual equipment, etc.
- All media, brochures, audio visuals, translated materials, etc., developed under this grant must be submitted to the Commission in advance (allow at least four weeks for review) of printing or production for approval and must clearly state "FUNDED BY THE OHIO COMMISSION ON MINORITY HEALTH" or display the Commission seal. The Commission seal is available electronically by request. Failure to comply with this requirement will result in disqualification of the item(s) for reimbursement.
- Grantees must confirm the dates, times and locations of their Minority Health Month activities immediately after the notification of award occurs. If you miss this deadline, we cannot guarantee that your events will appear on the statewide calendar. Please be accurate in reporting times, locations and the agency phone number. This will be the information listed on all materials distributed by the Commission. This information is used to complete the Minority Health Month Calendar of Events; therefore, accuracy and a prompt response are essential. The final confirmation of events constitutes a contract between the grantee and the Commission. Changes without Commission approval may result in non-payment.
- The grantee must contact the Commission immediately in writing of any changes in the dates, times or location of events.

- The Commission will not be responsible for changes to the calendar after March 1, 2015.
- The grantee is responsible for providing notification to the public of these changes.
  NEW REQUIREMENT:
- The grantee are required to implement the attached survey using all the questions. Please note grantees are able to add additional questions to this survey.
- The grantee must submit the survey results to include actual numbers of responses for each question as a part of their final report.

FUNDING

The maximum grant award for Minority Health Month 2015 is up to $2,500 per applicant.

Approved Minority Health Month activities will be paid on a reimbursement basis. **Only those items in the approved budget, accompanied by receipts, cancelled checks and/or invoices are reimbursable.** Any unapproved changes in the original terms of the grant award by the grantee agency may result in termination of the grant.

PROPOSAL SUBMISSION

The enclosed **application with original signatures and three (3) copies** must be completed and received in the Commission office no later than **5:00 p.m. on Monday, July 29, 2014** to be considered for funding. Applications and other materials received after this deadline will be returned without review. **Handwritten applications or those submitted by fax or email will not be accepted.** Incomplete applications or those not received on Commission forms will be deemed ineligible.

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

PROPOSAL FORMAT

- Applications must be submitted on 8 ½ by 11 WHITE paper only. No colored paper will be accepted.
- Applications must be typed in Times New Roman or similar font and must be12 point in size.
- Applications must clearly indicate ORIGINAL and COPIES and must be attached with paper clips.
- No binders or separation tabs permitted.

John R. Kasich
GOVERNOR

Gregory L. Hall, MD
CHAIRPERSON

COMMISSION ON MINORITY HEALTH

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RECEIPT OF ACCEPTANCE

This receipt confirms that the following grant proposal has been received by the application deadline. 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: _____

This must be a business address, no home addresses allowed

_____

_____

County of Agency: _____ Federal Tax I.D. Number: _____

(Attach a copy of 501(C)(3) letter)

Total amount you are requesting: $ _____ ☐ check if using a 501 (C)(3) from a parent agency

Executive Director: _____ Phone: ( ) _____

Title: _____ Fax: ( ) _____

(Executive Director of Application Agency) E-mail: _____

Project Director: _____ Phone: ( ) _____

E-mail: _____

Fiscal Officer: _____ Phone: ( ) _____

(Cannot be the same as Executive Director) E-mail: _____

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: MHM 2015 - _____

ENCLOSE WITH ORIGINAL APPLICATION AND THREE COPIES

Instructions for Completion of Receipt of Acceptance

Project Name:	The name assigned to this activity or service. The project name cannot be used for other funding sources.
Applicant Agency/Organization:	The legal name of the agency. Include D.B.A., A.K.A., etc. The name must 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. **Agencies with only a PO Box are not eligible. Home addresses are not allowed.**
County of Agency:	List resident county of administrative office.
Federal Tax I.D.:	Self-explanatory.
Amount Requested:	Specify total amount you requesting for MHM 2015.
Executive Director:	Chief Executive Officer of the applicant agency and title. Include area code and telephone number. This cannot be a home telephone number.
Project Director:	The person who has the authority to make operational decisions for the project. Include area code and telephone number. This cannot be a home 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 Commission will assign a number to the application that should be referenced on all correspondence. A copy of this form will be returned to the applicant to verify that the grant was received before the deadline. This does not confirm that the grant application has been determined to be complete.

Do not submit this page with the grant application

THIS PAGE MUST BE COMPLETED

YOU MUST DESCRIBE YOUR EVENT
MHM 2015
Program

PROJECT DESCRIPTION

Must include:

1. Describe the activities that will meet the funding criteria.
2. A narrative description of the planned activities/service and the number of people to be served.
3. The specific method(s) in which the activity will be advertised and the specific method it will be promoted.
4. Health screenings or activities that require follow-up services and/or referrals.
5. Describe the type of health screenings to be provided.
6. Describe the plan for follow up activities for health screenings.
7. Describe how individuals with abnormal findings for health screenings will be referred.
8. Resumes of presenters (if known).
9. Describe the target population including race and age.
10. Describe your recruitment plan.
11. How will your target population access your program? Bus line? Adequate parking? Road construction concerns?

Agency Name _____

PROPOSED ACTIVITIES
Minority Health Month
April 2015

Please note that the information listed on this page will be the information used to print the statewide calendar of events. All dates, times and locations must be verified prior to printing, but please be specific with the information provided. **NOTE: TBA is not an acceptable response on this section. All information must be filled in and accurate. Please be aware of Spring Break or Holiday Schedules if you are targeting the school system or planning an event at a school. The proposed activities must be held on separate days.**

Please do not leave any blank spaces
USE SEPARATE SHEET IF NECESSARY

Agency Name			
City	County	Proposed number of clients to be served per event	
Contact Person	Contact Person Telephone **(cannot be a home phone number)**	Contact Person Email	
Date(s) of Proposed Activity(ies) **(list each event separately)**	Summary of activity/event Provide a brief, detailed summary of your activity. This info will be listed on the calendar. **30 word limit/ 3 line maximum**	Location activity will be held **(list name of facility, address, city, phone number to be used by the public)**	Time(s) activity will be held **(list each event separately)**
	Event Name: _____ **Summary:** **3 line maximum**		

Please note that retail sale of products is prohibited at these events. MHM 15- _____

Attach additional sheets as necessary. Signature: _____
Executive Director

PROPOSED ACTIVITIES
Minority Health Month
April 2015

Please note that the information listed on this page will be the information used to print the statewide calendar of events. All dates, times and locations must be verified prior to printing, but please be specific with the information provided. **NOTE: TBA is not an acceptable response on this section. All information must be filled in and accurate. Please be aware of Spring Break or Holiday Schedules if you are targeting the school system or planning an event at a school. The proposed activities must be held on separate days.**

Please do not leave any blank spaces
USE SEPARATE SHEET IF NECESSARY

Agency Name				
City		County	Proposed number of clients to be served per event	
Contact Person		Contact Person Telephone **(cannot be a home phone number)**	Contact Person Email	
Date(s) of Proposed Activity(ies) **(list each event separately)**	Summary of activity/event Provide a brief, detailed summary of your activity. This info will be listed on the calendar. **30 word limit/ 3 line maximum line**		Location activity will be held **(list name of facility, address, city, phone number to be used by the public)**	Time(s) activity will be held **(list each event separately)**
	Event Name: _____ **Summary:** **3 line maximum**			

Please note that retail sale of products is prohibited at these events. MHM 15- _____

Attach additional sheets as necessary. Signature: _____
Executive Director

MINORITY HEALTH MONTH 2015
INVASIVE PROCEDURE FORM

Agency Name:_____ Grant No: MHM 2015-_____

1. Will you be providing "invasive" procedures as part of your grant activities?

☐YES (answer questions below) ☐NO (proceed to next page)

1. Please list the "invasive" procedures you will provide at Minority Health Month activities? *Invasive means any procedure that will require a puncture or incision (i.e., blood tests, etc.) or that may result in a puncture or incision (i.e., manicures, pedicures, etc.)*. Please list and specify the name of the company or agency that will provide each service.

2. Please list the company and contact information that will provide liability insurance for each applicable activity.

3. <u>Please attach a copy of liability policy.</u>

Signature _____ Date_____

MINORITY HEALTH MONTH BUDGET-*PART I*

Amount Requested from Commission Only (See reverse side for instructions)

(Attach copy of 501 (C) (3) letter)

Agency Name: _____ MHM 2015 - _____

Executive Director: _____ Contact Person: _____

Federal Tax I.D. Number _____ Phone: ( ) _____

Column A - Budget Category **Attach Budget Narrative/Justification** (specific categories only, narrative should provide detailed line item amounts)	Column B - List Commission costs only
1. Speakers (specify and itemize)	
2. Rentals (specify and itemize)	
3. Program Supplies, contracts & Other (itemize)	
4. Administrative Cost (itemize) **(cannot to exceed 10%)**	
5. Total Commission Cost **(cannot exceed $2,500)**	

By signing below, we certify that at least 20% of our funds are from sources other than the Ohio Commission on Minority Health. The Commission reserves the right to evaluate and/or document the sources of funds. In addition, we certify that the information contained in this proposal is, to the best of our knowledge, correct and reflective of the accounting and program records of the agency.

_____ _____

Executive Director Date Fiscal Officer Date

Must bear original signatures

DO NOT WRITE BELOW THIS LINE

☐ Disapproved in full ☐ Approved as submitted

☐ Approved with conditions:

_____ _____

Angela C. Dawson, Executive Director Date

This form must be signed by the Executive Director and Fiscal Officer

NOTE: Do not alter or modify form. Only this form will be accepted.

BUDGET JUSTIFICATION/NARRATIVE-PART II

(THIS **PAGE IS MANDATORY AND MUST BE COMPLETED IN ORDER FOR THE APPLICATION TO BE CONSIDERED COMPLETE**)

Agency Name: _____ MHM 2015 - _____

Executive Director: _____ Contact Person: _____

Federal Tax I.D. Number _____ Phone: ( ) _____

Speakers: Include a copy of the resume for all speakers, registered dieticians, consultants and contracted individuals, if available at time of grant submission. If not available, this must be submitted if the grant is awarded, by the same due date of the Agreement of Terms.

Rentals:

Program Supplies:

Administrative Cost: **(administrative cost will be reduced to 10% of actual expenditures)**

Signature _____ Date _____

INSTRUCTIONS FOR COMPLETION OF THE BUDGET FORM

Agency Name: Insert the legal name of your agency. It must match the name on the 501(c)(3).

MHM 2015 - ___: A number will be assigned to the Minority Health Month application when it arrives in the Commission office. The agency must use this number on all budget forms and correspondence with the Commission.

Executive Director: Insert the name of the Chief Executive Officer of the applicant agency and official title.

Contact Person: The name of the person who has day-to-day responsibility for the Minority Health Month project.

Federal Tax I.D. Number: This number is provided to your organization by the Internal Revenue Service. The number is used for reporting income received by your organization to the IRS. This number may or may not be the same as your 501 (C) (3) number depending on the holder of this exempt certification. This number may also be called Employer Identification Number (EIN) or Taxpayer Identification Number (TIN).

Phone: Applicant should give the number of the contact person(s) during normal business hours, if different from agency's telephone number.

Budget Category:

Speakers

Column A: Identify each speaker (by name and topic) whose speaking fee will be paid by the Commission.

Column B: Identify the amount of the speaking fee being charged to the Commission (the Commission may approve in full or part).

Rentals

Column A: Specify each rented item with unit cost charged to the Commission (rental of chairs, tables, rooms, etc.). e.g. 50 chairs at $.80/chair.

Column B: Specify the cost of each rented item being charged to the Commission.

Supplies, Contracts & Other

Column A: Make a list of all supplies (e.g. staples, pencils, paper goods, etc.)with unit costs, and contracts (video service, printing, etc.).

Column B: Identify the cost of each product or service to be purchased.

Administrative Cost

Column A: Specify the line item.

Column B: Enter cost, not to exceed **10% of program budgeted amount.** (if program activities only add up to $1,700 the total amount charged for administrative cost may not exceed $170)

Total Commission Cost: Add up the dollar amounts in Column B. This determines the Commission share of your Minority Health Month event. **Note: Total Commission cost cannot exceed up to $2,500.00.**

Executive Director: The budget form must be signed **(original signature)** by the Chief Executive Officer of the applicant agency. The budget cannot be approved if this line is blank or signed by someone else. The Executive Director may not sign off as the fiscal officer. Signatures must show segregation of duties.

Fiscal Officer: The budget form must be signed **(original signature)** by the Fiscal Officer of the applicant Agency. This individual cannot be related or married to the Executive Director.

INSTRUCTIONS FOR COMPLETION OF THE BUDGET FORM

ADMINISTRATIVE COST: Not to exceed 10% of **requested amount. This amount may change based on awarded amount when your revised budget is submitted.**

SPEAKER(S) FEES: List the anticipated number of speakers and/or topics and the rate of reimbursement for each speaker. The Commission will not reimburse fees or travel for out-of-state speakers unless prior approval is received. (Include resume, curriculum, vitae, etc.) The Commission encourages grantees to pursue usual and customary speaker fees.

RENTAL (equipment, space, etc.): All items to be rented must be listed. State the duration and cost of rental per item. Rental agreements may be required if the project is selected for funding. Itemize and provide the unit costs for the items to be rented. (You may not rent space from yourself).

SUPPLIES, CONTRACTS AND OTHER: For purposes of Commission funds, supplies consist of expendable property items which have a useful product life of one year or less and are necessary for the event (staples, scissors, paper, pens, etc.) Itemize and provide the unit costs for the goods and services in this category. Incentives may not exceed 10% of requested amount.

PRINTING: Includes typesetting, actual printing or photocopying of material which is completed by a commercial printing company. Included also are costs for pamphlets, brochures and flyers. (Please itemize). Internal photocopying which is not documented with an invoice or receipt should not be charged to this grant. Quantities should be justified based on the number of people to be served by this project.

ADVERTISING: Specify medium of advertisement, e.g., TV, radio, newspapers, etc. Provide unit costs.

CONTRACTS: Contract personnel are individuals hired to work on the project but who are not regular, salaried or hourly employees of the grantee agency. The contract line item requires supporting documentation in the form of a photocopy of the contract (or draft of a contract) between the agency for the Commission-funded project and the contractor(s). At a minimum, the contract must include the following information:

- effective time period of the contract including beginning and ending dates;
- hourly rate of compensation;
- total dollar amount of compensation for the grant period pending approval of work;
- specific services provided to the project by the contractor(s);
- a termination clause which allows the agency or contractor(s) to serve notice that the contract may be ended, if necessary, prior to the effective ending date of the contract; and
- signature of the contractor(s) and the agency's appointing authority will be required on final contracts.

HEALTH SCREENINGS: Provide contract from a healthcare provider who will provide health screenings at your event. The contract should estimate the total number of health screenings to get a total amount you are requesting from the Commission i.e., unit cost (nurse time + cost of medical supplies) X total number to be served.

The unit cost is equal to nurse time and medical supplies. Reimbursement will be based on total number of participants screened.

FOOD/REFRESHMENTS: Food and refreshments are not reimbursable under this grant unless part of a food demonstration. Events that include food demonstrations must be accompanied by transference of knowledge (i.e., handouts, recipe cards, cookbooks, etc.) and client participation. A Registered Dietician/Licensed Dietitian (not a caterer) must approve and supervise such events. Food may not exceed more than 10% of requested amount.

GENERAL GUIDELINES

The Commission **<u>will not</u>** reimburse a project for:

a) agency personnel (staff) or contracts with other non profit or proprietary entities to execute events
b) rental of agency's own space
c) equipment purchase
d) insurance
e) security
f) out-of-state travel or purchases
g) fines, penalties, overdraft charges
h) out of state speakers' fees
i) internal purchase of goods, services educational materials and/or supplies
j) items purchased prior to the date the grant was awarded
k) see RFP for additional requirements
l) travel reimbursement (for recruiting or providing a mode of transportation to the event)
m) start-up and/or meeting cost
n) ink cartridges
o) personal auto mileage
p) gas cards
q) copiers
r) entertainers
s) Reimbursement of speakers fee with gift card

The Commission **<u>will</u> reimburse up to 10% of the total amount awarded** for each of the following:

- Administrative costs
- Food (if it is based on hands-on nutrition activity supervised by Registered Dietician/Licensed Dietician, see guidelines on page 3)
- Interpreter fees
- Incentives/awards. **CASH AWARDS OR CASH INCENTIVES WILL BE DISALLOWED**
- Bus passes for participants and agency vehicle mileage will be permitted.

Insert a copy of your organization's IRS 501(c)3 documentation here.

The following form must be submitted ONLY if you have never received Commission funding.

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

Go to link for Minority Health Month on Commission web site for form, if needed.

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.

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-8ECI 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-8ECI 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:

SECTION 5 – CONTACT INFORMATION & PERSON TO RECEIVE PURCHASE ORDER		
NAME:		
WEBSITE:		
PHONE:	FAX:	EMAIL:
PREFERRED METHOD OF BEING CONTACTED: (CHECK ONE)	☐ PHONE	☐ 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 ADDITITIONAL 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)				
☐ 2/10 NET 30	☐ NET 30	☐ NET 45	☐ NET 60	☐ 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

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:
☐ Individual/sole proprietor ☐ C Corporation ☐ S Corporation ☐ Partnership ☐ Trust/estate

☐ Limited liability company. Enter the tax classification (C=C corporation, S=S corporation, P=partnership) ▶

☐ Other (see instructions) ▶

☐ 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 *How to get a TIN* on page 3.

Social security number
☐☐☐ – ☐☐ – ☐☐☐☐

Note. If the account is in more than one name, see the chart on page 4 for guidelines on whose number to enter.

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.

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,
- 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.

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(a), 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 4947.

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 $600 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 (1-800-829-3676).

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.

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.

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 individual on the account [1]
3. Custodian account of a minor (Uniform Gift to Minors Act)	The minor [2]
4. a. The usual revocable savings trust (grantor is also trustee)	The grantor-trustee [1]
b. So-called trust account that is not a legal or valid trust under state law	The actual owner [1]
5. Sole proprietorship or disregarded entity owned by an individual	The owner [3]
6. Grantor trust filing under Optional Form 1099 Filing Method 1 (see Regulation section 1.671-4(b)(2)(i)(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 [4]
9. Corporation or LLC electing corporate status on Form 8832 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)(i)(B))	The trust

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

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

[3] You must show your individual name and you may also enter your business or "DBA" 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.

[4] List first and circle the name of the trust, estate, or pension trust. (Do not furnish the TIN 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.

***Note.** Grantor also must provide a Form W-9 to trustee of trust.

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 1-800-908-4490 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 1-800-829-4059.

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 (1-877-438-4338).

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

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 3406, 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.

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 United States, provide Form W-9 to the partnership to establish your U.S. status and avoid section 1446 withholding on your share of partnership income.

Cat. No. 10231X Form **W-9** (Rev. 8-2013)

AUTHORIZATION AGREEMENT FOR DIRECT DEPOSIT OF EFT PAYMENTS

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

TYPE OF TRANSACTION: ☐ ADD ☐ CHANGE/UPDATE ☐ INACTIVATE

NAME OF COMPANY OR INDIVIDUAL

ADDRESS

CITY	STATE	ZIP

PHONE	EMAIL

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

CHECK ALL THAT APPLY

☐ RSC - PCA

☐ ODJFS PROVIDER (PROVIDER ID NUMBER REQUIRED) ☐☐☐☐☐☐☐

☐ LOTTERY WINNER

☐ DODD PROVIDER (PROVIDER ID NUMBER REQUIRED) ☐☐☐☐☐☐☐

☐ ALL OTHER: _____

SECTION 2 – NEW FINANCIAL INFORMATION

NEW FINANCIAL INSTITUTION NAME	PHONE

TYPE OF ACCOUNT ☐ CHECKING ☐ SAVINGS

NEW ACCOUNT NUMBER

NEW TRANSIT ROUTING/ABA NUMBER

SECTION 3 – OLD/PRIOR FINANCIAL INFORMATION - MUST BE PROVIDED TO CHANGE/UPDATE ACCOUNT

OLD/PRIOR FINANCIAL INSTITUTION NAME	PHONE

OLD/PRIOR ACCOUNT NUMBER

OLD TRANSIT ROUTING/ABA NUMBER

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/authtam/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 **E-mail**: vendor@ohio.gov **Fax**: 1 (614) 485-1052	**Phone:** 1 (877) OHIO - SS1 (1-877-644-6771) 1 (614) 338-4781 **Website:** www.ohiosharedservices.ohio.gov **E-mail:** vendor@ohio.gov

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) <u>Required if a CHANGE/UPDATE</u>

- 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).

NOTE: The bank letter must be on bank letterhead and signed by a bank representative. It must include the name on the account, type of account, routing number, & account number. Exceptions will be made for Prepaid Cards.

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 or 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

_____
(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

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 the DHHS, Office for Civil Rights, 330 Independence Avenue, S.W., Washington, D.C. 20201.

HHS-641 (Rev. 12/82)

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

_____ (herinafter 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 GIVES 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 are authorized to sign this Assurance on behalf of the Applicant.

Date _____

_____
(Applicant type or print)

_____
Signature and Title of Authorized Official

_____

_____
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)

OHIO COMMISSION ON MINORITY HEALTH

2015 MINORITY HEALTH MONTH

MHM EVENT ATTENDEE SURVEY

APRIL _ _, 2015

SATISFACTION SURVEY

In evaluating your participation at the Minority Health Month (MHM) event, please rate the quality of the following:	Very Poor	Poor	Good	Very Good	Excellent	Comments
Minority health information offered at the event.	1	2	3	4	5	
Healthy behavior information offered at the event.	1	2	3	4	5	
Access to the event (transportation, parking, etc.)	1	2	3	4	5	
Recruitment efforts (flyers, media announcements, emails, etc.)	1	2	3	4	5	
The organization of the event.	1	2	3	4	5	
The overall quality of the event.	1	2	3	4	5	
Which Aspect of the 2015 MHM Health Event did you Like the **Most**?						
Which Aspect of the 2015 MHM Health Event did you Like the **Least**?						