



## COMMISSION ON MINORITY HEALTH

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@ocmh.state.oh.us](mailto:minhealth@ocmh.state.oh.us)

John R. Kasich  
GOVERNOR

Gregory L. Hall, MD  
CHAIRPERSON

April 10, 2017

Dear Colleagues:

**The 2018/2019 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 round three of availability of funds up to \$280,000 for fiscal year 2018 to support demonstration grants with a priority focus on the prevention of **Type 2 diabetes or cardiovascular disease**. Quality grants targeting infant mortality, 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. Additionally, grantees must report on the changes in outcome achievements quarterly. Grantees are required to collect baseline data, report on all measures quarterly and provide a quarterly comparison of all measures between quarters.

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.mih.ohio.gov](http://www.mih.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 **Thursday, April 20, 2017 at 10:00 am and 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, 18<sup>th</sup> Floor, Columbus, Ohio 43215, no later than **5:00 p.m. on Monday, May 22, 2017**.

You have our best wishes as you prepare your application.

Sincerely,

*Angela C. Dawson*

Angela C. Dawson  
Executive Director

Enclosures

**Ohio Commission on Minority Health  
Request for Proposals  
Fiscal Years 2018  
Demonstration Grant  
Round 3**

**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 2018-19.

**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.

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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 2018-19 the Commission has determined that grants designed to prevent Type 2 diabetes and cardiovascular disease will be considered for 2018/19 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 the prevention of infant mortality, certain cancers (breast, lung, mouth, throat and prostate), substance abuse, or violence will receive consideration. All grants must contain a lifestyle modification component to include diet, exercise, and screenings.**

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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 2018/ 2019.
- Conduct a minimum of two Minority Health Month events during April of 2018/2019.

#### **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 2017-18. **ONLY ONE APPLICATION WILL BE ACCEPTED PER AGENCY.** July 1, 2017 through June 30, 2018, constitutes the first funding period covered by this RFP. Notification of funding will be in early June 2017. As with all grants, funding is contingent on the approval of the State Budget and the availability of funds. Grants will be effective July 2017, **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 2<sup>nd</sup> month of the 1<sup>st</sup> Quarter of funding.**

**IMPORTANT:** This is a performance-based grant. The 2018 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 2018 –June 2019.

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;

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- 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., May 22, 2017.** 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, 18<sup>th</sup> Floor  
Columbus, Ohio 43215**

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

**Technical Assistance Session:**

**Register now!**

Demonstration Webinar – <https://attendee.gotowebinar.com/register/2906169042914614019>

. Click on the link and choose ONE of two webinars below:

April 20, 2017 at 10:00 AM EST **OR** April 20, 2017 at 2:00 PM EST.

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## 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](http://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 **Thursday, April 20 at 10:00 am and 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.

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.

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### 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.

Grantees are required to collect baseline data, report on all measures quarterly and provide a quarterly comparison of all measures between quarters. The following sample objectives will show the comparison of measures:

- a. How many individuals have been identified as pre-diabetic at program enrollment and have moved out of that status based on the A1C by the end of the quarter, year to date?
- b. How many individuals have been identified as pre-diabetic at program enrollment and have moved out of that status based on the A1C year to date?
- c. How many individuals have reduced their BMI by 10% from program enrollment to the end of the quarter?
- d. How many individuals have reduced their BMI by 10% from program enrollment, year to date?
- e. How many individuals have shown an increase in knowledge related to educational component by end of the quarter?
- f. How many individuals have shown an increase in knowledge related to educational component by year to date?
- g. How many individuals have shown an increase in physical activity related to exercise component by end of the quarter?
- h. How many individuals have shown an increase in physical activity related to exercise component by year to date?

### 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

It is required that projects select indicators that document a change in 1) the required clinical measurement such as A1C reduction, body weight reduction, blood pressure reduction, cholesterol level reduction, or other relevant clinical health measurements. In addition, all funded projects must also measure change in increased physical activity as well as knowledge, skills and awareness.

Funded programs are responsible for contracting to for the collection of clinical health measures directly or through partnerships. The quarterly collection of these measures are the ultimate responsibility of the funded 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 project action plan the collection of required participant data (clinical measures, feedback) on a quarterly basis to allow for the reporting of behavioral outcomes that aligns with OCMH's quarterly reporting schedule.**

**Organizations must also be able to report on degrees of change for all clinical measures on a quarterly basis. Reporting on degree of change will allow OCMH to see the direct impact the programs are making on participants and determine programmatic changes that may need to occur in implementation, participant education sessions, etc.**

**Clinical measures data analysis that shows the programmatic impact of the data should be reported on in every quarter report. For example, when reporting degree of change on participant's A1Cs..."During the first quarter the average A1C was 5.6 and during the second quarter the average A1C is 5.4. Furthermore, the minimum A1C was \_\_\_\_, and the maximum A1C was \_\_\_\_. The improvement in A1Cs could best be attributed to \_\_\_\_ (insert qualitative detail to support data). This comparison and degree of change should be outlined for all clinical measures.**

**Additionally, for each objective not reached by the end of the quarter the grantee must report on a plan to achieve the objective in the upcoming quarter.**

**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.**
- **Grantees targeting minor participants (children) must describe a through 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.**

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- 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.

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 2018 and are ongoing without gaps in services.

## **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.mih.ohio.gov](http://www.mih.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 in the budget justification.

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

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## **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 in 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.
- 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 for all clinical measures and collect and report participant data on a quarterly basis to determine behavior outcomes. To include a comparison of the degree of change between all clinical and non-clinical measures each quarter after baseline data is measured. Reporting on degree of change will allow OCMH to see the direct impact the programs are making on participants and determine programmatic changes that may need to occur in implementation, participant education sessions, etc.**
- **Applicant acknowledges that for each objective not reached by the end of the quarter the grantee must report on a plan to achieve the objective in the upcoming quarter.**

#### **V. Budget Appropriateness and Reasonableness**

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- 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.
- Grantees must build in and account for the projected cost for the collection of all clinical measures into the budget. Meaning that all grantees must submit a plan on how the clinical measures will be collected quarterly and the associated costs. Grantees may contract with an outside agency or include an existing staff member’s time into the budget to obtain all required clinical and non-clinical measures.

**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.

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## **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:

- All grant recipients must have a fully executed Acknowledgement of Terms (AOT), to include original signatures on the AOT as well as compliance with all identified program and all identified fiscal special conditions within 60 days of grant notice. The AOT will be provided to grant recipients after the awarding of the grant. Failure to meet this requirement will result in forfeiture of the grant.
- 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, usually conducted 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.

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John R. Kasich  
GOVERNOR

Gregory L. Hall, M D  
CHAIRPERSON

COMMISSION ON MINORITY HEALTH

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**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 2018-\_\_\_\_\_

**ENCLOSE WITH ORIGINAL APPLICATION AND FIVE COPIES.**

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

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- 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. P.O. Boxes are not 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 Commission 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 does not confirm that the grant application has been determined to be complete.

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**PROJECT APPLICATION**

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**NOTE:** Where applicable, instructions have been included.

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

**MIH 2018 - \_\_\_\_\_**

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, 2017 through June 30, 2018

**Budget Period: July 1, 2017 through June 30, 2018**

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 \_\_\_\_\_



## PROJECT APPLICATION – INSTRUCTIONS

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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.**

DO NOT SUBMIT THIS PAGE WITH RFP

**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 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 (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**

**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 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.**

## PROJECT ACTION PLAN – FY 2018

---

Agency Name: \_\_\_\_\_

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

**Fiscal Year 2018  
Budget Pages**

**SECTION I: PERSONNEL AND FRINGE BENEFITS FY 2018**

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

Agency Name: \_\_\_\_\_ Grant #: MIH 2018-\_\_\_\_\_

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 (SPECIFY SOURCE AND ITEMIZE AMOUNT)
				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

<input type="checkbox"/> Approved as submitted <input type="checkbox"/> Disapproved <input type="checkbox"/> Approved with condition  Condition (s):
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## SECTION I: PERSONNEL AND FRINGE BENEFITS – INSTRUCTIONS

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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).
- 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.
  - 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.
  - 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: Where appropriate, match must be identified for each line item.



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

DO NOT SUBMIT THIS PAGE WITH RFP

<b>(A) TRAVEL</b> (Itemize and attach written narrative justification for each item. )	I. Total Budget	II. Amount Requested From Commission
MINORITY HEALTH MONTH Expo Travel cost		
SUBTOTAL		
<b>(B) EQUIPMENT</b> - Rental/Leasing only (Itemize and attach written narrative justification for each item)		
SUBTOTAL		

AGENCY NAME \_\_\_\_\_



## 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 2018.

### 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](http://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](http://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.

**DO NOT SUBMIT THIS PAGE WITH RFP**

<b>(E) ADMINISTRATIVE COSTS</b> <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 \_\_\_\_\_

## SECTION II: NON-PERSONNEL - INSTRUCTIONS

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(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.

*(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 2018 - \_\_\_\_\_

**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** \_\_\_\_\_

**SECTION III: ANTICIPATED PERIODIC DISTRIBUTION OF COMMISSION FUNDS ONLY**

**SFY 2018**

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

**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.*

SOURCE

AMOUNT

- 1. Local Appropriations \$ \_\_\_\_\_
- 2. Gifts and Contributions \$ \_\_\_\_\_
- 3. In-kind Contributions *(itemize)* \$ \_\_\_\_\_
- 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.**

**AGENCY NAME** \_\_\_\_\_

### **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.

**DO NOT SUBMIT THIS PAGE WITH RFP**



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.)

**AGENCY NAME** \_\_\_\_\_

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.**)

**AGENCY NAME** \_\_\_\_\_

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" (1B 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.

**AGENCY NAME** \_\_\_\_\_





## APPLICANT CHECKLIST

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(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
- 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 all signatures in Blue Ink. No color copies of signatures will be accepted. Failure to submit required original signatures, in blue ink could result in the disqualification of your application.
- 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.

Insert an original W-9 form,  
signed in blue ink, for your  
organization, here.

To obtain the form, paste the  
Internal Revenue  
Service link below into your  
browser:

[http://www.irs.gov/  
pub/irs-pdf/fw9.pdf](http://www.irs.gov/pub/irs-pdf/fw9.pdf) .