**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@ocmh.state.oh.us

March 2, 2015

Dear Colleagues:

Due to the limited response to the Systemic Lupus Erythematosus (SLE) Request for Proposal (RFP), OCMH is re-releasing the grant on March 2, 2015 with a due date of April 6, 2015. OCMH will prioritize grants that provide service delievery in Northwest, Central, and Southeast Ohio. The enclosed RFP provides detailed submission guidance and criteria for funding. An electronic version of this packet is located on our website at www.mih.ohio.gov. Please remember to include your agency's 501(c)(3) determination letter with the application.

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

In light of that, the Ohio Commission on Minority Health announces the availability of funds up to $84,000 for fiscal year 2016-17 to support lupus programming focusing on patient and public education. Grant funds will not exceed $14,000 per applicant agency, per year, for a maximum of six funded grants. Funding priority will be given to service areas demonstrating greatest need for lupus programming such as providing lupus health education to the public and/or persons with lupus and their caregivers. **This is a competitive-bid process**.

I strongly encourage you to thoroughly read the application and to attend the Technical Assistance session (TA) via webinar. The TA 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 **Tuesday, March 3, 2015 at 2:00 pm and on Thursday, March 5, 2015 at 10:00 am**. Please note that we will not be able to accommodate individual requests to provide this information

Remember that an original and five copies of your grant application must be received in the Commission office at 77 S. High Street, 18th Floor, Columbus, Ohio 43215, no later than **5:00 p.m. on Monday, April 6, 2015**.

You have our best wishes as you prepare your application.

Sincerely,

*Angela C. Dawson*

Angela C. Dawson
Executive Director
Enclosure

# Ohio Commission on Minority Health
# Request for Proposals
# Fiscal Years 2016-2017

## Systemic Lupus Erythematosus (SLE)

### BACKGROUND

Systemic Lupus Erythematosus (SLE) is a potentially serious, complicated, generalized, inflammatory, connective tissue disease that can affect many different organs of the body in varying combinations. The vast majority of persons with lupus, about 90 percent, are young women. The disease usually begins in adolescence or young adult life. Although the disease may start acutely, the course of the disease is usually chronic and irregular, with periods of activity alternating with periods of remission.

The manifestations of SLE can be quite diverse; they include: joint inflammation (arthritis), fever, a red skin rash (especially in sun-exposed areas), pleurisy (a painful inflammation of the membrane surrounding the lungs and lining the chest cavity), anemia, thrombocytopenia (decreased blood platelets), kidney disease, brain involvement, pneumonia, heart disease and eye disease.

Individuals with Lupus have certain immune system abnormalities. Instead of the immune system serving its normal protective function, it forms antibodies that attack healthy tissues and organs.

It is now clear that SLE is much more common than it was thought to be 25 years ago. It is one of the most frequent, serious disorders of young women. According to the Lupus Foundation of America, between 1.4 million and 2.0 million people have been diagnosed with Lupus.

An overall prevalence rate for lupus has been reported as: 1 in 185 people in the United States; 1 in 123 Caucasian women; and 1 in 62 minority women. In general, blacks have higher rates of incidence, prevalence and mortality than whites. The age of onset of SLE is approximately 6 years earlier for blacks than for whites. The peak age of mortality from Lupus is also earlier in blacks than whites. The incidence rate in black women peaks at the 25 - 34 year old age group. Lupus can also affect men and the elderly.

In addition to African-Americans, Puerto Ricans (residing in New York City), Chinese, Japanese, Filipinos, and ethnic Hawaiian women (residing in Oahu, Hawaii) have exhibited increased risk of SLE. Lupus appears to be unusually common in Chinese women, according to recent studies in Hawaii and Malaysia and observations in the People's Republic of China.

### INTRODUCTION

The Ohio Commission on Minority Health announces the availability of funds up to $84,000.00 for fiscal year 2016 to support lupus programming focusing on patient and public education. Grant funds will not exceed $14,000.00 per applicant agency per year for a maximum of six funded grants. Funding priority will be given to service areas demonstrating greatest need for lupus programming.

In SFY Year 1994, the Ohio General Assembly appropriated funds to the Ohio Commission on Minority Health to provide funding for programs designed to serve Ohioans affected by Systemic Lupus Erythematosus. The Lupus grant program targets all Ohioans in need of services regardless of race, ethnicity or income. It is a goal of this grant program to serve the diverse needs of each city receiving funds.

In July of 1987, the Commission on Minority Health was created by Amended Substitute House Bill 171 for the purpose of providing health promotion and prevention of disease among minority Ohioans who are economically disadvantaged. Grants will be awarded on a statewide competitive bid basis to public or private, non profit 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

Applications will be accepted from eligible 501 (c) (3), community-based agencies or public organizations within Ohio. Current Lupus grantees that are programmatically and fiscally in compliance and have demonstrated quality services are eligible to apply.

Grant funds and services are limited to the city where applicant is located. In some circumstances adjacent areas may be considered; however, in no event can grant funds be used for regional or statewide projects.

Priority will be given to 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 non profit organization that has a 501 (c) (3);
- Develop a plan that establishes a management board for the administration of the grant, composed of proportionate representation of the population to be served and submit said plan with the grant application;
- Answer all questions on Administrative Compliance Form, and
- Grantee must comply with all current and applicable laws, regulations, rules, and administrative guidelines of the Ohio Commission on Minority Health.

**The Commission strongly encourages you to thoroughly read the application and to long-in the Technical Assistance (TA) Webinar sessions that can be accessed through the Ohio Commission on Minority Health Website: www.mih.ohio.gov Technical assistance for this grant application will be discussed and may prove invaluable as you develop your proposal. Please note that we will not be able to accommodate individual request to provide this information.**

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, offer or 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.

## FUNDING

The Commission will grant awards up to $14,000.00 to fund or support Lupus health promotion activities that focus on patient and public education. The funding period is July 1, 2015 to June 30, 2016. The grant period is July 1, 2015 through June 30, 2016. Funds must be budgeted on an annual basis, not to exceed the grant award.

**IMPORTANT: This is a performance-based grant. The second year of funding is non-competitive but is contingent on measured outcome during the first year of funding. 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.**

Preference will be given to grants that focus expenses on costs related to program services. Equipment purchases will be disallowed and agency personnel expenses should be kept to a minimum.

Successful applicants will be required to participate in Commission supported training.

## PROPOSAL GUIDELINES

Grantees should review the criteria and apply for funding appropriate to the services delineated. Grants will be evaluated using this criteria and Commission funding decisions will be based on them and performance.

**DO NOT SUBMIT THIS PAGE WITH RFP**

Applicants that are funded will be required to work with our Research Evaluation Enhancement Project Team, technical assistance to develop and standardize objectives that will be implemented during the funding period along with a standardized evaluation mechanism. More information about this will be shared during the start-up SLE Webinar session in June 2015.

**Critical Guidelines**

- Projects are required to provide twelve (12) months of active program/face to face services through optimal health support groups.
- Projects are required to conduct Lupus Optimal Health group services in July and ongoing. Marketing and outreach activities are not considered program services.
- Grantees will be required to participate in the kick-off events for Minority Health Month in March 2016 and 2017. The grant application should address attendance at these events under the travel section of the budget.
- Commission funds cannot be used to develop educational materials.
- Patient education activities **must** provide strong educational components. Grant funds can be used to pay for expert presenters and result in the transference of skills (i.e. health literacy, relaxation, exercise, positive thinking, proper dietary practices and other techniques that will improve coping mechanism of persons with lupus and/or their caregivers).
- Commission funds can be used to support awareness projects for the community at-large. This public awareness campaign may be a useful way to help identify cases of lupus for people who have the disease and do not know it. Such public awareness campaigns can be used to generate more public support for lupus concerns. Public awareness campaigns are not viewed as exclusive activities and must be conducted in conjunction with other activities e.g. patient education in this section. Funds allocated to support this activity must be reasonable and budgetary proportionate.

Due to the limited funds it is preferential that applicants specify how they intend to meet the needs of diverse population groups based on demonstrated need and/or risk; as opposed to proposing a non-targeted general initiative and/or limiting efforts to one racial/ethnic group to the exclusion of others.

An applicant must meet all criteria in each category to be considered for funding:

**Patient Education**

- Conduct at least **one** monthly face to face optimal health support group meeting that is facilitated by a ***trained facilitator*** and includes ***balanced presentations***.
- Provide a referral list of area facilities and physicians that provide medical treatment for SLE related medical conditions (i.e. rheumatologists, dermatologists, nephrologists, etc.).
- Conduct a training opportunity that enhances the combination of patient, caregiver and professional education on the subject of SLE (i.e. workshop, conference or seminar). A mechanism to capture demographics for all services must be in place.
- Provide outreach to minority women via: Telephone Hotline, Literature Updates, On-line Education Sessions, Teleconference Education Discussions, Home Visits, Peer Counseling, and Self-Management Skills.

**Public Education**

- Include caregivers and children of persons living with lupus at monthly *support group* meetings.
- Conduct presentations that enhance SLE education.
- Participate in local events (i.e. health fairs).
- Participate in Lupus Awareness Month (May 2016).
- Enhance public education via media outlets.
- **Each funded agency is required to administer the "symptom checklist" – This is a mandatory requirement of funded agencies.**

**Grantees are required to maintain participant files.**

**Participating Files must contain the following:**

1. **Individual file for all program participants.**
2. **Program participant's files should not include their first and last names or home address. The participant identifications system can be: (first name, last initial, or vice versa), numbers, group name, sub group, alphabetic.**
3. **All progress notes must be written in blue ink and updated after each program activity and signed and dated by the Project Director.**

**Definitions:**

**Patient Education Sessions:**
An organized group of face to face individuals led by a trained facilitator in an effort to receive information, share experiences and coping techniques. The group may set its own format for meetings, which may include educational, facilitated discussions or social events.

**Trained Facilitator:**
The individuals responsible for coordinating the work of the patient education sessions. All new grantees are required to be trained in group facilitation and conflict resolution. The required training will be conducted as part of the Commission's mandatory all grantee training.

**Balanced Presentation:**
A presentation that allows group members to share their personal experiences and an expert speaker to provide factual knowledge which results in the transference of skills.

**PROPOSAL PREPARATION**

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

The Lupus technical assistance sessions will be conducted on on Tuesday, March 3, 2015 at 2:00 pm and on Thursday, March 5, 2015 at 10:00 am. 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.

**Complete the Receipt of Acceptance, assurances and compliance forms, Rehibilitation Act of 1973, Civil Rights Act of 1964, W-9, Board and Employee Composition Forms, as well as Vendor Forms. Include a copy of 501(c)(3) status, most recent audit report and board resolution.**

**Agency must include a board resolution approving the submission of the application.** ***(Not included in the page count).***

**DO NOT SUBMIT THIS PAGE WITH RFP**

## PROPOSAL FORMAT

- Applicants must be submitted on single sided sheets of paper. No two sided copies will be accepted.
- 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 attach with paper clips.
- No binders or separation tabs permitted.
- All signatures must be signed in BLUE INK.

**All applications must be received by 5:00 p.m., April 6, 2015.** Any application or supporting documentation received after that date and time will be returned without review. **The proposal must be typed on Commission forms. FAXED, EMAILED AND HANDWRITTEN APPLICATIONS WILL NOT BE ACCEPTED.**

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

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

## PROPOSAL PREPARATION

Responses to this RFP should be prepared following the format described below. Proposals, which 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.

Narratives should carefully address the instructions that follow. The narrative section is limited **to 13 single-spaced pages** excluding appendices and required forms. Identifying information (applicant name) should appear in the footer at the bottom of each page, along with page number.

(1) **Complete and submit all forms to include type written pages for the following: Receipt of Acceptance, Project Application, Description of Applicant Agency, Problem Need Statement, Method of Implementation, Project Summary, Program Evaluation, Project Action Plan, assurance, and compliance forms. Include the copy of 501 (c) (3) letter, recent audit report and board resolution (approving the submission of the application), vendor information forms, agency's most recent audit, board and employee composition forms, and W-9 form.**

(2) **Proposal Narrative**

a. Description of Applicant Agency (two pages maximum)

All Narratives must be written in a complete sentence structure.

Describe the agency's mission, mandate, and previous experience (including previous Commission grants) in providing services to the targeted group(s) (racial/ethnicity) and/or training specific to lupus.

Include accomplishments and how the target population(s) will benefit by the project being implemented through the agency's service delivery mechanism.

Collect health baseline information of the participants and their caregivers and measure the outcomes quarterly after participants have participated in the program activities offered by your agency.

Grantees that are funded will be required to work with REEP to implement evaluation mechanisms.

Staff descriptions must include job descriptions, contracts of personnel assigned to grant, and resumes, if available.

b. Problem Need Statement (three pages maximum)

All Narratives must be written in a complete sentence structure.

Provide narrative information about the populations to be served in your city/area. Identify such factors as race or ethnicity, age, etc., geographical area(s) or similarly disadvantaged area to be served and sources of community support.

Define the specific problems and needs to be addressed by the proposed project. Support the extent of the problem and needs statement with statistics, research findings, or other documentation.

List the expected outcomes of the project.

**Provide letters of support from appropriate organizations. If organizations are providing services to the project, the extent of their involvement should be described.**

**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. Method of Implementation and Evaluation

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

In a complete written sentence structure provide a brief narrative that describes the major tasks and activities planned and how they will be accomplished.

- Hours and location(s) of activities;
- Measurable goals with outcome objectives (what you plan to accomplish);
- Outreach/recruitment approaches for the target population(s);
- Culturally-specific components that reflect the target population's attitudes, values and beliefs;
- How effectiveness of the project will be measured; and
- Applicants must identify the number of persons with lupus to be served **AND** the number of caregivers to be served

E. Project Action Plan – FY 2015 *(use attached form)*

Project Action Plan must list goals and objectives with projected number of participants to be served for the year of the project that are clearly defined and measurable in process and client behavior outcome changes. 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 objectives, which are focused on client outcome rather than process outcome (recruitment, hiring staff, etc.). Outcome focused objectives are designed to create measurable behavioral changes.

(3) **Budget Forms** - Instructions are on the reverse side of each form as appropriate. Attach a budget justification or narrative must be attached describing unit cost and itemization of each line item.

- **Applicants must submit their most recent completed agency audit.**

## PROPOSAL EVALUATION

Responses to this RFP that 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.

The final selection process will involve a ranking system based on scores, reflecting compliance with the evaluation criteria.

**Evaluation Criteria for Applications (Items which are considered during review of grant applications):**

(1) **Service Area Design**

- The need for the program is well documented.
- The project explains assurances for provision of technically accurate information.
- Programs are directed at a clearly defined target population consistent with the Commission's definition for economically disadvantaged minority(ies).

(2) **Innovativeness and Impact**

- The project is designed specifically for the proposed target population.
- The project will result in some measurable impact on the identified population.
- The applicant states expected outcomes as a result of proposed interventions.

(3) **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, reasonably addressed during the grant period, and accomplished with the dollars available for the project.

(4) **Budget Appropriateness and Reasonableness**

- At least 20% of the applicant's operating budget during the funding period is from a source other than the Commission is clearly documented. In other words, the Commission cannot be the sole funding source of an agency. This 20% should not be perceived as matching funds.
- All line item costs are appropriate and reasonable/justifiable.
- Costs support direct client activities.
- All line items must be itemized and list a unit cost for each requested expenditure.

*Applicants that are funded will be required to work with our Research Evaluation Enhancement Project to develop standardized objectives that will be implemented during this funding period along with a standard evaluation mechanism.*

(5) **Evaluation**

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



**DO NOT SUBMIT THIS PAGE WITH RFP**

- Applicants that are funded will be required to work with Research Evaluation and Enhancement Project (REEP) team on a technical assistance session to develop standardized objectives a standard evaluation mechanism.

**NOTE:** **Please double check your grant proposal for accuracy and completion. Missing pages, omitted sections and mathematical errors may result in disqualification for funding**. Utilize the attached RFP checklist, if item(s) is omitted and/or missing pages, your RFP will be returned to your agency without a review.

## 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. Grant management is required by your agency to be responsible for:

- Return signed Acknowledgement of Terms and respond to the Program and Fiscal Special Conditions, if any are given.
- Submission of Program and Fiscal quarterly reports (on appropriate Commission forms).
- Participation in MHM Kickoff Expo sponsored by the Commission. In an effort to raise awareness required 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 REEP Panel to develop common job objectives and evaluation tool.
- Responsible for Biennial Program Report by required deadline.
- Responsible for conducting two Lupus Awareness Month activities in May of 2015.

## DEADLINE

The original and five copies of the grant application must be received in the Commission office by **5:00 p.m. on Monday, April 6, 2015**. Applications and other materials received after this deadline will be returned without review. All applications must be typewritten, **handwritten applications or those submitted by fax will not be accepted and will be returned without review.**

**We recommend allowing sufficient time to access the building and go through security.**
**Address applications to:**

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

## Technical Assistance Session:

Join us for a webinar on Mar 03, 2015 at 2:00 PM EST. Register now!

https://attendee.gotowebinar.com/register/7544958006088657665

Join us for a webinar on March 05, 2015 at 10:00 AM EST. Register now!

https://attendee.gotowebinar.com/register/640822129585519361

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**John R. Kasich**
GOVERNOR

**Gregory L. Hall, MD**
CHAIRPERSON

**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

# RECEIPT OF ACCEPTANCE

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. IF YOUR AGENCY DOES NOT HAVE 501-C-3 STATUS, STOP HERE – DO NOT SUBMIT THE APPLICATION)**

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: SLE 2016-2017_____

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

## Instructions for Completion of Receipt of Acceptance

| | |
|---|---|
| **Project Name:** | The name assigned to this activity or service. The project name can not 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. P.O. Boxes are not acceptable. |
| **County of Agency:** | List resident county of administrative office. |
| **Federal Tax I.D.:** | Self-explanatory. |
| **Amount Requested:** | Self-explanatory. |
| **Executive Director:** | Chief Executive Officer of the applicant agency and title. Include area code and telephone number. |
| **Project Director:** | The person who has the authority to make operational decisions for the project. Include area code and 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 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 RFP**

## PROJECT APPLICATION PAGE ONE

**NOTE:**

Where applicable, instructions have been placed on reverse side of page.

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

**SLE 2016-2017** _____

1. Applicant Agency Information:

   Name of Director: _____Title: _____

   Agency Name: _____

   Address: _____

   City: _____, OH Zip: _____ County: _____

   Telephone #: (_____) _____ Fax #: (_____) _____ E-mail _____

2. Project Title: _____

3. Federal Tax I.D.: _____

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

   Name: _____ Phone (_____) _____

   Mailing Address: _____

   City: _____, OHIO Zip:_____

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

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

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

   a. That funds granted as a result of this application are to be used for the purposes set forth herein 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.

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

g. That the applicant agency is in compliance with:

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

____ Statement of compliance submitted herewith

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

____ Statement of compliance submitted herewith

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

(A) _____

Signature of Agency Director (Blue Ink) Date

(B) _____

Signature of Auditor or Fiscal Officer (Blue Ink) Date

## PROJECT APPLICATION – INSTRUCTIONS

Project name as indicated on the Receipt of Acceptance.

Federal Tax I.D. Number of the applicant agency.

Provide the name and telephone number for the fiscal officer who can answer specific questions about this application.

Read assurances of compliance with the terms of the grant application.

A. Original signature of the Chief Executive Officer of the applicant agency (Executive Director, Senior Pastor, Health Commissioner, etc.), and date (Stamped signature is not acceptable).

B. Original signature of the applicant agency Fiscal Officer and date (Stamped signature is not acceptable).

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

- For non profit agency, a 501 (C)(3) must be included with the application before it will be reviewed.
- Is there a letter or statement from your Governing Board, signed by the Chairperson, authorizing you to apply for this grant?

**DO NOT SUBMIT THIS PAGE WITH RFP**

## PROPOSAL PREPARATION

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.

**Complete the Receipt of Acceptance, assurances and compliance forms, W-9, and Vendor Forms. Include a copy of 501(c)(3) status, most recent audit report and board resolution. Agency must include a board resolution approving the submission of the application.** ***(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 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. Within the agency's plan describe the degree to which program staff are culturally competent. Describe how the agency will collect health base line information of the participant, the caregiver, and measure the outcome quarterly after program participation.

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.

List the expected outcome of the project.

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.

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)*

**DO NOT SUBMIT THIS PAGE WITH RFP**

D. Project Action Plan – FY 2016 *(use attached form)*

Project Action Plan must list goals and objectives with projected number of participants to be served for the year of the project that are clearly defined and measurable in process and client behavior outcome changes. 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 objectives, which are focused on client outcome rather than process outcome (recruitment, hiring staff, etc.). Outcome focused objectives are designed to create measurable behavioral changes.

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.

A sample action plan is included as a guide.

E. Method of Implementation

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

- 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

Describe in details, 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 responses to a statement such as, "we will hire an evaluator", will be considered non-responsive.

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**Insert W-9**

Signed in blue ink.

**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**



AGENCY NAME_____

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

## SAMPLE-PROJECT ACTION PLAN – FY 2016

**Note:** Project Action Plan should support the proposed methodology in the program narrative.

| Goals/Objectives | Approach | Activities | Evaluation | Responsibilities | Timeline |
|---|---|---|---|---|---|
| ▪ **How many persons with lupus do you plan to serve via Optimal Support Group?**<br>▪ **How many caregivers who attended the group do you plan to serve?**<br>▪ **How many individuals do you plan to serve with non-support group activities.**<br>▪ **What are your specific Public Education plans?** | How will you do it? | What will take place? | What results do you expect?<br>How will you measure it? | Who will be responsible? | Applicants must list the activities for each month of the year along with the frequency of each activity? |
| Patient Education<br>Goal 1:To provide Systemic Lupus Erthematosus (SLE) education to __lupus patients and ____Caregivers.<br><br>Objective:<br>a. By June 2016 at least ____Lupus patients will receive a list of area facilities and physicians that provide treatment for SLE related medical conditions. | An up to date list will be maintained and available at support meetings and upon request to individuals requesting physician referrals. | An up to date list of rheumatologist will be available through telephone, email, meetings, and/or by mail request. | The expected outcome is that program participants are seeing a doctor in order to manage symptoms at least once a year. A question will be included in the quarterly evaluation to measure compliance. | Program Staff | From July 2015 to June 2016 |
| b. By June 2016 at least _____Lupus patients will attend _____ out of _____ support group meetings, which are facilitated by trained facilitator with balanced presentations. | A minimum of ____ meetings will be scheduled by June 2016 and conducted by a trained facilitator.<br>Participants must attend no less than ____ out of ____group meetings. | See attached meeting schedule. | Sign in sheets will be used to track attendance. | Program Staff | From July 2015 to June 2016 |

****Please note you time line must reflect activities within each month of the year. This must include face to face groups, public education, and non-support group activities.**

## SAMPLE-PROJECT ACTION PLAN – FY 2016

**Note:** Project Action Plan should support the proposed methodology in the program narrative.

| Goals/Objectives | Approach | Activities | Evaluation | Responsibilities | Timeline |
|---|---|---|---|---|---|
| ▪ Project how many participants you plan to serve, in whole numbers?<br>▪ Project how many participants will participate in the frequency of your program activity designed?<br>▪ Project how many participants will show quarterly health outcome behavior changes. | ▪ How will you do it? | ▪ What will take place? | ▪ What results do you expect?<br>▪ How will you measure it?<br>▪ Refer to the Evaluation Guidance Packet for required areas.<br>▪ What are your plans to collect participant data quarterly? | ▪ Who will be responsible? | ▪ What will happen by the end of the first quarter an ongoing on a quarterly basis? |
| Patient Education<br><br>c. By June 30, 2015, the Lupus support group facilitator will provide at least ___ phone calls and provide at least ___home visit, provide self-management skills to al least___ lupus patients and ___caregivers during support group meetings. | Phone calls and/or home and hospital visits will take place. Self-management skills will be provided in support group meetings, phone calls and home visits. | Lupus patients will receive educational brochures and other resources from reputable sources. | Home visits/and telephone calls will be logged on the communication sheet. At least two presenters at support group meetings will be a physician and a rheumatologist in order to highlight self-management skills. | Program Staff | From July 2015 to June 2016 |
| d. By June 30, 2016 at least ____ Lupus presentations within target area lupus information will be provided for at least ____ health fairs in order to provide outreach mechanisms for increasing the number of participants, especially minority women. Through the following mechanisms:<br>a._____<br>b._____<br>c._____ | Community outreach will be accomplished by targeting populations affected by lupus. | Outreach will take place at churches, schools, adult education facilities, physician offices and civic organizations in the affected populations. | The program facilitator will participate in at least __ participations, or health fairs. Meeting notices will be send to physician's offices and churches. | Program Staff | From July 2015 to June 2016 |

Agency Name _____

## SAMPLE-PROJECT ACTION PLAN – FY 2016

**Note:** Project Action Plan should support the proposed methodology in the program narrative.

| Goals/Objectives | Approach | Activities | Evaluation | Responsibilities | Timeline |
|---|---|---|---|---|---|
| ▪ **How many persons with lupus do you plan to serve via Optimal Support Group?**<br>▪ **How many caregivers who attended the group do you plan to serve?**<br>▪ **How many individuals do you plan to serve with non-support group activities.**<br>▪ **What are your specific Public Education plans?** | How will you do it? | What will take place? | What results do you expect?<br>How will you measure it? | Who will be responsible? | Applicants must list the activities for each month of the year along with the frequency of each activity? |
| Patient Education<br>Optional Objective:<br>e. By June 30, 2016 at least _____ people will access the lupus informational line for event information and accurate lupus information. Lupus | The Lupus _____information hotline is available _____to date literature is available. | Information is updated ____ on the Lupus information line. Literature will be available upon request or to persons recognized as needing more information related to their situation. | Literature will be available upon request or as needed. A monthly data report provided by the target area will communication department is used to track calls to the lupus __information line. | Program Staff | By June 30, 2016 |
| f. By June 30, 2015 at least _____ county residents will be reached through a Lupus Awareness Month Campaign.<br><br>**Public Education:**<br><br>**Goal 2:**<br>**To increase awareness among county residents and promote involvement in lupus awareness activities.** | Lupus awareness activities will be held and advertising will take place supporting this event. | Lupus awareness activities will be conducted as follows:<br>_____<br>_____<br>_____. | Increased awareness of lupus among county residents. At least ____ individuals will hear or read about lupus awareness and program availability. | Program Staff | By June 30, 2016 |
| Objectives:<br>g. By June 30, 2016 at least ___ caregivers and family members of persons living with lupus will participate in monthly support group meetings. | Caregiver/family members are considered active attendees and allowed to voice their concerns and ask questions. | Lupus patients will continue to be encouraged to bring their caregivers and children to meetings, through the following methnods_____<br>_____<br>_____. | It is expected that at least ___ participants will be caregivers | Program Staff | By June 30, 2016 |

****Please note you time line must reflect activities within each month of the year. This must include face to face groups, public education, and non-support group activities.**

Agency Name _____

## SAMPLE-PROJECT ACTION PLAN – FY 2016

**Note:** Project Action Plan should support the proposed methodology in the program narrative.

| Goals/Objectives | Approach | Activities | Evaluation | Responsibilities | Timeline |
|---|---|---|---|---|---|
| ▪ **How many persons with lupus do you plan to serve via Optimal Support Group?**<br>▪ **How many caregivers who attended the group do you plan to serve?**<br>▪ **How many individuals do you plan to serve with non-support group activities.**<br>▪ **What are your specific Public Education plans?** | How will you do it? | What will take place? | What results do you expect?<br>How will you measure it? | Who will be responsible? | Applicants must list the activities for each month of the year along with the frequency of each activity? |
| Patient Education<br><br>Optional Objective:<br>h. By June 30, 2016 at least _____ people will presentations that enhance SLE education will be conducted and lupus awareness information will be displayed during at least ___ local events including health fairs. | Staff will participate in health fairs and conduct presentations through the county. | Public Education activities will be scheduled and coordinated by facilitator. | Program Staff will participate in at least _____ health fairs or presentations. | Program Staff | From July 2015 to June 2016 |
| Public Education<br><br>i. By June 2016 awareness of support group meetings for county residents will be enhanced by sending public service announcements to at least __ media and community organizations. | Monthly support group meetings announcements will be sent to media and community.org. | Monthly PSA's will be sent to media, outlets, print, audio, television and community.org.<br><br>The checklist will be administered at health fairs, presentations, and outreach activities | Support group participants will be asked how they became aware of support group as indicated on group participant form. | Program Staff | From July 2015 to June 2016 |
| j. By June 30, 2016 at least __ copies of the Lupus symptom checklist will be distributed. | The Symptom checklist will be administered. | A referral list and lupus information sheets will be provided to individuals who take the checklist. | It is expected that more people will be aware of lupus symptoms. This will be measured by the number distributed and patients having 4 or more symptoms.<br>. | Program Staff | From July 2015 to June 2016 |

****Please note you time line must reflect activities within each month of the year. This must include face to face groups, public education, and non-support group activities.**

Agency Name _____

## SAMPLE-PROJECT ACTION PLAN – FY 2016

**Note:** Project Action Plan should support the proposed methodology in the program narrative.

| Goals/Objectives | Approach | Activities | Evaluation | Responsibilities | Timeline |
|---|---|---|---|---|---|
| ▪ **How many persons with lupus do you plan to serve via Optimal Support Group?**<br>▪ **How many caregivers who attended the group do you plan to serve?**<br>▪ **How many individuals do you plan to serve with non-support group activities.**<br>▪ **What are your specific Public Education plans?** | How will you do it? | What will take place? | What results do you expect?<br>How will you measure it? | Who will be responsible? | Applicants must list the activities for each month of the year along with the frequency of each activity? |
| Patient Education<br>k. By June 30, 2016 the Lupus Support Group Facilitator will provide the following: (Water bottle, Zumba, coffee club etc.) | This activity will take place _____ _____ _____. | Support group members will be educated on activity. | Feedback on activities of participants will be completed after each activity. | Program Staff | Between July 2015 and May 2016 |

****Please note you time line must reflect activities within each month of the year. This must include face to face groups, public education, and non-support group activities.**

Agency Name _____

## PROJECT ACTION PLAN – FY 2016

**Note:** Project Action Plan should support the proposed methodology in the program narrative.

| Goals/Objectives | Approach | Activities | Evaluation | Responsibilities | Timeline |
|---|---|---|---|---|---|
| ▪ Project how many participants you plan to serve, in whole numbers?<br>▪ Project how many participants will participate in the frequency of your program activity designed?<br>▪ Project how many participants will show quarterly health outcome behavior changes. | ▪ How will you do it? | ▪ What will take place? | ▪ What results do you expect?<br>▪ How will you measure it?<br>▪ Refer to the Evaluation Guidance Packet for required areas.<br>▪ What are your plans to collect participant data quarterly? | ▪ Who will be responsible? | ▪ What will happen by the end of the first quarter an ongoing on a quarterly basis? |
| | | | | | |

****Please note you time line must reflect activities within each month of the year. This must include face to face groups, public education, and non-support group activities.**

Agency Name _____

## INSTRUCTIONS FOR COMPLETING THE PROJECT ACTION PLAN

**GOALS/OBJECTIVES:** Goals and Objectives in Project Action Plan may be used for this section.

- Establish clearly defined and measurable goals/objectives (using numbers not percentages).
- Must support the program narrative methodology.

**APPROACH:**

- Describe what plan or method will be implemented.
- Identify strategies for achieving objectives.

**ACTIVITIES:**

- Develop a list of activities or tasks related to each strategy.
- Set priorities among activities/tasks related to achieving the objectives **ON A MONTHLY BASIS**.
- Is the strategy culturally specific? Does it consider beliefs, attitudes and practices of the specific population?

**RESPONSIBILITY:**

- Name the person or collaborating organization responsible for task completion.

**TIMELINE:**

- For each task/activity assign a beginning and ending time.
- Avoid using by June 30th; quarterly outcomes must be part of the timeline.
- Consider if the implementation timeframe is reasonable and realistic.

**PLEASE NOTE CHANGES TO TIMELINE REQIREMENT MONTHLY ACTIVITIES.

## SECTION I: PERSONNEL AND FRINGE BENEFITS FY 2016

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

Agency Name: _____ Grant #: SLE 2016_____

| SALARIES AND WAGES | I | II | III | IV | V | VI | VII |
|---|---|---|---|---|---|---|---|
| POSITION/NAME | ANNUAL SALARY | MONTHS ON PROJECT | % OF TIME ON PROJECT | AMOUNT REQUESTED FROM COMMISSION | FRINGE BENEFITS | % OF FRINGE BENEFITS | OTHER SOURCES OF SUPPORT (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

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

Condition (s):

## SECTION I: PERSONNEL AND FRINGE BENEFITS – INSTRUCTIONS

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

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 devote exclusively to the project under this grant; for example, a 40-hour per week agency employee who provides 20 hours of service on this project would be listed as 50%.

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

a) Example: 1) An employee with an annual salary of $15,000 who works 12 months at 50% of his/her time would earn $7,500 from Commission funds; 2) An employee with an annual salary of $20,000 who works nine months at 25% of his/her time on the project would earn $3,750 from the Commission.

b) If the agency pays one rate during a probationary period with an increase after probation, state budget assumptions on separate lines for each category and provide a narrative explanation.

c) Only employees who implement services detailed in the project proposal may charge their time to 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 Fiscal Officer.**

**DO NOT SUBMIT THIS PAGE WITH RFP**

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

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

| (C) SUPPLIES, CONTRACTS, ETC.<br>(Itemize and attach written narrative justification for each item) | I. Total Budget | II. Amount Requested From Commission |
|---|---|---|
| | | |
| SUBTOTAL | | |
| **(D) LUPUS AWARENESS MONTH**<br>(Itemize and attach written narrative justification for each item) | | |
| | | |
| SUBTOTAL | | |

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

## 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 $.575 cents per mile. Example: 2,000 miles at $.52 cents = $1150.00

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. All funded grantees are required to allot funds to support Lupus Awareness Month activities in May 2013.

- Travel cost (mileage, meals, and hotel accommodations) to attend the Health Expo and Community Awards Ceremony scheduled for **March, 2015.**

B. **Equipment**:

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

- VCRs/accessories
- Portable cameras
- Television
- Computers
- Ink Cartridges
- Typewriters
- Furniture
- Vehicle purchases
- Reflotron machines
- Copiers
- Refrigerators
- Baby/infant seats, etc.
- Cell phones
- Agency vehicles, maintenance/reimbursement/gas

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

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

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

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

**Printing**: Costs may include typesetting, actual printing or photocopying of recruitment/advertising material which is completed by a commercial printing company. Included also are costs for copying 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).

**DO NOT SUBMIT THIS PAGE WITH RFP**

| (E) ADMINISTRATIVE COSTS (Itemize and attach written narrative justification for each item) | 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.**

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 clause, signatures of lessee and lessor;

   d. approved rent is non-transferable from the original site to a new or relocated site.

   e. Rent will not be approved for:

      - space which is paid for by another state/federal program or private grant;
      - space in buildings purchased with federal funds;
      - space donated to the applicant agency.
      - utilities: heat, water, electricity, etc.

**DO NOT SUBMIT THIS PAGE WITH RFP**

## BUDGET JUSTIFICATION/NARRATIVE – FY 2016 ☐ ADDITIONAL SHEET ATTACHED

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

Agency Name: _____ Grant Number: SLE 2016-_____

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

**SECTION II: NON PERSONNEL:**

**A. Travel:**

**a. Minority Health Month**

**B. Equipment:(lease/rental)**

**C. Supplies, Contracts, Etc.:**

**D. Lupus Awareness Month:**

**E. Administrative Costs:**

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

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

**SFY 2016**

| Budget Category | Total Year | 1st Quarter | 2nd Quarter | 3rd Quarter | 4th Quarter |
|---|---|---|---|---|---|
| **Section I:**<br>Personnel *(salaries and fringes)*<br><br>**Section II:**<br>A. Travel<br>MHM<br>B. Equipment(lease/rental)<br><br>C. Supplies, Contracts & Other<br><br>D. Lupus Awareness Month<br><br>E. Administrative Costs | | | | | |
| **Total Project Cost**<br>**(Total of all budget categories)** | **$14,000.00** | **$** | **$** | **$** | **$** |

**SOURCE OF AGENCY SUPPORT**

LIST ALL SOURCES OF AGENCY SUPPORT AMOUNTS WHICH WILL BE USED FOR THIS PROJECT:

**All services are free of charge and open to the public as well as the target population fundraising is prohibited under this grant fund.**

| SOURCE | AMOUNT |
|---|---|
| 1. Local Appropriations | $ _____ |
| 2. Gifts and Contributions | $ _____ |
| 3. In-kind Contributions *(itemize)* | $ _____ |
| 4. State | $ _____ |
| 5. Federal | $ _____ |
| 6. Other | $ _____ |
| **TOTAL AMOUNT OF APPLICANT MATCH (hard cash)** | $ _____ |
| **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.**

## 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**

## SECTION IV: ADMINISTRATIVE COMPLIANCE

**This Form is mandatory. Failure to respond to all questions will deem this grant application incomplete and will be disqualified. If information is cut off, use additional pages if necessary.**

**IF ADDITIONAL PAGES ARE NEEDED PLEASE ATTACH**

****This section must be completed in its entirety****

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

1. List all sources of agency funds.

2. List all sources of third-party funding.

3. Does the project's budget include documentation of 20% operational cost from sources other than the Commission?

☐ Yes ☐ No

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

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

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

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

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

**IF ADDITIONAL PAGES ARE NEEDED PLEASE ATTACH**

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.

Add a check box for the yes and no in question 6.

   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.)

**IF ADDITIONAL PAGES ARE NEEDED PLEASE ATTACH**

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.)

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.

**IF ADDITIONAL PAGES ARE NEEDED PLEASE ATTACH**

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.**)

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

**IF ADDITIONAL PAGES ARE NEEDED PLEASE ATTACH**

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.

17. Does the agency have liability insurance coverage? ☐YES ☐NO

    If yes, list company.

## SECTION V: BOARD COMPOSITION

☐ ADDITIONAL SHEET ATTACHED

| Name/Title | Age | | | Gender | | Race/Ethnicity | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | 34 | 35-50 | 51 | Male | Female | W | B | H | NAI | API |
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White, Black, Hispanic, Native American Indian, Asian/Pacific Islander

Signature Date

*(This sheet must bear original signature. IN BLUE INK)*

## SECTION VI: EMPLOYEE COMPOSITION

☐ ADDITIONAL SHEET ATTACHED

| Employee Name | Job Title | Age | | | Gender | | Race/Ethnicity | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | 34 | 35-50 | 51 | Male | Female | W | B | H | NAI | API |
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**W**hite, **B**lack, **H**ispanic, **N**ative **A**merican **I**ndian, **A**sian/**P**acific **I**slander
Include both full-time and part-time employees. Exclude temporary employees.

Signature Date

*(This sheet must bear original signature. IN BLUE INK)*

## APPLICANT CHECKLIST

**Documents listed below yield high point values for your grant application process. Please note that if any of the information is missing or omitted, the application will be returned to the agency without review.**

- ❑ Receipt of Acceptance is enclosed **as cover page with completion of information requested**.
- ❑ Review application to assure that all sections have been answered completely and budget pages are tallied correctly.
- ❑ Check to assure that appropriate signatures have been entered, dated and are in BLUE INK.
- ❑ Check all figures for typing errors and to assure that all calculations are correct.
- ❑ Include the complete State of Ohio Vendor Forms. The information should match information listed on the W-9 Form. The OCMH will process this form with Shared Services.
- ❑ Attach a copy of 501(c)(3) letter from the Internal Revenue Service
- ❑ Attach signed statement for Rehabilitation Act of 1973
- ❑ Attach signed statement for Civil Rights Act of 1964
- ❑ Attach completed and signed W-9 Form (you must use the attached form; forms before the January 2005 revision date are not acceptable.)
- ❑ Complete Board and Employee compositions forms (do not leave blank space)
- ❑ Complete questionnaires and insert Administrative of Compliance (answer all).
- ❑ Include copies of all contracts and job descriptions funded by this grant.
- ❑ Complete Project Application-All pages must be single sided.
- ❑ Complete and attach the "Program Narrative" portion of the grant application.
  - Description of Applicant Agency
  - Problem Need Statement
  - Method of Implementation
  - Project Action Plan
  - Board Resolution

- **Complete ALL BUDGET FORMS**:
  - Budget pages (personnel and anticipated periodic distribution pages must be signed by the agency executive director and fiscal officer). The executive director may not sign off on behalf of the fiscal officer as this does not show segregation of duties. This must be an original signature in Blue Ink.
- Provide Budget Narrative page (s)
- All line items must be itemized and list a unit cost for each requested expenditure.
- Vendor Information Form
- Number all pages of the grant application. All pages must be single sided.
- Specify the name of your agency on the bottom of all sheets.
- Note: ALL OF THE ABOVE FORMS, DOCUMENTS TYPE WRITTEN SECTIONS I, II, III AND IV MUST BE COMPLETED.
- The original grant application with original signatures in Blue Ink (**Signature Stamps are not acceptable**) and five (5) copies of the grant are submitted to:

**The Ohio Commission on Minority Health**

**77 S. High Street, 18th Floor**

**Columbus, Ohio 43215**

**Please double check your proposal to ensure you have included all required information. <u>Failure to submit the required documents</u> will deem your application ineligible and it will be returned without review.**

Re: Potential State of Ohio Vendor Registration

Please complete the following forms and submit them with your completed grant package to the Commission 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** - 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.

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 .

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

To obtain the form, paste the Ohio Shared Services link below, into your browser:

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

Insert an original Authorization Agreement for Direct Deposit of EFT Payments form (OBM-4310), signed in blue ink, here.

To obtain the form, paste the Ohio Shared Services Link below into your browser:

http://media.obm.ohio.gov/oss/documents/EFT+FORM+-+REVISED+01+14+2014.pdf

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