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

September 22, 2014

Re: Statewide Minority Health Coalition 2015

Dear Colleagues:

The Ohio Commission on Minority Health announces the availability of funds up to $25,000 for fiscal year 2014-2015 to support a Statewide African American Health Coalition designed to advocate for improved access to high quality and culturally competent health care, to increase the awareness of health disparities and the related strategies to improve health outcomes, to impact public policy, support public health promotion and system change to eliminate health disparities among the African American population. Grant funds will not exceed $25,000 in year one. Year two continuation funding is contingent upon successful implementation of grant requirements and the availability of funding. Projected funding for year two is $60,000.The Commission will fund up to one African American Health Coalition Grant.

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.

The Commission strongly encourages a thorough review of the application. Please allow ample time to write and fully develop the proposal. Application deadlines will not be extended.

Applicants must submit an original application along with five copies of your grant application to the Commission office located in the Vern Riffe Building located at 77 S. High Street, Columbus, Ohio 43215. Applications must be received by 5:00 pm, Friday, October 24, 2014. 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.** The original application should be signed in blue ink.

Please ensure that you allow for ample time to find parking and obtain entry into the building.

Best wishes as you prepare your application!

Sincerely,

Angela C. Dawson
Executive Director

Enclosures

Ohio Commission on Minority Health
Request for Proposals
Fiscal Years 2014-15
Statewide African American Health Coalition Grant

BACKGROUND

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

The Commission was established by Amended Substitute House Bill 171 and commenced operation on July 1, 1987. The Commission is interested in funding projects that are innovative, culturally sensitive, and specific in their approach toward reduction of the incidence and severity of those diseases or conditions that 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 2014-15.

A primary goal within the Ohio Commission on Minority Health's current strategic plan is to, "Strengthen and broaden leadership and policy agenda for addressing health disparities at all levels." Within this goal is the strategy to, "Continue to develop and strengthen the infrastructure and capacity of OCMH local offices of minority health, the OCMH ethnic coalitions, and Commission-funded agencies." At present, the Commission has supported the development of statewide ethnic health coalitions for three of its four, mandated minority health populations, Asian American, Hispanic American, and Native American. To date, the state of Ohio has no statewide African American health coalition. To that end, the measure by which the Commission would fully address the aforementioned strategy would be to engage existing partners to develop a statewide African American health coalition.

Therefore, Commission seeks to implement a statewide African American Health Coalition to implementing evidence-based policy, systems, and environmental changes that reduce health disparities among the African American population. The Centers for Disease Control and Prevention states that, "A (community) coalition is a group of individuals representing many organizations who agree to work together to achieve a common goal. A coalition brings professional and grass-roots organizations from multiple sectors together, expands resources, focuses on issues of community concern, and achieves better results than any single group could achieve alone."

INTRODUCTION

The Ohio Commission on Minority Health announces the availability of funds for a Statewide African American Coalition grant not to exceed $25,000. Grant funds will not exceed $25,000 in year one. Year two continuation funding is contingent upon successful implementation of grant requirements. Projected funding for year two is $60,000.The Commission will fund up to one African American Health Coalition Grant. 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. The grant will be awarded on a competitive bid basis to a 501 (c) (3), community-based agency or organization.

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 non-governmental public or private organization which has an active status 501 (c)(3);
- Applicants must be a pre-existing organization or coalition representing the targeted population for no less than two years and have addressing health issues as a priority within their strategic plan and/or mission statement.
- 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;
- Include no less than three collaborating agencies representing the target population within each of the five regions as determined in the map included in this RFP;
- These collaborating agencies must sign a memorandum of agreement to be members of the newly established statewide African American Health Coalition;
- Grantees must meet all licensure and certification requirements of the State of Ohio; and
- Answer all questions listed on the Administrative Compliance form.

The following are ineligible for funding consideration:

- Individuals;
- Local or State governmental entities;
- 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.

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 not to 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

This funding will support the utilization of community based organizations to develop a statewide African American Health coalition to increase the awareness of minority health disparities, broaden the leadership to address these disparities and improve minority input to policy decisions to improve minority health outcomes.

Impacting health policy along with culturally relevant health promotion and disease prevention and coalition development constitute the focus for this grant program. For state biennium 2014-15 the Commission has determined that this grant will focus on the development of an African American Statewide Health Coalition. **Applicants must comprehensively implement strategies to impact health policy to improve health outcomes within the targeted minority population.**

Priority will be given to applicants who detail how they will:

- Convene, support and coordinate the activities of a Statewide African American Health Coalition;
- Develop a collaborative membership to include no less than three organizations representing the targeted population from each of the five regions of the state as indicated on the enclosed map.
- Develop an action plan that responds to the pre-established goals which align with the overarching goals of the U.S. Department of Health and Human Services – Office of Minority Health National Stakeholder Strategy for Achieving Health Equity.
- Ensure participation of community members from the population being served to include service in leadership roles, shared decision making authority and, at a minimum, coalition membership in sufficient proportion to the state's population of African Americans;
- Conduct health and public policy research to inform the work of the coalition, contractors, and partners;
- Host one health policy forum in each of the five regions of the state
- Obtain a 501c3 for the newly formed Statewide African American Health Coalition by May 2015 with an established strategic plan and operational board with members representing each region of the state.
- Provide training and technical assistance to build the capacity of community members, the coalition, contractors and partners on:
    - policy approaches to address health disparities within the African American population in Ohio, including promotion of policy, systems and environmental changes that increase opportunities for increased access to a more diverse culturally competent workforce and increased health parity;
    - Economic development to promote sustainability of the statewide coalition and its activities to include skills for effective:
        - Grant seeking skills
        - Collaboration
        - Partnership building

Attention should be paid to 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 outcomes.

PROGRAMMING REQUIREMENT

All funded grantees must:

- Attend the OCMH Minority Health Month Kickoff in March 2015
- Complete an agreement of terms and respond to special conditions
- Submit quarterly fiscal and programmatic reports

FUNDING

The Request for Proposals has a maximum funding ceiling of $25,000 per applicant agency for State Fiscal Year 2015. **ONLY ONE APPLICATION WILL BE ACCEPTED PER AGENCY**. October 1, 2014 through June 30, 2015, constitutes the funding period covered by this RFP. Grants will be awarded in November 2014 with an immediate startup required.

The Commission will not consider funding for proposals:

- which seek funding to support residential services;
- when treatment constitutes the primary service;
- which requests funds for the purpose of construction or renovation;
- to conduct research and/or studies independent of service delivery;
- 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, that did not attempt to institutionalize the services.

APPLICATION DEADLINE/PROPOSAL PREPARATION

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

All applications must be received by 5:00 p.m., Friday, October 24, 2014. 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.**

Please note our offices are on the 18th Floor, therefore, 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

NOTE: Applicants are strongly recommended to participate in the technical assistance webinar sessions. Visit our website for dates and times.

PROPOSAL PREPARATION (15 page limit)

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. Include a copy of 501(c)(3) status, most recent audit report and board resolution. *(Not included in the page count).*

I. Proposal Narrative

A. Description of Applicant Agency

- Describe the agency's mission and mandate.
- Describe history of the coalition and provide an overview of the coalition past activities including consumer membership. 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 projects implemented to date with the targeted population and the results.
- Describe the coalition's history on health issues an policy development/recommendations. (If organization does not have policy development experience, please provide a detailed overview of your efforts to expand the coalition's capacity to address health policy).
- Describe facility where coalition activities will be based including days and hours of operation.
- Provide a chart of the proposed project's organizational structure.

B. Problem Need Statement

Provide an overview of the need for health coalitions and policy efforts to impact African American health disparities.

Include 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 forum participants to be served, meetings projected to attend, etc.), geographical area(s), or similarly disadvantaged area(s) to be served and sources of community support.

Submit letters of commitment from appropriate organizations along with Memorandums of Agreement from no less than three organizations that serve the targeted population within each of the five regions of the state. The memorandums of agreement must outline the activities or services the will provide to the project.

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)*

D. Project Action Plan – FY 2015 *(use format found on attached form)*

The Project Action Plan must respond to the pre-established modified goals which align with the overarching goals of the U.S. Department of Health and Human Services – Office of Minority Health National Stakeholder Strategy for Achieving Health Equity. Grantees are encouraged to use this document and the corresponding strategies as a resource in the development of the action plan.
Please see the attached link for this document:
http://minorityhealth.hhs.gov/npa/templates/content.aspx?lvl=1&lvlid=33&ID=286

- **Mandatory Goals:**

  Program Goal 1: Increase awareness of the significance of health disparities, their impact on the state, and the actions necessary to improve health outcomes for the targeted population in Ohio.
  Program Goal 2: Increase and broaden the leadership for addressing health disparities at all levels and initiate state and local public health policy activities to impact health outcomes of the targeted population.
  Program Goal 3: Increase access to quality health care and improve healthcare outcomes for the targeted population in Ohio.
  Program Goal 4: Improve cultural and linguistic competency and the diversity of the health related workforce in Ohio.
  Program Goal 5: Improve data availability, and coordination, utilization and diffusion of research and evaluation outcomes for the targeted population.

All of the overarching goals must identify SMART objectives of the project that are clearly defined and measurable. 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 quarterly SMART objectives, which are focused on impact rather than process outcome (hiring staff, etc.). Outcome focused objectives are designed to create measurable knowledge changes. SMART objectives refer to objectives that are **S**pecific, **M**easurable, **A**chievable, **R**ealistic and **T**ime-based. A sample template for a SMART objective is as follows:

By the end of the second quarter, 45 out of 50 or (90%) of the health forum participants will indicate in increase in knowledge of health disparities that impact African Americans.

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 activities/services to be provided;
- proposed location(s) of activities;
- how the target population(s) will be involved in the administration and execution of the grant;
- how the project will ensure that the activities reflect the target population's attitudes, values and beliefs;
- how the project will ensure that all five regions of the state are represented and are actively involved in planning and implementation
- how the project will ensure that activities are located within each region of the state

F. Evaluation

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, documenting intervention and assess the degree to which intended objectives are achieved by clients or agency. The evaluation plan should include community participant feedback forms and obtain basic demographics and baseline information and to measure changes in knowledge and awareness levels and satisfaction measures.

G. **Budget Forms**

Use the attached budget pages to provide cost associated with developing and implementing your proposed demonstration grant. Instructions are on the reverse side of 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 to review this EO.)

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

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

PROPOSAL EVALUATION / 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 evaluation criteria. The weighing 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 evaluation criteria. Grants will be awarded to the highest ranking applicants who represent a combination of geographic, demographic and service delivery/program activity mix, targeted to ethnic/racial groups, and policy and awareness focus identified by the Commission.

Review Criteria for Applications

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

I. Service Area Design

- There is clear documentation of the identification of a disproportionately at-risk population.
- There is a provision of an overview of the ability to represent the population at statewide level
- 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. Innovativeness and Impact

- The project is designed specifically for the proposed target population and includes a mechanism to determine community satisfaction.
- The project will result in some measurable impact on the identified population.
- The applicant states expected outcomes 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 and can be reasonably addressed during the grant period and can be accomplished with the dollars available for the project.

IV. Budget Appropriateness and Reasonableness

- Administrative Code 3704-2-02 states**:** ***"That at least twenty percent of applicant funds and/or resources are received from sources other than grants awarded by the Commission on Minority Health"***. In other words, the Commission cannot be the sole funding source of an agency. This 20% should not be perceived as matching funds and in-kind sources can be used.
- Specified line item costs are appropriate and reasonable/justifiable.
- Costs support grant activities.

NOTE:	Please double-check your grant proposal for accuracy and completion. Missing pages, omitted sections and mathematical errors may result in disqualification.

John R. Kasich
GOVERNOR

Gregory L. Hall, MD
CHAIRPERSON

COMMISSION ON MINORITY HEALTH

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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)

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: MGS 2015_____

ENCLOSE WITH ORIGINAL APPLICATION AND FIVE COPIES. DO NOT ATTACH.

INSTRUCTIONS FOR COMPLETION OF RECEIPT OF ACCEPTANCE

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.: Self-explanatory.

Amount Requested: Self-explanatory.

Project Name: The name assigned to this activity or service. The project name cannot 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 that 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.

PROJECT APPLICATION

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

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

MGS 2015 - _____

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: October 1, 2014 through June 30, 2015

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.

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

g. That the applicant agency is in compliance with:

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

____ Statement of compliance submitted herewith

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

____ Statement of compliance submitted herewith

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

(A) _____ _____

Signature of Agency Director Date

(B) _____ _____

Signature of Auditor or Fiscal Officer 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.

B. Original signature of the applicant agency Fiscal Officer and date.

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

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

_____

_____
Applicant's mailing address

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

HHS-441 (Rev: 12/82)

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

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.

Insert W-9 Here

Insert Vendor Forms

PROJECT ACTION PLAN – FY 2015

Agency Name:_____

The applicant must use the modified goals listed below from the United States Department of Health and Human Services – Office of Minority Health National Stakeholder Strategy for Achieving Health Equity overarching goals in the implementation of this application.

Applicants must complete the action plan using these established goals to address disparities and achieve health equity.
Please complete the set of questions below for each project goal. Each goal can have multiple SMART objectives. However, each goal must have **at least one** SMART objective. The Project Action Plan must list goals and SMART objectives of the project that are clearly defined and measurable. Project time frames must be quarterly and 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 quarterly SMART objectives, which are focused on impact rather than process outcome (hiring staff, etc.). Outcome focused objectives are designed to create measurable knowledge changes. SMART objectives refer to objectives that are **S**pecific, **M**easurable, **A**chievable, **R**ealistic and **T**ime-based.

The following objective is an example of a SMART objective:

By the end of the second quarter, 45 out of 50 or (90%) of the policy health forum participants indicate an increase in knowledge regarding health disparities.

Program Goal 1: Increase awareness of the significance of health disparities, their impact on the state, and the actions necessary to improve health outcomes for the targeted population in Ohio.
Program Goal 2: Increase and broaden the leadership for addressing health disparities at all levels and initiate state and local public health policy activities to impact health outcomes of the targeted population.
Program Goal 3: Increase access to quality health care and improve healthcare outcomes for the targeted population in Ohio.
Program Goal 4: Improve cultural and linguistic competency and the diversity of the health related workforce in Ohio.
Program Goal 5: Improve data availability, and coordination, utilization and diffusion of research and evaluation outcomes for the targeted population.

Please number goals and corresponding objectives as follows:
Goal 1
Objective 1a
Objective 1b

Goal 2
Objective 2a
Objective 2b

Activity Information (Must complete for each SMART objective)

First Quarter SMART Objective 1:

Title of Activity:

Expected Date of Activity: Beginning Date: MM/DD/YYYY Ending Date: MM/DD/YYYY Occurs: Weekly Bi-Weekly Monthly

Duration of Activity: __ hours

Number of Anticipated Participants:

Anticipated Location of Activity:
(Street Address)

City: State: Zip:

Facility Phone Number: ( ) 000-0000

Responsible Staff Member:

Responsible Staff Person's Grant title:

Responsible Staff Member's

Responsible Staff Member's E-Mail:

Telephone Number: ( ) 000-0000

Fiscal Year 2015
Budget Pages

SECTION I: PERSONNEL AND FRINGE BENEFITS FY 2015

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

Agency Name: _____ Grant #: MGS 2015-_____

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 Date

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

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

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

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

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

(A) TRAVEL (Itemize and attach written narrative justification for each item. Do not include MHM)	**I. Total Budget**	**II. Amount Requested From Commission**
SUBTOTAL		
(B) EQUIPMENT - Rental/Leasing only (Itemize and attach written narrative justification for each item)		
SUBTOTAL		

(C) SUPPLIES, CONTRACTS, ETC. (Itemize and attach written narrative justification for each item)	I. Total Budget	II. Amount Requested From Commission
SUBTOTAL		
(D) Policy Health Forums (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 $.52 cents per mile. Example: 2,000 miles at $.45 cents = $1040.00
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 $90.00 plus room tax (if applicable).
iii. Meal expenses are allowable for dinner and breakfast when on an approved overnight stay, not to exceed $56.00 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. Grantees will be required to attend the OCMH Minority Health Month Kick off. Travel expenses must be included in this section.

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
- Typewriters
- Furniture *(will provide state/federal salvage applications to successful grantees)*
- Vehicle purchases
- Reflotron machines
- Copiers
- Refrigerators
- Baby/infant seats, etc.

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

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

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

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

Printing: Costs may include typesetting, actual printing, or photocopying of the material that 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).

D. Health Policy Forums:

All funded grantees are required to allot funds to support:

- At least five (5) health policy with one in each region of the state
- Forum cost must be detailed within the budget document
- Detailed information about these events will be discussed at the Technical Assistance Session.

(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)		

TOTAL AGENCY SUPPORT $_____
(This could represent 20% of funds from other sources, and may be verified by the Commission.)

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
    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 must be itemized and list unit costs.)

Agency Name: _____ Grant Number: MGS 2015 -_____

SECTION I: PERSONNEL AND FRINGE BENEFITS:

SECTION II: NON-PERSONNEL:

A. Travel:

B. Equipment:

C. Supplies, Contracts, Etc.:

D. Health Policy Forums:

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 2015

BUDGET CATEGORY	Total Year	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter
A. Personnel *(salaries and fringes)*					
B. Travel					
C. Equipment					
D. Supplies, Contracts & Other					
E. Health Policy Forums					
F. Administrative Costs					
Total Project Cost (Total of all budget categories)	$	$	$	$	$

SOURCE OF AGENCY MATCH

LIST ALL SOURCES OF AGENCY SUPPORT AMOUNTS THAT WILL BE USED FOR THIS PROJECT:
Fundraising is prohibited under this grant.

SOURCE	AMOUNT
1. Local Appropriations	$
2. Gifts and Contributions	$
3. In-kind Contributions *(itemize)*	$
4. State	$
5. Federal	$
6. Other	$
TOTAL AMOUNT OF AGENCY SUPPORT	$
TOTAL AMOUNT REQUESTED FROM COMMISSION	$

Executive Director Date

Fiscal Officer 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.

This section is mandatory. Failure to respond to all questions will deem this grant application incomplete and will be disqualified.

SECTION IV: ADMINISTRATIVE COMPLIANCE FY 2015

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

1. List all sources of agency funds.

2. List all sources of third-party funding.

3. Does the project's budget include documentation of 20% operational costs from sources other than the Commission?
   ☐ YES ☐ NO

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

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

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

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

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

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.)

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

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.**)

13. Are project funds budgeted for equipment, supplies and contracts? ☐ YES ☐ NO (If No, please go to **Question #14**) (include additional pages if necessary)

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.

SECTION V: BOARD COMPOSITION

☐ ADDITIONAL SHEET ATTACHED

Name/Title	Age			Gender		Race/Ethnicity				
	34	35-50	51	Male	Female	W	B	H	NAI	API

White, **B**lack, **H**ispanic, **N**ative **A**merican **I**ndian, **A**sian/**P**acific **I**slander

Signature Date

*(This sheet **must** bear original signature.)*

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

White, **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.

APPLICANT CHECKLIST

(Do not return to Commission)

- ☐ Receipt of Acceptance attached to the top of each application *(copy & originals)*.
- ☐ Review application to assure that all sections have been answered completely.
- ☐ Check to assure that appropriate signatures have been entered and dated.
- ☐ Check all figures for typing errors and to assure that all calculations are correct. *(Does budget match budget narrative?)*
- ☐ Attach a copy of 501 (c)(3) letter from the Internal Revenue Service.
- ☐ Attach statement for Rehabilitation.
- ☐ Attach statement for Civil Rights.
- ☐ Attach completed W-9 Form (*you must use the attached form; forms before the November 2005 revision date are not acceptable*.)
- ☐ Include a copy of the agency's most recent audit.
- ☐ Include copies of all contracts and job descriptions funded by this grant.
- ☐ Complete and attach the "Program Narrative" portion of the grant application.
- ☐ Complete and attach the "Project Action Plan" portion of the grant application.
- ☐ Complete descriptions of the mandatory "Health Policy Forums" portion of the grant application.
- ☐ Number all pages of the grant application.
- ☐ Specify the name of your agency on the bottom of all sheets.
- ☐ The original with original signatures and five (5) copies are submitted.
- ☐ 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.

State of Ohio Regions

County	Region	Region Number
Allen	Northwest	1
Auglaize	Northwest	1
Crawford	Northwest	1
Defiance	Northwest	1
Erie	Northwest	1
Fulton	Northwest	1
Hancock	Northwest	1
Hardin	Northwest	1
Henry	Northwest	1
Huron	Northwest	1
Lucas	Northwest	1
Mercer	Northwest	1
Ottawa	Northwest	1
Paulding	Northwest	1
Putnam	Northwest	1
Sandusky	Northwest	1
Seneca	Northwest	1
Van Wert	Northwest	1
Williams	Northwest	1
Wood	Northwest	1
Wyandot	Northwest	1
Delaware	Central	2
Fairfield	Central	2
Franklin	Central	2
Knox	Central	2
Licking	Central	2
Madison	Central	2
Marion	Central	2
Morrow	Central	2
Pickaway	Central	2
Richland	Central	2
Union	Central	2
Ashland	Northeast	3
Ashtabula	Northeast	3
Columbiana	Northeast	3
Cuyahoga	Northeast	3
Geauga	Northeast	3
Holmes	Northeast	3
Lake	Northeast	3
Lorain	Northeast	3
Mahoning	Northeast	3

County	Region	Region Number
Medina	Northeast	3
Portage	Northeast	3
Stark	Northeast	3
Summit	Northeast	3
Trumbull	Northeast	3
Wayne	Northeast	3
Adams	Southwest	4
Brown	Southwest	4
Butler	Southwest	4
Champaign	Southwest	4
Clark	Southwest	4
Clermont	Southwest	4
Clinton	Southwest	4
Darke	Southwest	4
Fayette	Southwest	4
Greene	Southwest	4
Hamilton	Southwest	4
Highland	Southwest	4
Logan	Southwest	4
Miami	Southwest	4
Montgomery	Southwest	4
Pike	Southwest	4
Preble	Southwest	4
Ross	Southwest	4
Scioto	Southwest	4
Shelby	Southwest	4
Warren	Southwest	4
Athens	Southeast	5
Belmont	Southeast	5
Carroll	Southeast	5
Coshocton	Southeast	5
Gallia	Southeast	5
Guernsey	Southeast	5
Harrison	Southeast	5
Hocking	Southeast	5
Jackson	Southeast	5
Jefferson	Southeast	5
Lawrence	Southeast	5
Meigs	Southeast	5
Monroe	Southeast	5
Morgan	Southeast	5
Muskingum	Southeast	5
Noble	Southeast	5
Perry	Southeast	5

County	Region	Region Number
Tuscarawas	Southeast	5
Vinton	Southeast	5
Washington	Southeast	5