COMMISSION ON MINORITY HEALTH

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GOVERNOR

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August 10, 2015

Dear Colleagues:

The 2016/2017 State of Ohio Biennial Budget provided an increase in funding to the Ohio Commission on Minority Health (Commission). This funding will allow for the Replication and Expansion of the Certified Pathways Community HUB Model to address infant mortality. In light of that, the Ohio Commission on Minority Health announces the availability of funds for fiscal years 2016/2017 to support model expansion and replication grants. This is a competitive-bid process.

This funding will provide support to expand three existing Pathways Community HUBs and this funding will also provide support for the replication and implementation of ***three new*** Pathways Community HUBs. The three new HUBS must be located in and target services within one of the following areas: Akron, Cleveland, Columbus, Dayton, Youngstown and Southeast Ohio. Please note the Commission will only award funding for the development of three New Pathways Community HUBs within three of the identified six areas of the state which are listed above.

Please note, this grant mandates the: adoption and implementation of the "Pathways Community HUB Model, the achievement of Pathways Community HUB model certification as a condition of funding along with required clinical measures and pathways measures which are not optional to demonstrate projected outcomes. Applicants must demonstrate the ability to implement quarterly clinical and pathways measures and evaluate program effectiveness.

Attached is the Request for Proposal that provides detailed submission guidance, criteria for funding and grant requirements. 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. I strongly encourage you to thoroughly read the application and to attend the Technical Assistance session (TA) via webinar. The Technical Assistance session will discuss the grant application process and provide information to assist you in the development of your proposal. The schedule for TA sessions will be available on our website on August 10, 2015.

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, September 28, 2015.

Please be aware that you will need to allow yourself adequate time to park and clear the security process if you are hand delivering your application. You have our best wishes as you prepare your application.

Sincerely,

Angela C. Dawson

Angela C. Dawson
Executive Director

Ohio Commission on Minority Health
Request for Proposals
Fiscal Years 2016-17
Certified Pathways Community HUB Model
Expansion/Replication Infant Mortality Grant

BACKGROUND

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

The Commission was established by Amended Substitute House Bill 171 and commenced operation on July 1, 1987. The Commission is interested in funding projects which are innovative, culturally sensitive and specific in their approach toward reduction of the incidence and severity of those diseases or conditions which are responsible for excess morbidity and mortality in minority populations. In 2000, the Commission provided seed funding to support the Community Health Access Project who helped to develop the Community Pathways HUB Model. Since then the Commission has funded the implementation of this model through our demonstration grant funding program.

The 2016/2017 State of Ohio Biennial Budget provided an increase in funding to the Ohio Commission on Minority Health. This funding was allocated to initiate the Certified Pathways Community HUB Model Expansion and Replication – Infant Mortality funding opportunity. This funding will provide support to expand three existing Pathways Community HUBs and this funding will also provide support for the replication and implementation of ***three new*** Pathways Community HUBs. The three new HUBS must be located in and target services within one of the following areas: Akron, Cleveland, Columbus, Dayton, Youngstown and Southeast Ohio. Please note the Commission will only award funding for the development of three New Pathways Community HUBs within three of the identified six areas of the state. **All grantees must agree to implement the Pathways Community HUB model and obtain certification as a condition of funding.**

The HUB Model is an evidence based community care coordination approached that has also demonstrated effectiveness within racial and ethnic populations. The Pathways Community HUB Model has been endorsed by several federal agencies such as: Agency for Healthcare Research and Quality, Center for Medicaid and Medicare Services, Center for Disease Control and Prevention, Health Resources and Services Administration, National Institute of Medicine and others. Applicants for funding are encouraged to visit the Agency for Healthcare Research and Quality to view the resource tool: https://innovations.ahrq.gov/qualitytools/connecting-those-risk-care-quick-start-guide-developing-community-care-coordination

In addition, the Kresge Foundation has funded the creation of the Pathways HUB Certification Process. **All grantees must agree to be certified and/or maintain certification to retain funding.** The HUB Certification Prerequisites and HUB Certification Standards can be located in Appendix A. This Certification Process will be overseen by the Rockville Institute. For additional information on the certification process which will occur in Year 2 of this funding cycle, contact Ms. Brenda Leath at brendaleath@RockvilleInstitute.org or PCHCP@RockvilleInstitute.org. The costs for certification are an allowable cost can be located in Appendix B.

This grant initiative is designed to assist the Commission in achieving the Healthy People 2020 goals of reducing the rate of all infant deaths and the reducing preterm births by 10%. All grantees must work to achieve these established goals along with efforts to address increase early and adequate access to prenatal healthcare, timely post-partum visits, increasing safe sleep practices, access to behavioral health services and the provision of other services that decrease the social determinant of health risk factors that impact birth outcomes.

INTRODUCTION

The Ohio Commission on Minority Health announces the availability of funds for FY16/17 for Infant Mortality grants. Grant funds in will not exceed:

- Year 1 - $180,000 for Existing Pathways Community HUB applicants in FY2016
- Year 2 - $ 75,000 for Existing Pathways Community HUB applicants in FY2017
- Year 1 - $105,000 for New HUB applicants in FY2016
- Year 2 - $211,000 for New HUB applicants in FY2017

The Commission will fund up to three existing Pathways Community HUBs and the implementation of three new Pathways Community HUBs.

Amended Substitute House Bill 171 established Commission grants for the purpose of health promotion and prevention of disease among minority Ohioans who are economically disadvantaged. Minority groups are defined as African Americans, Hispanics, Native American Indians and Asians. Given that this grant is a model replication effort, All grantees will be required primary target population will be minority at-risk pregnant women, given that this grant is a model replication effort, Southeast Ohio applicants will be required to target minority at-risk pregnant women along with the majority population in their area.

This is a competitive-bid process and funding will be awarded to 501 (c) (3), community-based agencies or organizations. This Request for Proposal solicits grant applications meeting the requirements set forth in Chapter 3704 of the State of Ohio Administrative Code. Applications will be accepted exclusively from agencies or institutions meeting the eligibility criteria established by the Commission on Minority Health.

ELIGIBILITY

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

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

The following are ineligible for funding consideration:

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

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

PUBLIC RECORD NOTICE

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

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

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

FUNDING

The Request for Proposals has a maximum funding ceilings as follows: Year 1 - $180,000 for Existing Pathways Community HUB applicants in FY2016 and Year 1 - $105,000 for New HUB applicants in FY2016 per applicant agency for State Fiscal Years 2016-17. ONLY ONE APPLICATION WILL BE ACCEPTED PER AGENCY. The time period of December 1, 2015 through June 30, 2016, constitutes the first funding period covered by this RFP. Notification of funding will be in late November 2015. As with all grants, funding is contingent on the availability of funds. Grants will be effective December 1, 2015.

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

The Commission will not consider funding for proposals:

- Which seek funding to support residential services;
- When treatment constitutes the primary service;
- Which request funds for the purpose of construction or renovation;
- To conduct research and/or studies independent of service delivery;
- Which are legislatively mandated and funded by other public dollars;
- Exclusively designed to conduct conferences or workshops; or
- Agencies, previously funded by the Commission on a fiscal year or biennial grant award using the same model to continue service delivery.
- Agencies, previously funded by the Commission on a fiscal year or biennial grant award, with a modified model that did not obtain at least 75% of cash funding of the original award from an external source.

APPLICATION DEADLINE/PROPOSAL PREPARATION

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

PROPOSAL FORMAT

- Applications must be submitted on 8 ½ by 11 WHITE paper only. No colored paper will be accepted.
- Application must be submitted single side of paper. No double-sided pages allowed.
- Applications must be typed in Times New Roman or similar font and must be12 point in size.
- Applications must not exceed 55 total pages, this does not including Commission application documents.
- Applications must clearly indicate ORIGINAL and COPIES and must be stapled or attached with paper clips.
- All signatures must be signed in BLUE INK.
- No binders or separation tabs permitted.

All applications must be received in our offices by 5:00 p.m., Monday, September 28, 2015. Any application or supporting documentation received after that date and time will be returned without review. The proposal must be typed on Commission forms.

FAXED, EMAILED AND HANDWRITTEN APPLICATIONS WILL NOT BE ACCEPTED.

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

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

PROPOSAL PREPARATION

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

Technical Assistance Session:

Register now!

Pathways Community HUB Model Expansion/Replication Webinar

Join us for a webinar on August 19, 2015 at 10:00 AM EST. Register now!

https://attendee.gotowebinar.com/register/1563236522168301058

OR

Join us for a webinar on August 20, 2015 at 2:00 PM EST. Register now!

https://attendee.gotowebinar.com/register/6237031753425493250

The technical assistance sessions will be conducted on Wednesday, August 19, 2015 at 10:00 am and on Thursday, August 20, 2015 at 2:00 pm. Please note that we will not be able to accommodate individual requests to provide this information.

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

We anticipate a higher than usual response to this grant solicitation. Please allow ample time to write your response and fully develop your application. Do not provide brief items of information assuming that your agency is known to the Commission. We use external reviewers so it is important that you use concise, but comprehensive responses.

Please remember to submit the agency's 501(c) (3) IRS status letters with the grant application.

Complete the following Commission application documents: Receipt of Acceptance, assurances and compliance forms, W-9, and vendor forms, budget forms. All forms must have original signature in blue ink. Include a copy of applicant agency 501(c) (3) status, the applicant agency most recent audit report (1 copy of audit only) and board resolution. Agency must include a board resolution on agency letterhead approving the submission of the application. The resolution must be signed in blue ink. *(These pages are not included in the page count).*

Grant Participation Requirements:

The Ohio Commission on Minority Health expects successful applicants will be able to meet the following grant requirements.

1. All grant recipients must read, sign and complete the Acknowledgement of Terms (AOT) to include addressing assigned program and fiscal special conditions. The Acknowledgement of Terms will be provided to grant recipients after the awarding of the grant.

2. All grantees must attend a mandatory four day, grant start up orientation and Community Pathways HUB training in Columbus, Ohio. Therefore, applicants must account for travel, meal and lodging within their program budget. The State will reimburse based on rates for lodging within the Continental United States (CONUS) set by the federal General Administration (GSA). Mileage reimbursement may not exceed the State of Ohio rate of $.52 per mile.

3. All funded agencies must agree to enter their data into the Care Coordination System which was developed for the HUB Pathways Model. http://carecoordinationsystems.com/. (The costs related to Care Coordination Systems are estimated to be up to $25,000 per year; pro-rated as needed. This is an allowable cost.)

4. All funded agencies must provide the Commission's Research Evaluation Enhancement Program (REEP) access to their data within the Care Coordination System to allow for review, analysis, and monitoring of aggregate data and related information.

5. All funded agencies must track, monitor and report on client services and pathways and provide updates to the CCS data system in a timely manner to ensure monthly reports are accurate.

6. All grantees must provide quarterly program, fiscal and evaluation reports to update the Commission on program progress and outcomes to date.

7. All grantees must participate on monthly statewide HUB calls on a standing date to be shared in the AOT.

8. Existing Pathways Community HUB applicants must:
   a. Obtain certification prior to receipt of funding.
   b. Coordinate with the OCMH to provide HUB orientation training.
   c. Agree to mentor an assigned agency implementing a new HUB replication.
   d. Establish required on-going regular communication with the assigned "New HUB".
   e. Expand HUB service delivery within one month of funding.
   f. Provide Pathways care coordination services within the first month of funding to the targeted at-risk population.
   g. Expand staff as needed within the first month of funding.

9. New HUB Grantees must agree to:
   a. Participate in HUB model orientation training.
   b. Implement recruiting and hiring of staff within the first month of funding.
   c. Adopt and implement the Pathways Community HUB model within 90 days of funding.
   d. Begin the certification process within 6 months of Pathways HUB model service implementation.
      (The costs related to the certification process is an allowable costs up to $15,000 in Year two – see Appendix 2 certification cost information.)
   e. Obtain Certification no later than May 2017.
   f. New Pathways Community HUB applicants and identified HUB care coordination agencies must agree to replicate the Model and participate in HUB Model training and mentoring process.
   g. Participate in on-going communication with assigned "Existing HUB".

10. All funded grantees must comprehensively address reduction/elimination of known risk factors through the implementation of the 20 Pathways and monitor these risk factors through a quality improvement program and data submission in a required data system.

11. All funded grantees must participate in the OCMH Minority Health Month Expo activity for 2016/ 2017. This statewide visibility campaign is held each year Columbus Ohio on the last Thursday in March of 2016 and 2017. In an effort to raise awareness about health disparities, OCMH funded agencies are required to set up a display table at the annual event.

12. All grantees must create or maintain a Community Pathways HUB Advisory Board. This Community Advisory Board shall include no less than one member who has received services from the community HUB.

13. Each existing HUB must deliver services to a minimum of 125 at-risk pregnant women prioritizing minority women within FY16.

14. Each new HUB must deliver services to a minimum of 50 at-risk pregnant women prioritizing minority women within FY 16.

15. Each existing HUB must deliver services to a minimum of 100 at-risk pregnant women prioritizing minority women within FY17.

16. Each new HUBS must deliver services to a minimum of 125 at-risk pregnant women prioritizing minority women within FY17.

17. 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.

18. All grantees are required to submit: Annual Program Evaluation Reports, a 2016 Annual Program Reports and a 2017 Biennial Program Report by the required deadlines.

Proposal Narrative

1. Description of Applicant Agency

   a. Provide a statement(s) of competencies to implement the project requirements, why the applicant is best suited to implement and achieve the projected goals, as well as the applicant's and it HUB partner's connection to the community (ies) to be served. Each applicant must provide evidence of its ability to lead community interventions to address infant mortality disparities. Evidence of this ability may include: documentation of past efforts of leading community interventions to address health disparities; reports of improved indicators by population, age, socioeconomic status; published articles, public reports or documents specific to improvement in health status.

   b. Applicant should include the agency's mission and mandate, successful and previous involvement with minority populations, description of how this project will enhance the agency's service delivery capacity, areas of expertise, key personnel, and credentials of proposed staff, job technical experience and unique capabilities. Describe agency's plan to ensure that assigned program staff are culturally/linguistically competent. Applicants should include key staff job descriptions, contracts of staff assigned, and resumes of staff assigned to the grant.

   c. Describe the planning process that led to the development of this proposal to create a Pathways Community HUB. Provide a description of the existing or proposed HUB's mechanism or plan to communicate its strategies, programs and progress to the community it serves.

   d. Provide a description of the existing or proposed HUB's infrastructure and capacity to fully implement the Pathways Community HUB model. Describe the HUBS plan to coordinate the network of care coordination agencies targeting most at-risk clients. The HUB musts have adequate infrastructure to track and document the delivery of services to those at-risk and must have the capability to document the Pathways process and outcomes, process payments to care coordination agencies and contract with an invoice payers.

   e. Provide a description of the capacity to assess and monitor each at-risk client and to provide care coordination services. Provide a table that lists the care coordination agencies and the services that each agency will provide to address the medical, behavioral health, social, environmental and educational needs of pregnant women who are most at-risk. Current or potential care coordinating agencies that will contract through the HUB.

   f. The Applicant agency must submit copies of written agreements with each of the care coordination agency members. Applicant must submit Memorandums of Agreement from the HUB partner agencies which clearly identify their roles and responsibilities and a commitment to work through the HUB. These signed agreements must contain language that requires the care coordination agencies to use the standardized Pathways. These signed agreements must outline the staff, activities and/or services they will provide to the project and generally describe how this project will impact/improve the identified problem. The originals must be signed in blue ink.

   g. The community and / or region the HUB is or proposes to serve. (i.e., geographic service area - census tracts, zip codes, county, region; and Physical address of the HUB; and Physical addresses of contracted care coordination agencies; and if the HUB covers more than one county (regional), then an explanation of how and why this service area was established.) Describe the facilities where services will be provided including days and hours of operation and their accessibility to the population. Describe how the technical accuracy of the project's health component will be assured.

h. Provide a description of the existing or proposed HUB's plan to promote collaboration, intersectoral teamwork as well as community-clinical linkages

i. Provide a description of the plan to hire or retain a HUB Director who possess the experience and skills to effectively manage the HUB including a commitment to community health and equity as well as strong business and communication skills.

j. Provide a description of how the existing or proposed HUB is a neutral entity and how it operates in a transparent and accountable manner. Include a copy of your policy that describes the criteria and process to refer clients to care coordination agency members. This policy includes how referrals are distributed when a client meets the eligibility requirements;

2. Problem Need Statement

a. Identify and define the problems related to infant mortality and factors contributing to poor birth outcomes that will be addressed by your program. Describe and document (with data) demographic information on the disparities with emphasis on the geographical areas that will be the focus of the project and the significance or prevalence impacting the target minority group. Support this information with statistics, research findings, or other documentation pertinent to your community/target population.

b. Define the specific HUB target areas such as counties, communities, zip codes and/or census tracks.

c. Provide a statistical overview of the existing issues or social determinants of health that impact birth outcomes in the targeted areas, and identify the at-risk population needs to be addressed by the proposed project.

d. 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.

e. Describe the community needs assessment(s) that included local data specific to medical, behavioral health, social, environmental and educational factors that guides the existing or proposed HUB in its efforts to improve health and reduce inequities.

3. Project Abstract

a. Provide a summary of the proposed project to include goals and objectives along with a concise overview of the purpose, rationale and methodology to be utilized by the project. *(Limit = 500 words or less)*

4. Project Action Plan

The Project Action Plan must list goals and SMART objectives with the projected number of participants to be served for the first year of the project that are clearly defined and measurable in process and client behavior outcomes. According to the Centers for Disease Control and Prevention, SMART objectives are:

Specific: Concrete and well defined so that you know where you are going and what to expect when you arrive
Measureable: Numbers and quantities provide a means of measurement and comparison. All goals should project the number to be achieved vs. the number served.

(Example: During FY16, 200 pregnant at risk women will be served with 160 or 80% being minority at risk pregnant women. This allows for monitoring goal achievement on a quarterly basis.)
Achievable: Feasible and easy to put into action
Realistic: Considers constraints such as resources, personnel, cost, and time frame
Time-Bound: A time frame helps to set boundaries around the objective

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.

The Project Action plan must be formatted using the following items: Numbered Goals, Numbered SMART Objectives, Approach (How will you do it?), Activities (What will take place), Evaluation (Anticipated results, which tools used to collect data), Responsibilities (Who will be responsible?), and Timeline (Time frame in which each activity will take place.) An example of the Project Action Plan can be located in Appendix C.

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

At a minimum, all applicants must address the following Goals and Outcome Objectives in their Project Action Plan:

Goal 1: Replicate or Expand the Pathways Community HUB

1.1 Project the number of staff who will participate in the HUB model orientation training.
1.2 Project the number of HUB care coordination agencies you will have and the services they will deliver.
1.3 Project your timeline to train the HUB agencies in the required model.
1.4 Project the number of payers that will support the HUB model implementation in the first year.
1.5 Project the development of the quality improvement plan.

Goal 2: Reduce and Eliminate Ohio's Infant Morality Rate

2.1 Project the number of women to be served with no less than 80% being at-risk minority pregnant women. (The exception being Southeast Ohio grantees who must target minority women in their service area.)
2.2 Project the number of women to be enrolled during the first trimester of pregnancy, and second trimester of pregnancy of the total women served.
2.3 Project the number of prenatal visits to be achieved for those enrolled in the 1st, and 2nd trimester of total entered into the program.
2.4 Project the number of enrolled women who will achieve a healthy birth weight baby of the total babies born.
2.5 Project the number of babies born who achieve a birth weight or preterm birth rate better than the county or target area as a whole.
2.6 Project the number of women without healthcare coverage who will be enrolled in Medicaid and/or the Federal Marketplace and have a medical home who have no access to medical care of the total women served.
2.7. Project the number of infants born who will secure a medical home and begin well baby visits within 1 month of birth of the total infants served.
2.8 Project the number of women enrolled with who attend post-partum visits within 21-56 days of giving Birth to the total women served.

2.9 Project the number of at risk pregnant who will receive safe sleep training.

Goal 3: Reduce and eliminate Social Determinants as pre- and post-natal service delivery barriers that most often prevent pregnant mothers from receiving pre-natal care.

3.1 Project the number of women who will complete the pathway who are referred for community referral to, and follow up for educational attainment services and resources.
3.2 Project the number of women who will complete the pathway who are referred for community referral to, and follow up for employment services and resources.
3.3 Project the number of women who will complete the pathway who are referred for community referral to, and follow up for housing attainment and resources.
3.4 Project the number of women who will complete the pathway who are referred for community referral to, and follow up for behavioral health services and resources.

Goal 4: Target, monitor and report on all 20 Pathways within data system.

4.1 Explain how your HUB has or will obtain this web-based software, conduct training for HUB agencies and implementation, and report outcomes to the commission.
4.2 Track, monitor and report on client services and pathways within the data system.
4.3 Provide Commission (REEP) access to aggregate data.

Goal 5: Obtain/Retain Certification

5.1 Participate in certification orientation training and mentoring sessions.
5.2 Project Certification Status completion
5.3 Project status on meeting each of the HUB Certification prerequisites
5.4 Project the number and percentage of achievement of the HUB standards

5. Model Adoption and Implementation

Provide a comprehensive narrative describing the applicant agency and the participating HUB agencies ability to adopt the Certified Pathways Community Hub model. The explanation should at a minimum include:

a. Describe the current mechanism or plan to ensure that staff of the HUBs and HUB care coordination agencies receive training on the HUB model, to include a description of the current mechanism or plan to ensure implementation of a continuous quality improvement plan, program competent supervision, and adequate staff training.

b. Participation in the ongoing mentoring calls and face to face sessions.

c. Capacity to adopt the model and begin implementation within 90 days of funding.

d. A description of the applicant's capacity to reach the projected number of individuals.

e. Provide a description of the HUB's mission, program goals, and objectives.

f. Provide the proposed days and hours of operation and location(s) of activities date/month.

g. Provide a description of the culturally-specific components that reflect the target population's attitudes, values and beliefs to include a description of the current mechanism or plan to ensure that staff of the HUBs and HUB care coordination agencies receive cultural and linguistic training and provide culturally and linguistically proficient services.

h. Provide a description of the HUB's or proposed HUB's ability to comprehensively address the reduction and elimination of known risk factors through the implementation of the 20 Pathways and monitor these risk factors through data submission in a required data system.

i. Explain who the existing HUB or new Hub contracts with or plans to contract with to pay for care coordination outcomes. Explain how the HUB will document the payment process to care coordination agencies, and contract with and invoice payers.

j. Provide a sample of how outcomes are paid, i.e., demonstrate what triggers a funder to make a payment to the HUB and for the HUB to make payment to a care coordination organization.

k. Describe the current mechanism or plan to ensure a level of staff training at the HUBs and HUB care coordination age to demonstrate compliance to HIPPA, continuous quality improvement, competent supervision, and adequate staff training.

l. Provide a copy of your HIPAA Agreement that will be signed between the HUB and care coordination agencies and how you train staff and contractors on HIPAA.

m. Provide confirmation that the HUB does not refer to any community care coordinators that it may employ or provide a plan and timeline to refer clients to the care coordination agency members based on the needs of the clients.

n. Provide a copy of the HUB's organizational chart that includes all departments, personnel and reporting structure. If the HUB is an affiliate of a larger umbrella organization, then the relationship should be reflected.

o. Explain the target population for HUB care coordination to address infant mortality in line with the principles of the HUB model to identify and engage at-risk individuals, documenting risk factors and addressing those risk factors in a pay for performance, outcome-focused approach.

p. Document how the HUB is or will be advised by a Community Advisory Board, to include how the target population(s) will be involved; and provide a list of current members.

q. Document the applicant's understanding that this program should not be viewed as a supplement to the agency or other systems.

6. <u>Evaluation</u>

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

As an evidenced-based model, the HUB must have the infrastructure and capacity to fully implement the Pathways Community HUB Model. Therefore, the HUB must have adequate infrastructure to track and document, and monitor the delivery of services to those at-risk and must have the capability to document the Pathways process and outcomes.

All Commission funded grantees must agree to enter their data in a common data system developed for the HUB Pathways model and provide the Commission and Research and Evaluation Enhancement Program (REEP) panel of Wright State University access to review, monitor, and analyze information and aggregate data.

This grant requires implementation of clinical and non-clinical measures for the 20 Pathways. These measures must be a of the evaluation section. Organizations must demonstrate the ability to implement quarterly clinical and non-clinical measures to evaluate program effectiveness. Please ensure that you build into your plan the collection of required participant data (clinical measures, feedback) on a quarterly basis to allow for the reporting of behavioral outcomes.

a. Describe the agencies capacity to:

Provide reports to the Ohio Commission on Minority Health must include, at a minimum:

- Number and demographics of clients served
- Number of births of infants, weights of infants (normal weight, low birth weight, very low birth weight, term of birth (ie:preterm)
- Number and demographics of infants served
- Risk (Social Determinant) tracking over time
- Information by client, care coordinator, agency, and HUB
- List of standardized Pathways
- Initiated Pathways (Number of women in this status)
- Pathways in Process (Number of women in this status)
- Incomplete Pathways and
- Completed Pathways

b. Provide a description of the role of the evaluator in the program's design, implementation, the process and outcomes through the Care Coordination Systems which is designed to track, monitor, and report on client services.

c. The projected numbers for evaluation purposes must be based on those who both participate in educational programing as well as non-clinical and clinical measures.

d. Describe, in detail, the method(s) that will be used to determine whether the established standardized Pathways goals and objectives are being met by the HUB and whether the expected outcomes are being achieved.
Do not state in percentages. Limiting your responses to statements such as, "we will hire a data analyst", will be considered non-responsive.

e. Provide an overview of the valid time-lined outcomes and effectiveness of the project.

f. Provide an overview of how the current or proposed continual quality improvement plan will impact service delivery changes.

Institutional Review Board (IRB)

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

G. Year Two Project Summary

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

7. Budget Forms

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

b. Provide a budget narrative describing unit cost and itemization of each line item.

c. 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).

d. Internal capacity is an essential requirement of Commission grants.

e. All services paid for by OCMH funds must be free and without cost to the participant. Program services must be open to the public as well as the targeted population.

f. Fundraising is prohibited under this grant opportunity.

PROPOSAL REVIEW / SELECTION

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

A weighted system will be applied to the proposal criteria. The weighed system will not be shared with applicants.
The final selection process will involve a ranking system based on the weighted score, reflecting compliance with the proposal criteria. Grants will be awarded to the highest ranking applicants who represent a combination of geographic, demographic, service delivery/program activity mix, targeted to ethnic/racial groups, and diseases and conditions identified by the Commission as identified in this RFP.

Proposal Scoring
(Listing of some of the items which are considered during the review of grant applications):

I. Service Area Design

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

II. Innovation and Impact

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

III. Program Design

- The applicant has demonstrated that cultural beliefs, attitudes and practices have been considered and included in designing the program.
- Barriers to service; i.e., availability, acceptability, language and cost have been considered, and appropriate recourse is included in the approach to the project.
- The problems to be addressed are clearly stated in specific rather than general terms, can be reasonably addressed during the grant period, and can be accomplished with the dollars available for the project.
- Program design should describe the clinical and non-clinical measure procedures that ensure data collection and reporting procedures.
- Program participants are involved in the Community Advisory Board.

IV. Evaluation

- The applicant has a plan to measure required areas per the RFP evaluation guidance.
- The applicant has plans to establish baseline data and collect and report participant data on a quarterly basis to determine behavior outcomes.
- The applicant has a plan to provide continuous quality improvement.
- The applicant has a plan to ensure the timely provision of information to the data system.
- The applicant has a mechanism to allow the data analysis to inform the program implementation.

V. Budget Appropriateness and Reasonableness

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

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

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

(Grant Application Cover Page)

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

TO BE COMPLETED BY APPLICANT:

Please check:
New HUB Application: ☐ **New Existing HUB Application** ☐

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: HUB 2016/17-_____ENCLOSE WITH ORIGINAL APPLICATION AND FIVE COPIES.

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

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

DO NOT SUBMIT THIS PAGE WITH RFP

NOTE: Where applicable, instructions have been included.

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

HUB 2016/17 - _____

1. Applicant Agency Information:

   Name of Director:_____ Title _____
   Agency Name: _____
   Address: _____
   City: _____, OHIO Zip: _____ County: _____
   Telephone #: (_____ _____ Fax #: (____) _____
2. Federal Tax I.D.: _____

3. Project Title:_____
4. Project Director (Only if different from agency director)
   Name: _____ Phone (____) _____
   Mailing Address: _____
   City: _____, OHIO Zip: _____

5. Name of Fiscal Officer: _____ Phone (___) _____
6. Project Period: December 1, 2015 through June 30, 2016
   Budget Period: December 1, 2015 through June 30, 2016

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

   a. That funds granted as a result of this application are to be used for the purposes set forth therein and administered in compliance with the "Commission's Administrative Rules" and other applicable terms and conditions established by the Commission on Minority Health.

   b. That the project budget contained herein includes grant funds requested, applicant funds and in-kind contributions obligated to support the project and any anticipated income to be generated by the grant funds and applicant support. That any expenditure of grant funds, obligated applicant support and project income will be included in the project budget or subsequent budget revisions will have prior written authorization from the Commission and will have separate accountability with supportive documentation.

   c. That project funds are exclusive of any unauthorized federal funds and will not be used as matching requirements for federal grants.

   d. That all project records will be made available to State agents upon request for review or audit and will not be disposed of without written authorization from the Commission, and that a copy of all audits of project funds will be submitted to the Commission.

   e. That the balances of any unspent grant funds and project income, and any expenditure of project funds not authorized by the Commission will be transferred to the Commission within thirty (30) days after termination of funding.

AGENCY NAME_____

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

g. That the applicant agency is in compliance with:

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

____ Statement of compliance submitted herewith

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

____ Statement of compliance submitted herewith

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

(A) _____ _____

Signature of Agency Director (Blue Ink) Date

(B) _____ _____

Signature of Auditor or Fiscal Officer (Blue Ink) Date

AGENCY NAME_____

Project name as indicated on the Receipt of Acceptance.

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

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

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

A. Original signature of the Chief Executive Officer of the applicant agency (Executive Director, Senior Pastor, Health Commissioner, etc.), and date.

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

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

DO NOT SUBMIT THIS PAGE WITH RFP

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

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

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

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

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

Date _____ _____
(Applicant type or print)

_____
Signature and Title of Authorized Official (Blue Ink)

_____

_____
Applicant's mailing address

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

 AGENCY NAME_____

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

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

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

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

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

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

_____
Name of Designee(s) (Type or Print)

_____ _____
Name of Recipient (Type or Print) Street Address or P.O. Box

_____ _____
(IRS) Employer Identification Number City

_____
State Zip

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

_____ _____
Date Signature and Title of Authorized Official (Blue Ink)

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

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

HUB Project Action Plan: _____ ☐ Additional Sheet(s) Attached

Fiscal Year 2016
Budget Pages

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 #: HUB 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. Any personnel listed in this section must be employed by applicant agency.

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

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

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

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

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

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

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

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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 Expo Travel cost Minority Health Month Expo Hotel Accommodations Minority Health Month Food expenses Grantee Training Travel costs Grantee Training Hotel costs Grantee Training Food costs Local Travel		
SUBTOTAL		
(B) EQUIPMENT - Rental/Leasing only (Itemize and attach written narrative justification for each item)		
SUBTOTAL		

AGENCY NAME_____

SUPPLIES, CONTRACTS, ETC. (Itemize and attach written narrative justification for each item)	I. Total Budget	II. Amount Requested From Commission
FISCAL AUDIT YEAR II ONLY		
SUBTOTAL		

AGENCY NAME_____

SECTION II: NON-PERSONNEL – INSTRUCTIONS

A. Travel

i. State estimated number of miles that will be traveled and the rate at which payment would be made, not to exceed the federal rate of $.52 cents per mile. Example: 2,000 miles at $.52 cents = $1,040.00

ii. Projected number of overnight lodgings, number of people involved and the rate per day/per person should be stated. Lodging rate per day/per person may not exceed the state rate of $80.00 plus room tax (if applicable).

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

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

v. Fees for conferences/training sessions, when determined to be related to specific job-duties and/or responsibilities, are reimbursable or allowable. Projected number of such sessions and costs should be stated.

vi. Only employees who implement services detailed in the project proposal may be reimbursed for actual travel expenses.

vii. Include travel cost (mileage, meals, and hotel accommodations) to attend the Awards Ceremony/ Health Expo scheduled for March 2016 and the Mandatory Grantee Training.

viii. Refer to the Ohio Office of Budget and Management/Travel Rules for applicable hotel and food rates.

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/tablets/laptops
- Ink Cartridges
- Typewriters
- Furniture *(will provide state/federal salvage applications to successful grantees)*
- Cell Phones
- Vehicle purchases
- Reflotron machines
- Copiers
- Refrigerators
- Baby/infant seats, cribs, clothing, shoes
- Wii and other high priced computer games

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, and pens) is considered office supplies.

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

Printing:	Costs may include typesetting, actual printing or photocopying of the material which is completed by a commercial printing company. Included also are costs for pamphlets, brochures and flyers. Provide the unit cost.
Contracts:	Agreements for all sub-contracts must be submitted with the following being addressed: scope of service, beginning/ending date, hourly rate and total number of contract hours.
Advertising:	Specify the media and cost of advertisement (e.g. 3 ads at $50.00 per ad).
Evaluator:	As indicated in the Proposal Preparation section, the internal evaluator must be selected from the approved list of REEP evaluators. A list of these evaluators is located on our website at www.mih.ohio.gov (need actual area listed).
Program Audit:	If funded for Year II, agencies must include the cost for a program audit.

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(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.

AGENCY NAME_____

SECTION II: NON-PERSONNEL - INSTRUCTIONS

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

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

1) Administrative charges: salaries of support staff (administrators, secretaries, accountants). Provide the percentage of time on the project per line item;

2) Rental/space leasing: space rental is an allowable cost. Space for which rental fees will be paid must meet the following requirements:

   a. The number of months and the rate at which payment will be made should be stated;

   b. When rent is shared among several programs, the amount charged to the Commission must not exceed the Commission's fair share. The agency must submit documentation of how the Commission's fair share was determined (e.g., if Commission-funded project uses 20% of the space, the Commission may be charged no more than 20% of the total rent);

   c. Submit a copy of the lease which includes the building owner's name, location of the building, square footage, total amount of rent paid, terms of agreement, termination

   d. Clause, signatures of lessee and lessor;

   e. Approved rent is non-transferable from the original site to a new or relocated site.

3) Rent will not be approved for:

   a. Space which is paid for by another state/federal program or private grant;

   b. Space in buildings purchased with federal funds;

   c. Space donated to the applicant agency.

   d. Utilities: heat, water, electricity, etc.

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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: HUB 2016 -_____

SECTION I: PERSONNEL AND FRINGE BENEFITS:

SECTION II: NON PERSONNEL:

A. Travel:

B. Equipment: (Rental Only)

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

D. Administrative Costs:

AGENCY NAME_____

SECTION III: ANTICIPATED PERIODIC DISTRIBUTION OF COMMISSION FUNDS ONLY

SFY 2016

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. Minority Health Month					
F. Administrative Costs					
Total Project Cost (Total of all budget categories)	$	$	$	$	$

SOURCE OF AGENCY SUPPORT

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

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

_____

Executive Director (Blue Ink) Date

_____

Fiscal Officer (Blue Ink) Date

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

AGENCY NAME_____

SECTION III: ANTICIPATED PERIODIC DISTRIBUTION – INSTRUCTIONS

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

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

OTHER SOURCES OF FUNDING:

- 20% of project funds must be received from sources other than the Commission'.
- Applicants must identify the source of their other funding to detail no less than 20 % of the amount requested from the Commission.

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

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

SECTION IV: ADMINISTRATIVE COMPLIANCE

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

1. List all sources of agency funds.

2. List all sources of third-party funding.

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

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

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

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

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

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

AGENCY NAME_____

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.)

AGENCY NAME_____

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)

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).

AGENCY NAME_____

14. Is the project entering into any contracts for the procurement of goods and services? YES NO (If No, go to Question #15).

If YES, do contracts meet the following conditions:

a. Definition of a sound and complete agreement YES NO

b. Administrative remedies for violations YES NO

c. Termination provisions YES NO

15. Has an audit of the agency's funds been conducted during the past year? YES NO

If yes, please attach one (1) copy with the original of this application.

Is an audit of the agency anticipated during the coming year? YES NO

If yes, what individual(s) or organization is scheduled to perform the audit and what is the approximate date of completion?

16. If the applicant is a non-governmental agency, does it carry adequate fidelity bond coverage as indemnification against losses resulting from the fraud or lack of integrity, honesty or fidelity of one or more employees, officers, or other persons holding a position of trust? YES NO

If yes, attach a copy of the bonding agreement. If no, explain actions that will be taken to comply.

AGENCY NAME_____

SECTION V: ADVISORY BOARD COMPOSITION

☐ ADDITIONAL SHEET ATTACHED

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

White, Black, Hispanic, Native American Indian, Asian/Pacific Islander

Signature _____ Date

(This sheet must bear original signature .In Blue Ink.)

Agency Name _____

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, Black, Hispanic, Native American Indian, Asian/Pacific Islander-Include both full-time and part-time employees. Exclude temporary employees.

Signature _____ Date

(This sheet must bear original signature. In Blue Ink.)

Agency Name _____

APPLICANT CHECKLIST

(Do not return this form to Commission)

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

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

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

Go to link for the Internal Revenue Service’s web site for form, if needed.

INSERT VENDOR FORMS

Please go to The Ohio Commission on Minority Health Website for forms if needed.

Re: Potential State of Ohio Vendor Registration

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

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

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

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

Send the completed forms to:

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

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

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

VENDOR INFORMATION FORM

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

SECTION 1 – PLEASE SPECIFY TYPE OF ACTION

☐ NEW **(W-9 OR W-8ECI FORM ATTACHED)** ☐ CHANGE OF CONTACT PERSON/INFORMATON

☐ ADDITIONAL ADDRESS – (**A COPY OF AN INVOICE OR A LETTER INCLUDING THE ADDRESS IS REQUIRED)**

☐ CHANGE OF ADDRESS – (**PLEASE PROVIDE OLD ADDRESS BELOW OR ATTACH LETTER)**

ADDRESS TO BE REPLACED:

☐ CHANGE OF TIN **(W-9 & LETTER OF CLARIFICATION OF CHANGE, WHICH INCLUDES NEW & OLD TIN IS REQUIRED)**

☐ CHANGE OF NAME **(W-9 & LETTER OF CLARIFICATION OF CHANGE, MUST INCLUDES NEW & OLD NAME IS REQUIRED)**

☐ CHANGE OF PAY TERMS ☐ CHANGE OF PO DISPATCH METHOD ☐ OTHER_____

SECTION 2 – PLEASE PROVIDE VENDOR INFORMATION

LEGAL BUSINESS OR INDIVIDUAL NAME: (MUST MATCH W-9 OR W-8ECI FORM)

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

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

SECTION 3 – PLEASE PROVIDE COMPLETE ADDRESS

ADDRESS:		COUNTY:
CITY:	STATE:	ZIP CODE:

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

ADDRESS:		COUNTY:
CITY:	STATE:	ZIP CODE:

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

SECTION 5 – CONTACT INFORMATION & PERSON TO RECEIVE PURCHASE ORDER		
NAME:		
WEBSITE:		
PHONE:	FAX:	EMAIL:
PREFERRED METHOD OF BEING CONTACTED: (CHECK ONE)	☐ PHONE	☐ EMAIL

SECTION 6 – INDIVIDUAL TO RECEIVE EMAIL NOTICE OF BID EVENTS - A USER ID & PASSWORD WILL BE SENT TO THE EMAIL ADDRESS BELOW	
NAME:	
EMAIL:	PHONE:
TO ADD AN ADDITITIONAL OR REPLACE A STRATEGIC SOURCING CONTACT PERSON ☐ ADDITIONAL CONTACT PERSON ☐ REPLACE CONTACT PERSON **(WILL BE MARKED INACTIVE)** NAME:	
EMAIL:	PHONE:

SECTION 7 – PAYMENT TERMS (PLEASE CHECK ONE – IF NONE IS SELECTED THEN NET 30 WILL APPLY)				
☐ 2/10 NET 30	☐ NET 30	☐ NET 45	☐ NET 60	☐ NET 90

SECTION 8 – PURCHASE ORDER DISTRIBUTION – OTHER THAN USPS MAIL
EMAIL **OR** FAX:

SECTION 9 – PLEASE SIGN & DATE	
PRINT NAME:	
SIGNATURE: (DIGITAL SIGNATURES NOT ACCEPTED AT THIS TIME)	DATE:

SECTION 10 – STATE OF OHIO AGENCY CONTACT PERSON (AGENCY RECEIVING PAYMENTS FROM)
AGENCY CONTACT NAME/EMAIL/PHONE:

COMMENTS:

Note: This document contains sensitive information. Sending via non-secure channels, including e-mail and fax can be a potential security risk.

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

Form **W-9**
(Rev. December 2014)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

Give Form to the requester. Do not send to the IRS.

Print or type
See **Specific Instructions** on page 2.

1 Name (as shown on your income tax return). Name is required on this line; do not leave this line blank.

2 Business name/disregarded entity name, if different from above

3 Check appropriate box for federal tax classification; check only **one** of the following seven boxes:
☐ Individual/sole proprietor or single-member LLC ☐ C Corporation ☐ S Corporation ☐ Partnership ☐ Trust/estate
☐ Limited liability company. Enter the tax classification (C=C corporation, S=S corporation, P=partnership) ▶ _____
Note. For a single-member LLC that is disregarded, do not check LLC; check the appropriate box in the line above for the tax classification of the single-member owner.
☐ Other (see instructions) ▶

4 Exemptions (codes apply only to certain entities, not individuals; see instructions on page 3):
Exempt payee code (if any) _____
Exemption from FATCA reporting code (if any) _____
(Applies to accounts maintained outside the U.S.)

5 Address (number, street, and apt. or suite no.)

Requester's name and address (optional)

6 City, state, and ZIP code

7 List account number(s) here (optional)

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on line 1 to avoid backup withholding. For individuals, this is generally your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the Part I instructions on page 3. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN* on page 3.

Note. If the account is in more than one name, see the instructions for line 1 and the chart on page 4 for guidelines on whose number to enter.

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

or

Employer identification number
☐☐ – ☐☐☐☐☐☐☐

Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me); and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding; and
3. I am a U.S. citizen or other U.S. person (defined below); and
4. The FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct.

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the certification, but you must provide your correct TIN. See the instructions on page 3.

Sign Here **Signature of U.S. person ▶** **Date ▶**

General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

Future developments. Information about developments affecting Form W-9 (such as legislation enacted after we release it) is at *www.irs.gov/fw9*.

Purpose of Form

An individual or entity (Form W-9 requester) who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) which may be your social security number (SSN), individual taxpayer identification number (ITIN), adoption taxpayer identification number (ATIN), or employer identification number (EIN), to report on an information return the amount paid to you, or other amount reportable on an information return. Examples of information returns include, but are not limited to, the following:

- Form 1099-INT (interest earned or paid)
- Form 1099-DIV (dividends, including those from stocks or mutual funds)
- Form 1099-MISC (various types of income, prizes, awards, or gross proceeds)
- Form 1099-B (stock or mutual fund sales and certain other transactions by brokers)
- Form 1099-S (proceeds from real estate transactions)
- Form 1099-K (merchant card and third party network transactions)
- Form 1098 (home mortgage interest), 1098-E (student loan interest), 1098-T (tuition)
- Form 1099-C (canceled debt)
- Form 1099-A (acquisition or abandonment of secured property)

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN.

If you do not return Form W-9 to the requester with a TIN, you might be subject to backup withholding. See *What is backup withholding?* on page 2.

By signing the filled-out form, you:

1. Certify that the TIN you are giving is correct (or you are waiting for a number to be issued),

2. Certify that you are not subject to backup withholding, or

3. Claim exemption from backup withholding if you are a U.S. exempt payee. If applicable, you are also certifying that as a U.S. person, your allocable share of any partnership income from a U.S. trade or business is not subject to the withholding tax on foreign partners' share of effectively connected income, and

4. Certify that FATCA code(s) entered on this form (if any) indicating that you are exempt from the FATCA reporting, is correct. See *What is FATCA reporting?* on page 2 for further information.

Note. If you are a U.S. person and a requester gives you a form other than Form W-9 to request your TIN, you must use the requester's form if it is substantially similar to this Form W-9.

Definition of a U.S. person. For federal tax purposes, you are considered a U.S. person if you are:

- An individual who is a U.S. citizen or U.S. resident alien;
- A partnership, corporation, company, or association created or organized in the United States or under the laws of the United States;
- An estate (other than a foreign estate); or
- A domestic trust (as defined in Regulations section 301.7701-7).

Special rules for partnerships. Partnerships that conduct a trade or business in the United States are generally required to pay a withholding tax under section 1446 on any foreign partners' share of effectively connected taxable income from such business. Further, in certain cases where a Form W-9 has not been received, the rules under section 1446 require a partnership to presume that a partner is a foreign person, and pay the section 1446 withholding tax. Therefore, if you are a U.S. person that is a partner in a partnership conducting a trade or business in the United States, provide Form W-9 to the partnership to establish your U.S. status and avoid section 1446 withholding on your share of partnership income.

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

- In the case of a disregarded entity with a U.S. owner, the U.S. owner of the disregarded entity and not the entity;
- In the case of a grantor trust with a U.S. grantor or other U.S. owner, generally, the U.S. grantor or other U.S. owner of the grantor trust and not the trust; and
- In the case of a U.S. trust (other than a grantor trust), the U.S. trust (other than a grantor trust) and not the beneficiaries of the trust.

Foreign person. If you are a foreign person or the U.S. branch of a foreign bank that has elected to be treated as a U.S. person, do not use Form W-9. Instead, use the appropriate Form W-8 or Form 8233 (see Publication 515, Withholding of Tax on Nonresident Aliens and Foreign Entities).

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

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

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

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

If you are a nonresident alien or a foreign entity, give the requester the appropriate completed Form W-8 or Form 8233.

Backup Withholding

What is backup withholding? Persons making certain payments to you must under certain conditions withhold and pay to the IRS 28% of such payments. This is called "backup withholding." Payments that may be subject to backup withholding include interest, tax-exempt interest, dividends, broker and barter exchange transactions, rents, royalties, nonemployee pay, payments made in settlement of payment card and third party network transactions, and certain payments from fishing boat operators. Real estate transactions are not subject to backup withholding.

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

Payments you receive will be subject to backup withholding if:

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

Certain payees and payments are exempt from backup withholding. See *Exempt payee code* on page 3 and the separate Instructions for the Requester of Form W-9 for more information.

Also see *Special rules for partnerships* above.

What is FATCA reporting?

The Foreign Account Tax Compliance Act (FATCA) requires a participating foreign financial institution to report all United States account holders that are specified United States persons. Certain payees are exempt from FATCA reporting. See *Exemption from FATCA reporting code* on page 3 and the Instructions for the Requester of Form W-9 for more information.

Updating Your Information

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

Penalties

Failure to furnish TIN. If you fail to furnish your correct TIN to a requester, you are subject to a penalty of $50 for each such failure unless your failure is due to reasonable cause and not to willful neglect.

Civil penalty for false information with respect to withholding. If you make a false statement with no reasonable basis that results in no backup withholding, you are subject to a $500 penalty.

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

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

Specific Instructions

Line 1

You must enter one of the following on this line; **do not** leave this line blank. The name should match the name on your tax return.

If this Form W-9 is for a joint account, list first, and then circle, the name of the person or entity whose number you entered in Part I of Form W-9.

a. **Individual.** Generally, enter the name shown on your tax return. If you have changed your last name without informing the Social Security Administration (SSA) of the name change, enter your first name, the last name as shown on your social security card, and your new last name.

Note. ITIN applicant: Enter your individual name as it was entered on your Form W-7 application, line 1a. This should also be the same as the name you entered on the Form 1040/1040A/1040EZ you filed with your application.

b. **Sole proprietor or single-member LLC.** Enter your individual name as shown on your 1040/1040A/1040EZ on line 1. You may enter your business, trade, or "doing business as" (DBA) name on line 2.

c. **Partnership, LLC that is not a single-member LLC, C Corporation, or S Corporation.** Enter the entity's name as shown on the entity's tax return on line 1 and any business, trade, or DBA name on line 2.

d. **Other entities.** Enter your name as shown on required U.S. federal tax documents on line 1. This name should match the name shown on the charter or other legal document creating the entity. You may enter any business, trade, or DBA name on line 2.

e. **Disregarded entity.** For U.S. federal tax purposes, an entity that is disregarded as an entity separate from its owner is treated as a "disregarded entity." See Regulations section 301.7701-2(c)(2)(iii). Enter the owner's name on line 1. The name of the entity entered on line 1 should never be a disregarded entity. The name on line 1 should be the name shown on the income tax return on which the income should be reported. For example, if a foreign LLC that is treated as a disregarded entity for U.S. federal tax purposes has a single owner that is a U.S. person, the U.S. owner's name is required to be provided on line 1. If the direct owner of the entity is also a disregarded entity, enter the first owner that is not disregarded for federal tax purposes. Enter the disregarded entity's name on line 2, "Business name/disregarded entity name." If the owner of the disregarded entity is a foreign person, the owner must complete an appropriate Form W-8 instead of a Form W-9. This is the case even if the foreign person has a U.S. TIN.

Line 2

If you have a business name, trade name, DBA name, or disregarded entity name, you may enter it on line 2.

Line 3

Check the appropriate box in line 3 for the U.S. federal tax classification of the person whose name is entered on line 1. Check only one box in line 3.

Limited Liability Company (LLC). If the name on line 1 is an LLC treated as a partnership for U.S. federal tax purposes, check the "Limited Liability Company" box and enter "P" in the space provided. If the LLC has filed Form 8832 or 2553 to be taxed as a corporation, check the "Limited Liability Company" box and in the space provided enter "C" for C corporation or "S" for S corporation. If it is a single-member LLC that is a disregarded entity, do not check the "Limited Liability Company" box; instead check the first box in line 3 "Individual/sole proprietor or single-member LLC."

Line 4, Exemptions

If you are exempt from backup withholding and/or FATCA reporting, enter in the appropriate space in line 4 any code(s) that may apply to you.

Exempt payee code.

- Generally, individuals (including sole proprietors) are not exempt from backup withholding.
- Except as provided below, corporations are exempt from backup withholding for certain payments, including interest and dividends.
- Corporations are not exempt from backup withholding for payments made in settlement of payment card or third party network transactions.
- Corporations are not exempt from backup withholding with respect to attorneys' fees or gross proceeds paid to attorneys, and corporations that provide medical or health care services are not exempt with respect to payments reportable on Form 1099-MISC.

The following codes identify payees that are exempt from backup withholding. Enter the appropriate code in the space in line 4.

1—An organization exempt from tax under section 501(a), any IRA, or a custodial account under section 403(b)(7) if the account satisfies the requirements of section 401(f)(2)

2—The United States or any of its agencies or instrumentalities

3—A state, the District of Columbia, a U.S. commonwealth or possession, or any of their political subdivisions or instrumentalities

4—A foreign government or any of its political subdivisions, agencies, or instrumentalities

5—A corporation

6—A dealer in securities or commodities required to register in the United States, the District of Columbia, or a U.S. commonwealth or possession

7—A futures commission merchant registered with the Commodity Futures Trading Commission

8—A real estate investment trust

9—An entity registered at all times during the tax year under the Investment Company Act of 1940

10—A common trust fund operated by a bank under section 584(a)

11—A financial institution

12—A middleman known in the investment community as a nominee or custodian

13—A trust exempt from tax under section 664 or described in section 4947

The following chart shows types of payments that may be exempt from backup withholding. The chart applies to the exempt payees listed above, 1 through 13.

IF the payment is for . . .	THEN the payment is exempt for . . .
Interest and dividend payments	All exempt payees except for 7
Broker transactions	Exempt payees 1 through 4 and 6 through 11 and all C corporations. S corporations must not enter an exempt payee code because they are exempt only for sales of noncovered securities acquired prior to 2012.
Barter exchange transactions and patronage dividends	Exempt payees 1 through 4
Payments over $600 required to be reported and direct sales over $5,000[1]	Generally, exempt payees 1 through 5[2]
Payments made in settlement of payment card or third party network transactions	Exempt payees 1 through 4

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

[2] However, the following payments made to a corporation and reportable on Form 1099-MISC are not exempt from backup withholding: medical and health care payments, attorneys' fees, gross proceeds paid to an attorney reportable under section 6045(f), and payments for services paid by a federal executive agency.

Exemption from FATCA reporting code. The following codes identify payees that are exempt from reporting under FATCA. These codes apply to persons submitting this form for accounts maintained outside of the United States by certain foreign financial institutions. Therefore, if you are only submitting this form for an account you hold in the United States, you may leave this field blank. Consult with the person requesting this form if you are uncertain if the financial institution is subject to these requirements. A requester may indicate that a code is not required by providing you with a Form W-9 with "Not Applicable" (or any similar indication) written or printed on the line for a FATCA exemption code.

A—An organization exempt from tax under section 501(a) or any individual retirement plan as defined in section 7701(a)(37)

B—The United States or any of its agencies or instrumentalities

C—A state, the District of Columbia, a U.S. commonwealth or possession, or any of their political subdivisions or instrumentalities

D—A corporation the stock of which is regularly traded on one or more established securities markets, as described in Regulations section 1.1472-1(c)(1)(i)

E—A corporation that is a member of the same expanded affiliated group as a corporation described in Regulations section 1.1472-1(c)(1)(i)

F—A dealer in securities, commodities, or derivative financial instruments (including notional principal contracts, futures, forwards, and options) that is registered as such under the laws of the United States or any state

G—A real estate investment trust

H—A regulated investment company as defined in section 851 or an entity registered at all times during the tax year under the Investment Company Act of 1940

I—A common trust fund as defined in section 584(a)

J—A bank as defined in section 581

K—A broker

L—A trust exempt from tax under section 664 or described in section 4947(a)(1)

M—A tax exempt trust under a section 403(b) plan or section 457(g) plan

Note. You may wish to consult with the financial institution requesting this form to determine whether the FATCA code and/or exempt payee code should be completed.

Line 5

Enter your address (number, street, and apartment or suite number). This is where the requester of this Form W-9 will mail your information returns.

Line 6

Enter your city, state, and ZIP code.

Part I. Taxpayer Identification Number (TIN)

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

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

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

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

How to get a TIN. If you do not have a TIN, apply for one immediately. To apply for an SSN, get Form SS-5, Application for a Social Security Card, from your local SSA office or get this form online at *www.ssa.gov*. You may also get this form by calling 1-800-772-1213. Use Form W-7, Application for IRS Individual Taxpayer Identification Number, to apply for an ITIN, or Form SS-4, Application for Employer Identification Number, to apply for an EIN. You can apply for an EIN online by accessing the IRS website at *www.irs.gov/businesses* and clicking on Employer Identification Number (EIN) under Starting a Business. You can get Forms W-7 and SS-4 from the IRS by visiting IRS.gov or by calling 1-800-TAX-FORM (1-800-829-3676).

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

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

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

Part II. Certification

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

For a joint account, only the person whose TIN is shown in Part I should sign (when required). In the case of a disregarded entity, the person identified on line 1 must sign. Exempt payees, see *Exempt payee code* earlier.

Signature requirements. Complete the certification as indicated in items 1 through 5 below.

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

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

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

4. Other payments. You must give your correct TIN, but you do not have to sign the certification unless you have been notified that you have previously given an incorrect TIN. "Other payments" include payments made in the course of the requester's trade or business for rents, royalties, goods (other than bills for merchandise), medical and health care services (including payments to corporations), payments to a nonemployee for services, payments made in settlement of payment card and third party network transactions, payments to certain fishing boat crew members and fishermen, and gross proceeds paid to attorneys (including payments to corporations).

5. Mortgage interest paid by you, acquisition or abandonment of secured property, cancellation of debt, qualified tuition program payments (under section 529), IRA, Coverdell ESA, Archer MSA or HSA contributions or distributions, and pension distributions. You must give your correct TIN, but you do not have to sign the certification.

What Name and Number To Give the Requester

For this type of account:	Give name and SSN of:
1. Individual	The individual
2. Two or more individuals (joint account)	The actual owner of the account or, if combined funds, the first individual on the account[1]
3. Custodian account of a minor (Uniform Gift to Minors Act)	The minor[2]
4. a. The usual revocable savings trust (grantor is also trustee)	The grantor-trustee[1]
b. So-called trust account that is not a legal or valid trust under state law	The actual owner[1]
5. Sole proprietorship or disregarded entity owned by an individual	The owner[3]
6. Grantor trust filing under Optional Form 1099 Filing Method 1 (see Regulations section 1.671-4(b)(2)(i)(A))	The grantor*
For this type of account:	**Give name and EIN of:**
7. Disregarded entity not owned by an individual	The owner
8. A valid trust, estate, or pension trust	Legal entity[4]
9. Corporation or LLC electing corporate status on Form 8832 or Form 2553	The corporation
10. Association, club, religious, charitable, educational, or other tax-exempt organization	The organization
11. Partnership or multi-member LLC	The partnership
12. A broker or registered nominee	The broker or nominee
13. Account with the Department of Agriculture in the name of a public entity (such as a state or local government, school district, or prison) that receives agricultural program payments	The public entity
14. Grantor trust filing under the Form 1041 Filing Method or the Optional Form 1099 Filing Method 2 (see Regulations section 1.671-4(b)(2)(i)(B))	The trust

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

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

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

[4] List first and circle the name of the trust, estate, or pension trust. (Do not furnish the TIN of the personal representative or trustee unless the legal entity itself is not designated in the account title.) Also see *Special rules for partnerships* on page 2.

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

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

Secure Your Tax Records from Identity Theft

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

To reduce your risk:

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

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

If your tax records are not currently affected by identity theft but you think you are at risk due to a lost or stolen purse or wallet, questionable credit card activity or credit report, contact the IRS Identity Theft Hotline at 1-800-908-4490 or submit Form 14039.

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

Victims of identity theft who are experiencing economic harm or a system problem, or are seeking help in resolving tax problems that have not been resolved through normal channels, may be eligible for Taxpayer Advocate Service (TAS) assistance. You can reach TAS by calling the TAS toll-free case intake line at 1-877-777-4778 or TTY/TDD 1-800-829-4059.

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

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

If you receive an unsolicited email claiming to be from the IRS, forward this message to *phishing@irs.gov.* You may also report misuse of the IRS name, logo, or other IRS property to the Treasury Inspector General for Tax Administration (TIGTA) at 1-800-366-4484. You can forward suspicious emails to the Federal Trade Commission at: *spam@uce.gov* or contact them at *www.ftc.gov/idtheft* or 1-877-IDTHEFT (1-877-438-4338).

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

Privacy Act Notice

Section 6109 of the Internal Revenue Code requires you to provide your correct TIN to persons (including federal agencies) who are required to file information returns with the IRS to report interest, dividends, or certain other income paid to you; mortgage interest you paid; the acquisition or abandonment of secured property; the cancellation of debt; or contributions you made to an IRA, Archer MSA, or HSA. The person collecting this form uses the information on the form to file information returns with the IRS, reporting the above information. Routine uses of this information include giving it to the Department of Justice for civil and criminal litigation and to cities, states, the District of Columbia, and U.S. commonwealths and possessions for use in administering their laws. The information also may be disclosed to other countries under a treaty, to federal and state agencies to enforce civil and criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism. You must provide your TIN whether or not you are required to file a tax return. Under section 3406, payers must generally withhold a percentage of taxable interest, dividend, and certain other payments to a payee who does not give a TIN to the payer. Certain penalties may also apply for providing false or fraudulent information.

AUTHORIZATION AGREEMENT FOR DIRECT DEPOSIT OF EFT PAYMENTS

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

SECTION 1

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

NAME OF COMPANY OR INDIVIDUAL

ADDRESS

CITY	STATE	ZIP

PHONE	EMAIL

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

CHECK ALL THAT APPLY ☐ RSC - PCA ☐ ODJFS PROVIDER (PROVIDER ID NUMBER REQUIRED)

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

☐ ALL OTHER: _____

SECTION 2 – NEW FINANCIAL INFORMATION

NEW FINANCIAL INSTITUTION NAME	PHONE

TYPE OF ACCOUNT ☐ CHECKING ☐ SAVINGS

NEW ACCOUNT NUMBER

NEW TRANSIT ROUTING/ABA NUMBER

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

OLD/PRIOR FINANCIAL INSTITUTION NAME	PHONE

OLD/PRIOR ACCOUNT NUMBER

OLD TRANSIT ROUTING/ABA NUMBER

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

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

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

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

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

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

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

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

PRINT NAME	
SIGNATURE (DIGITAL SIGNATURE NOT ACCEPTED AT THIS TIME)	DATE

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

NOTE:

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

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

Phone: 1 (877) OHIO - SS1 (1-877-644-6771)
1 (614) 338-4781
Website: www.ohiosharedservices.ohio.gov
E-mail: vendor@ohio.g

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

SECTION 1

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

  Enter your phone number & email address. When your email address is provided, you will receive an automated email notification stating your banking information has been added or updated in our system.
- Enter your Employer Identification Number or your Social Security Number (required).
- Please enter your OAKS Vendor Id Number (if known).
- Check all that applies. If you are an ODJFS or DODD provider please check mark to indicate & add Provider Id Number or please specify, if you are a RSC-PCA, Lottery Winner, or All Other.

SECTION 2 (New Information)

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

SECTION 3 (Old/Prior Information) <u>Required if a CHANGE/UDATE</u>

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

SECTION 4

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

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

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