



COMMISSION ON MINORITY HEALTH

John R. Kasich
GOVERNOR

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September 7, 2015

Dear Colleagues:

Due to the limited response to the Systemic Lupus Erythematosus (SLE) Request for Proposal (RFP), OCMH is re-releasing the grant on September 7, 2015 with a due date of October 12, 2015. OCMH will prioritize grants that provide service delivery in Northwest, Central, and Southeast Ohio. The enclosed RFP provides detailed submission guidance and criteria for funding. An electronic version of this packet is located on our website at www.mih.ohio.gov. Please remember to include your agency's 501(c)(3) determination letter with the application.

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

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

I strongly encourage you to thoroughly read the application and to view the Technical Assistance session (TA) via webinar. The TA session is available on our website, www.mih.ohio.gov, by clicking on the Grant Opportunities tab, and scrolling to the Lupus RFP section.

Remember that an original and five copies of your grant application must be received in the Commission office at 77 S. High Street, 18th Floor, Columbus, Ohio 43215, no later than **5:00 p.m. on Monday, October 12, 2015. If the due date falls on a holiday, the application is due the following business day.**

You have our best wishes as you prepare your application.

Sincerely,

Angela C. Dawson

Angela C. Dawson
Executive Director
Enclosure

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

Systemic Lupus Erythematosus (SLE)

BACKGROUND

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

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

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

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

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

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

INTRODUCTION

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

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

In July of 1987, the Commission on Minority Health was created by Amended Substitute House Bill 171 for the purpose of providing health promotion and prevention of disease among minority Ohioans who are economically disadvantaged. Grants will be awarded on a statewide competitive bid basis to public or private, non profit 501 (c) (3), community-based agencies or organizations.

This Request for Proposal solicits grant applications meeting the requirements set forth in Chapter 3704 of the Ohio Administrative Code. Applications will be accepted exclusively from agencies or institutions meeting the eligibility criteria established by the Commission on Minority Health.

ELIGIBILITY

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

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

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

- Demonstrate that at least 20% of project funds are received from sources other than grants awarded by the Commission on Minority Health;
- Be a public or private non profit organization that has a 501 (c) (3);
- Develop a plan that establishes a management board for the administration of the grant, composed of proportionate representation of the population to be served and submit said plan with the grant application;
- Answer all questions on Administrative Compliance Form, and
- Grantee must comply with all current and applicable laws, regulations, rules, and administrative guidelines of the Ohio Commission on Minority Health.

The Commission strongly encourages you to thoroughly read the application and to view the Technical Assistance (TA) Webinar sessions. The TA session is available on our website, www.mih.ohio.gov, by clicking on the Grant Opportunities tab, and scrolling to the Lupus RFP section. Technical assistance for this grant application will be discussed and may prove invaluable as you develop your proposal. Please note that we will not be able to accommodate individual request to provide this information.

The following are ineligible for funding consideration:

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

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

PUBLIC RECORD NOTICE

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

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

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

FUNDING

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

IMPORTANT: This is a performance-based grant. The second year of funding is non-competitive but is contingent on measured outcome during the first year of funding. The Commission reserves the right to terminate the grant prior to the second funding cycle if the project does not perform in accordance with stated, measurable outcomes.

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

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

PROPOSAL GUIDELINES

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

DO NOT SUBMIT THIS PAGE WITH RFP

Applicants that are funded will be required to work with our Research Evaluation Enhancement Project Team, technical assistance to develop and standardize objectives that will be implemented during the funding period along with a standardized evaluation mechanism. More information about this is shared in the start-up SLE session powerpoint, found on the Commission homepage, in the Current Grantees box.

Critical Guidelines

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

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

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

Patient Education

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

Public Education

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

Grantees are required to maintain participant files.

Participating Files must contain the following:

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

Definitions:

Patient Education Sessions:

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

Trained Facilitator:

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

Balanced Presentation:

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

PROPOSAL PREPARATION

The Commission strongly encourages you to thoroughly read the application and to view the technical assistance session webinar 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.

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

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

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

DO NOT SUBMIT THIS PAGE WITH RFP

PROPOSAL FORMAT

- Applicants must be submitted on single sided sheets of paper. No two sided copies will be accepted.
- Applications must be submitted on 8 ½ by 11 WHITE paper only. No colored paper will be accepted.
- Applications must be typed in Times New Roman or similar font and must be 12 point in size.
- Applications must clearly indicate ORIGINAL and COPIES and must be attached with paper clips.
- No binders or separation tabs permitted.
- All signatures must be signed in BLUE INK.

All applications must be received by 5:00 p.m. October 12, 2015. If the due date falls on a holiday, the application is due the following business day. Any application or supporting documentation received after that date and time will be returned without review. **The proposal must be typed on Commission forms. FAXED, EMAILED AND HANDWRITTEN APPLICATIONS WILL NOT BE ACCEPTED.**

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

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

PROPOSAL PREPARATION

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

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

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

(2) **Proposal Narrative**

a. Description of Applicant Agency (two pages maximum)

All Narratives must be written in a complete sentence structure.

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

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

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

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

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

b. Problem Need Statement (three pages maximum)

All Narratives must be written in a complete sentence structure.

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

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

List the expected outcomes of the project.

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

C. Project Abstract

During the review process, the abstract is separated from the grant for the reviewer to have a summary of the proposed project. Therefore provide goals and objectives with a concise overview of the purpose, rationale and methodology to be utilized by the project. (*Limit = 500 words or less*)

D. Method of Implementation and Evaluation

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

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

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

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

Project Action Plan must list goals and objectives with projected number of participants to be served for the year of the project that are clearly defined and measurable in process and client behavior outcome changes. Project time frames must conform to the funding period. Although certain tasks (such as advertising for positions, hiring staff or identifying dates when advisory committees meet) are important steps in the project's evolution, these items need not appear as goals and objectives. Major tasks and activities should be indicated for each objective.

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

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

PROPOSAL EVALUATION

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

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

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

(1) Service Area Design

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

(2) Innovativeness and Impact

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

(3) Program Design

- The applicant has demonstrated that cultural beliefs, attitudes and practices have been considered and included in designing the program.
- Barriers to service; i.e., availability, acceptability, language and cost have been considered and appropriate recourse is included in the approach to the project.

The problems to be addressed are clearly stated in specific rather than general terms, reasonably addressed during the grant period, and accomplished with the dollars available for the project.

(4) Budget Appropriateness and Reasonableness

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

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

(5) Evaluation

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

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

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

GRANT REPORTING/PARTICIPATION REQUIREMENTS

Prior to submitting this proposal, please be aware that there are grant reporting mechanisms and evaluation reports that are required to be submitted to the Commission on a quarterly basis if funded. Grant management is required by your agency to be responsible for:

- Return signed Acknowledgement of Terms and respond to the Program and Fiscal Special Conditions, if any are given.
- Submission of Program and Fiscal quarterly reports (on appropriate Commission forms).
- Participation in MHM Kickoff Expo sponsored by the Commission. In an effort to raise awareness required OCMH funded Program Grantees are required to set up a display table at the Annual Health Expo.
- The Program Director and REEP Evaluator will participate face to face, by Webinar, and/or conference call with REEP Panel to develop common job objectives and evaluation tool.
- Responsible for Biennial Program Report by required deadline.
- Responsible for conducting two Lupus Awareness Month activities in May of 2016.

DEADLINE

The original and five copies of the grant application must be received in the Commission office by **5:00 p.m. on Monday, October 12, 2015. If the deadline falls on a holiday, the application is due the following business day.** Applications and other materials received after this deadline will be returned without review. All applications must be typewritten, **handwritten applications or those submitted by fax will not be accepted and will be returned without review.**

We recommend allowing sufficient time to access the building and go through security.

Address applications to:

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

John R. Kasich
GOVERNOR

Gregory L. Hall, MD
CHAIRPERSON



COMMISSION ON MINORITY HEALTH

77 South High Street, 18th Floor, Columbus, Ohio 43215

Phone: (614) 466-4000

Fax: (614) 752-9049

Website: <http://www.mih.ohio.gov>

Email: minhealth@ocmh.state.oh.us

RECEIPT OF ACCEPTANCE

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

TO BE COMPLETED BY APPLICANT:

Project Name: _____

Applicant Agency/Organization: _____

Complete Mailing Address: _____

(No P.O. Boxes) _____

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

(Attach a copy of 501(C)(3) letter. IF YOUR AGENCY DOES NOT HAVE 501-C-3 STATUS, STOP HERE – DO NOT SUBMIT THE APPLICATION)

Total year one amount you are requesting: \$ _____

Executive Director: _____ Phone: () _____

E-mail: _____ Fax: () _____

Project Director: _____ Phone: () _____

E-mail: _____ Fax: () _____

Fiscal Officer: _____ Phone: () _____

E-mail: _____ Fax: () _____

DO NOT WRITE BELOW THIS LINE

Date Received: _____ Received by: _____

The above-named grant application has been assigned the following identification number. Please use this number to refer to your grant in any correspondence or inquiry:

GRANT I.D. NUMBER: SLE 2016-2017 _____

ENCLOSE WITH ORIGINAL APPLICATION AND FIVE COPIES.

Instructions for Completion of Receipt of Acceptance

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

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PROJECT APPLICATION PAGE ONE

NOTE:

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

Do **NOT** write in this space. For
Commission use only.
SLE 2016-2017 _____

1. Applicant Agency Information:

Name of Director: _____ Title: _____

Agency Name: _____

Address: _____

City: _____, OH Zip: _____ County: _____

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

2. Project Title: _____

3. Federal Tax I.D.: _____

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

Name: _____ Phone (_____) _____

Mailing Address: _____

City: _____, OHIO Zip: _____

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

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

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

- a. That funds granted as a result of this application are to be used for the purposes set forth herein and administered in compliance with the "Commission's Administrative Rules" and other applicable terms and conditions established by the Commission on Minority Health.
- b. That the project budget contained herein includes grant funds requested, applicant funds and in-kind contributions obligated to support the project and any anticipated income to be generated by the grant funds and applicant support. That any expenditure of grant funds, obligated applicant support and project income will be included in the project budget or subsequent budget revisions will have prior written authorization from the Commission and will have separate accountability with supportive documentation.
- c. That project funds are exclusive of any unauthorized federal funds and will not be used as matching requirements for federal grants.
- d. That all project records will be made available to State agents upon request for review or audit and will not be disposed of without written authorization from the Commission, and that a copy of all audits of project funds will be submitted to the Commission.

PROJECT APPLICATION – INSTRUCTIONS

Project name as indicated on the Receipt of Acceptance.

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

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

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

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

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

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

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PROPOSAL PREPARATION

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

Complete the Receipt of Acceptance, assurances and compliance forms, W-9, and Vendor Forms. Include a copy of 501(c)(3) status, most recent audit report and board resolution. Agency must include a board resolution approving the submission of the application. (Not included in the page count).

I. Proposal Narrative

A. Description of Applicant Agency

Describe the agency's mission and mandate. Also describe successful and previous involvement with minority populations. Include accomplishments and indicate how this project will enhance the agency's service delivery capacity. Describe facility where activity will be provided including days and hours of operation. Describe how the technical accuracy of the project's health component will be assured. Staff Description: Include job description, contracts of staff assigned, and resumes of staff assigned to the grant. Within the agency's plan describe the degree to which program staff are culturally competent. Describe how the agency will collect health base line information of the participant, the caregiver, and measure the outcome quarterly after program participation.

B. Problem Need Statement

Define the specific target area including a description of the problems and needs to be addressed by the proposed project. Support the problem and needs statement with statistics, research findings, or other documentation pertinent to your community/target population.

Identify and include narrative information about the targeted population (identify such factors as race or ethnicity, age, sex, number of clients to be served, etc.), geographical area(s), or similarly disadvantaged area(s) to be served and sources of community support.

List the expected outcome of the project.

Submit letters of support from appropriate organizations. Their letters must outline the activities or services they will provide to the project and generally describe how this project will impact/improve the identified problem.

C. Project Abstract

During the review process, the abstract is separated from the grant for the reviewer to have a summary of the proposed project, therefore, provide goals and objectives with a concise overview of the purpose, rationale and methodology to be utilized by the project. (Limit = 500 words or less)

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

Project Action Plan must list goals and objectives with projected number of participants to be served for the year of the project that are clearly defined and measurable in process and client behavior outcome changes. Project time frames must conform to the funding period. Although certain tasks (such as advertising for positions, hiring staff or identifying dates when advisory committees meet) are important steps in the project's evolution, these items need not appear as goals and objectives. Major tasks and activities should be indicated for each objective.

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

Describe in detail the method(s) that will be used to determine whether the established goals and objectives are being met and whether the expected outcomes are being achieved. Do not state in percentages.

A sample action plan is included as a guide.

E. Method of Implementation

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

- detailed description of services to be provided;
- demonstration and verification that the proposed services/activities are medically and technically accurate;
- proposed days and hours of operation and location(s) of activities date/month;
- how the target population(s) will be involved in the administration and execution of the grant;
- the linkages between the program design and the goals and objectives the program intends to achieve;
- the culturally-specific components that reflect the target population's attitudes, values and beliefs;
- a description of the aspects of the proposal that make it a demonstration grant; and
- a description of the role of the evaluator in the program's design, implementation and goal attainment.

F. Evaluation

Describe in details, the method(s) that will be used to determine whether the established goals and objectives are being met and whether the expected outcomes are being achieved. **Do not state in percentages**. Limiting your responses to a statement such as, "we will hire an evaluator", will be considered non-responsive.

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

_____(hereinafter called the "Applicant")

Name of Applicant (type or print)

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

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

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

Date _____

(Applicant type or print)

Signature and Title of Authorized Official (Blue Ink)

Applicant's mailing address

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

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

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

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

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

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

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

Name of Designee(s) (Type or Print)

Name of Recipient (Type or Print)

Street Address or P.O. Box

(IRS) Employer Identification Number

City

State

Zip

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

Date

Signature and Title of Authorized Official (Blue Ink)

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

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

SAMPLE-PROJECT ACTION PLAN – FY 2016

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

Goals/Objectives	Approach	Activities	Evaluation	Responsibilities	Timeline
<ul style="list-style-type: none"> ▪ How many persons with lupus do you plan to serve via Optimal Support Group? ▪ How many caregivers who attended the group do you plan to serve? ▪ How many individuals do you plan to serve with non-support group activities. ▪ What are your specific Public Education plans? 	How will you do it?	What will take place?	<p>What results do you expect?</p> <p>How will you measure it?</p>	Who will be responsible?	Applicants must list the activities for each month of the year along with the frequency of each activity?
<p>Patient Education</p> <p>Goal 1: To provide Systemic Lupus Erythematosus (SLE) education to ___lupus patients and ___Caregivers.</p> <p>Objective:</p> <p>a. By June 2016 at least ___Lupus patients will receive a list of area facilities and physicians that provide treatment for SLE related medical conditions.</p> <p>b. By June 2016 at least ___Lupus patients will attend ___ out of ___ support group meetings, which are facilitated by trained facilitator with balanced presentations.</p>	<p>An up to date list will be maintained and available at support meetings and upon request to individuals requesting physician referrals.</p> <p>A minimum of ___ meetings will be scheduled by June 2016 and conducted by a trained facilitator.</p> <p>Participants must attend no less than ___ out of ___group meetings.</p>	<p>An up to date list of rheumatologist will be available through telephone, email, meetings, and/or by mail request.</p> <p>See attached meeting schedule.</p>	<p>The expected outcome is that program participants are seeing a doctor in order to manage symptoms at least once a year. A question will be included in the quarterly evaluation to measure compliance.</p> <p>Sign in sheets will be used to track attendance.</p>	<p>Program Staff</p> <p>Program Staff</p>	<p>From July 2015 to June 2016</p> <p>From July 2015 to June 2016</p>

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

SAMPLE-PROJECT ACTION PLAN – FY 2016

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

Goals/Objectives	Approach	Activities	Evaluation	Responsibilities	Timeline
<ul style="list-style-type: none"> ■ Project how many participants you plan to serve, in whole numbers? ■ Project how many participants will participate in the frequency of your program activity designed? ■ Project how many participants will show quarterly health outcome behavior changes. 	<ul style="list-style-type: none"> ■ How will you do it? 	<ul style="list-style-type: none"> ■ What will take place? 	<ul style="list-style-type: none"> ■ What results do you expect? ■ How will you measure it? ■ Refer to the Evaluation Guidance Packet for required areas. ■ What are your plans to collect participant data quarterly? 	<ul style="list-style-type: none"> ■ Who will be responsible? 	<ul style="list-style-type: none"> ■ What will happen by the end of the first quarter an ongoing on a quarterly basis?
<p>Patient Education</p> <p>c. By June 30, 2015, the Lupus support group facilitator will provide at least ___ phone calls and provide at least ___ home visit, provide self-management skills to at least ___ lupus patients and ___ caregivers during support group meetings.</p> <p>d. By June 30, 2016 at least ___ Lupus presentations within target area lupus information will be provided for at least ___ health fairs in order to provide outreach mechanisms for increasing the number of participants, especially minority women. Through the following mechanisms:</p> <ul style="list-style-type: none"> a. _____ b. _____ c. _____ 	<p>Phone calls and/or home and hospital visits will take place. Self-management skills will be provided in support group meetings, phone calls and home visits.</p> <p>Community outreach will be accomplished by targeting populations affected by lupus.</p>	<p>Lupus patients will receive educational brochures and other resources from reputable sources.</p> <p>Outreach will take place at churches, schools, adult education facilities, physician offices and civic organizations in the affected populations.</p>	<p>Home visits/and telephone calls will be logged on the communication sheet. At least two presenters at support group meetings will be a physician and a rheumatologist in order to highlight self-management skills.</p> <p>The program facilitator will participate in at least ___ participations, or health fairs. Meeting notices will be send to physician's offices and churches.</p>	<p>Program Staff</p> <p>Program Staff</p>	<p>From July 2015 to June 2016</p> <p>From July 2015 to June 2016</p>

Agency Name _____

SAMPLE-PROJECT ACTION PLAN – FY 2016

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

Goals/Objectives	Approach	Activities	Evaluation	Responsibilities	Timeline
<ul style="list-style-type: none"> ▪ How many persons with lupus do you plan to serve via Optimal Support Group? ▪ How many caregivers who attended the group do you plan to serve? ▪ How many individuals do you plan to serve with non-support group activities. ▪ What are your specific Public Education plans? 	How will you do it?	What will take place?	What results do you expect? How will you measure it?	Who will be responsible?	Applicants must list the activities for each month of the year along with the frequency of each activity?
<p>Patient Education Optional Objective: e. By June 30, 2016 at least ____ people will access the lupus informational line for event information and accurate lupus information. Lupus</p> <p>f. By June 30, 2015 at least ____ county residents will be reached through a Lupus Awareness Month Campaign.</p> <p>Public Education:</p> <p>Goal 2: To increase awareness among county residents and promote involvement in lupus awareness activities.</p> <p>Objectives: g. By June 30, 2016 at least ____ caregivers and family members of persons living with lupus will participate in monthly support group meetings.</p>	<p>The Lupus ____ information hotline is available ____ to date literature is available.</p> <p>Lupus awareness activities will be held and advertising will take place supporting this event.</p> <p>Caregiver/family members are considered active attendees and allowed to voice their concerns and ask questions.</p>	<p>Information is updated ____ on the Lupus information line. Literature will be available upon request or to persons recognized as needing more information related to their situation.</p> <p>Lupus awareness activities will be conducted as follows: _____ _____ _____.</p> <p>Lupus patients will continue to be encouraged to bring their caregivers and children to meetings, through the following methods _____ _____ _____.</p>	<p>Literature will be available upon request or as needed. A monthly data report provided by the target area will communication department is used to track calls to the lupus ____ information line.</p> <p>Increased awareness of lupus among county residents. At least ____ individuals will hear or read about lupus awareness and program availability.</p> <p>It is expected that at least ____ participants will be caregivers</p>	<p>Program Staff</p> <p>Program Staff</p> <p>Program Staff</p>	<p>By June 30, 2016</p> <p>By June 30, 2016</p> <p>By June 30, 2016</p>

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

Agency Name _____

SAMPLE-PROJECT ACTION PLAN – FY 2016

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

Goals/Objectives	Approach	Activities	Evaluation	Responsibilities	Timeline
<ul style="list-style-type: none"> ▪ How many persons with lupus do you plan to serve via Optimal Support Group? ▪ How many caregivers who attended the group do you plan to serve? ▪ How many individuals do you plan to serve with non-support group activities. ▪ What are your specific Public Education plans? 	How will you do it?	What will take place?	<p>What results do you expect?</p> <p>How will you measure it?</p>	Who will be responsible?	Applicants must list the activities for each month of the year along with the frequency of each activity?
<p><u>Patient Education</u></p> <p>Optional Objective:</p> <p>h. By June 30, 2016 at least _____ people will presentations that enhance SLE education will be conducted and lupus awareness information will be displayed during at least ___ local events including health fairs.</p> <p><u>Public Education</u></p> <p>i. By June 2016 awareness of support group meetings for county residents will be enhanced by sending public service announcements to at least __ media and community organizations.</p> <p>j. By June 30, 2016 at least ___ copies of the Lupus symptom checklist will be distributed.</p>	<p>Staff will participate in health fairs and conduct presentations through the county.</p> <p>Monthly support group meetings announcements will be sent to media and community.org.</p> <p>The Symptom checklist will be administered.</p>	<p>Public Education activities will be scheduled and coordinated by facilitator.</p> <p>Monthly PSA's will be sent to media, outlets, print, audio, television and community.org.</p> <p>The checklist will be administered at health fairs, presentations, and outreach activities</p> <p>A referral list and lupus information sheets will be provided to individuals who take the checklist.</p>	<p>Program Staff will participate in at least _____ health fairs or presentations.</p> <p>Support group participants will be asked how they became aware of support group as indicated on group participant form.</p> <p>It is expected that more people will be aware of lupus symptoms. This will be measured by the number distributed and patients having 4 or more symptoms.</p>	<p>Program Staff</p> <p>Program Staff</p> <p>Program Staff</p>	<p>From July 2015 to June 2016</p> <p>From July 2015 to June 2016</p> <p>From July 2015 to June 2016</p>

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

Agency Name _____

SAMPLE-PROJECT ACTION PLAN – FY 2016

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

Goals/Objectives	Approach	Activities	Evaluation	Responsibilities	Timeline
<ul style="list-style-type: none"> ▪ How many persons with lupus do you plan to serve via Optimal Support Group? ▪ How many caregivers who attended the group do you plan to serve? ▪ How many individuals do you plan to serve with non-support group activities. ▪ What are your specific Public Education plans? 	How will you do it?	What will take place?	What results do you expect? How will you measure it?	Who will be responsible?	Applicants must list the activities for each month of the year along with the frequency of each activity?
<u>Patient Education</u> k. By June 30, 2016 the Lupus Support Group Facilitator will provide the following: (Water bottle, Zumba, coffee club etc.)	This activity will take place _____ _____ _____	Support group members will be educated on activity.	Feedback on activities of participants will be completed after each activity.	Program Staff	Between July 2015 and May 2016

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

Agency Name _____

PROJECT ACTION PLAN – FY 2016

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

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

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

Agency Name _____

INSTRUCTIONS FOR COMPLETING THE PROJECT ACTION PLAN

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

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

APPROACH:

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

ACTIVITIES:

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

RESPONSIBILITY:

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

TIMELINE:

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

****PLEASE NOTE CHANGES TO TIMELINE REQUIREMENT MONTHLY ACTIVITIES.**

SECTION I: PERSONNEL AND FRINGE BENEFITS – INSTRUCTIONS

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

- Column I. Provide the yearly salary budgeted for each position listed. The amount should be consistent with similar positions in the agency based on Full-Time Equivalency (FTE).
- Column II. The total number of months of employment projected per position for this grant.
- Column III. Calculate the percent of time the employee will devote exclusively to the project under this grant; for example, a 40-hour per week agency employee who provides 20 hours of service on this project would be listed as 50%.
- Column IV. Amount of the employee's salary that will be funded by the Commission based on annual salary (Column I), number of months on the project (Column II) and the percentage of time on the project (Column III).
- a) Example: 1) An employee with an annual salary of \$15,000 who works 12 months at 50% of his/her time would earn \$7,500 from Commission funds; 2) An employee with an annual salary of \$20,000 who works nine months at 25% of his/her time on the project would earn \$3,750 from the Commission.
 - b) If the agency pays one rate during a probationary period with an increase after probation, state budget assumptions on separate lines for each category and provide a narrative explanation.
 - c) Only employees who implement services detailed in the project proposal may charge their time to this grant.
- Column V. List the fringe benefits for all positions listed in the budget.
- Column VI. List the percentage of employee fringe benefits.
- Column VII. Where appropriate, match must be identified for each line item.



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

DO NOT SUBMIT THIS PAGE WITH RFP

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

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

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

SECTION II: NON-PERSONNEL – INSTRUCTIONS

A. Travel:

- i. State estimated number of miles that will be traveled and the rate at which payment would be made, not to exceed the federal rate of **\$.575 cents per mile. Example: 2,000 miles at \$.52 cents = \$1150.00**
- ii. Projected number of overnight lodgings, number of people involved and the rate per day/per person should be stated. Lodging rate per day/per person may not exceed the state rate of \$80.00 plus room tax (if applicable).
- iii. Meal expenses are allowable for dinner and breakfast when on an approved overnight stay, not to exceed \$27.00 per day with receipts for full days of travel preceded and followed by overnight stays.
- iv. Out-of-state travel is a non-allowable cost under this grant.
- v. Fees for conferences/training sessions, when determined to be related to specific job-duties and/or responsibilities, are reimbursable or allowable. Projected number of such sessions and costs should be stated.
- vi. Only employees who implement services detailed in the project proposal may be reimbursed for actual travel expenses.
- vii. All funded grantees are required to allot funds to support Lupus Awareness Month activities in May 2016.
 - Travel cost (mileage, meals, and hotel accommodations) to attend the Health Expo and Community Awards Ceremony scheduled for **March, 2016**.

B. Equipment:

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

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

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

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

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

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

Printing: Costs may include typesetting, actual printing or photocopying of recruitment/advertising material which is completed by a commercial printing company. Included also are costs for copying pamphlets, brochures and flyers. Provide the unit cost.

Contracts: Agreements for all sub-contracts must be submitted with the following being addressed: scope of service, beginning/ending date, hourly rate and total number of contract hours.

Advertising: Specify the media and cost of advertisement (e.g. 3 ads at \$50.00 per ad).

DO NOT SUBMIT THIS PAGE WITH RFP

(E) ADMINISTRATIVE COSTS (Itemize and attach written narrative justification for each item)	I. Total Budget	II. Amount Requested From Commission
SUBTOTAL		
SUBTOTAL - Non-personnel (Section II)		
TOTAL (Section I and II)		



The attached budget narrative must be completed and submitted in order for this application to be considered complete.

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 clause, signatures of lessee and lessor;
 - d. approved rent is non-transferable from the original site to a new or relocated site.
 - e. Rent will not be approved for:
 - space which is paid for by another state/federal program or private grant;
 - space in buildings purchased with federal funds;
 - space donated to the applicant agency.
 - utilities: heat, water, electricity, etc.

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

Agency Name: _____ Grant Number: SLE 2016-_____

SECTION I: PERSONNEL AND FRINGE BENEFITS:

SECTION II: NON PERSONNEL:

A. Travel:

a. Minority Health Month

B. Equipment:(lease/rental)

C. Supplies, Contracts, Etc.:

D. Lupus Awareness Month:

E. Administrative Costs:

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

SECTION III: ANTICIPATED PERIODIC DISTRIBUTION OF COMMISSION FUNDS ONLY

SFY 2016

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

SOURCE OF AGENCY SUPPORT

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

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

<u>SOURCE</u>	<u>AMOUNT</u>
1. Local Appropriations	\$ _____
2. Gifts and Contributions	\$ _____
3. In-kind Contributions (<i>itemize</i>)	\$ _____
4. State	\$ _____
5. Federal	\$ _____
6. Other	\$ _____
TOTAL AMOUNT OF APPLICANT MATCH (hard cash)	\$ _____
TOTAL AMOUNT REQUESTED FROM COMMISSION	\$ _____

 Executive Director (Blue Ink) Date

 Fiscal Officer (Blue Ink) Date



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

SECTION III: ANTICIPATED PERIODIC DISTRIBUTION – INSTRUCTIONS

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

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

DO NOT SUBMIT THIS PAGE WITH RFP

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.)

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.

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

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

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

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

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

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

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

If yes, list company.

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

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: <input type="checkbox"/> Individual/sole proprietor or single-member LLC <input type="checkbox"/> 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. <input type="checkbox"/> 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) _____ <i>(Applies to accounts maintained outside the U.S.)</i>
	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 ▶
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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 persons 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) b. So-called trust account that is not a legal or valid trust under state law	The grantor-trustee ¹ 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.

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



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):

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SECTION 3 – PLEASE PROVIDE COMPLETE ADDRESS

ADDRESS:		COUNTY:
CITY:	STATE:	ZIP CODE:

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

ADDRESS:		COUNTY:
CITY:	STATE:	ZIP CODE:

SECTION 5 – CONTACT INFORMATION & PERSON TO RECEIVE PURCHASE ORDER		
NAME:		
WEBSITE:		
PHONE:	FAX:	EMAIL:
PREFERRED METHOD OF BEING CONTACTED: (CHECK ONE) <input type="checkbox"/> PHONE <input type="checkbox"/> 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 ADDITIONAL 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)		
<input type="checkbox"/> 2/10 NET 30 <input type="checkbox"/> NET 30 <input type="checkbox"/> NET 45 <input type="checkbox"/> NET 60 <input type="checkbox"/> NET 90		
SECTION 8 – PURCHASE ORDER DISTRIBUTION – OTHER THAN USPS MAIL		
EMAIL <u>OR</u> 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.

<p>SUBMIT FORM TO:</p> <p>Mail: Ohio Shared Services Attn: Vendor Maintenance P.O. Box 182880 Cols., OH 43218-2880</p> <p>Email: vendor@ohio.gov</p> <p>Fax: 1 (614) 485-1052</p>	<p>QUESTIONS? PLEASE CONTACT:</p> <p>Phone: 1 (877) OHIO - SS1 (1-877-644-6771) 1 (614) 338-4781</p> <p>Website: www.ohiosharedservices.ohio.gov/</p> <p>Email: vendor@ohio.gov</p>
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Insert an original Authorization Agreement for Direct Deposit of EFT Payments form (OBM-4310), signed in blue ink, here.



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: <input type="checkbox"/> ADD <input type="checkbox"/> CHANGE/UPDATE <input type="checkbox"/> INACTIVATE												
NAME OF COMPANY OR INDIVIDUAL												
ADDRESS												
CITY	STATE	ZIP										
PHONE	EMAIL											
FEDERAL EMPLOYER ID (EIN) OR SOCIAL SECURITY NUMBER (SSN)												
<table border="1" style="display: inline-table; border-collapse: collapse;"> <tr> <td style="width: 20px; height: 20px;"></td> </tr> </table>												
CHECK ALL THAT APPLY	<input type="checkbox"/> RSC - PCA	<input type="checkbox"/> ODJFS PROVIDER (PROVIDER ID NUMBER REQUIRED)										
		<table border="1" style="display: inline-table; border-collapse: collapse;"> <tr> <td style="width: 20px; height: 20px;"></td> </tr> </table>										
	<input type="checkbox"/> LOTTERY WINNER	<input type="checkbox"/> DODD PROVIDER (PROVIDER ID NUMBER REQUIRED)										
		<table border="1" style="display: inline-table; border-collapse: collapse;"> <tr> <td style="width: 20px; height: 20px;"></td> </tr> </table>										
	<input type="checkbox"/> ALL OTHER: _____											
SECTION 2 – NEW FINANCIAL INFORMATION												
NEW FINANCIAL INSTITUTION NAME		PHONE										
TYPE OF ACCOUNT	<input type="checkbox"/> CHECKING	<input type="checkbox"/> SAVINGS										
NEW ACCOUNT NUMBER												
NEW TRANSIT ROUTING/ABA NUMBER												
SECTION 3 – OLD/PRIOR FINANCIAL INFORMATION - MUST BE PROVIDED TO CHANGE/UPDATE ACCOUNT												
OLD/PRIOR FINANCIAL INSTITUTION NAME		PHONE										
OLD/PRIOR ACCOUNT NUMBER												
OLD TRANSIT ROUTING/ABA NUMBER												

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

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

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

PRINT NAME

SIGNATURE (DIGITAL SIGNATURE NOT ACCEPTED AT THIS TIME)

DATE

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

NOTE:

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

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

SUBMIT FORM TO:	QUESTIONS? PLEASE CONTACT:
Mail: Ohio Shared Services Attn: Vendor Maintenance P.O. Box 182880 Cols., OH 43218-2880 E-mail: vendor@ohio.gov Fax: 1 (614) 485-1052	Phone: 1 (877) OHIO - SS1 (1-877-644-6771) 1 (614) 338-4781 Website: www.ohiosharedservices.ohio.gov E-mail: vendor@ohio.gov

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

SECTION 1

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

SECTION 2 (New Information)

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

SECTION 3 (Old/Prior Information) Required if a CHANGE/UPDATE

- 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.

APPLICANT CHECKLIST

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

- Receipt of Acceptance is enclosed **as cover page with completion of information requested.**
- Review application to assure that all sections have been answered completely and budget pages are tallied correctly.
- Check to assure that appropriate signatures have been entered, dated and are in BLUE INK.
- Check all figures for typing errors and to assure that all calculations are correct.
- Include the completed State of Ohio Vendor Forms. The information should match information listed on the W-9 Form. The OCMH will process this form with Shared Services.
- Attach a copy of 501(c)(3) letter from the Internal Revenue Service
- Attach signed statement for Rehabilitation Act of 1973
- Attach signed statement for Civil Rights Act of 1964
- Attach completed W-9 Form, signed in blue ink.

- Complete Board and Employee compositions forms (do not leave blank space)
- Complete questionnaires and insert Administrative of Compliance (answer all).
- Include copies of all contracts and job descriptions funded by this grant.
- Complete Project Application-All pages must be single sided.

- Complete and attach the "Program Narrative" portion of the grant application.
 - Description of Applicant Agency
 - Problem Need Statement
 - Method of Implementation
 - Project Action Plan
 - Board Resolution

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

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

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

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