

**To: Ohio Health Departments – IAP Program Applicants**

**From: Deborah Arms, Chief, Division of Prevention  
Ohio Department of Health**

**Subject: Notice of Availability of Funds – Competitive Grant  
January 1, 2008 – December 31, 2008 Budget Period**

The Ohio Department of Health (ODH), Division of Prevention, Bureau of Infectious Disease Control, announces the availability of grant funds to support the activities for the Immunization Action Plan (IAP) program. IAP funds are designed to support activities that will increase immunization rates in children under two years of age. Funds should assist programs in reaching the goal of increasing immunization rates of two-year-olds to ninety percent by 2010.

Local public health districts are eligible to apply. Up to 88 grants may be awarded, but no more than one grant may be awarded in each county. Total funding for IAP grants is expected to approximate \$4 million dollars. If multiple health districts in a county or region apply jointly for funding, one health district must act as the lead agency/fiscal agent for the grant.

Individual eligible counties may apply for an amount less than or equal to the amount stated for their county in Appendix 2 (2008 Immunization Action Plan Grant Maximum Funds Available). However, if a county is eligible for less than \$20,000, that county health department agency must partner with another (preferably neighboring) county public health agency for a minimum award of \$20,000.

Applications to serve multiple counties are encouraged. Applicants proposing to serve multiple counties may apply for the sum of the funds available for all counties to be served. Dollars designated for a county must be spent to specifically address the objectives outlined in this RFP.

All interested parties must complete and submit the Notice of Intent to Apply (NOIAF) form (attached to the RFP) no later than **Friday, September 14, 2007**, to be eligible to apply for funding.

Applicants must attend GMIS 2.0 training to be eligible to apply for funding. Unless previously done so, complete and return the GMIS 2.0 training form (attached to the RFP) if training for GMIS 2.0 is needed. This training will allow you to submit an application via the Internet using the Grants Management Information System (GMIS 2.0). All grant applications must be submitted via the Internet using the GMIS 2.0.

The RFP will provide detailed information about the background, intent and scope of the grant, policy, procedures, performance expectations, and general information and requirements associated with the administration of the grant. Please read and follow the directions carefully.

Please contact David Feltz at (614) 466-0413, or [dave.feltz@odh.ohio.gov](mailto:dave.feltz@odh.ohio.gov) with any questions regarding this Request for Proposal.

**Ohio Department of Health  
Grants Administration  
Central Master Files, 4<sup>th</sup> Floor  
246 N. High Street  
Columbus, OH 43215**

# NOTICE OF INTENT TO APPLY FOR FUNDING

Ohio Department of Health  
Division of Prevention  
Bureau of Infectious Disease Control

**ODH Program Title: Immunization Action Plan ( IAP )**

**ALL INFORMATION REQUESTED MUST BE COMPLETED.**  
**(Please Print Clearly or Type)**

County of Applicant Agency \_\_\_\_\_

**Federal Tax Identification Number** \_\_\_\_\_

NOTE: The applicant agency/organization name must be the same as that on the IRS letter.

This is the legal name by which the tax identification number is assigned.

**Type of Applicant Agency**     County Agency     Hospital     Local Schools  
(Check One)                       City Agency         Higher Education     Not-for Profit

**Applicant Agency/Organization** \_\_\_\_\_

**Applicant Agency Address** \_\_\_\_\_

**Agency Contact Person/Title** \_\_\_\_\_

**Telephone Number** \_\_\_\_\_

**E-mail Address** \_\_\_\_\_

**Please check all applicable:**     Our agency will need GMIS 2.0 training  
                                                   Our agency has completed GMIS 2.0 training  
                                                   First time applying for an ODH grant

**Mail, E-mail or Fax To:**                      **Tammy Butler, Immunization Program**  
                                                          **Ohio Department of Health**  
                                                          **35 E. Chestnut, 7<sup>th</sup> Floor**  
                                                          **Columbus, Ohio 43215**  
                                                          **E-mail: [tammy.butler@odh.ohio.gov](mailto:tammy.butler@odh.ohio.gov)**  
                                                          **Fax: 614-728-4279**

**Ohio Department of Health  
GMIS 2.0 TRAINING**

**ALL INFORMATION REQUESTED MUST BE COMPLETED for EACH EMPLOYEE  
FROM YOUR AGENCY WHO WILL ATTEND A GMIS 2.0 TRAINING SESSION.**

*(Please Print Clearly or Type)*

**Grant Program** \_\_\_\_\_ **RFP Due Date** \_\_\_\_\_

**County of Applicant Agency** \_\_\_\_\_

**Federal Tax Identification Number** \_\_\_\_\_

**NOTE:** The applicant agency/organization name must be the same as that on the IRS letter. This is the legal name by which the tax identification number is assigned and as listed, if applicable, currently in GMIS.

**Applicant Agency/Organization** \_\_\_\_\_

**Applicant Agency Address** \_\_\_\_\_

**Agency Employee to attend training** \_\_\_\_\_

**Telephone Number** \_\_\_\_\_

**E-mail Address** \_\_\_\_\_

**GMIS 2.0 Training Authorized by:** \_\_\_\_\_

(Signature of Agency Head or Agency Fiscal Head)

**Required**

**Please Check One:**

\_\_\_\_\_ **Yes – I ALREADY have access to the  
ODH GATEWAY (SPES, ODRS, LHIS, etc)**

\_\_\_\_\_ **No – I DO NOT have access to the ODH GATEWAY**

**Please indicate your training date choices: 1<sup>st</sup> choice \_\_\_\_\_, 2<sup>nd</sup> choice \_\_\_\_\_, 3<sup>rd</sup> choice \_\_\_\_\_**

**Mail, E-mail, or Fax To:**

**GAIL BYERS**

**Grants Administration Unit**

**Ohio Department of Health**

**246 N. High Street**

**Columbus, Ohio 43215**

**E-mail: [gail.byers@odh.ohio.gov](mailto:gail.byers@odh.ohio.gov)**

**Fax: [614-752-9783](tel:614-752-9783)**

*CONFIRMATION OF YOUR GMIS 2.0 TRAINING SESSION WILL BE E-MAILED TO YOU*



**ALL APPLICATIONS MUST BE SUBMITTED VIA THE INTERNET**

# **OHIO DEPARTMENT OF HEALTH**

## **DIVISION OF PREVENTION**

### **BUREAU OF INFECTIOUS DISEASE CONTROL**

#### **IMMUNIZATION ACTION PLAN REQUEST FOR PROPOSALS (RFP)**

**FOR  
FISCAL YEAR 2008  
(01/01/08 – 12/31/08)**

**Local Public Applicant**

**COMPETITIVE GRANT APPLICATION INFORMATION**

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## **I. APPLICATION SUMMARY and GUIDANCE**

An application for an ODH grant consists of a number of required parts – an electronic component submitted via an Internet Website: ODH Application Gateway – GMIS 2.0 (**which is sent with electronic acknowledgment in lieu of signature page**), various paper forms and attachments. All the required parts of a specific application must be completed and submitted by the application due date. **Any required part that is not submitted on time will result in the entire application not being considered for review.**

The application summary information is provided to assist your agency in identifying funding criteria:

- A. Policy and Procedure:** Uniform administration of all ODH grants is governed by the Ohio Department of Health Grants Administration Policies and Procedures Manual (GAPP). This manual must be followed to assure adherence to the rules, regulations and procedures for preparation of all Subgrantee applications. The GAPP manual is available on the ODH web-site at <http://www.odh.ohio.gov> (Click on “About ODH,” click on “ODH Grants” and then click on “GAPP Manual.”)
- B. Application Name:** Immunization Action Plan (IAP)
- C. Purpose:** IAP funds are designed to raise infant immunization rates in Ohio to reach the 2010 goal that 90 % of children will be up-to-date on immunizations by two years of age. This goal will be accomplished primarily through immunization assessment and education activities.
- D. Qualified Applicants:** Local public health districts are eligible to apply. Agencies currently funded under the Immunization Action Plan (IAP) program as well as local public health agencies not currently funded with IAP funds in 2007 are eligible to apply. Eligible counties are listed in Appendix 2. Applicants funded in 2007 must have demonstrated acceptable performance from July 2006 – July 2007. If multiple health districts in a county or region apply jointly for funding, one health district must act as the lead agency/fiscal agent for the grant.
- E. Service Area:** Applicants must apply for funds to cover a minimum of one county in the state of Ohio. Counties with smaller population sizes should combine efforts to create an application for two or more counties.
- F. Number of Grants and Funds Available:**  
Up to 88 grants may be awarded, but no more than one grant may be awarded in each county. Total funding for IAP grants is expected to approximate \$4 million dollars. Funds originate from both federal and state funding sources. Two or more local health districts may collaborate on an application.

Individual eligible counties may apply for an amount less than or equal to the amount stated for their county in Appendix 2 (2008 Immunization Action Plan Grant Maximum

Funds Available). However, if a county is eligible for less than \$20,000, that county health department agency must partner with another (preferably neighboring) county public health agency for a minimum award of \$20,000.

Counties eligible to participate in the WIC Immunization project and the Perinatal Hepatitis B project should refer to the corresponding additional amounts listed in Appendix 2.

Applications to serve multiple counties are encouraged. Applicants proposing to serve multiple counties may apply for the sum of the funds available for all counties to be served. Dollars designated for a county must be spent to specifically address the objectives outlined in this RFP.

Awards will be based upon all of the following criteria:

1. The resident birth cohort of children in the applicant county;
2. The number of VFC providers in each applicant county;
3. The ability of applicants to meet stated program objectives in 2006 and 2007 (if applicable);
4. The soundness and score of applicant responses to requirements for 2008.

*No grant award will be issued for less than \$20,000. The minimum amount is exclusive of any required matching amounts and represents only ODH funds granted. Applications submitted for less than the minimum amount will not be considered for review. Applicants are encouraged to partner with other counties.*

- G. Due Date:** Applications, including any required forms and required attachments mailed or electronically submitted via GMIS 2.0 Send/Record Comments are due by **Monday October 15, 2007**. Attachments and/or forms sent electronically must be transmitted by the application due date. Attachments and/or forms mailed that are non-internet compatible must be post marked or received on or before the application due date.

Contact David Feltz at (614) 466-4643 or [dave.feltz@odh.ohio.gov](mailto:dave.feltz@odh.ohio.gov) with any questions.

- H. Authorization:** Authorization of funds for this purpose is contained in the Catalog of Federal Domestic Assistance (CFDA) Number 93.268 the Federal Immunization Grant (PHS Act 317) award. Additional authorization of funds for this purpose is contained in Am. Sub. HB 119.

- I. Goals:** The goal of the IAP program is to achieve and maintain 90% vaccination coverage levels for universally recommended vaccines among children less than 24 months of age through:
- Assessing and improving health district immunization rates through use of local Immunization Information System (IIS)
  - Assessing and improving the immunization rates of providers throughout the applicant county (or counties)

- Increasing the percentage of children participating in the state or local Immunization Information System (IIS)
- Identifying geographic pockets of low immunization levels and providing additional immunization education to parents and health care providers in those areas
- Educating immunization providers and other providers who provide primary care to children
- Collaborating with WIC
- Implementing additional and targeted reminder and recall activities to improve local health department immunization rates.

**J. Program Period and Budget Period:** The program period begins on January 1, 2008 and ends on December 31, 2008. The budget period for this application will begin on January 1, 2008 and end on December 31, 2008.

**K. Local Health Districts Improvement Standards:** This grant program will address the Local Health Districts Improvement Goal 3701-36-07 – “Promote Healthy Lifestyles,” Standard 3701-36-07-03 – “Prevention, health promotion, early intervention, and outreach services are provided directly or through contracts or partnerships.” The Local Health District Improvement Standards are available on the ODH web-site <http://www.odh.ohio.gov>. (Click on “Local Health Districts” then “Local Health Districts Improvement Standards,” Then click “Local Health District Improvement Goals/ Standards/ Measures.”)

**L. Public Health Impact Statement:** All applicant agencies that are not local health districts must communicate with local health districts regarding the impact of the proposed grant activities on the Local Health Districts Improvement Standards.

1. *Public Health Impact Statement Summary* - Applicant agencies are required to submit a summary of the program to local health districts prior to submitting the grant application to ODH. The program summary, not to exceed one page, must include:

- (1) The Local Health District Improvement Standard(s) to be addressed by grant activities;
- (2) A description of the target population to be served;
- (3) A summary of the services to be provided or activities to be conducted; and,
- (4) A plan to coordinate and share information with appropriate local health districts.

The Applicant must submit the above summary as part of their grant application to ODH. This will document that a written summary of the proposed activities was provided to the local health districts with a request for their support and/or comment about the activities as they relate to the Local Health Districts Improvement Standards. **(not required for continuation cycle, if unchanged).**

2. *Public Health Impact Statement of Support* - Include with the grant application a

statement of support from the local health districts, if available. If a statement of support from the local health districts is not obtained, indicate that when the program summary is submitted with the grant application. If an applicant agency has a regional and/or statewide focus, a statement of support must be submitted from at least one local health district, if available. **(not required for continuation cycle, if unchanged).**

- M. Appropriation Contingency:** Any award made through this program is contingent upon the availability of funds for this purpose, i.e., timely funding provided to the Ohio Department of Health Immunization Program by the Centers for Disease Control and Prevention. In view of this, the subgrantee agency must be prepared to cover the cost of operating the program in the event of a delay in grant payments.
- N. Programmatic, Technical Assistance and Authorization for Internet Submission:** *Initial authorization for Internet submission will be distributed at your GMIS 2.0 Training Session.* Please contact David Feltz at (614) 466-4643 or [dave.feltz@odh.ohio.gov](mailto:dave.feltz@odh.ohio.gov) for assistance.

For competitive RFPs ONLY: Applicant must attend or must document in writing, prior attendance at Grants Management Information System 2.0 (GMIS 2.0) training in order to receive authorization for Internet submission.

- O. Acknowledgment:** An electronic message will appear in GMIS 2.0 that acknowledges ODH system receipt of the Internet submission.
- P. Late Applications:** Applications are dated the time of actual submission via the Internet utilizing GMIS 2.0. Required attachments and/or forms sent electronically must be transmitted by the application due date. Required attachments and/or forms mailed that are non-Internet compatible must be postmarked or received on or before the application due date of **Monday, October 15, 2007.**

Applicants should request a legibly dated postmark, or obtain a legibly dated receipt from the U.S. Postal Service, or a commercial carrier. Private metered postmarks shall **not** be acceptable as proof of timely mailing. Applicants can hand-deliver attachments to ODH, Grants Administration, Central Master Files; but they must be delivered by 4:00 p.m. on the application due date. FAX attachments will not be accepted. **GMIS 2.0 applications and required application attachments received late will not be considered for review.**

- Q. Successful Applicants:** Successful applicants will receive official notification in the form of a “Notice of Award” (NOA). The NOA, issued under the signature of the Director of Health, allows for expenditure of grant funds.
- R. Unsuccessful Applicants:** Within 30 days after a decision to disapprove or not fund a grant application for a given program period, written notification, issued under the signature of the Director of Health, or his designee shall be sent to the unsuccessful

applicant.

- S. Review Criteria:** All proposals will be judged on the quality, clarity and completeness of the application. Applications will be judged according to the extent to which the proposal:
1. Contributes to the advancement and/or improvement of the health of Ohioans;
  2. Is responsive to policy concerns and program objectives of the initiative/program/ activity for which grant dollars are being made available;
  3. Is well executed and is capable of attaining program objectives;
  4. Describes specific objectives, activities, milestones and outcomes with respect to time-lines and resources;
  5. Estimates reasonable cost to the Ohio Department of Health, considering the anticipated results;
  6. Demonstrates that program personnel are well qualified by training and/or experience for their roles in the program and the applicant organization has adequate facilities and personnel;
  7. Provides an evaluation plan, including a design for determining program success;
  8. Is responsive to the special concerns and program priorities specified in the request for proposal; and,
  9. Has demonstrated acceptable past performance.
  10. Has demonstrated compliance to GAPP Chapter 100, Section 108.1 Independent Audit Scope.

Applications will be evaluated based on the criteria in the Application Review Form in Appendix 1, page 23.

The Ohio Department of Health will make the final determination and selection of successful/unsuccessful applicants and reserves the right to reject any or all applications for any given request for proposals. There will be no appeal of the Department's decision.

- T. Freedom of Information Act:** The Freedom of Information Act and the associated Public Information Regulations (45 CFR Part 5) of the U. S. Department of Health and Human Services require the release of certain information regarding grants requested by any member of the public. The intended use of the information will not be a criterion for release. Grant applications and grant-related reports are generally available for inspection and copying except that information considered to be an unwarranted invasion of personal privacy will not be disclosed. For specific guidance on the availability of information, refer to 45 CFR Part 5.

- U. Ownership Copyright:** Any work produced under this grant will be the property of the Ohio Department of Health/Federal Government. The Department's ownership will include copyright. The content of any material developed under this grant **must** be approved in advance by the awarding office of the Ohio Department of Health. All material(s) must clearly state:

Funded by Ohio Department of Health/Federal Government  
Bureau of Infectious Disease Control  
Immunization Program

- V. Reporting Requirements:** Successful applicants are required to submit subgrantee program and expenditure reports. Reports must adhere to the Ohio Department of Health, Grants Administration Policies and Procedures (GAPP) Manual. Reports must be received before the Department will release any additional funds.

**Note: Failure to assure quality of reporting such as submitting incomplete and/or late program or expenditure reports will jeopardize the receipt of your agency flexibility status and/or further payments.**

Submit reports as follows:

- 1. Program Reports:** Subgrantee Program Reports **must** be completed and submitted **via the SPES (Subgrantee Performance Evaluation System)** by the following dates: July 15, 2008 and January 15, 2009. Additional required attachments associated with a Program Report may be sent electronically associated with an email. Any paper non-Internet compatible report attachments must be submitted to Central Master Files by the specific report due date. The program progress report must contain all of the items outlined in Appendix 3.

*Submission of Subgrantee Program Reports via the Ohio Department of Health's SPES system indicates acceptance of ODH Grants Administration Policy and Procedure (GAPP).*

- 2. Subgrantee Program Expenditure Reports:** Subgrantee Program Expenditure Reports **must** be completed and submitted **via the internet** by the following dates: April 15, 2008; July 15, 2008; October 15, 2008; January 15, 2009.

*Submission of Subgrantee Program Expenditure Reports via the Ohio Department of Health's GMIS 2.0 system indicates acceptance of ODH Grants Administration Policy and Procedure (GAPP). Clicking the "submit" button signifies your authorization of the submission as an agency official and constitutes your electronic acknowledgment and acceptance of GAPP rules and regulations.*

- 3. Final Expense Reports:** A Subgrantee Final Expense Report reflecting total expenditures for the fiscal year must be completed and submitted **via GMIS 2.0** on or before February 15, 2009. The information contained in this report must reflect the program's accounting records and supportive documentation. Any cash balances

must be returned with the Subgrantee Final Expense Report. The Subgrantee Final Expense Report serves as an invoice to return unused funds.

*Submission of the Subgrantee Final Expense Report via the Ohio Department of Health's GMIS 2.0 system indicates acceptance of ODH Grants Administration Policy and Procedure (GAPP). Clicking the "submit" button signifies your authorization of the submission as an agency official and constitutes your electronic acknowledgment and acceptance of GAPP rules and regulations.*

4. **Inventory Report:** A listing of all equipment purchased in whole or in part with **current** grant funds (Equipment Section of the approved budget) must be submitted via the Internet as part of the Subgrantee Final Expense Report. At least once every two years, inventory must be physically inspected by the subgrantee. Equipment purchased with ODH grant funds must be tagged as property of ODH for inventory control. Such equipment may be required to be returned to ODH at the end of the grant program period.

- W. Special Condition(s):** Responses to all special conditions **must be submitted via the Internet within 30 days of receipt of the first quarter payment.** A Special Conditions link is available for viewing and responding to special conditions. This link is viewable only after the issuance of the subgrantee's first payment. The 30-day time period, in which the subgrantee must respond to special conditions, will begin when the link is viewable. Failure to submit satisfactory responses to the special conditions or a plan describing how those special conditions will be satisfied will result in the withholding of any further payments until satisfied.

*Submission of response to grant special conditions via the Ohio Department of Health's GMIS 2.0 system indicates acceptance of ODH Grants Administration Policy and Procedure (GAPP). Clicking the "submit" button signifies your authorization of the submission as an agency official and constitutes your electronic acknowledgment and acceptance of GAPP rules and regulations.*

- X. Unallowable Costs:** Funds **may not** be used for the following:

1. To advance political or religious points of view, or for fund raising or lobbying, but must be used solely for the purpose as specified in this announcement;
2. To disseminate factually incorrect or deceitful information;
3. Consulting fee for salaried program personnel to perform activities related to grant objectives;
4. Bad debts of any kind;
5. Lump sum indirect or administrative costs;
6. Contributions to a contingency fund;
7. Entertainment;
8. Fines and penalties;
9. Membership fees -- unless related to the program and approved by ODH;
10. Interest or other financial payments;
11. Contributions made by program personnel;

12. Costs to rent equipment or space owned by the funded agency;
13. Inpatient services;
14. The purchase or improvement of land; the purchase, construction, or permanent improvement of any building;
15. Satisfying any requirement for the expenditure of non-federal funds as a condition for the receipt of federal funds;
16. Travel and meals over the current state rates (see OBM Website <http://www.obm.ohio.gov/mppr/travel.asp>);
17. All costs related to out-of-state travel, unless otherwise approved by ODH, and described in the budget narrative;
18. Training longer than one week in duration, unless otherwise approved by ODH;
19. Contracts, for compensation, with advisory board members;
20. Grant-related equipment costs greater than \$300, unless justified and approved by ODH;
21. Payments to any person for influencing or attempting to influence members of Congress or the Ohio General Assembly in connection with awarding of grants; and
22. Local registry software products or maintenance.

**Use of grant funds for prohibited purposes will result in the loss or recovery of those funds.**

**Y. Audit:** Subgrantees currently receiving funding from the Ohio Department of Health are responsible for submitting an independent audit report that meets OMB Circular A-133 requirements, a copy of the auditor's management letter, a corrective action plan, if applicable and a data collection form ( for single audits ) within 30 days of the receipt of the auditor's report, but not later than 9 months after the end of the subgrantees's fiscal year.

Potential subgrantees not currently receiving funding from the Ohio Department of Health must submit an independent audit report that meets OMB Circular A-133 requirements, a copy of the auditor's management letter, and if applicable, a corrective action plan and a data collection form ( for single audits ) with this grant application.

Subgrantees that have an agency fiscal year that ends on or after January 1, 2004 which expend \$500,000 or more in Federal awards in its fiscal year are required to have a single audit. The fair share of the cost of the single audit is an allowable cost to Federal awards provided that the audit was conducted in accordance with the requirements of OMB Circular A-133.

Subgrantees that have an agency fiscal year that ends on or after January 1, 2004 which expend less than the \$500,000 threshold require a financial audit conducted in accordance with Generally Accepted Government Auditing Standards. The financial audit is not an allowable cost to the program.

Audit documents must be sent to the ODH, Grants Administration, Central Master Files

address. Reference GAPP Chapter 100, Section 108 and OMB Circular A-133, Audits of States, Local Governments, and Non-Profit Organizations for additional audit requirements.

**Z. Submission of Application:**

The Internet application submission must consist of the following:

1. Application Information
2. Project Narrative
3. Project Contacts
4. Budget
  - Primary Reason
  - Funding
  - Cash Needs
  - Justification
  - Personnel
  - Other Direct Costs
  - Equipment
  - Contracts
  - Compliance Section D
  - Summary
5. Civil Rights Review Questionnaire (EEO Survey)
6. Assurances Certification
7. Ethics Certification
8. Attachments as required by Program

**Complete  
& Submit  
Via Internet**

***IAP Budget Summary Sheet***

An original and one (1) copy of the following forms, available on the Internet, must be completed, printed, signed in blue ink with original signatures and mailed to the address listed below:

1. Electronic Funds Transfer (EFT) Form. **(Required if new agency, thereafter only if banking information has changed)**
2. IRS W-9 Form **(Required if new agency, thereafter only when tax identification number or agency address information has changed). One of the following forms must accompany the IRS W-9 Form:**
  - a. Vendor Information Form **(New Agency Only)**
  - b. Vendor Information Change Form **(Existing Agency with tax identification number, name and/or address change(s))**

**Complete,  
Sign &  
Mail To  
ODH**

Two (2) copies of the following documents must be mailed to the address listed below:

**Copy &  
Mail To  
ODH**

1. Public Health Impact Statement (**for competitive cycle only; for continuation, only if changed**)
2. Statement of Support from the Local Health Districts (**for competitive cycle only; for continuation, only if changed**)
3. Liability Coverage (**Non-Profit Organizations only; proof of current liability coverage and thereafter at each renewal period**)
4. Evidence of Non-Profit Status (**Non-Profit Organizations only; for competitive cycle only; for continuation, only if changed**)

One (1) copy of the following documents must be mailed to the address listed below:

**Complete  
Copy &  
Mail To  
ODH**

1. Current Independent Audit (latest completed organizational fiscal period; **only if not previously submitted**)
2. Declaration Regarding Material Assistance/Non-Assistance to a Terrorist Organization (DMA) Questionnaire (**Required by ALL Non-Governmental Applicant Agencies**)
3. **Attachments** (non-Internet compatible) as required by Program: None

**Ohio Department of Health  
Grants Administration  
Central Master Files, 4<sup>th</sup> Floor  
246 N. High Street  
Columbus, Ohio 43215**

## II. APPLICATION REQUIREMENTS AND FORMAT

Access to the on-line Grants Management Information System 2.0 (GMIS 2.0), will be provided after your GMIS 2.0 training session.

*All applications must be submitted via the Internet. Submission of all parts of the grant application via the Ohio Department of Health's GMIS 2.0 system indicates acceptance of ODH Grants Administration Policy and Procedure (GAPP). Submission of the application signifies your authorization as an agency official and constitutes your electronic acknowledgment and acceptance of GAPP rules and regulations in lieu of an executed Signature Page document*

- A. Application Information:** Information on the applicant agency and its administrative staff must be accurately completed in its entirety. Include e-mail addresses for receipt of acknowledgements. This information will serve as the basis for necessary communication between the agency and the ODH.
- B. Budget:** Prior to completion of the budget section, please review page 7 of the RFP for unallowable costs. Match or Applicant Share is not required by this program; do not include match or Applicant Share in the budget and/or the Applicant Share column of the Budget Summary. Only the narrative may be used to identify additional funding information from other resources.
  - 1. Primary Reason and Justification Pages:** Provide a detailed narrative budget justification that describes how the categorical costs are derived. Discuss the necessity, reasonableness, and allocability of the proposed costs. Describe the specific functions of the personnel, consultants, and collaborators. Explain and justify equipment, travel, (including any plans for out-of-state travel), supplies and training costs. If you have joint costs refer to GAPP Chapter 100, Section 103 and Section D(9) of the application for additional information. All budgeted costs must relate to the accomplishment of a grant objective, as outlined in the methodology section on page 14. The applicant must identify the total cost for each objective on the IAP Budget Summary Sheet (Appendix 4).
  - 2. Funding, Cash Needs, Personnel, Other Direct Costs, Equipment, Contracts & Confirmation of Contractual Agreement (CCA) Form(s):** Submit a budget with these sections and form(s) completed as necessary to support costs for the period January 1, 2008 to December 31, 2008.

Funds may be used to support personnel, their training, travel (see OBM Website <http://www.obm.ohio.gov/mppr/travel.asp>) and supplies directly related to planning, organizing, and conducting the Initiative/program activity described in this announcement.

Where appropriate, retain all contracts on file. The contracts should not be sent to ODH. A completed "Confirmation of Contractual Agreement" (CCA) form must be

submitted via GMIS 2.0 for each contract once it has been signed by both parties. The submitted CCA must be approved by ODH before contractual expenditures are authorized.

*Submission of the “Confirmation of Contractual Agreement” (CCA) via the Ohio Department of Health’s GMIS 2.0 system indicates acceptance of ODH Grants Administration Policy and Procedure (GAPP). Clicking the “submit” button signifies your authorization of the submission as an agency official and constitutes your electronic acknowledgement and acceptance of GAPP rules and regulations. CCA’s cannot be submitted until after the grant period begins.*

Where appropriate, itemize all equipment (**minimum \$300.00 unit cost value**) to be purchased with grant funds in the Equipment Section.

**3. Compliance Section D:** Answer each question on this form as accurately as possible. Completion of the form ensures your agency’s compliance with the administrative standards of ODH and federal grants.

**4. Funding, Cash Needs and Budget Summary Sections:** Enter information about the funding sources, budget categories and forecasted cash needs for the program. Distribution should reflect the best estimate of need by quarter. Failure to complete this section will cause delays in receipt of grant funds.

**C. Assurances Certification:** Each subgrantee must submit the “Federal and State Assurances for Subgrantees” form. This form is submitted automatically with each application via the Internet. The Assurances Certification sets forth standards of financial conduct relevant to receipt of grant funds and is provided for informational purposes. The listing is not all-inclusive and any omission of other statutes does not mean such statutes are not assimilated under this certification. Complete the form by entering the State and Congressional Districts. By submission of an application, the subgrantee agency agrees by electronic acknowledgement to the financial standards of conduct as stated therein.

**D. Project Narrative:**

**1. Executive Summary:** Provide a brief synopsis of the purpose, methodology, and evaluation plan of this project. Identify target populations, services and programs to be offered and list the agency or agencies that will provide those services. Describe the public health problems that the program will address.

**2. Description of Applicant Agency/Documentation of Eligibility/Personnel:**

Note the following issues in this section:

- Summarize the agency's structure as it relates to this program and, as the lead agency, how it will manage the program and work with any other participating agencies (e.g., subcontracted local health districts, other health districts within the applicant county). Describe plans for meeting

with multiple health department agencies involved with this program.

- Describe plans for implementing quality assurance methods to improvement of immunization rates.
- Note any personnel or equipment deficiencies that will need to be addressed in order to carry out this grant.
- Describe plans for hiring and training, as necessary. Delineate all personnel who will be directly involved in program activities. Include the relationship between program staff members, staff members of the applicant agency, and other partners and agencies that will be working on this program.

**3. Problem/Need:** Identify and describe the local health status concern that will be addressed by the program; do not restate national and state data. The specific health status concerns that the program intends to address may be stated in terms of health status (e.g. morbidity and/or mortality) or health system (e.g., accessibility, availability, affordability, appropriateness of health services) indicators. The indicators should be measurable in order to serve as baseline data upon which the evaluation will be based. Note the following issues in this section:

- Clearly identify the target population. Identify the number of births that occurred to residents in each applicant county in 2005 or 2006. Identify the number of children under 24 months of age seen for immunizations at each local health district in the applicant county in 2006. Identify the number children under 24 months of age that were given a 1<sup>st</sup> dose of MMR vaccine during the 2006 calendar year at each local health district in the applicant county or counties.
- State past efforts and progress towards improving immunization rates in the applicant's immunization clinics, including changes in rates observed through the use of CoCASA (Comprehensive Clinical Assessment Software Application) and the AFIX (Assessment, Feedback, Incentives, eXchange) process.
- Describe data regarding immunization rates. Clearly list the series completion rates (4:3:1:3:3) measured using the CoCASA software during 2006 and 2007 for each health department applicant.
- Describe any additional immunization survey results used in the past 5 years to indicate low levels of immunization coverage in the applicant county or counties.
- List all immunization clinic site locations, clinic hours, and type of clinic (appointment only, walk-in only, or the clinic schedules appointments and accepts walk-ins) for all children seen in public health clinics in the applicant county or counties.
- Describe how the agency insures there are no barriers for children to receive immunizations at public health clinics in the applicant county or counties.
- Briefly describe the immunization reminder and recall process for all children seen in public health clinics in the applicant county or counties.
- Describe the process taken to insure that immunization histories are properly

documented and forwarded successfully to the State Immunization Registry (IMPACT SIIS) for all children seen in public health clinics in the applicant county or counties.

- List the names of the health care providers who vaccinate children in the applicant county; identify the non-VFC health care providers.
- Provide an indication of the number of physician offices or clinics (e.g., family practice, pediatricians) that provide primary care services for children, but do not provide immunizations.
- Describe other agencies and organizations that also address this need and are willing to play a role in the project (e.g., health care providers, schools, community service organizations).

**4. Methodology:** In a narrative format, identify the following program goals, objectives and activities in this section. *Reminder: the primary goal of the IAP grant is to achieve and maintain 90% vaccination coverage levels for universally recommended vaccines among children less than 24 months of age. All IAP grant applicants must respond to each of the following required program objectives (Objectives 1 - 6). Only applicants eligible for additional funding for Perinatal Hepatitis B activities, as identified in Appendix 2, should respond to Objective 7.*

Note: your responses to each of the following objectives should be SMART.

Specific (focused)

Measurable

Achievable

Realistic

Time-phased

## **IAP Grant Objectives:**

### **Objective 1: Health District Self-Assessment (AFIX)**

*IAP grantee agencies will successfully use the AFIX (Assessment, Feedback, Incentives, eXchange) process to regularly assess the immunization rates of clients they serve to improve on-time vaccination rates of children under age 24 months of age.*

*Note:* Staff who will be conducting AFIX assessments and feedbacks must meet the AFIX Core Competencies (see Appendix 5) and complete required ODH AFIX trainings.

*Note:* For additional information on this objective, refer to the red "AFIX Project for Ohio" binder.

- 1a Describe past successes and challenges each health department agency has encountered incorporating the quality assurance AFIX process to improve immunization rates. Include new procedures, activities, and protocols that have been implemented.
- 1b Describe the activities your agency will use to **Assess** the immunization rates of children under 36 months of age with your health district immunization records. Note who will enter immunization records into your registry and print the necessary CoCASA reports. This assessment is to be performed at least twice during the grant year. The CoCASA Summary Reports (4:3:1:3:3, 4:3:1:3:3:1, and 4:3:1:3:3:1:3), Single Antigen Report (4:3:1:3:3:1:3), and Diagnostic Report (4:3:1:3:3:1) provide adequate assessment results.

- 1c Identify key process start and completion dates for each measurable planned activity. Describe the activities your agency will perform to involve immunization staff in the **AFIX Feedback** process. Identify who will lead the discussion on health district strengths, weaknesses, and strategies for improvement. Identify who will participate in the feedback. Identify key process start and completion dates for each measurable planned activity.
- 1d Describe how staff will be encouraged through **Incentives** to improve your immunization delivery system. Incentives must be tied to measurable objectives (e.g., increasing rates, decreasing missed opportunities). Identify key process start and completion dates for each measurable planned activity.
- 1e Describe how staff will **eXchange** ideas and information to better improve your immunization rates. Identify key process start and completion dates for each measurable planned activity.
- 1h Describe your evaluation measure for this objective. The evaluation measure tells what will be used and how it will be used to determine whether or not the objective was met. Your statement must explain the process for using a specific instrument to assess the extent to which the objective was achieved.

**Objective 2: Immunization Provider Assessments (AFIX)**

*IAP grantee agencies will successfully use the AFIX (Assessment, Feedback, Incentives, eXchange) process to assess the immunization rates of immunization providers in their respective community to improve on-time vaccination rates of children under age 24 months of age.*

*Note:* For additional information on this objective, refer to the materials in the red "AFIX Project for Ohio" binder. You must use the forms and instructions in the ODH AFIX binder when conducting assessments and feedbacks.

- 2a Describe past successes and challenges each health department agency has encountered providing the quality assurance AFIX process to immunization providers in your communities.
- 2b List the names of staff who will conduct AFIX assessments and feedbacks for (non-health district) providers. Please note that all assessors and other staff reviewing the data are required to complete a "Data Collection Confidentiality Agreement" each project year, a copy of which needs to be on file with the ODH Immunization Program before any assessments are conducted. Participating health districts must submit a list of all assessors and other staff who will be reviewing the data by January 31 of each year.
- 2c Identify the **number** of pediatric and family practices in your county that do provide immunizations. Identify the **number** of pediatric and family practices in your county that do not provide immunizations.
- 2d Identify the target number of AFIX's planned for 2008.
- 2e Describe your promotion plan for AFIX's among the pediatric and family practices in your jurisdiction. Identify key process start and completion dates for each measurable planned activity.
- 2h Describe your evaluation measure for this objective. The evaluation measure tells what will be used and how it will be used to determine whether or not the objective was met. Your statement must explain the process for using a specific instrument to assess the extent to which the objective was achieved.

### **Objective 3: Immunization Education - Geographic Pockets of Need**

*IAP grantee agencies will use existing data to evaluate where under-immunized children reside and target educational and informational messages to immunization consumers in those geographic areas to improve the rate of timely immunization.*

- 3a List geographic areas in your county identified as pockets of low immunization levels. Justify the rationale for determination of these geographic pockets.  
*Note:* Some data for determining pockets of need may be obtained at [www.census.gov](http://www.census.gov), the Health Statistics/Information Warehouse link on [www.odh.ohio.gov](http://www.odh.ohio.gov), [www.ode.state.oh.us](http://www.ode.state.oh.us) (click on Data for information on Free and Reduced Lunch Program statistics), or review the Health Professional Shortage Area (HPSA) data.
- 3b Describe any plans for re-assessing these pockets of needs. Identify key process start and completion dates for each measurable planned activity.
- 3c Describe your plan to provide targeted immunization information to immunization consumers among identified pockets of need. Consumers need to know the following information to seek and accept immunizations:
- Information about vaccine-preventable diseases;
  - Vaccines are safe and effective;
  - Immunization recommendations for their age group;
  - Locations of facilities providing immunizations for underserved and underinsured populations;
  - VFC program;
  - Responsibility to maintain a personal immunization record and to bring it to provider visits.
- Identify key process start and completion dates for each measurable planned activity.
- 3h Describe your evaluation measure for this objective. The evaluation measure tells what will be used and how it will be used to determine whether or not the objective was met. Your statement must explain the process for using a specific instrument to assess the extent to which the objective was achieved.

### **Objective 4: Provider Education**

*IAP grantee agencies will successfully educate immunization providers in their respective community with current vaccine recommendations and information so children can be immunized effectively and on-time.*

- 4a List the names of staff who will be trained to conduct the Maximizing Office Based Immunization (MOBI) program in the applicant county. Note that MOBI trainers must complete an annual training certification.  
*Note:* Contact the Ohio Chapter of the American Academy of Pediatrics at (614) 846-6350 for more information about MOBI trainings.
- 4b Describe your promotion plan for MOBI among the pediatric and family practices in your jurisdiction. Identify key process start and completion dates for each measurable planned activity.
- 4c Describe your implementation plan for MOBI among the pediatric and family practices in your jurisdiction. Identify the number of MOBI presentations you anticipate you will *conduct*. Identify key process start and completion dates for each measurable planned activity.
- 4d Describe your plan to ensure that your health district's immunization staff will stay current on immunization information, including participation in CDC sponsored Satellite Conferences regarding immunizations. Identify key process start and completion dates

- for each measurable planned activity.
- 4e Describe your plan to educate public and private immunization providers in your county through methods, other than MOBI, including CDC satellite conferences and mailings. Topics should include vaccine schedules, contraindications and misconceptions, vaccine storage and handling, vaccine preventable disease reporting, Standards for Pediatric Immunization Practice, perinatal Hepatitis B prevention, and strategies for improving immunization rates (e.g., AFIX). For providers in your county that do not provide immunizations, describe a plan to inform those providers about immunization opportunities in your county (e.g., clinic schedules, locations, cost of immunizations) to encourage them to appropriately refer children for immunizations. Identify key process start and completion dates for each measurable planned activity.
- 4f Describe your plan to notify all obstetricians and hospitals with maternity services in your county of the need to immediately report Hepatitis B Surface Antigen positive (HBsAg+) pregnant women to you and to the ODH Perinatal Hepatitis B Prevention Program (PHBPP). Identify key process start and completion dates for each measurable planned activity.
- 4h Describe your evaluation measure for this objective. The evaluation measure tells what will be used and how it will be used to determine whether or not the objective was met. Your statement must explain the process for using a specific instrument to assess the extent to which the objective was achieved.

**Objective 5: Collaboration with WIC**

*IAP grantee agencies will promote the screening and referral of children seen at WIC (Women, Infants, and Children) program sites to a public or private immunization provider for timely vaccinations. Local health district immunization clinics will refer all potentially eligible children to the local WIC agency in a timely manner.*

- 5a Describe *how* all children less than three years of age attending WIC clinics will be screened, assessed, and referred for immunizations. Identify key process start and completion dates for each measurable planned activity.
- 5b Describe *how* the referred children will be placed into an active recall system. Describe how the recall system will function. Identify key process start and completion dates for each measurable planned activity.
- 5c Describe how children presenting at health district immunization clinics who are eligible for WIC benefits will be referred to the most appropriate WIC certification center. Identify key process start and completion dates for each measurable planned activity.
- 5h Describe your evaluation measure for this objective. The evaluation measure tells what will be used and how it will be used to determine whether or not the objective was met. Your statement must explain the process for using a specific instrument to assess the extent to which the objective was achieved.

*Note:* WIC Administrative Series Completion (previously named WICPR870) and WIC Immunization Series Completion (previously named WICPR850) reports can be used as evaluation tools for this objective. These reports can be printed by the WIC staff from their certification system by clicking on “Run Additional Reports” under the reports menu, then selecting these options from the “Management Reports – Immunizations” menu.

**Objective 6: Immunization Reminder and Recall Systems**

*IAP grantee agencies will implement a successful reminder and recall system for immunization*

*consumers, including timely pre-appointment reminders of immunizations that are due and culturally appropriate recall requests if the infant or toddler is behind on vaccinations.*

- 6a Describe your plan to remind a parent of upcoming immunizations. Include a description of how children are identified for pre-appointment reminders, the timing of the reminder, and the types of reminders.

*Note:* A pre-appointment reminder is to be delivered shortly before each scheduled or recommended “appointment,” according to the current ACIP recommendations. ODH recommends a reminder letter, card, or phone call to the parent from 1 to 5 days prior to the “appointment.”

*Note:* SIIS may be used for the reminder system to meet this objective if:

- Immunization data is entered or transmitted to SIIS at least semi-monthly,
- Historic immunization data for children under 36 months of age is included, and
- Your local health district has *not* turned off the reminder function (on the Clinics screen under Defaults on the Impact SIIS web site).

Identify key process start and completion dates for each measurable planned activity.

- 6b Describe your plan to recall children under 24 months of age who are *behind* on immunizations. (e.g., use of CoCASA missing immunization report or other registry reports). The plan should demonstrate multiple attempts at recall over the period of a year. Describe how children will be tracked for ongoing immunization compliance if they fail to show up for immunizations. Identify key process start and completion dates for each measurable planned activity.

*Note:* Health districts should refer to the definition of Moved or Going Elsewhere (MOGE) on page 2 of the Assessment section of the red "AFIX Project for Ohio" binder. Only records that meet the specified definition should be marked as MOGE. Local computer and registry systems must enable compliance with this definition of MOGE.

- 6c Describe your plan to *remind families* of reported cases of hepatitis B surface antigen (HBsAg) positive pregnant women to have infants and household and sexual contacts complete the hepatitis B vaccine series on schedule. Explain how you will remind families to have infants of HBsAg+ mothers complete post-vaccination serology testing.

*Note:* Specific instruction on how to operate a perinatal prevention program are available through the ODH STD prevention program (614-466-2446). The ODH protocol for perinatal Hepatitis B prevention should be followed.

Identify key process start and completion dates for each measurable planned activity.

- 6h Describe your evaluation measure for this objective. The evaluation measure tells what will be used and how it will be used to determine whether or not the objective was met. Your statement must explain the process for using a specific instrument to assess the extent to which the objective was achieved.

A response to Objective 7 is required only by the seven counties that are eligible for additional funds for these activities, due to levels of morbidity in those counties. Eligible counties are Cuyahoga, Franklin, Hamilton, Lucas, Mahoning, Montgomery, and Summit.

**Objective 7: Perinatal Case Identification and Follow-up**

*Health districts must implement a system to ensure that all Hepatitis B Surface Antigen positive (HBsAg+) pregnant females are identified and that their newborn infants, and infants born to females for whom no HBsAg test result is on record, are given Hepatitis B Immune Globulin (HBIG) and Hepatitis B Vaccine (HBV) within twelve hours of birth. In addition, each child born to an HBsAg+ female must be followed to ensure that the remaining two doses of HBV are administered by six months of age, and that a post-vaccine serology is drawn and tested by fifteen months of age. Finally, all HBsAg+ pregnant females must be counseled about their condition, and all household and sexual contacts of the female should be identified, interviewed, tested, and, if necessary, vaccinated with three doses of HBV.*

- 7a Describe your plan to ensure that all HBsAg+ pregnant females are identified prior to delivery. This should include a plan for working with ODH Perinatal Hepatitis B Prevention Program (PHBPP) staff, obstetrics offices, and hospitals in your county and counties contiguous to yours. Identify key process start and completion dates for each measurable planned activity.
- 7b Describe the system you will utilize to ensure that no infant is delivered that will not receive HBIG and HBV within twelve hours of birth. This should include females known to be HBsAg+ and those for whom no prenatal test is on record. Identify key process start and completion dates for each measurable planned activity.
- 7c Describe your plan to track all infants born to HBsAg+ females to ensure completion of the three dose HBV series and a post test serology. Identify key process start and completion dates for each measurable planned activity.
- 7d Describe the process your agency will use to identify, interview, test, and if necessary, vaccinate all sexual and household contacts of HBsAg+ females identified through the PHBPP. Identify key process start and completion dates for each measurable planned activity.
- 7e Describe how your agency will inform and periodically remind obstetricians, pediatricians, and general practitioners in your jurisdiction about the PHBPP, and the need to report all HBsAg+ females to the local health district in a timely manner. Identify key process start and completion dates for each measurable planned activity.
- 7f Describe how your agency will work with the health jurisdictions contiguous to yours to ensure that all requirements of this objective are met in those counties. Identify key process start and completion dates for each measurable planned activity.
- 7g Describe how your agency will report perinatal hepatitis B cases to the Ohio Department of Health, and how you will track the progress of each case. Identify key process start and completion dates for each measurable planned activity.
- 7h Describe your evaluation measure for this objective. The evaluation measure tells what will be used and how it will be used to determine whether or not the objective was met. Your statement must explain the process for using a specific instrument to assess the extent to which the objective was achieved.

- E. Electronic Funds Transfer (EFT) Form:** Print in PDF format and mail to ODH, Grants Administration, Central Master Files address. The completed EFT form **must** be dated and signed, in blue ink, with original signatures. Submit the original and one (1) copy. **(Required only if new agency, thereafter only when banking information has changed.)**
- F. Internal Revenue Service (IRS) W-9 Form:** Print in PDF format and mail to ODH, Grants Administration, Central Master Files address. The completed IRS W-9 form **must** be dated and signed, in blue ink, with original signatures. Submit the original and one (1) copy. **(Required if new agency, thereafter only when tax identification number or agency address information has changed.) One of the following forms must accompany the IRS, W-9:**
- 1. Vendor Information Form (New Agency Only) OR**
  - 2. Vendor Information Change Form (Existing Agency with tax identification number, name and/or address change(s).**  
Print in PDF format and mail to ODH, Grants Administration, Central Master Files address. The completed appropriate Vendor Form **must** be dated and signed, in blue ink, with original signatures. Submit the original and one (1) copy with the IRS, W-9 form.
- G. Public Health Impact Statement Summary:** Submit two (2) copies of a one-page program summary regarding the impact to proposed grant activities on the Local Health Districts Improvement Standards **(for competitive cycle only; for continuation, only if changed).**
- H. Public Health Impact Response/Statement:** Submit two (2) copies of the response/statement(s) of support from the local health district(s) to your agency's communication regarding the impact of the proposed grant activities on the Local Health Districts Improvement Standards. If a statement of support from the local health district is not available, indicate that and submit a copy of the program summary your agency forwarded to the local health district(s) **(for competitive cycle only; for continuation, only if changed).**
- I. Liability Coverage:** Liability coverage is required for all non-profit agencies. Non-profit organizations **must** submit documentation validating current liability coverage. Submit two (2) copies of the Certificate of Insurance Liability **(Non-Profit Organizations only; proof of current liability coverage and thereafter at each renewal period).**
- J. Non-Profit Organization Status:** Non-profit organizations **must** submit documentation validating current status. Submit two (2) copies of the Certificate of Insurance Liability **(Non-Profit Organizations only; current liability coverage and thereafter at each renewal period).**

**K. Declaration Regarding Material Assistance/Non-Assistance to a Terrorist Organization (DMA) Questionnaire:** The DMA is a Questionnaire that must be completed by all grant applicant agencies to certify that they have not provided “material assistance” to a terrorist organization (Sections 2909.32, 2909.33 and 2909.34 of the Ohio Revised Code). The completed DMA Questionnaire **must** be dated and signed, in blue ink, with the Agency Head’s signature. The DMA Questionnaire (in PDF format. [Adobe Acrobat](#) is required) is located at the Ohio Homeland Security Website:

[http://www.homelandsecurity.ohio.gov/DMA\\_Terrorist/HLS\\_0038\\_Contracts.pdf](http://www.homelandsecurity.ohio.gov/DMA_Terrorist/HLS_0038_Contracts.pdf)

- Print a hard copy of the form once it has been downloaded. The form must be completed in its entirety and your responses must be truthful to the best of your knowledge. **(Required by all Non-Governmental Applicant Agencies)**

**L. EEO Survey** - The Civil Rights Review Questionnaire (EEO) Survey will be part of the Application Section of GMIS 2.0. Subgrantees must complete the questionnaire as part of the application process. This questionnaire is submitted automatically with each application via the Internet.

**M. Ethics Certification:**

Attach a statement in the project narrative section that as duly authorized representative of the Subgrantee Agency, you certify that:

In accordance with Executive order 2007-01S:

1. Subgrantee Agency has reviewed and understands the Governor’s Executive Order 2007-01S
2. Subgrantee Agency has reviewed and understands the Ohio ethics and conflict of interest laws, and
3. Subgrantee Agency will take no action inconsistent with those laws and this order.
4. Subgrantee Agency understands that failure to comply with the Executive Order 2007-01S is, in itself, grounds for termination of this grant and may result in the loss of other grants with the State of Ohio.

Refer to GMIS 2.0 Bulletin Board – Governor’s Executive Order 2007-01S (Ethics)

**N. Attachments as Required by Program:** Submit the following attachments electronically through GMIS 2.0.

- A completed two-page *CoCASA Assessment Analysis* template, using CoCASA data with an assessed as of date of August 1, 2007 for all participating health districts. An electronic copy of the template is available on the AFIX Project for Ohio CD or through the ODH Immunization Program.
- The completed IAP Budget Summary Sheet

**III. APPENDICES**

- (1) Application Review Form
- (2) 2008 Immunization Action Plan (IAP) Grant Maximum Funds Available
- (3) IAP Semi-Annual Progress Report Instructions

- (4) IAP Budget Summary Sheet
- (5) AFIX Core Competencies

Appendix 1

**Immunization Action Plan (IAP) 2008 Application Review Form**

Applicant Name: \_\_\_\_\_ GMIS #: \_\_\_\_\_

Counties included: \_\_\_\_\_

Score Summary

<b>Application Element</b>	<b>Score</b>	<b>Point Value</b>
Budget Cover Page		3
IAP Budget Summary Sheet		2
Executive Summary		2
Description of Applicant Agency/Documentation of Eligibility/Personnel		4
Problem/Need		11
Obj. 1: Health district Self-Assessment (AFIX)		15
Obj. 2: Immunization Provider Assessments (AFIX)		16
Obj. 3: Immunization Education in Geographic Pockets of Need		10
Obj. 4: Provider Education		15
Obj. 5: Collaboration with WIC		10
Obj. 6: Immunization Reminder and Recall Systems		7
Obj. 7: Perinatal Case ID and Follow-up (Optional Standard)		<i>Optional</i> 10 or 0 (circle one)
Complete CoCASA Assessment Analysis		5
Past Performance		33 or 30 (circle one)
<b>Total Application Point Score</b>		143 or 130 (circle one)
<b>Total Application % Score</b>		NA

## 2008 IAP Application Review Form

### Budget Cover Page

- Do budgeted items relate to required grant objectives? Y N
- Are budgeted items justified adequately? Y N

List any LHDs that will be subcontractors: \_\_\_\_\_

Maximum Funding Allowed (sum amounts for multiple counties): \$ \_\_\_\_\_

Requested funding amount: \$ \_\_\_\_\_

Score: \_\_\_\_\_ / 3

Notes:

### IAP Budget Summary Sheet

- Is the IAP Budget Summary Sheet submitted correctly? Y N
- Is an adequate share of the budget allocated to provider education (e.g., MOBI) and assessment (AFIX) activities? Y N

Score: \_\_\_\_\_ / 2

Notes:

### Program Narrative

#### Executive Summary

- Did the applicant provide an adequate overview? Y N

Score: \_\_\_\_\_ / 2

Notes:

#### Description of Applicant Agency/Documentation of Eligibility/Personnel

- Applicant adequately summarize the agency structure & management of the IAP grant? Y N
- Describe plans for quality assurance methods? Y N
- Note any personnel or equipment deficiencies? Y N
- Describe plans for hiring & training / partners? Y N

Score: \_\_\_\_\_ / 4

Notes:

#### Problem/Need

- Identify the birth cohort correctly? No. \_\_\_\_\_ Y N
- Identify the # of children <24 months seen for shots? Y N

- Identify the # of MMR 1 <24 months? No. \_\_\_\_\_ Y N
- Stated past efforts toward improving rates? Y N
- Describe the 43133 data regarding immunization rates? Y N
- Describe additional survey result information? Y N
- List all immunization clinic locations – public health? Y N
- Describe no barriers policies? Y N
- Describe the process to forward info to Impact SIIS? Y N
- List the names of the health care providers who vaccinate? Y N
- Described other organizations involved in promoting imm.? Y N

Score: \_\_\_\_ / 11

Notes:

### Methodology

#### *Objective 1: Health District Self-Assessment (AFIX)*

- 1a – Explain past challenges (3 pts)
- 1b – Description of assessing (3 pts)
- 1c – Describe feedback – includes all staff (3 pts)
- 1d – Incentives have measurable criteria (2 pts)
- 1e – Describe exchange plan? (2 pts)
- 1h – Evaluation measurable statement? (2 pts)

Score: \_\_\_\_ / 15

Notes:

#### *Objective 2: Immunization Provider Assessments (AFIX)*

- 2a – Explain past challenges? (1 pt)
- 2b – List names of staff? (2 pt)
- 2c – Id the number of imm providers? (2 pts)
- 2d - Id the target number of AFIX's planned? = \_\_\_\_\_ (3 pts)
- 2d – Is the target number adequate? (2 pts)
- 2e – Describe promotion plan? (4 pts)
- 2h – Evaluation measurable statement? (2 pts)

Score: \_\_\_\_ / 16

Notes:

*Objective 3: Immunization Education – Geographic Pockets of Need*

- 3a – Areas listed and method is reasonable? (1 pt)
- 3a – Justify rationale for determination of areas? (1 pt)
- 3b – Plan to re-assess pockets of needs? (2 pts)
- 3c – Targeted immunization information to consumers? (4 pts)
- 3h - Evaluation - measurable statement? (2 pts)

Score: \_\_\_\_/ 10

Notes:

*Objective 4: Provider Education*

- 4a - List MOBI staff (e.g., nurse, health educ.)? (1 pt)
- 4b - MOBI promotion plan is adequate? (4 pts)
- 4c – MOBI implementation plan adequate? (4 pts)
- 4d – Education for LHD staff? (2 pts)
- 4e – Non-MOBI education for provider offices? (2 pts)
- 4h - Evaluation - measurable statement? (2 pts)

Score: \_\_\_\_/ 15

Notes:

*Objective 5: Collaboration with WIC*

- 5a – Described screening, assessing, and referring? (3 pts)
- 5b – Describe how referred kids are recalled (3 pts)
- 5c – Plan to actively refer to WIC (not just a poster)? (2 pts)
- 5h - Evaluation - measurable statement? (2 pts)

Score: \_\_\_\_/ 10

Notes:

*Objective 6: Reminder and Recall Systems*

- 6a – Plans for reminders? (2 pt)
- 6b – Plans for recall? (2 pt)
- 6c – Reminder for HBsAg+? (1 pt)
- 6h - Evaluation - measurable statement? (2 pts)

Score: \_\_\_\_/ 7

Notes:

**(Only 7 applicants eligible)**

*Objective 7: Perinatal Case Identification and Follow-up*

- 7a – Identify HBsAg+? (1 pt)
- 7b – HBIG and HBV w/in 12 hours? (1 pt)
- 7c – Track infants for HBV and post test serology? (2 pts)
- 7d – Contact follow-up? (1 pt)
- 7e – Educate providers about reporting cases? (1 pt)
- 7f – Work with contiguous jurisdictions? (1 pt)
- 7g – Reporting to ODH? (1 pt)
- 7h - Evaluation - measurable statement? (2 pts)

Score: \_\_\_\_\_ / 10 (if applicable)

Notes:

**Complete CoCASA Assessment Analysis template**

- Correctly completed the 2 page template?
- Included reports for all LHD's included in application?
- Sent as e-mail attachment?

Score: \_\_\_\_\_ / 5

Notes:

**Past Performance**

- Score from January 15, 2007 progress report? \_\_\_\_\_ / 14  
(Use average if multi-county)
- Score from July 15, 2007 progress report? \_\_\_\_\_ / 16 (or 19)  
(Use average if multi-county)

Score: \_\_\_\_\_ / 30 (or 33)

Notes:

**Special Conditions:**

**Comments to Subgrantee:**

Reviewer Signature: \_\_\_\_\_

Appendix 2

2008 Immunization Action Plan (IAP) Grant Maximum Funds *					
County	Core	WIC Pilot	WIC Expand	Perinatal Hep. B	Total
Adams	10,520				10,520
Allen	30,000	28,000			58,000
Ashland	13,955				13,955
Ashtabula	37,035				37,035
Athens	17,110				17,110
Auglaize	20,000				20,000
Belmont	25,000				25,000
Brown	17,855				17,855
Butler	95,615	37,903			133,518
Carroll	21,700				21,700
Champaign	15,229				15,229
Clark	30,875		30,000		60,875
Clermont	58,605		30,000		88,605
Clinton	12,295				12,295
Columbiana	34,075				34,075
Coshocton	20,000				20,000
Crawford	20,000				20,000
Cuyahoga	380,096	38,660	30000	40,000	496,756
Darke	25,100				25,100
Defiance	20,900				20,900
Delaware	48,585				48,585
Erie	14,330				14,330
Fairfield	35,320				35,320
Fayette	10,000				10,000
Franklin	326,145	38,042	30,000	40,000	434,187
Fulton	21,000				21,000
Gallia	18,600				18,600
Geauga	25,000				25,000
Greene	50,220				50,220
Guernsey	15,000				15,000
Hamilton	266,300	38,585	30,000	40,000	374,885
Hancock	21,140				21,140
Hardin	10,000				10,000
Harrison	17,000				17,000
Henry	20,900				20,900
Highland	13,980				13,980
Hocking	10,000				10,000
Holmes	23,700				23,700
Huron	25,100				25,100
Jackson	25,100				25,100
Jefferson	16,065				16,065
Knox	25,100				25,100

Lake	49,045				49,045
Lawrence	20,720				20,720
Licking	42,900		30,000		72,900
Logan	15,000				15,000
Lorain	75,580		30,000		105,580
Lucas	137,610	38,400	30,000	40,000	246,010
Madison	24,100				24,100
Mahoning	86,400	38,190		40,000	164,590
Marion	18,530				18,530
Medina	41,250				41,250
Meigs	10,000				10,000
Mercer	11,085				11,085
Miami	30,000				30,000
Monroe	15,000				15,000
Montgomery	149,960	38,300	30,000	40,000	258,260
Morgan	10,000				10,000
Morrow	10,000				10,000
Muskingum	24,890				24,890
Noble	15,229				15,229
Ottawa	16,800				16,800
Paulding	10,000				10,000
Perry	11,910				11,910
Pickaway	15,535				15,535
Pike	15,000				15,000
Portage	35,600				35,600
Preble	20,900				20,900
Putnam	25,500				25,500
Richland	65,585				65,585
Ross	18,380				18,380
Sandusky	15,340				15,340
Scioto	24,615				24,615
Seneca	15,270		30,000		45,270
Shelby	24,347				24,347
Stark	134,464	38,678			172,862
Summit	140,000	38,678	30,000	40,000	248,678
Trumbull	58,500				58,500
Tuscarawas	28,185				28,185
Union	12,665				12,665
Van Wert	20,000				20,000
Vinton	25,100				25,100
Warren	56,165				56,165
Washington	25,100				25,100
Wayne	34,545				34,545
Williams	22,000				22,000
Wood	29,140				29,140
Wyandot	24,700				24,700

\* IAP Grant Maximum Funds are contingent on funding sources for 2008. Funding levels will be adjusted if full funding is not received from CDC and State of Ohio GRF.

## Appendix 3

### **2008 Immunization Action Plan (IAP) Semi-Annual Progress Report Instructions**

Please use the following instructions to prepare the semi-annual progress report for your Immunization Action Plan Subgrant. Please follow instructions carefully, as progress reports are scored. All 2008 IAP reports are due to ODH on the following dates: July 15, 2008 and January 15, 2009.

1. Re-state each IAP objective as stated in the 2008 IAP RFP.
2. Provide a narrative of the progress made towards each objective during the previous 6 month period (January – June 2008 or July – December 2008). Each objective should be addressed with the identification of specific successes and challenges encountered and the solutions instituted. Significant achievements must be described in depth, as well as instances when objectives were not met. Be specific in your description of accomplishments.
3. Provide samples of locally produced promotional materials, pamphlets, articles, letters, or reports created during the report period that directly relate to grant objectives (e.g., newsletters). *Attachments that cannot be submitted electronically through SPES (Subgrantee Performance Evaluation System) should be submitted in hard copy to Central Master Files.* Send any hard copy attachments, noting your grant number and agency name on the front page, with one original and two copies to:  
Ohio Department of Health  
Grants Administration, Central Master Files  
246 N. High Street, 4<sup>th</sup> Floor  
Columbus, OH 43215
4. Submit the following CoCASA reports. These reports should be submitted electronically through SPES (Subgrantee Performance Evaluation System).
  - A completed AFIX Assessment Analysis form
  - CoCASA Summary Report for 4:3:1:3:3 and 4:3:1:3:3:1
  - Single antigen report for 4:3:1:3:3:1:3
5. Complete and submit page 1 of the AFIX Feedback form to reflect the results of the AFIX feedback session with your health district staff. The form is available on the AFIX CD and in the “AFIX Project for Ohio” red binder. This completed form should be submitted with your report as evidence of completion of Objective 1 (AFIX Self-Assessment). Contact your Immunization Consultant if you need assistance performing a feedback session.

If you have any questions, please contact David Feltz or Tammy Butler at (614) 466-4643.

Appendix 4

### IAP Budget Summary Sheet 2008 IAP Application

Each applicant must complete and submit a separate IAP Budget Summary Sheet for each county that is included in the grant application.

Applicant name (Lead agency): \_\_\_\_\_

County: \_\_\_\_\_

Amount Requested	IAP Grant Objective
\$	Obj. 1: Health District Self-Assessment (AFIX)
\$	Obj. 2: Immunization Provider Assessments (AFIX)
\$	Obj. 3: Immunization Education in Geographic Pockets of Need
\$	Obj. 4: Provider Education
\$	Obj. 5: Collaboration with WIC
\$	Obj. 6: Immunization Reminder and Recall Systems
(If applicable) \$	Obj. 7: Perinatal Case ID and Follow-up ( <i>Optional Standard</i> )
\$	<b>Total Budget Requested</b>



## **Assessment, Feedback, Incentives and Exchange (AFIX) Project for Ohio**

### **Core Competencies**

The Ohio Department of Health (ODH) Immunization Program has developed a list of Core Competencies for those conducting AFIX. These competencies are the minimum skills necessary for an individual to be successful at conducting AFIX. It is expected that those assigned to conduct AFIX have these skills.

Knowledge of computers including:

- Experience using desktop and laptop computers
- Experience using disks, CD, and/or flash drives to save and transfer data
- Experience using printers
- Experience using Word, email, and other basic applications
- Experience using the internet

Knowledge of the Immunization Schedule including:

- Current ACIP schedule
- Familiarity with concepts including minimum intervals, minimum ages, catch-up schedules, invalid doses, etc.

Knowledge of strategies for improving immunization rates including:

- Reminder systems
- Recall systems
- Simultaneous administration
- Impact SIIS

Ability to speak in front of and with groups of people, including physicians, nurses and other office staff

Ability to travel to ODH AFIX trainings and to conduct AFIXs.

(3/2006)