MEMORANDUM

Date: February 15, 2008

To: Eligible Ohio Department of Health Women's Health Services Program Applicants

From: Karen F. Hughes, MPH, Chief
Division of Family and Community Health Services
Ohio Department of Health

Subject: Notice of Funds-Continuation Application
July 1, 2008-June 30, 2009-Women's Health Services Program

The Ohio department of Health (ODH), Division of Family and Community Health services (DFCHS), Bureau of Child and Family Health Services (BCFHS), announces the availability of grant funds to support the Women's Health Services Program. The purpose of the Women's Health Services Program is to improve the health and well-being of women, infants, children and families by assuring health care access for a vulnerable population of low-income women..

To obtain a grant application packet:

1. Go to the ODH website at http://www.odh.state.oh.us/
2. From the home page click on "About ODH";
3. From the next page click on "ODH Grants";
4. Next click on "Grant Request for Proposals", this will give you a pull down menu with current RFPs by name; and
5. Select and highlight the Women's Health Services Program RFP and click "Submit". This process invokes Adobe Acrobat and displays the entire RFP. You can then read and/or print the document as desired.

Only those agencies currently funded for this grant are eligible to apply for these funds. Grant applications are due April 7, 2008 for the funding period of July 1, 2008 through June 30, 2009. All applications and attachments are due Monday, April 7, 2008. Electronic applications received after Monday April 7, 2008 will not be considered for funding. Faxed, hand-delivered or mailed applications will not be accepted.

All grant applications must be submitted via the Internet, using GMIS 2.0. Initial authorization for internet submission will be distributed at your GMIS 2.0 Training Session.

If you have questions regarding this application please contact Judith Hauser, Health Planning Administrator, ODH Family Planning Program, by phone at (614) 644.1107 or by e-mail at Judith.Hauser@odh.ohio.gov or by fax at (614) 564.2433.

ALL APPLICATIONS MUST BE SUBMITTED VIA THE INTERNET

OHIO DEPARTMENT OF HEALTH

DIVISION OF
Family and Community Health Services

BUREAU OF
Child and Family Health Services

WOMEN'S HEALTH SERVICES PROGRAM
REQUEST FOR PROPOSALS (RFP)
FOR
FISCAL YEAR 2009
07/01/08—06/30/09
Local Public Applicant Agencies
Non-Profit Applicants

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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 the internet website: ODH Application Gateway – GMIS 2.0 which includes 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 ensure adherence to the rules, regulations and procedures for preparation of all Subgrantee applications. The GAPP manual is available on the ODH web-site *http://www.odh.ohio.gov* (Click on "About ODH," click on "ODH Grants" and then click on "GAPP Manual.)" The application review form is viewed as Appendix A.

B. Application Name: Women's Health Services Program

C. Purpose: The overarching goal of the Women's Health Services Program is to improve the health and well-being of women, infants, children and families by assuring access to health care services for a vulnerable population of low-income women (Appendix #B). The requirements of this Request for Proposals (RFP) are found in the OAC rule 3701-68-01 (Women's Health Services Program), as required by Section Am. Sub. HB 119 (127th General Assembly) and available on the ODH web-site *http://www.odh.ohio.gov* (click on Rules and Regulations, then click on Final Rules; then click on 3701-68; then click on 3701-69-01 for program guidance).

D. Qualified Applicants: Only agencies, currently funded under the Women's Health Services Program are eligible to apply (Appendix #C-WHSP-Available Funding). All applicants must be a local public or non-profit agency. To be considered for review, applicant agencies must sign and submit the ODH Women's Health Services Program Assurances (Attachment #1) and the ODH Women's Health Services Program Eligibility Certification (Attachment #2). For continuation grants, the applicant must have demonstrated acceptable performance standards during the previous grant period.

E. Service Area: Applicants shall clearly define the specific geographic area and the specific population to be served with the grant funds provided. This grant shall not establish residency requirements for eligible clients. When awarding the grants, the director shall also consider the need for women's health services throughout the state.

F. **Number of Grants and Funds Available:** Up to twenty-one (21) grants may be awarded for a total amount of $1,577,521. Eligible agencies may apply for a maximum of their Women's Health Services Program award for FY08 (Appendix C). No grant award will be issued for less than **$30,000**. 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

G. **Due Date:** Applications including any required forms and required attachments mailed or electronically submitted via GMIS 2.0 are due by Monday, April 7, 2008. 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 postmarked or received on or before the application due date.

Contact Judith B. Hauser, Health Planning Administrator at 614.644.1107 or Judith.Hauser@odh.ohio.gov with any questions.

H. **Authorization:** Authorization of funds for this purpose is contained in Amended Substitute House Bill 119 (127th Ohio General Assembly).

I. **Goals:** The overarching goal of the Women's Health Services Program is to improve the health and well-being of women, infants, children, and families by assuring health care access for a vulnerable population of low-income women (Appendix B).

Women's health care exists as a continuum across life. The division between the different components--child, adolescent, reproductive-aged women, and menopause is often arbitrary. The goals of care are to maintain healthy lifestyles and minimize health risks; specific objectives vary as to the stage of life. For each stage, comprehensive medical examinations are an ideal time to not only render care but to offer preventative services. Opportunities for screening in women's health target conditions such as reproductive tract cancers, breast cancer, sexually transmitted diseases, sexual coercion, domestic violence, substance abuse, and poor birth outcomes. Elimination of unhealthy lifestyles and prevention of chronic diseases, including cancer, may have an impact not only on long-term health of women but also on the reduction of conditions influencing the health of the next generation of children and adults, such as low birth weight infants.

The inter-relationship of poor birth outcomes with pre-pregnancy health is reflected in the infant mortality rate (IMR). The IMR is indicative of the overall state of maternal health and the quality and accessibility of primary health care. Since nearly half of all pregnancies in the United States are unplanned, a figure that is even higher for adolescents (90%), pre-pregnancy planning becomes important, particularly for vulnerable populations.

Programs must be focused on the target population of clients who are at the greatest risk for poor health outcomes. These are clients who have incomes at or below 100% of the federal poverty level and who are either uninsured or underinsured. Significant health disparities occur across segments of the population including differences by race/ethnicity, gender, education or income, disability, geographic location and special population groups. Many of the diseases or conditions accounting for the most disparate gaps in health status are preventable. Clients within this population, including those that work in full-time positions, often have no health insurance, insurance that does not cover needed services, insurance premiums that are cost-prohibitive, or a high deductible. All of these factors create a barrier to care. Most low-income female clients, 18 years and older, are ineligible for Medicaid unless they are pregnant or less than sixty days post-partum.

Funding received from the Women's Health Services grants must focus on programs that are comprehensive, collaborative and assure access to health care. The Women's Health Services Program Plan must reflect the above (Attachment #3). All services funded by this award must be available on the sliding fee scale to all clients served by this program (Appendix D). Initiation of the Women's Health Services Program required that services would be provided in underserved areas or would expand the existing programs to achieve a comprehensive balance of services and address health disparities (e.g., race/ethnicity, gender, education or income, disability, geographic location and special population groups). These are services that would not be possible to initiate or maintain without this grant. Attention should be paid so as to avoid duplication of services within a geographic area. A specific and realistic assessment to demonstrate need, including a resource inventory, must be performed prior to grant application. These programs of women's health services should include and are limited to the following:

- pelvic exams and lab testing;
- breast exams and patient education on breast cancer;
- screening for cervical cancer; screening and treatment for Sexually Transmitted Diseases (STDs) and HIV screening; voluntary choice of contraception, including abstinence and natural family planning;
- patient education and pre-pregnancy counseling on the dangers of smoking, alcohol, and drug use during pregnancy;
- education on sexual coercion and violence in relationships; and prenatal care or referral for prenatal care.

J. Program Period and Budget Period: The program period began July 1, 2005 and ends on June 30, 2009. The budget period for this application is July 1, 2008 through June 30, 2009.

K. Local Health Districts Improvement Standards: This grant program will address the Local Health Districts Improvement Goal 3701-36-05, "Monitor

Health Status", Standard(s) 3701-36-05-01, " Public health assessment processes and tools in place and continuously maintained and enhanced" and 3701-36-05-02, "Information about environmental threats and community health status being collected analyzed, and disseminated at defined intervals."; Goal 3701-36-07, "Promote Healthy Lifestyles", Standard 3701-36-07-03, "Prevention, health promotion, early intervention, and outreach services provided directly"; and Goal 3701-36-08,"Address the Need for Personal Health Services", Standard 3701-36-08-04, "Plans to reduce specific gaps in access to critical health services being developed and implemented through collaborative efforts". 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 Performance Standards Workgroup Information," and click the link "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. **In view of this, the subgrantee agency must be prepared to cover the costs 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 (new agencies). All other agencies will receive their authorization upon the posting of the Request for Proposal to the ODH website. Please contact Judith.Hauser@odh.ohio.gov or 614.644.1107 for questions regarding this RFP.

O. **Acknowledgment:** An 'Application Submitted' status will appear in GMIS 2.0 that acknowledges ODH system receipt of the application 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 April 7, 2008.

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 in areas related to programmatic and financial stewardship of grant funds.**
10. **Has demonstrated compliance to GAPP, Chapter 100.1,**

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.

These funds are appropriated by Substitute House Bill 119, 127th Ohio General Assembly.

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
Bureau of Child and Family Health Services
Women's Health Services 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 Subgrantee Performance Evaluation System (SPES)** by the following dates:

   Interim Report:
   Please note that this report is different than those required in previous RFPs. An interim evaluation report is due **October 6, 2008** for the period of 07/01/05-06/30/07 (Attachment # 4). The purpose of this report is to determine whether the applicant has achieved the service projections proposed during the period (July 1, 2005-June 30-1007) and to allow ODH to evaluate program performance. Any paper non-Internet compatible report attachments must be submitted to Central Master Files by the specific report due date. **Program Reports that do not include required attachments (non-Internet submitted) will not be approved**. All program report attachments must clearly identify the authorized program name and grant number.]

   Final Program Report
   A final progress report is due by **August 3, 2009** for the budget period 07/01/08-06/30/09. This report document accomplishments made on program goals and objectives (Attachment #5). Data from the program's clients should be used to calculate baseline rates and to measure performance outcomes.

   Submission of Subgrantee Program Reports via SPES indicates acceptance of ODH Grants Administration Policy and Procedure (GAPP).

   Data Reports
   Data reporting to the Ohio Department of Health Family Planning Program via the Ahlers & Associates data system is required. All data must be submitted each month to the data system by the 8th day of the following month in a manner as required by ODH.

   WHSP Cultural and Linguistically Appropriate Services (CLAS) Progress Report
   The WHSP CLAS Strategic Plan FY2009 Annual Progress Report must be submitted on the WHSP CLAS Strategic Plan FY2009 form (Attachment #6) by **August 3, 2009**. This report should describe the overall progress toward cultural competency on all fourteen goals, including results to date and comparison of actual problems or developments and work performed during this program period. The report should identify and elaborate on problems,

delays and adverse conditions that have affected the subgrantee's ability to meet the program goals and/or objectives.

2. **Subgrantee Program Expenditure Reports:** Subgrantee Program Expenditure Reports **must** be completed and submitted **via GMIS 2.0** by the following dates: October 15, 2008, January 15, 2009, April 15, 2009 and July 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 "Approval" 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 August 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 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 "Approval" 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 GMIS 2.0 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). Checking the "Selection" box and clicking the "Approve" 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. To provide abortion services or counseling for abortion or referrals for abortion, except in the case of a medical emergency; or if the applicant provides abortion services, the applicant's services are organized so that the women's health services are physically and financially separate from abortion-providing and abortion-promoting activities (Attachment # 2).

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 subgrantee'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 (and expend $500,000 or more in Federal awards per 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.

Once the audit is completed, a copy must be sent to the ODH, Grants Administration, Central Master Files address within 30 days. 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:

Complete & Submit Via Internet

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
   #3-Women's Health Services Program Work Plan, via GMIS 2.0
   #4-Women's Health Services Program Interim Report, via GMIS 2.0
   #5- Women's Health Services Program Final Report, via GMIS 2.0
   # 6- Women's Health Services Program CLAS Strategic Plan, via GMIS 2.0

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:

Complete, Sign & Mail To ODH

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)**
   c. Change request on Agency letterhead (**Existing Agency with tax identification number, name and/or address change(s).**

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 continuation, only if changed)**
2. Statement of Support from the Local Health Districts **(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 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. An original and two (2) copies of **Attachments** (non-Internet compatible) as required by Program:
   #1- Women's Health Services Program Assurances-Signed and Mailed
   #2- Women's Health Services Program Eligibility Certification-Signed and Mailed

   Ohio Department of Health
   Grants Administration
   Central Master Files, 4th 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 for those agencies requiring training. All others will receive access after the Request for Proposal (RFP) is posted to the ODH website.

All applications must be submitted via GMIS 2.0. 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. 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 9, Section I.X 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. Describe formula for allocating costs across all funding sources. Explain and justify equipment, travel, (including any plans for out-of-state travel that require special permission from program), supplies and training costs. If you have joint costs refer to GAPP Chapter 100, Section 103 and the Compliance Section D (9) of the application for additional information.

2. Personnel, Other Direct Costs, Equipment, & Contracts): Submit a budget with these sections and form(s) completed as necessary to support costs for the period July 1, 2008 to June 30, 2009.

Funds may be used to support personnel, their training, in-state 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.

Applicants are restricted to a maximum of ten percent (10%) of the total award for agency administrative costs. These costs should be itemized in the budget portion of the grant application. In addition, these costs must be listed as direct line items.

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 "Approval"Button signifies your authorization of the submission as an agency official and constitutes your electronic acknowledgement and acceptance of GAPP rules and regulations. CCAs 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 GMIS 2.0. 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. Review the form and then press the "complete" button. By submission of an application, the subgrantee agency agrees by electronic acknowledgment to the financial standards of conduct as stated therein.

D. Project Narrative:

1. Executive Summary: Using the previous grant applications from January 1, 2004-June 30, 2008, identify the target population, services and programs offered and describe how the applicant agency has provided those services; also describe the services and programs to be offered for this budget period. Describe the public health problems that the program will address and how the program has impacted women's health for the target population. Summarize the progress that this funding has achieved for improving the health of the target population during the past budget periods and the goals for this budget period. Describe how this program has expanded or enhanced services provided prior to the initiation of the Women's Health Services Program. Use program data and outcome evaluation information to describe this progress.

2. Description of Applicant Agency/Documentation of Eligibility/ Personnel: Briefly discuss the applicant agency's eligibility to apply for a continued award. Summarize the agency's structure as it relates to this program and, as the lead agency, how it will manage the program. For the following areas, describe changes, challenges and successes during the scope of this program:

- Describe personnel or equipment funded in order to carry out this grant; include training needs as necessary;
- Describe the personnel directly involved in program activities;
- Describe collaborations with other partners and agencies impacting on this program.

3. Problem/Need: Identify and describe the local health status concern that has been addressed by the program during this program cycle, do not restate national and state data. The specific health status concerns that the program addresses 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. Clearly identify the target population. Include a description of other agencies/organizations in the community where the agency is located that also address this problem/need.

4. Methodology: In a narrative, identify the program goals, objectives, and activities. Indicate how they have been evaluated and measured to determine the level of success of the program. Complete a program activities timeline to identify program objectives and activities and the start and completion dates for each (Attachment # 3.)

E. Civil Rights Review Questionnaire - EEO Survey: The Civil Rights Review Questionnaire (EEO) Survey is a 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.

F. Attachment(s): Attachments are documents deemed necessary to the application that are not a part of the GMIS 2.0 system. Attachments that are non-Internet compatible must be postmarked or received on or before the application due date. An original and the required number of copies of non-Internet compatible attachments must be mailed to the ODH, Grants Administration Central Master Files address on or before **April 7, 2008.** All attachments must clearly identify the authorized program name and program number. A minimum of an original and two (2) copies of non-Internet attachments are required.

G. 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.)**

H. Internal Revenue Service (IRS) W-9 & Vendor Forms: 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).**
3. **Change request on Agency letterhead (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.

I. **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).**

J. **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).**

K. **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; current liability coverage and thereafter at each renewal period).**

L. **Non-Profit Organization Status:** Non-profit organizations **must** submit documentation validating current status. Submit two (2) copies of the Internal Revenue Services (IRS) letter approving your non-tax exempt status **(Non-Profit Organizations only; for continuation, only if changed).**

M. **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

- 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)**

N. **Ethics Certification:** Attach a statement in the Project Narrative Section that, as a duly Authorized Representative of the Subgrantee Agency, you certify that in accordance with Executive Order 2007-01S:

a. Subgrantee Agency has reviewed and understands the Governor's Executive Order 2007-01S.

b. Subgrantee Agency has reviewed and understands the Ohio ethics and conflict of interest laws, and
c. Subgrantee Agency will take no action inconsistent with those laws and this order.
d. 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)

O. **Attachments as Required by Program:**

#1- Women's Health Services Program Assurances-Signed and Mailed
#2- Women's Health Services Program Eligibility Certification-Signed and Mailed
#3- Women's Health Services Program Work Plan, via GMIS 2.0
#4- Women's Health Services Program Interim Report, via GMIS 2.0
#5- Women's Health Services Program Final Report, via GMIS 2.0
#6- Women's Health Services Program CLAS Strategic Plan, via GMIS 2.0

III. APPENDICES

A. Women's Health Services Program Application Review Form
B. Women's Health Services Program Goals and Objectives
C. Women's Health Services Program-Available Funding (07/01/08-06/30/09
D. Sample Sliding Fee Scale 2007

Ohio Department of Health

Women's Health Services Program Assurances

Applicant must provide signed assurance that the following Women's Health Services Program components and/or statements of assurance will be in place by July 1, 2006.

Local health departments (LHDs): Applications submitted by LHDs must include all of the following components and/or statements of assurance to be considered eligible for the external objective review.

1. Evidence that one or more women's health services as defined in Ohio Revised Code (OAC), Rule 3701-68-01(A)(8) will be provided;
2. Evidence that services are to be provided directly, as an employee or under contract with the LHD, by licensed doctors, licensed nurses, licensed social workers and licensed counselors in a medical clinic setting;
3. Signed certification that the applicant does not provide abortion services or counseling for or referrals for abortion, except in the case of a medical emergency; **OR** if the applicant provides abortion services or counseling for or referrals for abortion, the applicant's services are organized so that the women's health services are physically and financially separate from abortion-providing and abortion-promoting activities;
4. Assurance that the program does not discriminate in the provision of services based on an individual's religion, race, national origin, handicapping condition, age, sex, number of pregnancies or marital status;
5. Assurance that the program provides services without subjecting individuals to any coercion to accept services or to employ any particular method of family planning;
6. Assurance that acceptance of services shall be solely on a voluntary basis and may not be made a prerequisite to eligibility for, or receipt of, any other services, assistance from, or participation in, any other program of the service provider;
7. Assurance that the costs for services provided by the program, if any are charged, shall be based on the patient's ability to pay and priority in the provision of services shall be given to persons from low-income families;
8. Evidence that all components of the application (e.g. assurances, narrative, budget, attachments) are complete;
9. Assurance that the applicant will implement clinical protocols consistent with the applicable guidelines set forth in Appendix of OAC rule 3701-68-01; and
10. Assurance that a Sliding Fee Scale reflecting the current Federal Poverty Guidelines will be used to assign charges to clients and that a schedule of charges, with sufficient proportional increments are used for clients with incomes between 101-250% of the Federal Poverty Level.

Signed _____Date _____

County _____Agency _____

Ohio Department of Health

Women's Health Services Program (GRF 440-416)

Eligibility Certification

By signing and dating this document, _____

(Name of Agency)

_____

(GMIS User Name)

certifies that it will comply with Section 206.42 of Amended Substitute House Bill 119 (127th Ohio General Assembly) which require that General Revenue Funds from appropriation item 440-416, Child and Family Health Services shall not be used as follows:

_____ The applicant does not provide abortion services or counseling for abortion or referrals for abortion, except in the case of a medical emergency;

OR

_____ If the applicant provides abortion services or counseling for or referrals for abortion, the applicant's services are organized so that the women's health services are physically and financially separate from abortion-providing and abortion-promoting activities.

_____

(Signature)

_____

(Print Name)

_____

(Title)

_____

(Date)

Attachment #2

[Type text]

Women's Health Services Program
Program Plan (July 1, 2008-June 30, 2009)

Agency Name:_____ GMIS 2 User Number _____

Directions: Goals are long-term and utilize local data (county, city, census tract) while the sub-objectives are short-term and utilize specific clinic data. Please provide baseline data where indicated. Please complete a program plan page for each of the goals and evaluation measures as listed in Appendix B.

Goal I: To reduce the percentage of unintended pregnancies in the WHSP program clients by increasing the availability and voluntary choice in effective contraceptive use.

Objectives (07/01/08-06/30/09)	Action Steps	Responsible Staff	Timeline (Start/End Dates)	Evaluation	Result(s)
1.				1.1 1.2	To be completed for Final Program Report (August, 2009)
2.				2.1	
3.				3.1	

WOMEN'S HEALTH SERVICES
INTERIM REPORT
Client and Service Users and Visit
July 1, 2008 – December 31, 2008

For each category in Column A indicate in Column B the number of visits you provided for the period of July 1, 2008-December 31, 2008 for Visit/Encounter Type. In Column C indicate the projected number of visits for the period of July 1, 2008-June 30, 2009. In Column D indicate the total number of unduplicated number of clients served in CY 2008. In Column E indicate the actual number of unduplicated clients served 07/01/08-12/31/08. Please notice that Column B requests actual **visits** provided and Column C requests projected number of **visits** (from the 07/01/08-06/30/09 application). Columns D and E refer to the number of **unduplicated clients** served. (Shaded areas are to be left blank.)

On a separate page, explain any variations from the original application in the projected and actual number of visits.

A. Category of Clients/Visits	B. Actual Number of Visits 07/01/08-12/31/08	C. Projected Number of Visits 07/01/08-06/30/09	D. Number of Unduplicated Clients Served CY2008	E. Number of Unduplicated Clients Served 07/01/08-12/31/08
1.Unduplicated Female Users				
2.Unduplicated Male Users				
User TOTAL				
3.Visits/Encounter Types				
Comprehensive Visits with prescriptive contraception				
Comprehensive Visits without prescriptive contraception				
Comprehensive Visits with prescriptive contraception/Postpartum				
Comprehensive Visits without prescriptive contraception/Postpartum				
Method Revisits				
Limited Visits				

Limited Visits(Pregnancy Test Only)				
Enabling Only Visits				
Prenatal Care Visits				
Visit TOTALS				

1. **Comprehensive medical visit with prescriptive contraception:** Report these visits that should include all of the following components as part of a comprehensive visit: pelvic exam & lab testing; breast exam; screening for cervical cancer; screening & treatment for STDs/HIV; prescriptive contraception (e.g., oral, injectable contraceptives; diaphragm; IUD; patch, NuvaRing); and education/counseling.
2. **Comprehensive medical visit with prescriptive contraception/Postpartum:** Report this number if the client comes to the clinic for a comprehensive exam and is also postpartum(within 60 days post-delivery).

3. **Comprehensive Visit without prescriptive contraception:** Report these visits that include all of the following components as part of a comprehensive visit: pelvic exam & lab testing; breast exam; screening for cervical cancer; screening & treatment for STDs/HIV; and education/counseling.

4. **Comprehensive Visit without prescriptive contraception/Postpartum:** Report this number if the client comes to the clinic for a comprehensive exam and is also postpartum(within 60 days post-delivery).

5. **Method Revisit:** Report this number for clients returning to clinic and having problems with the current method of contraception or wishes to change her method for whatever reason. These clients must have been seen by a health professional. Do not include clients visiting the clinic to pick up contraceptive supplies and who receive no counseling or medical services.

6. **Limited Visit:** Report these limited visits that are made when medical services are provided for the purpose of identifying and resolving specific health concerns. These visits may include pelvic exams for the evaluation of vaginal bleeding and discharge, Depo-Provera injections or test of cure with treatment for Chlamydia cultures.

7. **Limited Visit (Pregnancy Test Only)**: Report these visit for clients coming to the clinic for the pregnancy testing only.

8. **Enabling Only Visit:** Report these visits that were that were for education and counseling, either initial or follow-up, provided by a licensed professional outside of a regular comprehensive visit and includes any of the following components: education/counseling for breast cancer; cervical cancer; voluntary choice of contraception, including abstinence and

natural family planning; STD/HIV; sexual coercion/violence; referrals for prenatal care; and pre-pregnancy counseling (e.g., tobacco, alcohol, and other illicit drug use).

9. **Prenatal Care Visit:** These visits include all of the components of prenatal care as defined by the American College of Obstetricians and Gynecologists (ACOG) guidelines for prenatal and postpartum care. This must include documentation of a post-partum visit.

WOMEN'S HEALTH SERVICES
FINAL REPORT
July 1, 2008 – March 31, 2008

This report is due **April 7, 2009 via GMIS 2 Internet.**

Part I:
For each category in Column A indicate in Column B the number of visits you provided for the period of July 1, 2008-March 31, 2009 for Visit/Encounter Type. In Column C indicate the projected number of visits for the period of July 1, 2008-June 30, 2009. In Column D indicate the total number of unduplicated number of clients served in CY 2008. In Column E indicate the actual number of unduplicated clients served July 1, 20008-March 31, 2009. Please notice that Column B requests actual **visits** provided and Column C requests projected number of **visits** (from the 07/01/08-06/30/09 application). Columns D and E refer to the number of **unduplicated clients** served. (Shaded areas are to be left blank.)

On a separate page, explain any variations from the original application in the projected and actual number of visits.

A. Category of Clients/Visits	B. Actual Number of Visits 07/01/08-3/31/09	C. Projected Number of Visits 07/01/08-06/30/09	D. Number of Unduplicated Clients Served CY2008	E. Number of Unduplicated Clients Served 07/01/08-3/31/08
1.Unduplicated Female Users				
2.Unduplicated Male Users				
User TOTAL				
3.Visits/Encounter Types				
Comprehensive Visits with prescriptive contraception				
Comprehensive Visits without prescriptive contraception				
Comprehensive Visits with prescriptive contraception/Postpartum				
Comprehensive Visits without prescriptive contraception/Postpartum				
Method Revisits				
Limited Visits				

Limited Visits(Pregnancy Test Only)				
Enabling Only Visits				
Prenatal Care Visits				
Visit TOTALS				

10. **Comprehensive medical visit with prescriptive contraception:** Report these visits that should include all of the following components as part of a comprehensive visit: pelvic exam & lab testing; breast exam; screening for cervical cancer; screening & treatment for STDs/HIV; prescriptive contraception (e.g., oral, injectable contraceptives; diaphragm; IUD; patch, NuvaRing); and education/counseling.
11. **Comprehensive medical visit with prescriptive contraception/Postpartum:** Report this number if the client comes to the clinic for a comprehensive exam and is also postpartum(within 60 days post-delivery).

12. **Comprehensive Visit without prescriptive contraception:** Report these visits that include all of the following components as part of a comprehensive visit: pelvic exam & lab testing; breast exam; screening for cervical cancer; screening & treatment for STDs/HIV; and education/counseling.

13. **Comprehensive Visit without prescriptive contraception/Postpartum:** Report this number if the client comes to the clinic for a comprehensive exam and is also postpartum(within 60 days post-delivery).

14. **Method Revisit:** Report this number for clients returning to clinic and having problems with the current method of contraception or wishes to change her method for whatever reason. These clients must have been seen by a health professional. Do not include clients visiting the clinic to pick up contraceptive supplies and who receive no counseling or medical services.

15. **Limited Visit:** Report these limited visits that are made when medical services are provided for the purpose of identifying and resolving specific health concerns. These visits may include pelvic exams for the evaluation of vaginal bleeding and discharge, Depo-Provera injections or test of cure with treatment for Chlamydia cultures.

16. **Limited Visit (Pregnancy Test Only)**: Report these visit for clients coming to the clinic for the pregnancy testing only.

17. **Enabling Only Visit:** Report these visits that were that were for education and counseling, either initial or follow-up, provided by a licensed professional outside of a regular comprehensive visit and includes any of the following components: education/counseling for breast cancer; cervical cancer; voluntary choice of contraception, including abstinence and

natural family planning; STD/HIV; sexual coercion/violence; referrals for prenatal care; and pre-pregnancy counseling (e.g., tobacco, alcohol, and other illicit drug use).

18. **Prenatal Care Visit:** These visits include all of the components of prenatal care as defined by the American College of Obstetricians and Gynecologists (ACOG) guidelines for prenatal and postpartum care. This must include documentation of a post-partum visit.

Part II:

Utilizing the WHSP Program Plan (Attachment #3), summarize the agency's progress toward achieving the objectives as stated in Appendix B, Goals and Objectives, 2009. Describe successes and challenges.

1.Goal 1-To reduce the percentage of unintended pregnancies in WHSP clients by increasing the availability and voluntary choice in effective contraceptive use.

2. Goal 2-To improve the overall health (physical and social health) of clients served by WHSP.

3. Goal 3-To decrease the rates of Sexually Transmitted Diseases among WHSP clients

4. Goal 4-To increase the proportion of the priority population served by conducting focused community outreach programs.

Use this template to indicate your strategies to increase *Culturally and Linguistically Appropriate Services (CLAS*). Do not provide a sub-objective for each standard of the CLAS but only those that your agency is in need of the greatest improvement and which you are going to focus on during this grant year. To review the CLAS tool go to: http://www.odh.ohio.gov. Click on "Programs", click on "Family Planning-Title X". Click "submit". Scroll in the text to Cultural Competency, in red. Click on Cultural Competency to open the CLAS tool.

Agency Name: _____ GMIS User Number: _____

Goal: Develop a Strategic Plan to increase cultural competency for the agency and staff.

Objective	Activities	Person(s) Responsible	Begin/End Date	Evaluation Plans	Results/Outputs
Objective #__	e.g. Develop orientation materials; provide CLAS training, etc.	e.g. Project Manager; director of nursing , etc.	Entire grant year? Part of grant year?	Describe your evaluation methodology and indicators	What changes did you make? Did this increase your overall cultural competency? Complete this column and submit January 1, 2008 and June 30, 2008.
Obj. 1: Standard #1: Understandable and Respectful Care	.				
Obj. 2: Standard #2: Diverse Staff and Leadership					
Obj. 3: Standard #3: Ongoing Education and Training					
Obj.4: Standard #4: Language Assistance Services					
Obj.5: ***Standard #5:***					
Obj. 6 : Standard #6: Competence of Language Assistance					
Obj. 7: Standard #7: Patient-Related Materials					
Obj. 8: Standard #8: Written Strategic Plan					

Obj. 9: Standard #9: Organizational Self-Assessment					
Obj. 10: Standard #10 Patient / Consumer Data					
Obj. 11: Standard #11: Community Profile					
Obj. 12: Standard #12 Community Partnerships					
Obj. 13: Standard #13 Conflict/Grievance Processes					
Obj. 14: Standard #14 Implementation					

Women's Health Services Program
2009 Application Review Form

Applicant Agency: _____ Amount Requested: _____(2008)_____(2009)

County/Counties: _____ GMIS 2 User # _____

Criterion (Total Points)		
General Requirements	**Check Boxes**	**Comments**
1. GMIS application complete and on time……..	☐	
2. Attachments		
a. #1WHSP Assurances (Mailed)…….	☐	
b. #2 WHSP Program Eligibility Certification (Mailed)	☐	
c. #4 WHSP Program Plan……	☐	
d. #5 Interim Progress Report……..	☐	
e. #6 CLAS Plan …….	☐	
DMA Questionnaire (Page 17) only if non-governmental applicant agency		
****** If all not present, do not proceed further***		
Budget ***(*Note 1-Poor 2-Fair 3-Good 4-Above Average 5-Excellent)***	**Score 1 - 5**	**Comments**
1. **Budget Narrative**		
Must clearly reflect proposed programs and services designed to address the family planning needs		
******See later section for scoring of client and services projections***		
a. Narrative describes how categorical costs are derived…….	**1 2 3 4 5**	
b. Discussed necessity, reasonableness and allocation of proposed costs……...	**1 2 3 4 5**	
c. Describes specific functions of personnel, consultants and collaborators…...	**1 2 3 4 5**	
d. Explains and justifies equipment, travel, supplies and training costs……..	**1 2 3 4 5**	
2. **Budget Information**	**Check Boxes**	
3. Personnel		
a. Allocations across all funding sources…….	☐	
b. Job descriptions on file…….	☐	
c. Qualified (licensed, description of tasks)…….	☐	
4. Other Direct Costs		
a. Allowable costs only……	☐	
	☐	

b. Allocated across all funding sources……		
Budget Information (Continued)	**Check Boxes**	
5. Equipment……	☐	
6. Contracts……..	☐	
7. Section D – completed…….	☐	
8. Summary - includes grant award requested and program income to equal total program budget…….	☐	
Program Narrative (pg.14) ***(*Note 1-Poor 2-Fair 3-Good 4-Above Average 5-Excellent)***	**Score 1 - 5**	**Comments**
Executive Summary ***Describes any changes in the target population, services and programs offered since the competitive application***		
9. **Promotes healthy lifestyles at every encounter**…… a. Assess the following in clients: social, psychological, behavioral, environmental, and biological factors. Screens for the following: reproductive tract cancers, breast cancer, STDs, HIV, sexual coercion, intimate partner violence, substance abuse, tobacco abuse, obesity and poor birth outcomes b. Addresses pre and inter conception time periods c. Addresses pre pregnancy promotion period	**1 2 3 4 5**	
10. **Target population** – program is focused on the highest priority population of clients who are at greatest risk for poor health outcomes……. a. Less than 20 years of age, with less than 12 years of formal education b. Smokers c. African-Americans d. Those with previous poor pregnancy outcome e. Those who have incomes at or below 100% FPL5	**1 2 3 4 5**	
11. **Includes the following services**…….... a. Appropriate and effective FP methods b. Reproductive cancer screenings c. Education, counseling and testing for STD/HIV	**1 2 3 4 5**	

d. Abstinence education and counseling e. Nutrition and exercise counseling f. Smoking cessation g. Blood pressure screening		

Program Narrative *(Continued)*	**Score 1 - 5**	**Comments**
12. **Description of Agency** (a – f)……...…….……	**1 2 3 4 5**	
a. Discusses eligibility to apply b. Summarized agency structure c. Describes how it has managed program d. Notes any personnel or equipment deficiencies (if applicable) e. Describes plans for hire/training as needed f. Discuss relationship between applicant agency/partners		
13. **Problem/Need**-past three grant years (a – d)..……	**1 2 3 4 5**	
The following should be identified/described/explained/justified: a. Local health concern addressed by the program b. Challenges of reaching priority population since competitive application c. Other agencies/organizations addressing this problem/need d. Other public health partners		
e. Program potential to improve health outcomes……	**1 2 3 4 5**	
f. Progress made in addressing this problem/need since competitive application Justification of rationale for continuation of funding if serving <62% clients at or below 100% of FPL……...	**1 2 3 4 5**	
Attachments ***(*Note 1-Poor 2-Fair 3-Good 4-Above Average 5-Excellent)***	**Score 1 - 5**	**Comments**
14. **Attachment #2 Client and Services Projections**		
a. Completed with appropriate numbers……	**1 2 3 4 5**	
b. Justification of projections…….	**1 2 3 4 5**	
c. Discussion of challenges and comments……	**1 2 3 4 5**	
d. If current data shows <100%FPL is less than 62% description of plans for outreach and increased services to that target population	**1 2 3 4 5**	
15. **Attachment #4 Program Plan**		
a. **Goals** Application addresses all goals (Appendix B)	**1 2 3 4 5**	
b. **Objectives**-complete from RFP. The objectives are written by us. Have they included all? Baseline data?	**1 2 3 4 5**	

c. **Activities** – are they appropriate for the objective and specific? d. **Person Responsible** - ? appropriate e. **Interim completion dates** - have they indicated interim timelines? f. **Evaluations/Outcomes** - do they provide information on client numbers and outcomes or just generalizations. Should reflect measurement of objectives and activities…….	**1 2 3 4 5** **1 2 3 4 5** **1 2 3 4 5** **1 2 3 4 5**	

Attachments *(Continued)*	**Score 1 - 5**	**Comments**
16. **Attachment #6 Cultural Competency** Includes grid completed with three objective selected, appropriate activities and evaluation……...	**1 2 3 4 5**	
Total Points for section x (Multiplier)		
Past Performance	**Score 1 - 5**	**Comments**
17. **Past Performance** a. Comprehensive Review Report Results……. b. Technical Assistance Report Results……. c. Past response to special conditions and compliance issues……... d. Interim report……. e. Fiscal Status/Flexibility…….. f. Data review – compare to actual numbers in past client and services projections……..	 **1 2 3 4 5** **1 2 3 4 5** **1 2 3 4 5** **1 2 3 4 5** **1 2 3 4 5** **1 2 3 4 5**	

Review Notes

Strengths _____

_____

_____

Weaknesses _____

_____

_____

Approval _____

_____

Approval with Modifications

_____
_____
_____

Disapproval (The following criteria constitute grounds for disapproval of applications: 1. Incompleteness of grant proposal or inconsistency with BCFHS goals and/or the purpose of the ODH FP program and RFP); 2. Gross inappropriateness in the purpose, objectives, and activities of an application or its budgets measured by BCFHS review criteria; 3. Fraudulent presentation; or 4. Determination that grant funds are to be used as substitute for an existing project's current resources).

_____
_____

Comments _____
_____
_____

Special Conditions

_____
_____
_____
_____

Signature: _____ **Date:**_____
Reviewer

Email:_____ **Phone:**_____

Goal 1: To reduce the percentage of unintended pregnancies in WSHP clients by increasing the availability and voluntary choice in effective contraceptive use

Objective 1: By March 1, 2009, 100% of clients should be counseled and educated about all types of voluntary contraception, including abstinence and natural family planning and encouraged to select the best individualized method.

EVALUATION:

1.1 100 percent of clients that leave the appointment with a new method or renewing same method at annual visit have signed a method-specific consent form. (_____ records out of _____total number of charts reviewed).

1.2 Health center offers _____ (number) different types of contraception on site (not an outside pharmacy or referral).

1.3 (If health center does not provide prescriptive contraception) provide number of clients referred for appropriate follow-up care_____ and confirmed for follow up care_____.

1.4 If health center does not provide prescriptive contraception, provide rates of teen births in county for 20003 ____,2004_____, 2005_____ and 2006_____ .

***Objective 2*:** By March 1, 2009, monitor the proportion of unintended pregnancies among clients having pregnancy tests.

EVALUATION:

2.1 Of all positive pregnancy tests for clients using birth control, _____ % did not want to be pregnant later and _____% did not want to be pregnant at any time.

Objective 3: By March 1, 2009, 100% of clients <18 years of age starting a new method are contacted within three cycles to discuss any concerns/side effects.

EVALUATION:

3.1 _____percent of audited records (_____records out of _____ total number of charts reviewed) reflect that adolescent clients starting a new contraceptive method were contacted within three cycles.

Goal 2: To improve the overall health (physical and social health) of clients served by the WHSP.

***Objective 1*:** By March 1, 2009, 100% of all clients will be screened for alcohol abuse, tobacco use, other illicit drug abuse, and intimate partner violence. If positive, a referral will be made and documented

EVALUATION:

1.1 ____percent of clients were screened for risk factors: (#___of) clients out of (#___of) clients.

1.2 (#___) of positive screenings for substance abuse (unduplicated clients). How many had a referral made (#_____)

1.3 (#___) of positive screenings for domestic violence (unduplicated clients). How many had a referral made (#_____).

1.4 (#____) positive screenings for tobacco use (unduplicated clients). How many had a referral made (#_____)

1.5 (#___) of positive screenings for lack of social support (unduplicated clients). How many had a referral made (#_____)

1.6 Each client should have a body mass index (BMI) calculated and documented in the medical record.

***Objective 2*:** By March 1, 2009, 100% of female clients will receive cancer screening according to clinical guidelines (See ACOG, CDC, and ASCCP).

EVALUATION:

2.1 The Ohio Department of Health's Family Planning data demonstrates that a Pap test was performed for _____percent of comprehensive examinations.

2.2 The number of female clients aged 40 years and older who have received a mammogram referral according to clinical guidelines will increase from _____ (baseline) to _____.

2.3 100 percent of female clients aged 50 years and older will receive colon cancer screening during the examination or as a referral.

Goal 3: To decrease the rates of Sexually Transmitted Diseases (STDs) among WHSP clients

***Objective 1*:** By March 1, 2009, 100 percent of clients who obtain clinical services will be offered condoms.

EVALUATION:

1.1 ____% of family planning clients indicate use of condoms.

***Objective 2*:** Increase services to males, including male partner notification and treatment.

EVALUATION:

2.1 ___# of males were provided services compared to ___# in the previous grant year.

***Objective 3*:** By March 1, 2009, increase the percentage of sexually active clients under 25 years of age who are tested annually for Chlamydia.

EVALUATION:

3.1 Increase percent of all clients less than 25 years of age that were tested for Chlamydia infection during new visit/annual exams as per CDC Guidelines, (_____% compared with ____% in the previous grant year).

***Objective 4*:** By March 1, 2009, increase the percentage of sexually active clients under the age of 25 years who receive risk screening for Gonorrhea infections.

EVALUATION:

4.1 Increase the percent of all clients less than 25 years of age that were screened or tested for Gonorrhea infection during new visit/annual exams as per CDC Guidelines, (_____% compared with ____% in the previous grant year).

***Objective* 5:** By March 1, 2009, increase the percentage of clients that receive appropriate treatment within 14 days that test positive for Gonorrhea and/or Chlamydia.

EVALUATION:

5.1 Increase the percent of charts of clients with positive tests for Chlamydia/gonorrhea that have documentation of appropriate treatment within 14 days, (____% compared with ____% in the previous grant year).

***Objective 6*:** 100 percent of clients should be offered HIV testing and risk reduction counseling

EVALUATION:

6.1 Increase the percent of clients being offered HIV testing and risk reduction counseling, (____% compared with ____% in the previous grant year).

Goal 4: To increase the proportion of the priority population served by conducting focused community outreach programs.

Objective 1: By March 1, 2009, the percent of clients with income at 100% or less than FPL will increase from _____ to _____ (The percent is based on _____number of clients @ FP< 100% FPL for WH07 ÷ _____total number of clients WH07.

EVALUATION:

1.1 The agency will demonstrate evidence of at least one program-wide cultural competence training.

1.2 The agency will have conducted a needs assessment for reproductive health within the preceding five years.

1.3 The agency will have developed a written plan for outreach and community collaboration.

Women's Health Services Program
Available Funds 07/01/08-06/30/09

GMIS 2 Number	Agency Name	Award Eligibility
00210011WH01008	Allen County Health Department	$153,500
00610011WH0108	Auglaize County Health Department	36,106
00710011WH0108	Belmont County General Health District	33,500
01820011WH0108	Cleveland City Health Department	103,500
02110011WH0108	Delaware General Health District	33,500
02210011WH0108	Erie County Health Department	92,500
02310011WH0108	Fairfield County Combined General Health District	99,500
02520011WH0108	Columbus City Health Department	153,500
02610011WH0108	Fulton County Health Department	43,200
02710011WH0108	Gallia County General Health District	65,540
03010011WH0108	Cambridge-Guernsey Health Department	72,012
03010011WH0108	Henry County Health Department	153,500
03910011WH0108	Huron County General Health District	44,150
04810011WH0108	Lucas County Regional Health District	72,290
05710011WH0108	Montgomery County Combined Health District	93,500
07010011Wh0108	Mansfield Ontario Richland County Health Department	58,500
07210011WH0108	Sandusky County General Health District	33,500
07610011WH0108	Stark County Health Department	33,500
07710011WH0108	Summit County General Health District	85,500
007910011WH0108	Tuscarawas County General Health District	71,073
008810011WH0108	Wyandot County General Health District	45,750

Sample Sliding Fee Scale 2007 - Ohio Department of Health

Assessed Rate		Household Size 1	2	3	4	5	6	7	8
	annual	$ 10,210	$ 13,690	$ 17,170	$ 20,650	$ 24,130	$ 27,610	$ 31,090	$ 34,570
0%	monthly	$ 851	$ 1,141	$ 1,431	$ 1,721	$ 2,011	$ 2,301	$ 2,591	$ 2,881
	weekly	$ 196	$ 263	$ 330	$ 397	$ 464	$ 531	$ 598	$ 665
	annual	$10,211 - $ 14,038	$ 13,691 - $ 18,823	$ 17,171 - $ 23,608	$ 20,651 - $ 28,393	$ 24,131 - $33,178	$ 27,611 - $ 37,963	$ 31,091 - $ 42,748	$ 34,571 - $ 47,533
20%	monthly	$ 852 - $ 1,169	$ 1,142 - $ 1,568	$ 1,432 - $ 1,966	$ 1,722 - $ 2,365	$ 2,012 - $ 2,764	$ 2,302 - $ 3,163	$ 2,592 - $ 3,561	$ 2,882 - $ 3,960
	weekly	$ 197 - $ 269	$ 264 - $ 361	$ 331 - $ 453	$ 398 - $ 545	$ 465 - $ 637	$ 532 - $ 729	$ 599 - $ 821	$ 666 - $ 913
	annual	$14,039 - $ 17,867	$ 18,824 - $ 23,957	$ 23,609 - $ 30,047	$ 28,394 - $ 36,137	$ 33,179 - $42,227	$ 37,964 - $ 48,317	$ 42,749 - $ 54,407	$ 47,534 - $ 60,497
40%	monthly	$ 1,170 - $ 1,488	$ 1,569 - $ 1,995	$ 1,967 - $ 2,503	$ 2,366 - $ 3,010	$ 2,765 - $ 3,518	$ 3,164 - $ 4,025	$ 3,562 - $ 4,533	$ 3,961 - $ 5,040
	weekly	$ 270 - $ 343	$ 362 - $ 460	$ 454 - $ 577	$ 546 - $ 694	$ 638 - $ 811	$ 730 - $ 928	$ 822 - $ 1,045	$ 914 - $ 1,162
	annual	$17,868 - $ 21,695	$ 23,958 - $ 29,090	$ 30,048 - $ 36,485	$ 36,138 - $ 43,880	$ 42,228 - $51,275	$ 48,318 - $ 58,670	$ 54,408 - $ 66,065	$ 60,498 - $ 73,460
60%	monthly	$ 1,489 - $ 1,807	$ 1,996 - $ 2,423	$ 2,504 - $ 3,040	$ 3,011 - $ 3,656	$ 3,519 - $ 4,272	$ 4,026 - $ 4,888	$ 4,534 - $ 5,505	$ 5,041 - $ 6,121
	weekly	$ 344 - $ 416	$ 461 - $ 558	$ 578 - $ 701	$ 695 - $ 843	$ 812 - $ 985	$ 929 - $ 1,127	$ 1,046 - $ 1,270	$ 1,163 - $ 1,412
	annual	$21,696 - $ 25,524	$ 29,091 - $ 34,224	$ 36,486 - $ 42,924	$ 43,881 - $ 51,624	$ 51,276 - $60,324	$ 58,671 - $ 69,024	$ 66,066 - $ 77,724	$ 73,461 - $ 86,424
80%	monthly	$ 1,808 - $ 2,126	$ 2,424 - $ 2,851	$ 3,041 - $ 3,576	$ 3,657 - $ 4,301	$ 4,273 - $ 5,026	$ 4,889 - $ 5,751	$ 5,506 - $ 6,476	$ 6,122 - $ 7,201
	weekly	$ 417 - $ 490	$ 559 - $ 657	$ 702 - $ 824	$ 844 - $ 992	$ 986 - $ 1,159	$ 1,128 - $ 1,326	$ 1,271 - $ 1,494	$ 1,413 - $ 1,661
	annual	$ 25,525	$ 34,225	$ 42,925	$ 51,625	$ 60,325	$ 69,025	$ 77,725	$ 86,425
100%	monthly	$ 2,127	$ 2,852	$ 3,577	$ 4,302	$ 5,027	$ 5,752	$ 6,477	$ 7,202
	weekly	$ 491	$ 658	$ 825	$ 993	$ 1,160	$ 1,327	$ 1,495	$ 1,662

FOR FAMILY UNITS WITH MORE THAN 8 MEMBERS, ADD $3,480 FOR EACH ADDITIONAL FAMILY MEMBER.

SERVICES WILL NOT BE DENIED DUE TO INABILITY TO PAY.

BASED ON REVISED CSA POVERTY GUIDELINES PUBLISHED IN THE FEDERAL REGISTER ON 01/24/07
THESE GUIDELINES ARE EFFECTIVE ON 03/01/07.

Date: _____ **Project#:** _____ **Project Name:** _____

County: _____ **Agency Name:** _____