

MEMO

Date: March 23, 2011

To: Prospective Sickle Cell Services Program Applicants

From: Karen F. Hughes, M.P.H., Chief ~~KA~~
Division of Family and Community Health Services
Ohio Department of Health

Subject: Notice of Availability of Funds – State Fiscal Year 2012
(July 1, 2011 - June 30, 2012) Sickle Cell Services Program

The Ohio Department of Health (ODH), Division of Family and Community Health Services (DFCHS), Bureau for Children with Medical Handicaps (BCMh), announces the availability of grant funds to support activities of the Sickle Cell Services Program – Direct Service Initiative.

To obtain a grant application packet:

1. Go to the ODH website at <http://www.odh.ohio.gov>;
2. From the home page, click on “Funding Opportunities”;
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 grant RFP’s by name;
5. Select and highlight the Sickle Cell Program RFP and click “Submit”. This process invokes Adobe Acrobat and will display the entire RFP. You can then review the RFP to determine your organizations’ ability to meet the requirements of the grant and your intent to apply.

All grant applications must be submitted via the Internet, using GMIS 2.0. To be eligible for funding, all interested applicants must: 1) submit the attached *Notice of Intent to Apply for Funding (NOIAF)* form no later than Friday, April 15, 2011 and 2) attend a mandatory GMIS 2.0 Training Session. Please complete and return the attached *GMIS 2.0 Training form (APPENDIX A)* to indicate your specific training needs.

Should you have any questions, please contact Cheryl L. Jones, Sickle Cell Services Program Coordinator at (614) 728-6787, by e-mail at cheryl.jones@odh.ohio.gov, or by fax at (614) 728-3616.

NOTICE OF AVAILABILITY OF FUNDS

Ohio Department of Health
Division of Family and Community Health Services
Bureau for Children with Medical Handicaps

SICKLE CELL SERVICES PROGRAM

Competitive Grant Applications for State Fiscal Year 2012

Introduction/Background

The Ohio Department of Health (ODH), Division of Family and Community Health Services (DFCHS), Bureau for Children with Medical Handicaps (BCMh), announces the availability of grant funds to support activities of the Sickle Cell Services Program. Recipients will be expected to have an identifiable, functional unit or program organized for and capable of ensuring the provision of **regional** comprehensive services and care for newborns, children and adults identified with or at risk for sickle cell disease, sickle cell trait and other hemoglobinopathies. Comprehensive services for the purposes of this grant application, include but are not limited to: (1) tracking and follow up of abnormal hemoglobin results, including newborn and non-newborn test results; (2) hemoglobinopathy counseling and/or disease education for patients/consumers/families; (3) hemoglobinopathy education and resource materials, training, outreach and awareness activities for professionals and the public and (4) care coordination and/or referral to specialized medical teams and resources for diagnostic, preventive, transition and evaluative management of sickling hemoglobinopathies. **Support of clinical services is not a funding priority for this grant initiative.**

Authorization of funds of this program is contained in 3701.131 O.R.C. and Am. Sub. H. B. 1 of the 129th Ohio General Assembly.

Qualified Applicants

Qualified applicants are tertiary care or community-based facilities with an identifiable, functional unit or program organized for and capable of ensuring the provision of **regional** comprehensive services and care for newborns, children and adults identified with or at risk for sickle cell disease, sickle cell trait and other hemoglobinopathies.

Funding consideration shall be given only to those applicant facilities that demonstrate capability, experience and expertise in the provision of services as described above and whose programmatic activities **meet** or **exceed** the ODH Sickle Cell Services Program Standards and Criteria. The Standards and Criteria document (Revision Date – February 2011) is available on the ODH Web site at <http://www.odh.ohio.gov/odhPrograms/cmh/scell/scell1.aspx>.

Only one agency will be funded in each of the six (6) multi-county sickle cell service regions listed below:

- **Region I** - Adams, Brown, Butler, Clermont, Clinton, Hamilton, Highland and Warren
- **Region II** - Allen, Auglaize, Champaign, Clark, Darke, Greene, Hancock, Hardin, Logan, Mercer, Miami, Montgomery, Paulding, Preble, Putnam, Shelby and Van Wert
- **Region III** - Defiance, Erie, Fulton, Henry, Huron, Lucas, Ottawa, Sandusky, Seneca, Williams and Wood
- **Region IV** - Athens, Belmont, Coshocton, Delaware, Fairfield, Fayette, Franklin, Gallia, Guernsey, Harrison, Hocking, Jackson, Jefferson, Knox, Lawrence, Licking, Madison, Marion, Meigs, Monroe, Morgan, Morrow, Muskingum, Noble, Perry, Pickaway, Pike, Ross, Scioto, Union, Vinton, Washington and Wyandot
- **Region V** - Cuyahoga, Geauga, Lake, Lorain and Medina
- **Region VI** - Ashland, Ashtabula, Carroll, Columbiana, Crawford, Holmes, Mahoning, Portage, Richland, Stark, Summit, Trumbull, Tuscarawas and Wayne

All applicants must 1) be a local public or non-profit agency; 2) attend or document in writing prior attendance at Grant Management Information System (GMIS) 2.0 training and 3) have the capacity to accept an electronic funds transfer (EFT).

NOTICE OF AVAILABILITY OF FUNDS

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Applicants must **also** meet the additional programmatic requirements listed below to qualify for funding:

1. Must be able to provide required services across county lines within their identified service region;
2. Must be able to provide required services across institutional boundaries within a variety of health systems;
3. Must have a history of effective collaboration and cooperation within their communities; and
4. Must have a **non-grant funded** Medical Director/Medical Advisor that will be responsible for providing guidance and leadership to the applicant regarding the service and administrative components of the ODH Sickle Cell Services Program –Direct Service Initiative.

Note: Applicants that apply for funds under this initiative MAY NOT apply for additional grant funding under the ODH Sickle Cell Services Program - Statewide Family Support Initiative.

Program Period and Award Amounts

This is a competitive grant application. The program period for this application will be four (4) years, beginning July 1, 2011 and ending June 30, 2015. The budget period will be twelve (12) months beginning July 1, 2011 and ending June 30, 2012. Up to six (6) grants (one applicant per region) will be awarded for a total amount of approximately \$710,000. Qualified applicants for each region may apply for initial awards ranging from \$54,457 up to \$188,079. All awards are contingent on the availability of funds for this purpose.

To Obtain a Grant Application Packet

1. Go to the ODH website at <http://www.odh.ohio.gov>;
2. From the home page, click on “Funding Opportunities”;
3. From the next page, click on “ODH Grants”;
4. Next click on “Grant Request for Proposals (RFP)”. This will give you a pull down menu with current grant RFP’s by name;
5. Select and highlight the Sickle Cell Program RFP and click “Submit”. This process invokes Adobe Acrobat and will display the entire RFP. You can then review the RFP to determine your organization’s ability to meet the requirements of the grant and your intent to apply.

All interested applicants must submit a *Notice of Intent to Apply for Funding form (attached)*, no later than **Friday, April 15, 2011 to be eligible to apply for funding.** Upon receipt of your completed *Notice of Intent to Apply for Funding form*, ODH will:

- a. Create the grant application account for your organization. This account number will allow you to submit an application via the Internet using GMIS 2.0. All grant applications must be submitted via the Internet using GMIS 2.0.
- b. Assess your organizations’ GMIS 2.0 training needs and contact you regarding those needs. GMIS 2.0 training is mandatory for all interested applicants.

Once ODH receives your completed *Notice of Intent to Apply for Funding form*, creates the grant application account for your organization, and finalizes all GMIS 2.0 training requirements, you may proceed with the application process as outlined in the RFP.

Bidders Conference

All potential applicants are encouraged to participate in a Bidders’ Conference that will be held **via conference call on Friday, April 08, 2011 from 10:00 to 11:30 a.m. EST**. The conference call toll free number is 1-800-510-7500/Participant Access Code 9591760#. The Bidders’ Conference is scheduled to provide potential applicants with an opportunity to learn more about the RFP and ask clarifying questions. *Participation in the conference call is not a substitution for GMIS 2.0 Training.*

Note: To receive a copy of the Power Point for the Bidders Conference, send your e-mail address to Cheryl Jones at cheryl.jones@odh.ohio.gov by 12 Noon Thursday, April 07, 2011.



ALL APPLICATIONS MUST BE SUBMITTED VIA THE INTERNET

OHIO DEPARTMENT OF HEALTH

**DIVISION OF
Family and Community Health Services**

**BUREAU FOR
Children with Medical Handicaps**

**SICKLE CELL SERVICES PROGRAM
DIRECT SERVICE INITIATIVE
REQUEST FOR PROPOSALS (RFP)
FOR
FISCAL YEAR 2012
(07/01/11-06/30/12)**

**Local Public Applicant Agencies
Non-Profit Applicants**

COMPETITIVE GRANT APPLICATION INFORMATION

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I. APPLICATION SUMMARY and GUIDANCE

An application for an Ohio Department of Health (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 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 the ODH grants is governed by the ODH Grants Administration Policies and Procedures (GAPP) Manual. 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/about/grants/grants.aspx>.
- B. Application Name: SICKLE CELL SERVICES PROGRAM - DIRECT SERVICE INITIATIVE**
- C. Purpose:** To fund a network of Regional Sickle Cell Projects (RSCPs), who in partnership with the ODH Sickle Cell Services Program, work to (1) ensure and enhance the availability and accessibility of quality, comprehensive sickle cell services and care for newborns, children and adults; (2) promote patient/consumer/family/professional education to increase awareness and knowledge about hemoglobinopathies and (3) increase collaboration, coordination and utilization of all sickle cell-related services/resources in Ohio.

For the purposes of this grant application, comprehensive services may include, but are not limited to:

1. Tracking and follow-up of abnormal hemoglobin results, including newborn and non-newborn test results;
2. Hemoglobinopathy counseling and/or disease education for patients/consumers/families;
3. Hemoglobinopathy education and resource materials, training, outreach and awareness activities for professionals and the public; and
4. Care coordination and/or referral to specialized medical teams and resources for diagnostic, preventive, transition and evaluative management of sickling hemoglobinopathies.

Support of clinical services is not a funding priority of this grant initiative.

- D. Qualified Applicants:** Qualified applicants are tertiary care or community-based facilities with an identifiable, functional unit or program organized for and capable of ensuring the provision of **regional** comprehensive services and care for newborns, children and adults identified with or at risk for sickle cell disease, sickle cell trait and other hemoglobinopathies.

Funding consideration will be given only to those applicant facilities that demonstrate capability, experience and expertise in the provision of services as described above and whose programmatic activities **meet** or **exceed** the ODH Sickle Cell Services Program Standards and Criteria. The Standards and Criteria document is available on the ODH Web site at <http://www.odh.ohio.gov/odhPrograms/cmh/scell/scell1.aspx>.

All applicant agencies must 1) be a local public or non-profit agency; 2) attend or document in writing prior attendance at Grants Management Information System (GMIS) 2.0 training and 3) have the capacity to accept an electronic funds transfer (EFT).

Applicants must **also** meet the additional programmatic requirements listed below to qualify for funding:

1. Must be able to provide required services across county lines within their identified service region (refer to Service Area under this Section for a listing of counties by region);
2. Must be able to provide required services across institutional boundaries within a variety of health systems;
3. Must have a history of effective collaboration and cooperation within their communities. Shared or cooperative projects involving more than one agency/organization which enhances the ability to cut across geographic or service system boundaries are encouraged; and
4. Must have a **non-grant funded** Medical Director/Medical Advisor that will be responsible for providing guidance and leadership to the applicant regarding the service and administrative components of the ODH Sickle Cell Services Program - Direct Service Initiative. **Refer to the Appendix Section of the Standards and Criteria document for more information on the Role of the Medical Director/Medical Advisor.**

The following entities are **ineligible** for funding consideration:

- Individuals;
- National organizations;
- Facilities with a post office box as their only address and/or office phone number;
- Facilities applying for the sole purpose of acquiring funds to supplement existing programs without any plan for enlarging their scope of work;
- Facilities in the process of creating or starting a “functional unit or program” for the sole purpose of applying for a grant under this initiative;
- Facilities requesting funds to replicate activities currently funded by ODH or other funding sources;
- Facilities requesting funds under this initiative to pay for medical services and/or personnel that can be covered by 3rd party payers or other resources; and
- Facilities that **concurrently** apply for funds under the Direct Service Initiative and the ODH Sickle Cell Services Program - Statewide Family Support Initiative.

E. **Service Area:** Ohio is divided into six (6) regions. Each applicant will be required to provide regional services within one (1) of the ODH defined multi-county sickle cell service areas listed below:

- Region I – Adams, Brown, Butler, Clermont, Clinton, Hamilton, Highland and Warren
- Region II – Allen, Auglaize, Champaign, Clark, Darke, Greene, Hancock, Hardin, Logan, Mercer, Miami, Montgomery, Paulding, Preble, Putnam, Shelby and Van Wert
- Region III – Defiance, Erie, Fulton, Henry, Huron, Lucas, Ottawa, Sandusky, Seneca, Williams and Wood
- Region IV - Athens, Belmont, Coshocton, Delaware, Fairfield, Fayette, Franklin, Gallia, Guernsey, Harrison, Hocking, Jackson, Jefferson, Knox, Lawrence, Licking, Madison, Marion, Meigs, Monroe, Morgan, Morrow, Muskingum, Noble, Perry, Pickaway, Pike, Ross, Scioto, Union, Vinton, Washington and Wyandot
- Region V - Cuyahoga, Geauga, Lake, Lorain and Medina
- Region VI – Ashland, Ashtabula, Carroll, Columbiana, Crawford, Holmes, Mahoning, Portage, Richland, Stark, Summit, Trumbull, Tuscarawas and Wayne

F. **Number of Grants and Funds Available:** ODH Sickle Cell Services Program grants are comprised of funds generated from a portion of the state Newborn Screening fee. Up to six (6) grants (**one applicant per region**) may be awarded for the SFY 2012 competitive cycle for a total amount of \$710,000. Initial awards, which range from \$54,457 to \$188,079, are based on a population-based funding formula. Qualified applicants for each region may apply for initial awards as outlined on the SFY 2012 Funding Allocation (**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.

Note: Recipients may subcontract with other agencies for implementation of parts of the grant. Collaboration between agencies providing sickle cell services in the region is strongly encouraged. Applicant agencies must assume an oversight role for those agencies with whom they subcontract.

- G. Due Date:** Applications including any required forms and required attachments mailed or electronically submitted via GMIS 2.0 are due by **4:00 p.m. on or before Monday, May 09, 2011**. 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 Cheryl L. Jones, State Sickle Cell Services Program Coordinator at (614) 728-6787 or by e-mail at cheryl.jones@odh.ohio.gov with any questions.

- H. Authorization:** Authorization of funds for this program is contained in 3701.131 O.R.C. and Am. Sub. H. B. 1 of the 129th Ohio General Assembly.

- I. Goals:** In releasing funds for this initiative, the goals of the Sickle Cell Services Program are as follows:

- A. Promote the early identification of newborns, children and adults identified with or at risk for sickle cell disease, sickle cell trait and other hemoglobinopathies and facilitate their integration into systems of comprehensive service and care (which include treatment interventions, if applicable) that are available, accessible and culturally and linguistically appropriate.
- B. Increase the awareness, knowledge and skill level of Ohio professionals' about the special health care needs and services related to hemoglobinopathies through the promoted use of education, training and outreach.
- C. Expand community education and public awareness of hemoglobinopathies and related programs/services with special emphasis on meeting the needs and culture of unserved, under-served and/or **emerging** (*see Glossary*) population groups.

- J. Program Period and Budget Period:** This is a competitive grant application. The program period for this application will be four (4) years beginning July 1, 2011 and ending June 30, 2015. The budget period for this application will be twelve (12) months beginning July 1, 2011 and ending June 30, 2012.

- K. Local Health District Improvement Standards:** This grant program will address two (2) Local Health District Improvement Goal/Standard:

- 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 Districts Improvement Standards (FY 2005) are available on the ODH Web site at <http://www.odh.ohio.gov/localHealthDistricts/lhdImprovementStandards.aspx>.

L. Public Health Impact Statement: All applicant agencies that are not local health districts must communicate with local health districts (county and city) regarding the impact of the proposed grant activities on the Local Health District Improvement Standards.

1. *Public Health Impact Statement Summary* - Applicant agencies are required to submit a summary of the program to local health districts (county and city) prior to submitting the grant application to ODH. The program summary, **not to exceed one page**, must include:
 - The Local Health District Improvement Standard(s) to be addressed by grant activities;
 - A description of the demographic characteristics (e.g. age, race, gender, ethnicity) of the target population(s) **affected by hemoglobinopathies** and the geographical area in which they live (e.g. census tracts, census blocks, block groups). *This information must correlate with the Statement of Intent to Pursue Health Equity Strategies and the Problem Need;*
 - A summary of the regional services (county-specific) to be provided or programs/activities to be conducted; and
 - A plan to coordinate and share information with appropriate local health districts (county and city).

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 (**Required for competitive cycle only; not required for continuation cycle, if unchanged**).

Note: A complete listing of contact information for the Ohio Local Health Districts is available on the ODH Web site <http://www.odh.ohio.gov/localHealthDistricts/lhddirectory.aspx>.

2. *Public Health Impact Statement of Support* - Include with the grant application a statement of support from the local health district(s), if available (**ATTACHMENT #1**). If a statement of support from the local health district is not obtained, indicate that when the program summary is submitted with the grant application (**ATTACHMENT #1**). *If an applicant agency has a regional focus, a statement of support must be submitted (at a minimum) from each of the county and/or city health district(s) in the region with the largest estimated number (greater than 500) of sickle cell (HbAS) carriers. See APPENDIX D through APPENDIX I for Sickle Cell Target Population Projections for each region (Required for competitive cycle only; not required for continuation cycle, if unchanged).*

M. Statement of Intent to Pursue Health Equity Strategies: The ODH is committed to the elimination of health equities. All applicant agencies must submit a statement which outlines the intent of this application to address health disparities. This statement should **not exceed 1 ½ pages** and must:

(1) Explain the extent in which health disparities are manifested within the health status (e.g. morbidity and/or mortality) or health system (e.g. accessibility, availability, affordability, appropriateness of health services) focus of this application.

(2) Identify specific groups(s) who experience a disproportionate burden for the disease or health condition addressed by this application, including unserved, under-served and/or **emerging** populations (*see Glossary*) in the project's geographic catchment area(s). *This information must correlate with the Public Health Impact Statement Summary and the Problem Need.*

(3) Identify specific social and environmental conditions which lead to health disparities (social determinants). This statement must be supported by data.

The following section will provide a basic framework and links to information to understand health equity concepts. This information will also help in the preparation of this statement as well as respond to other portions of this application. **(Required for competitive cycle only; not required for continuation cycle, if unchanged).**

- **Basic Health Equity Concepts** – Certain groups in Ohio experience a disproportionate burden with regard to the incidence, prevalence and mortality of certain diseases or health conditions. These are commonly referred to as **health disparities**. Health disparities are not mutually exclusive to one disease or health conditions and are measurable through the use of various public health data. Most health disparities affect groups marginalized because of socioeconomic status, race/ethnicity, sexual orientation, gender, disability status, geographic location or some combination of these factors. People in such groups also tend to have less access to resources like health food, good housing, good education, safe neighborhoods, freedom from racism and other forms of discrimination. These are referred to as **social determinants**. Social determinants are necessary to support optimal health. The systematic and unjust distribution of social determinants among these groups is referred to as **health inequities**. As long as health inequities persist, marginalized groups will not achieve their best possible health. The ability of marginalized groups to achieve optimal health (like those with access to social determinants) is referred to as **health equity**. Public health interventions that incorporate social determinants into the planning and implementation of programs will contribute to the elimination of health disparities. For more resources on health equity, please visit the ODH Web site at:

<http://www.healthyohioprogram.org/healthequity/equity.aspx>

- N. Appropriation Contingency:** Any award made through the ODH Sickle Cell Services 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.**
- O. 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 submission of the NOIAF. Please contact: Cheryl L. Jones, State Sickle Cell Services Program Coordinator at (614) 728-6787 or by e-mail at cheryl.jones@odh.ohio.gov for questions regarding this RFP.

Applicant must attend or must document, in writing, prior attendance at GMIS 2.0 training in order to receive authorization for Internet submission.

Bidders Conference

All potential applicants are encouraged to participate in a Bidders' Conference that will be held **via conference call on Friday, April 08, 2011 from 10:00 to 11:30 a.m. EST**. The conference call toll free number is 1-800-510-7500/Participant Access Code 9591760#. The Bidders' Conference is scheduled to provide potential applicants with an opportunity to learn more about the RFP and ask clarifying questions. *Participation in the conference call is not a substitution for GMIS 2.0 Training.*

Note: To receive a copy of the Power Point for the Bidders Conference, send your e-mail address to Cheryl Jones at cheryl.jones@odh.ohio.gov by 12 Noon Thursday, April 07, 2011.

- P. Acknowledgement:** An "Application Submitted" status will appear in GMIS 2.0 that acknowledges ODH system receipt of the application submission.

- Q. 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, May, 09, 2011.**

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.**

- R. 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.

- S. 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.

- T. 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 programs 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 S.M.A.R.T. objectives, activities, performance measures and outcomes with respect to time-lines and resources;
5. Estimates reasonable cost to the ODH, considering the anticipated results;
6. Indicates that program personnel are well qualified by training and/or experience for their roles in the program and the applicant organization had adequate facilities and personnel;
7. Provides an evaluation plan and/or data source(s) that will be used to determine the level of success for the project;
8. Is responsive to the special concerns and program priorities specified in the request for proposals;
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; and
11. Explicitly identifies specific groups in the service area who experience a disproportionate burden of the diseases or health condition(s) and explains the root causes of health disparities.

Program Specific Review Criteria

In addition to the criteria listed above, applications will be reviewed based on the degree to which they specifically address the requirements of the Direct Service Initiative. Responses to the RFP, which are determined to be complete and in compliance with these requirements, will be reviewed in accordance with the Point Values contained on the Application Review Form (**APPENDIX B**).

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.**

- U. **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.
- V. **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, in writing, by the awarding office of the ODH. All material(s) must **clearly** state:

Funded in whole or in part by the Ohio Department of Health
 Bureau for Children with Medical Handicaps
 Sickle Cell Services Program
<http://www.odh.ohio.gov/odhPrograms/cmh/scell/scell1.aspx>

Note: Materials include, but are not limited to media, brochures, audio-visual and translated documents. Allow at least two (2) weeks in advance of printing or production for ODH review and approval. Failure to comply with the ownership copyright requirement may result in non-approval/payment of material(s).

- W. **Reporting Requirements:** Successful applicants are required to submit subgrantee program and expenditure reports. Reports must adhere to the ODH, 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 further payments.

Reports shall be submitted as follows:

- 1. **Program Reports:** Subgrantee Program Reports **must** be completed and submitted to ODH via the Internet by the following dates:

- *SFY 2012 Quarterly Program Performance Reports:*

1 st Quarter	(July-September 2011)	due October 15, 2011
2 nd Quarter	(October-December 2011)	due January 15, 2012
3 rd Quarter	(January-March 2012)	due April 15, 2012
4 th Quarter	(April-June 2012)	due July 15, 2012

- *SFY 2012 Education Event Reporting:*

1 st Quarter	(July-September 2011)	due October 15, 2011
2 nd Quarter	(October-December 2011)	due January 15, 2012
3 rd Quarter	(January-March 2012)	due April 15, 2012
4 th Quarter	(April-June 2012)	due July 15, 2012

- *Minimum Data Set (MDS):* due October 15, 2011 and April 15, 2012

Note: The formats for submission of the Quarterly Program Performance Reports, Education Event Reporting and MDS will be provided subsequent to official notification from ODH.

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.

2. **Subgrantee Program Expenditure Reports:** Subgrantee Program Expenditure Reports **must** be completed and submitted **via GMIS 2.0** by the following dates:

1 st Quarter	(July-September 2011)	due October 15, 2011
2 nd Quarter	(October-December 2011)	due January 15, 2012
3 rd Quarter	(January-March 2012)	due April 15, 2012
4 th Quarter	(April-June 2012)	due July 15, 2012

Submission of Subgrantee Program Expenditure Reports via the ODH's GMIS 2.0 system indicates acceptance of ODH GAPP. Clicking the "Approve" button signifies your authorization of the submission as an agency official and constitutes your electronic acknowledgement and acceptance of GAPP rules and regulations.

3. **Final Expenditure Reports:** A Subgrantee Final Expenditure Report reflecting total expenditures for the fiscal year must be completed and submitted **via GMIS 2.0 by 4:00 p.m. on or before August 15, 2012.** 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 Subgrantee Final Expenditure Report via the GMIS 2.0 system indicates acceptance of ODH GAPP. Clicking the "Approve" button signifies your authorization of the submission by an agency official and constitutes electronic acknowledgement 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 GMIS 2.0 as part of the Subgrantee Final Expenditure 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.

- X. **Special Condition(s):** Responses to all special conditions **must be submitted via the Internet (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 ODH's GMIS 2.0 system indicates acceptance of ODH GAPP. Checking the "selection" box and clicking the "Approve" button signifies authorization of the submission by an agency official and constitutes your electronic acknowledgement and acceptance of GAPP rules and regulations.

Y. 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 activities;
4. Bad debts of any kind;
5. Lump sum indirect or administrative costs;
6. Contributions to a contingency fund;
7. Entertainment;
8. Fines or 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 Web site at <http://obm.ohio.gov/MiscPages/TravelRule/> and click on OBM Travel Rule);
17. Costs related to out-of-state travel, unless otherwise approved, in writing, by ODH, and described in the budget narrative, including travelers name;
18. Training longer than one week in duration, unless otherwise approved, in writing, by ODH, including participant's name;
19. Contracts for compensation with advisory board members;
20. Grant-related equipment costs greater than \$300, unless *justified* in the budget narrative 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;

Program Specific Unallowable Costs

22. *Alcoholic beverages;*
23. *First class travel;*
24. *Goods and services for personal use;*
25. *Other Direct Cost Budget line-items related to Client Incentives, H1N1, MAECS User Fee, Pedometers, Pharmaceuticals, Subscriptions and Swiper User Fee;*
26. To reduce, replace or supplant existing applicant agency funds for sickle cell and other hemoglobinopathy services; and
27. *Unapproved educational or training activities*

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

- Z. Audit:** Subgrantees currently receiving funding from the ODH 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 no later than 9 months after the end of the subgrantee's fiscal year.

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.

Subgrantee audit reports (finalized and published, and including the audit Management Letters, if applicable) **which include internal control findings, questioned costs or any other serious findings, must include a cover letter which:**

- Lists and highlights the applicable findings;
- Discloses the potential connection or effect (direct or indirect) of the findings on subgrants passed-through the ODH;
- Summarizes a Corrective Action Plan (CAP) to address the findings. A copy of the CAP should be attached to the cover letter.

AA. Submission of Applications:

The GMIS 2.0 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. Attachments as required by Program
 - **ATTACHMENT #1** – Public Health Impact Statement of Support from Local Health Districts
 - **ATTACHMENT #2** – Curricula Vitae/Resumes
 - **ATTACHMENT #3** - Position Descriptions
 - **ATTACHMENT #4** – Project Organizational Chart
 - **ATTACHMENT #5** – **Required** S.M.A.R.T. Objectives
 - **ATTACHMENT #6** – **Select** S.M.A.R.T. Objectives

- **ATTACHMENT #7 – Optional S.M.A.R.T. Objectives**
- **ATTACHMENT #8 – Standards and Criteria Assurance Form**
- **ATTACHMENT #9 – Regional Sickle Cell Advisory Committee**
- **ATTACHMENT #10 – Letters of Support**
- **ATTACHMENT #11 – Letter of Documentation**
- **ATTACHMENT #12 – ODH Sub-Awardee FFATA Reporting Form for State Funded Grants (SAMPLE)**
- **ATTACHMENT #13 – Application Checklist**

An original and one copy of the following forms, available on GMIS 2.0, must be completed, printed, signed in blue ink with original signatures by the Agency Head or Agency Financial Head and mailed to the ODH Grants Administration address:

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

Two copies of the following documents must be mailed to the ODH 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. Statement of Intent to Pursue Health Equity Strategies **(for competitive cycle only; not required for continuation cycle, if unchanged)**
4. Liability Coverage **(Non-Profit Organizations only; proof of current liability coverage and thereafter at each renewal period)**
5. Evidence of Non-Profit Status **(Non-Profit Organizations only; for competitive cycle only; for continuation, only if changed)**

One copy of the following documents must be mailed to the ODH 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. Non-Internet Compatible Attachments as required by Program: **None**

**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 GMIS 2.0, will be provided after GMIS 2.0 training for those agencies requiring training. All others will receive access after submission of the NOIAF.

All applications must be submitted via GMIS 2.0. Submission of all parts of the grant application via the ODH's GMIS 2.0 system indicates acceptance of ODH GAPP. Submission of the Application signifies authorization by an agency official and constitutes electronic acknowledgement and acceptance of GAPP rules and regulations in lieu of an executed Signature Page document.

Note: The GMIS 2.0 Application Training Manual Parts 1-4 can be accessed on the ODH Web site at <http://www.odh.ohio.gov/about/grants/grants.aspx>.

- A. Application Information:** Information on the applicant agency and its administrative staff must be accurately completed. 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 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 budget narrative may be used to identify additional funding information from other resources. This includes resources committed by the applicant agency and /or contributed by external resources (if applicable) to support the grant including, but not limited to gifts received, contributed goods or services and/or personnel support (in-kind match).

The funded applicant must also adhere to the following budgetary restrictions:

- No more than 50% of the total personnel costs may be allocated for clerical support.
- No more than 10% of the total personnel cost may be allocated for administrative positions (e.g. Grant Manager).
- No more than 10% of the total personnel cost may be allocated for a R.N. to provide “follow-up” services (disease education) with parents/legal guardians of newborns identified via NBS with a positive hemoglobin disease result.
- No funds may be allocated for the position of Medical Director/Medical Advisor associated with the project.
- **No funds may be allocated for clinical services. This is not a funding priority of this grant initiative.**

In addition, for the SFY 2012 budget period (07/01/11 to 06/30/12), of the total grant allocation anticipated for each project, grant funds and/or applicant share funds must be allocated to (1) purchase educational materials (*culturally and linguistically sensitive*) for distribution to *targeted* regional audiences and (2) support travel and per diem expenses (if applicable) for attendance at all in-state meetings/educational venues as **requested/required** by ODH. This includes, *but is not limited to*:

- RSCP Directors Meetings – **Four times during SFY 2012 (quarterly)**. Dates TBD.
- RSCP NBS Coordinators Meetings – **Two times during SFY 2012**. Dates TBD.
- RSCP Educators Meetings – **Two times during SFY 2012**. Dates TBD.

1. **Primary Reason and Justification Pages:** Provide a detailed budget justification narrative that describes how the categorical costs are derived. Discuss the necessity, reasonableness, and allocability (*see Glossary*) 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 the Compliance Section D (9) of the application for additional information.

Note: The applicant should review APPENDIX J for definitions and instructions on completing the line-item budget and justification pages of the grant application. The budget justification must clearly describe each cost element and explain how each cost contributes to meeting the project's proposed objectives.

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 07/01/11 to 06/30/12.

Funds may be used to support personnel, their training, travel (see OBM Web site at <http://obm.ohio.gov/MiscPages/TravelRule/> and click on OBM Travel Rule) and supplies directly related to planning, organizing, and conducting the initiative/program/activity described in this announcement.

Submit as an upload in GMIS 2.0, a copy of the following documents:

- Curricula Vitae/Resumes for all grant funded and non-grant-funded (in-kind) personnel (**ATTACHMENT #2**) listed on the Personnel tab in GMIS 2.0. **Refer to the Staffing Composition and Administration Section of the Standards and Criteria for information on core and extended team staff.**

Note: Curricula Vitae/Resumes must be submitted via the GMIS 2.0 system for all new employees within 30 days of hire to become a part of the official file and for review by ODH.

- Position Descriptions for all personnel (**ATTACHMENT #3**) in which a curricula vitae/resume is submitted. **Refer to the Appendix Section of the Standards and Criteria for core team staff position description templates.** All applicant position descriptions must encompass the duties and responsibilities as outlined in the templates. If a staff member has not been selected for a vacant position, a description of the recruitment strategies for filling the position must be submitted.

Note: A position description is not required for the Medical Director/Medical Advisor.

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 GAPP. Clicking the "Approve" button signifies authorization of the submission by an agency official and constitutes electronic acknowledgement and acceptance of GAPP rules and regulations. CCAs cannot be submitted until after the 1st quarter payment has been issued.

Where appropriate, itemize all equipment (**minimum \$300.00 unit value cost**) 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 Assurances (Federal and State Assurances for Subgrantees) form. This form is submitted as part of each application via GMIS 2.0. The Assurances Certification sets forth the 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 acknowledgement to the financial standards of conduct as stated therein.

D. **Program Narrative:**

All responses and required attachments must be uploaded in GMIS 2.0. Attachments are documents deemed necessary to the applications that are not a part of the GMIS 2.0 system. All attachments must clearly identify the authorized program name and program number.

Project Narrative attachments must contain the following separate components:

1. **Project Abstract:**

Submit a summary/abstract of the application. The summary/abstract will be posted on the ODH Web page and/or distributed to provide information to the public and the Ohio legislature. Please prepare the summary/abstract so that it is clear, accurate, concise and without reference to other parts of the application. It must include a brief description of the proposed project including the needs to be addressed, the proposed services, the target population group(s) to be served and agencies or subcontractors that will be involved in the provision of programs/services/activities.

Please place the following at the top (left justification) of the abstract:

- Project Name
- Applicant Agency/Organization, if applicable
- Project Director
- Contact Person, if applicable
- Mailing/Physical Address
- Contact Phone Number
- E-Mail Address
- Internet Address, if applicable
- **Project Period: July 1, 2011-June 30, 2012**

Abstract Content:

PROBLEM/NEED: Briefly (in one or two paragraphs) state the local health concern(s) that will be addressed by the project.

METHODOLOGY: Using the work plan as a guide, describe in narrative format the programs, services and/or activities that will be provided/conducted by the project. This section is usually several paragraphs long.

TARGET POPULATION: Describe the segments of the target population that experience a disproportionate burden of the local health status concern that will be served by the project. This includes **emerging** populations in the project's geographic catchment area. *This must correlate with the Statement of Intent to Pursue Health Equity Strategies and the Public Health Impact Statement Summary.*

COLLABORATION AND COORDINATION: Identify other agencies or subcontractors that will be involved in the provision of programs/services/activities.

The project abstract must be **single-spaced and limited to one page** in length.

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

- Briefly describe the applicant agency's eligibility to apply addressing each item in the requirements as outlined in this Section under Qualified Applicants.
- Summarize the agency's structure as it relates to this program and, as the lead agency, how it will manage the program. Provide a one-page figure (**ATTACHMENT #4**) that depicts the organizational structure of the project, including subcontractors (if applicable) and other significant collaborators.
- Describe the capacity of your organization, its personnel and contractors to communicate effectively and convey information in a manner that is easily understood by diverse audiences. This includes persons of limited English proficiency, those who are not literate, have low literacy skills and individuals with disabilities.
- 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 or positions that will be directly involved in project activities.
- Describe the relationship between project staff members, staff members of the applicant agency and other partners and agencies that will be working on this project.

3. Problem/Need:

- Identify and describe the local health status concern that will be addressed by the project. Do not restate national and state data. The specific health status concerns that the project 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.
- Explicitly describe segments of the target population who experience a disproportionate burden of the local health status concern, including emerging populations. *This information must correlate with the Public Health Impact Statement Summary and Statement of Intent to Pursue Health Equity Strategies.*
- Include a description of other agencies/organizations also addressing this problem/need and how collaboration/coordination efforts will occur.

4. Objectives and Work Plan

- In lieu of a narrative methodology section, submit a Work Plan that will describe (1) program

goals and expected impact/outcomes/results; (2) S.M.A.R.T. (**S**pecific, **M**easurable, **A**chievable, **R**esults-Oriented and **T**ime-Based) objectives; (3) activities that will be implemented by identified responsible project staff; (4) performance measures; (5) timeline (start/finish completion dates) and (6) data sources that will be used to determine the level of success for the project.

Applicants may use the following options for the Work Plan:

1. **Required** S.M.A.R.T. objectives are listed on **ATTACHMENT #5**. These objectives pertain to all applicants and must be submitted as the objectives that the applicant will be working to accomplish during the funding period. The applicant must complete Column two (2) to indicate the activities that will be undertaken to address the required S.M.A.R.T. objectives (Column 1). For each activity, the staff person responsible for implementation of the activity must be listed. Activities must be numbered sequentially to match the Timeline dates. In Column three (3), write in the Timeline (start/finish) date for each activity. Unless the anticipated timeline date for a specific activity is the entire grant period, timeline dates should be based on actual completion dates.
2. **Select** S.M.A.R.T. objectives are listed on **ATTACHMENT #6**. Select the objective(s) that relate to the services that the applicant will provide and submit them as the objective(s) to accomplish during the funding period. **The applicant may select or choose not to select these objective(s).**
3. **Optional** S.M.A.R.T. objectives may be developed by the applicant and submitted as the objectives the subgrantee will be working to accomplish during the funding period. (**ATTACHMENT #7**). **Objectives must be written in the S.M.A.R.T. format.** Refer to <http://www.rapidbi.com/created/WriteSMARTobjectives.html> for more information related to writing S.M.A.R.T. objectives.

5. Additional Requirements

■ **Standards and Criteria Assurance Form**

The applicant must submit an assurance that, in applying for ODH grant funds, they meet and will comply with Sickle Cell Services Program Standards and Criteria. The Standards and Criteria document serves to outline service and administrative components required of all facilities that are requesting consideration to become a state-funded RSCP. Submission of the Assurance Form (**ATTACHMENT #8**) signifies authorization by an agency official that the applicant has thoroughly reviewed the document and meets the standards and criteria as set forth.

■ **Regional Sickle Cell Advisory Committee**

The applicant must describe plans to establish and maintain a **Regional Sickle Cell Advisory Committee** and the efforts that will be undertaken to recruit organization and consumer representatives for membership (**ATTACHMENT #9**). Membership composition of the committee should be multidisciplinary, multicultural and reflect a broad spectrum of the regional community who are knowledgeable about the community/agency they represent and who have insight into the recommended “best” practice standards for hemoglobinopathies and the provision of sickle cell services in Ohio. The advisory committee should include an adequate number of patients and family members of those affected with a hemoglobinopathy. **Refer to the Appendix Section of the Standards and Criteria for information the purpose and categories of membership representation for the Advisory Committee.**

■ **Letters of Support**

The applicant must provide a **current** letter of support from a minimum of five (5) partner individuals, groups and/or agency/organizations that support the purpose, scope and work of the applicant agency. One (1) letter must be submitted from at least three (3) of the entities (excluding local city and county health department/districts) listed on **ATTACHMENT #10**. Letters of support must be signed, dated and on official letterhead, if applicable.

■ **Letter of Documentation**

The applicant must identify and provide a letter of documentation (**ATTACHMENT #11**) from the Medical Director/Medical Advisor that will be responsible for providing guidance and leadership to the project regarding the five (5) service components and the four (4) administrative components of the Standards and Criteria. The letter of documentation must be signed, dated and document the role, responsibility and relationship of the Medical Director/Medical Advisor and the applicant agency. **Refer to the Appendix Section of the Standards and Criteria for information the Role of the Medical Director/Medical Advisor.**

- E. **Civil Rights Review Questionnaire – EEO Survey:** The Civil Rights Review Questionnaire (EEO) survey is 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 GMIS 2.0.
- F. **Attachment(s):** Attachments are documents deemed necessary to the application that are not 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 by **4:00 p.m. on or before Monday, May 09, 2011.** All attachments must clearly identify the authorized project name and project number.
- 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 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 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 in writing 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 copy of each.
- I. **Public Health Impact Statement Summary:** Submit two (2) copies of a one-page project summary regarding the impact to proposed grant activities on the Local Health Districts Improvement Standards (**for competitive cycles only; for continuation, only if changed**).

- J. Public Health Impact & Intent to Pursue Health Equity 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 District(s) Improvement Standards **and** the Intent to Pursue Health Equity Statement. 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 competitive cycle 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 non-governmental 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 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 Department of Public Safety/Ohio Homeland Security Website:

<http://www.publicsafety.ohio.gov/links/HLS0038.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. Federal Funding Accountability and Transparency Act (FFATA) Requirements:** The Federal Funding Accountability and Transparency act (FFATA) was signed on September 26, 2006. The intent is to empower every American with the ability to hold the government accountable for each spending decision. ODH is required to report all subgrants receiving \$25,000 or more of federal funds. All applicants applying for ODH grant funds are required to complete the FFATA Reporting Form. A sample of the FFATA Reporting Form is attached to this RFP **(ATTACHMENT # 12)**.

All applicants for ODH grants are required to obtain a Data Universal Number System (DUNS) and a Central Contractor Registration Number (CCR) and submit the information in the grant application. For information about the DUNS, go to <http://fedgov.dnb.com/webform>. For information about the CCR, go to www.ccr.gov.

Information on Federal Spending Transparency can be located at www.USAspending.gov or the Office of Management and Budget's website for Federal Spending Transparency at www.whitehouse.gov/omb/open.

(Required by all applicants, Attachment B is located on the GMIS 2.0 Bulletin Board. It must be completed and attached to the GMIS 2.0 Application/Project Comment Section.

- O. Attachments as Required by Program**

The applicant must submit the following to ODH via GMIS 2.0 by the filing due date, Monday, May 09, 2011:

ATTACHMENTS

ATTACHMENT #1 – Public Health Impact Statement of Support from Local Health Districts
ATTACHMENT #2 – Curricula Vitae/Resumes
ATTACHMENT #3 - Position Descriptions
ATTACHMENT #4 – Project Organizational Chart
ATTACHMENT #5 – **Required** S.M.A.R.T. Objectives
ATTACHMENT #6 – **Select** S.M.A.R.T. Objectives
ATTACHMENT #7 – **Optional** S.M.A.R.T. Objectives
ATTACHMENT #8 – Standards and Criteria Assurance Form
ATTACHMENT #9 - Regional Sickle Cell Advisory Committee
ATTACHMENT #10 – Letters of Support
ATTACHMENT #11 – Letter of Documentation
ATTACHMENT #12 – ODH Sub-Awardee FFATA Reporting Form for State Funded Grants
ATTACHMENT #13 - Application Checklist

III. APPENDICES

APPENDIX A - GMIS 2.0 Training Form
APPENDIX B - Application Review Form
APPENDIX C - Funding Allocation by Region
APPENDIX D - Sickle Cell Target Population Projections-Region I
APPENDIX E - Sickle Cell Target Population Projections-Region II
APPENDIX F - Sickle Cell Target Population Projections-Region III
APPENDIX G - Sickle Cell Target Population Projections-Region IV
APPENDIX H - Sickle Cell Target Population Projections-Region V
APPENDIX I - Sickle Cell Target Population Projections-Region VI
APPENDIX J - Instructions for Completing the Line-Item Budget
APPENDIX K – Glossary of Terms
APPENDIX L – Acronyms and Abbreviations
APPENDIX M - Anticipated Timetable

ATTACHMENTS AS REQUIRED BY PROGRAM

SFY 2012 - ATTACHMENT #1

PUBLIC HEALTH IMPACT STATEMENT OF SUPPORT FROM LOCAL HEALTH DISTRICTS

Include:

A statement support was obtained from the following local county and/or city health districts (*list below and upload all documents in GMIS 2.0*). Statements of support must be signed, dated and on official letterhead.

- 1.
- 2.
- 3.
- 4.
- 5.
- 5.
- 7.
- 8.
- 8.
- 10.

Include:

A statement of support was not obtained from the following local health districts (*list below and upload all documents in GMIS 2.0*).

- 1.
- 2.
- 3.
- 4.
- 5.
- 5.
- 7.
- 8.
- 8.
- 10.

Note: All attachments must clearly identify the authorized program name and grant application number.

SFY 2012 - ATTACHMENT #2

CURRICULA VITAE/RESUMES

Include:

The applicant must submit curricula vitae/resumes for all grant funded and non-grant funded (in-kind) personnel listed on the Personnel tab in GMIS 2.0 (*list below and upload all documents in GMIS 2.0*).. **Refer to the Staffing Composition and Administration Section of the Standards and Criteria for information on core and extended team staff.**

- 1.
- 2.
- 3.
- 4.
- 5.
- 6.
- 7.
- 8.
- 9.
- 10.

Note: All attachments must clearly identify the authorized program name and grant application number.

POSITION DESCRIPTIONS

Include:

The applicant must provide positions descriptions of all personnel in which a curricula vitae/resume is submitted (*list below and upload all documents in GMIS 2.0*). Position descriptions templates for core team staff are provided in the Appendix Section of the Standards and Criteria. All position descriptions must encompass the duties and responsibilities as outlined in the templates. If a staff member has not been selected for a vacant position, a description of the recruitment strategies for filling the position must be submitted.

Note: A position description is not required for the Medical Director/Medical Advisor.

- 1.
- 2.
- 3.
- 4.
- 5.
- 6.
- 7.
- 8.
- 9.
- 10.

Note: All attachments must clearly identify the authorized program name and grant application number.

PROJECT ORGANIZATIONAL CHART

Include:

The applicant must provide (via GMIS 2.0) a one-page figure that depicts the organizational structure of the project, including subcontractors (if applicable) and other significant collaborators.

Note: All attachments must clearly identify the authorized program name and grant application number.

SFY 2012
REQUIRED OBJECTIVES and WORKPLAN

Sickle Cell Project: _____ Project #: _____

Component: Procedures of Care (Newborns)

Goal A: Promote the early identification of newborns, children and adults identified with or at risk for sickle cell disease, sickle cell trait and other hemoglobinopathies and facilitate their integration into systems of comprehensive service and care (which include treatment interventions, if applicable) that are available, accessible and culturally and linguistically appropriate.

Expected Outcome/Impact/Result: All *newborns* identified with an **abnormal hemoglobin disease** result will receive follow-up services (e.g. confirmatory testing, hemoglobinopathy counseling, disease education, resource referrals and applicable treatment management) through a RSCP or non-RSCP provider.

One objective, numbered sequentially, per page. Duplicate form as needed.

(1) S.M.A.R.T. Objectives	(2) Work Plan Activities (Responsible Party)	(3) Timelines/ Start/Finish	(4) Performance Measure	(5) Data Source
A-1 (1). By June 30, 2012, 100 percent of the resident (<i>see Glossary</i>) and non-resident (<i>see Glossary</i>) newborns identified with an abnormal hemoglobin disease result (e.g. FS, FSA, FSC, FSE) will receive a confirmatory test by two (2) months of age.			A-1 (1). The number and percent of newborns (resident and non-resident) identified with an abnormal hemoglobin disease result that receives a confirmatory test by two (2) months of age.	A-1 (1) Minimum Data Set (MDS)

SFY 2012
REQUIRED OBJECTIVES and WORKPLAN

Sickle Cell Project: _____ Project #: _____

Component: Procedures of Care (Newborns)

Goal A: Promote the early identification of newborns, children and adults identified with or at risk for sickle cell disease, sickle cell trait and other hemoglobinopathies and facilitate their integration into systems of comprehensive service and care (which include treatment interventions, if applicable) that are available, accessible and culturally and linguistically appropriate.

Expected Outcome/Impact/Result: All *newborns* identified with an **abnormal hemoglobin disease** result will receive follow-up services (e.g. confirmatory testing, hemoglobinopathy counseling, disease education, resource referrals and applicable treatment management) through a RSCP or non-RSCP provider.

One objective, numbered sequentially, per page. Duplicate form as needed.

(1) S.M.A.R.T. Objectives	(2) Work Plan Activities (Responsible Party)	(3) Timelines/ Start/Finish	(4) Performance Measure	(5) Data Source
A-1 (2). By June 30, 2012, 100 percent of the newborns (resident and non-resident) <u>confirmed</u> with an abnormal hemoglobin disease result will be under appropriate treatment management by a board certified pediatric hematologist or BCMH provider (<i>see Glossary</i>).			A-1 (2). The number and percent of newborns (resident and non-resident) <u>confirmed</u> with an abnormal hemoglobin disease result that are under appropriate treatment management by a board certified pediatric hematologist or BCMH provider.	A-1 (2) MDS

SFY 2012
REQUIRED OBJECTIVES and WORKPLAN

Sickle Cell Project: _____ Project #: _____

Component: Procedures of Care (Newborns)

Goal A: Promote the early identification of newborns, children and adults identified with or at risk for sickle cell disease, sickle cell trait and other hemoglobinopathies and facilitate their integration into systems of comprehensive service and care (which include treatment interventions, if applicable) that are available, accessible and culturally and linguistically appropriate.

Expected Outcome/Impact/Result: All *newborns* identified with an **abnormal hemoglobin disease** result will receive follow-up services (e.g. confirmatory testing, hemoglobinopathy counseling, disease education, resource referrals and applicable treatment management) through a RSCP or non-RSCP provider.

One objective, numbered sequentially, per page. Duplicate form as needed.

(1) S.M.A.R.T. Objectives	(2) Work Plan Activities (Responsible Party)	(3) Timelines/ Start/Finish	(4) Performance Measure	(5) Data Source
<p>A-1 (3). By June 30, 2012, 100 percent of the newborns (resident and non-resident) <u>confirmed</u> with an abnormal hemoglobin disease result will have a family member (<i>see Glossary</i>) that receives (or has documentation of) hemoglobinopathy counseling (<i>see Glossary</i>) from a RSCP staff member or non-RSCP provider.</p>			<p>A-1 (3) (a) The number and percent of the newborns (resident and non-resident) <u>confirmed</u> with a hemoglobin disease result who have a family member that receives (or has documentation of) hemoglobinopathy counseling from a RSCP staff member or non-RSCP provider.</p> <p>A-1 (3) (b) The number of family members that receive hemoglobinopathy counseling from an RSCP staff member in association with a resident or non-resident newborn.</p>	<p>A-1 (3) (a) MDS</p> <p>A-1 (3) (b) MDS</p>

SFY 2012
REQUIRED OBJECTIVES and WORKPLAN

Sickle Cell Project: _____ Project #: _____

Component: Procedures of Care (Newborns)

Goal A: Promote the early identification of newborns, children and adults identified with or at risk for sickle cell disease, sickle cell trait and other hemoglobinopathies and facilitate their integration into systems of comprehensive service and care (which include treatment interventions, if applicable) that are available, accessible and culturally and linguistically appropriate.

Expected Outcome/Impact/Result: All *newborns* identified with an **abnormal hemoglobin disease** result will receive follow-up services (e.g. confirmatory testing, hemoglobinopathy counseling, disease education, resource referrals and applicable treatment management) through a RSCP or non-RSCP provider.

One objective, numbered sequentially, per page. Duplicate form as needed.

(1) S.M.A.R.T. Objectives	(2) Work Plan Activities (Responsible Party)	(3) Timelines/ Start/Finish	(4) Performance Measure	(5) Data Source
A-1 (4). By June 30, 2012, 100 percent of the newborns (resident and non-resident) with an abnormal hemoglobin disease result that are determined to be “lost to follow” (<i>see Glossary</i>) will be referred to a local health district (in the mother’s county of residence) for public health nurse (PHN) services.			A-1 (4). The number and percent of newborns (resident and non-resident) with an abnormal hemoglobin disease result that are determined to be “lost to follow-up” and are referred to a local health district (in the mother’s county of residence) for PHN services.	A-1 (4) MDS

SFY 2012
REQUIRED OBJECTIVES and WORKPLAN

Sickle Cell Project: _____ Project #: _____

Component: Procedures of Care (Newborns)

Goal A: Promote the early identification of newborns, children and adults identified with or at risk for sickle cell disease, sickle cell trait and other hemoglobinopathies and facilitate their integration into systems of comprehensive service and care (which include treatment interventions, if applicable) that are available, accessible and culturally and linguistically appropriate.

Expected Outcome/Impact/Result: Follow-up services (e.g. confirmatory testing, hemoglobinopathy counseling, and resource referrals) will be provided through an RSCP or non-RSCP provider to *newborns* identified with an **abnormal hemoglobin trait** result.

One objective, numbered sequentially, per page. Duplicate form as needed.

(1) S.M.A.R.T. Objectives	(2) Work Plan Activities (Responsible Party)	(3) Timelines/ Start/Finish	(4) Performance Measure	(5) Data Source
A-1 (5). By June 30, 2015, increase annually, to reach a goal of at least 75 percent , the number of newborns (resident and non-resident) identified with an abnormal hemoglobin trait (e.g. FAS, FAC, FAE) result that receive appropriate confirmatory testing in accordance with programmatic timelines and procedures.			A-1 (5). An annual increase in the number and percent of newborns (resident and non-resident) with an abnormal hemoglobin trait result that receive appropriate confirmatory testing in accordance with programmatic timelines and procedures.	A-1 (5) MDS

SFY 2012
REQUIRED OBJECTIVES and WORKPLAN

Sickle Cell Project: _____ Project #: _____

Component: Procedures of Care (Newborns)

Goal A: Promote the early identification of newborns, children and adults identified with or at risk for sickle cell disease, sickle cell trait and other hemoglobinopathies and facilitate their integration into systems of comprehensive service and care (which include treatment interventions, if applicable) that are available, accessible and culturally and linguistically appropriate.

Expected Outcome/Impact/Result: Follow-up services (e.g. confirmatory testing, hemoglobinopathy counseling, and resource referrals) will be provided through an RSCP or non-RSCP provider to *newborns* identified with an **abnormal hemoglobin trait** result.

One objective, numbered sequentially, per page. Duplicate form as needed.

(1) S.M.A.R.T. Objectives	(2) Work Plan Activities (Responsible Party)	(3) Timelines/ Start/Finish	(4) Performance Measure	(5) Data Source
A-1 (6) By June 30, 2015, increase annually, to reach a goal of at least 75 percent , the number of newborns (resident and non-resident) <u>confirmed</u> with a hemoglobin trait result that have a family member that receives (or has documentation of) hemoglobinopathy counseling from a RSCP staff member or non-RSCP provider.			A-1 (6) (a) An annual increase in the number and percent of newborns (resident and non-resident) <u>confirmed</u> with a hemoglobin trait result that have a family member that receives (or has documentation of) hemoglobinopathy counseling from a RSCP staff member or non-RSCP provider.	A-1 (6) (a) MDS
			A-1 (6) (b) The number of family members that receive face to face hemoglobinopathy counseling from an RSCP staff member in association with a resident or non-resident newborn.	A-1 (6) (b) MDS

SFY 2012
REQUIRED OBJECTIVES and WORKPLAN

Sickle Cell Project: _____ Project #: _____

Component: Procedures of Care (Newborns)

Goal A: Promote the early identification of newborns, children and adults identified with or at risk for sickle cell disease, sickle cell trait and other hemoglobinopathies and facilitate their integration into systems of comprehensive service and care (which include treatment interventions, if applicable) that are available, accessible and culturally and linguistically appropriate.

Expected Outcome/Impact/Result: Follow-up services (e.g. confirmatory testing, hemoglobinopathy counseling, and resource referrals) will be provided through an RSCP or non-RSCP provider to *newborns* identified with an **abnormal hemoglobin trait** result.

One objective, numbered sequentially, per page. Duplicate form as needed.

(1) S.M.A.R.T. Objectives	(2) Work Plan Activities (Responsible Party)	(3) Timelines/ Start/Finish	(4) Performance Measure	(5) Data Source
A-1 (6) Continued			A-1 (6) (c) The number of family members that receive telephone hemoglobinopathy counseling services from an RSCP staff member in association with a NBS result.	A-1 (6) (c) MDS

SFY 2012
REQUIRED OBJECTIVES and WORKPLAN

Sickle Cell Project: _____ Project #: _____

Component: Procedures of Care (Newborns)

Goal A: Promote the early identification of newborns, children and adults identified with or at risk for sickle cell disease, sickle cell trait and other hemoglobinopathies and facilitate their integration into systems of comprehensive service and care (which include treatment interventions, if applicable) that are available, accessible and culturally and linguistically appropriate.

Expected Outcome/Impact/Result: Follow-up services (e.g. confirmatory testing, hemoglobinopathy counseling, and resource referrals) will be provided through an RSCP or non-RSCP provider to *newborns* identified with an **abnormal hemoglobin trait** result.

One objective, numbered sequentially, per page. Duplicate form as needed.

(1) S.M.A.R.T. Objectives	(2) Work Plan Activities (Responsible Party)	(3) Timelines/ Start/Finish	(4) Performance Measure	(5) Data Source
A-1 (7) By June 30, 2015, decrease annually, to reach a goal of at least 25 percent , the number of <u>resident</u> newborns identified with a presumptive hemoglobin trait result that are reported by the RSCP (via case disposition) as “lost to follow-up” (LTF).			A-1 (7) An annual decrease in the number of <u>resident</u> newborns identified with a presumptive hemoglobin trait result that are reported by the RSCP (via case disposition) as LTF.	A-1 (7) MDS

SFY 2012
REQUIRED OBJECTIVES and WORKPLAN

Sickle Cell Project: _____ Project #: _____

Component: Procedures of Care (Non-newborns)

Goal A: Promote the early identification of newborns, children and adults identified with or at risk for sickle cell disease, sickle cell trait and other hemoglobinopathies and facilitate their integration into systems of comprehensive service and care (which include treatment interventions, if applicable) that are available, accessible and culturally and linguistically appropriate.

Expected Outcome/Impact/Result: Follow-up services (e.g. confirmatory testing, hemoglobinopathy counseling, disease education, resource referrals and applicable treatment management) will be provided through an RSCP or non-RSCP provider to *children and adults* identified with an **abnormal hemoglobin disease** result.

One objective, numbered sequentially, per page. Duplicate form as needed.

(1) S.M.A.R.T. Objectives	(2) Work Plan Activities (Responsible Party)	(3) Timelines/ Start/Finish	(4) Performance Measure	(5) Data Source
A-2 (1) By June 30, 2012, _____ (insert numerical projection) non-newborns (<i>see Glossary</i>) will receive confirmatory testing for a hemoglobin disease .			A-2 (1) The number of non-newborns that receive confirmatory testing for a hemoglobin disease .	A-2 (1) MDS

SFY 2012
REQUIRED OBJECTIVES and WORKPLAN

Sickle Cell Project: _____ Project #: _____

Component: Procedures of Care (Non-newborns)

Goal A: Promote the early identification of newborns, children and adults identified with or at risk for sickle cell disease, sickle cell trait and other hemoglobinopathies and facilitate their integration into systems of comprehensive service and care (which include treatment interventions, if applicable) that are available, accessible and culturally and linguistically appropriate.

Expected Outcome/Impact/Result: Follow-up services (e.g. confirmatory testing, hemoglobinopathy counseling, disease education, resource referrals and applicable treatment management) will be provided through an RSCP or non-RSCP provider to *children and adults* identified with an **abnormal hemoglobin disease** result.

One objective, numbered sequentially, per page. Duplicate form as needed.

(1) S.M.A.R.T. Objectives	(2) Work Plan Activities (Responsible Party)	(3) Timelines/ Start/Finish	(4) Performance Measure	(5) Data Source
A-2 (2) By June 30, 2012, _____ (insert numerical projection) non-newborns <u>confirmed</u> with a hemoglobin disease will receive (or have a family member that receives) hemoglobinopathy counseling from a RSCP staff member.			A-2 (2) The number of non-newborns <u>confirmed</u> with a hemoglobin disease who receive (or have a family member that receives) hemoglobinopathy counseling from an RSCP staff member.	A-2 (2) MDS

SFY 2012
REQUIRED OBJECTIVES and WORKPLAN

Sickle Cell Project: _____ Project #: _____

Component: Procedures of Care (Non-newborns)

Goal A: Promote the early identification of newborns, children and adults identified with or at risk for sickle cell disease, sickle cell trait and other hemoglobinopathies and facilitate their integration into systems of comprehensive service and care (which include treatment interventions, if applicable) that are available, accessible and culturally and linguistically appropriate.

Expected Outcome/Impact/Result: Follow-up services (e.g. confirmatory testing, hemoglobinopathy counseling, disease education, resource referrals and applicable treatment management) will be provided through an RSCP or non-RSCP provider to *children and adults* identified with an **abnormal hemoglobin trait** result.

One objective, numbered sequentially, per page. Duplicate form as needed.

(1) S.M.A.R.T. Objectives	(2) Work Plan Activities (Responsible Party)	(3) Timelines/ Start/Finish	(4) Performance Measure	(5) Data Source
A-2 (3) By June 30, 2012, _____ (insert numerical projection) non-newborns will receive confirmatory testing for a hemoglobin trait .			A-2 (3) The number of non-newborns that receive confirmatory testing for a hemoglobin trait .	A-2 (3) MDS

SFY 2012
REQUIRED OBJECTIVES and WORKPLAN

Sickle Cell Project: _____ Project #: _____

Component: Procedures of Care (Non-newborns)

Goal A: Promote the early identification of newborns, children and adults identified with or at risk for sickle cell disease, sickle cell trait and other hemoglobinopathies and facilitate their integration into systems of comprehensive service and care (which include treatment interventions, if applicable) that are available, accessible and culturally and linguistically appropriate.

Expected Outcome/Impact/Result: Follow-up services (e.g. confirmatory testing, hemoglobinopathy counseling, disease education, resource referrals and applicable treatment management) will be provided through an RSCP or non-RSCP provider to *children and adults* identified with an **abnormal hemoglobin trait** result.

One objective, numbered sequentially, per page. Duplicate form as needed.

(1) S.M.A.R.T. Objectives	(2) Work Plan Activities (Responsible Party)	(3) Timelines/ Start/Finish	(4) Performance Measure	(5) Data Source
A-2 (4) By June 30, 2012, _____ (insert numerical projection) non-newborns <u>confirmed</u> with a hemoglobin trait will receive (or have a family member that receives) hemoglobinopathy counseling from a RSCP staff member			A-2 (4) The number of non-newborns <u>confirmed</u> with a hemoglobin trait that receive (or have a family member that receives) hemoglobinopathy counseling from an RSCP staff member.	A-2 (4) MDS

SFY 2012
REQUIRED OBJECTIVES and WORKPLAN

Sickle Cell Project: _____ Project #: _____

Component: Collaboration and Coordination Activities

Goal A: Promote the early identification of newborns, children and adults identified with or at risk for sickle cell disease, sickle cell trait and other hemoglobinopathies and facilitate their integration into systems of comprehensive service and care (which include treatment interventions, if applicable) that are available, accessible and culturally and linguistically appropriate.

Expected Outcome/Impact/Result: Newborns, children and adults identified by the RSCP with an abnormal hemoglobin result will be integrated into systems of service and care facilitated by the RSCP or non-RSCP provider through interagency coordination and collaboration.

One objective, numbered sequentially, per page. Duplicate form as needed.

(1) S.M.A.R.T. Objectives	(2) Work Plan Activities (Responsible Party)	(3) Timelines/ Start/Finish	(4) Performance Measure	(5) Data Source
<p>A-3 (1) By June 30, 2012, RSCP staff will convene contact/networking meeting(s)* with each of the Help Me Grow (HMG)/County Central Intake and Referral Sites (CCIRS) (http://ohiohelpmegrow.org) in their region to increase awareness (<i>see Glossary</i>) about RSCP services and assure that 100 percent of the children with a confirmed hemoglobin disease result, age 0-3, are referred for HMG program services.</p> <p><i>*Includes telephone meetings</i></p>			<p>A-3 (1) (a) The number of contact/networking meetings convened by RSCP staff with HMG/CCIRS.</p> <p>A-3 (1) (b) The number of HMG/CCIRS personnel that attend contact/networking meetings.</p> <p>A-3 (1) (c) The number and percent of children with a confirmed hemoglobin disease result, age 0-3 that are referred for HMG program services.</p>	<p>A-3 (1) (a) Quarterly Performance Report</p> <p>A-3 (1) (b) Quarterly Performance Report</p> <p>A-3 (1) (c) Quarterly Performance Report</p>

SFY 2012
REQUIRED OBJECTIVES and WORKPLAN

Sickle Cell Project: _____ Project #: _____

Component: Culturally and Linguistically Appropriate Services

Goal A: Promote the early identification of newborns, children and adults identified with or at risk for sickle cell disease, sickle cell trait and other hemoglobinopathies and facilitate their integration into systems of comprehensive service and care (which include treatment interventions, if applicable) that are available, accessible and culturally and linguistically appropriate.

Expected Outcome/Impact/Result: The ODH grant-funded Sickle Cell Services Program will provide culturally and linguistically appropriate services to individuals/families identified with or at risk for sickle cell disease and other hemoglobinopathies.

One objective, numbered sequentially, per page. Duplicate form as needed.

(1) S.M.A.R.T. Objectives	(2) Work Plan Activities (Responsible Party)	(3) Timelines/ Start/Finish	(4) Performance Measure	(5) Data Source
<p>A-4 (1). By September 30, 2011, all current and new* RSCP staff (with patient/consumer/family contact) will complete the HRSA online course related to improving patient/consumer centered communication skills and practices. The course can be accessed at: http://www.hrsa.gov/publichealth/healthliteracy/index.html</p> <p><i>*New staff must complete within 90 days of hire</i></p>			<p>A-4 (1) (a) The number of current staff that complete the HRSA on-line course.</p> <p>A-4 (1) (b) The number of new staff that complete the HRSA on-line course.</p>	<p>A-4 (1) (a) Certificate of course completion submitted with 2nd Quarter Performance Report (October 15, 2011) for current staff</p> <p>A-4 (1) (b) Certificate of course completion submitted with Quarterly Performance Report (<i>within 90 days of hire</i>) for new RSCP staff</p>

SFY 2012
REQUIRED OBJECTIVES and WORKPLAN

Sickle Cell Project: _____ Project #: _____

Components: Culturally and Linguistically Appropriate Services

Goal A: Promote the early identification of newborns, children and adults identified with or at risk for sickle cell disease, sickle cell trait and other hemoglobinopathies and facilitate their integration into systems of comprehensive service and care (which include treatment interventions, if applicable) that are available, accessible and culturally and linguistically appropriate.

Expected Outcome/Impact/Result: The ODH grant-funded Sickle Cell Services Program will provide culturally and linguistically appropriate services to individuals/families identified with or at risk for sickle cell disease and other hemoglobinopathies.

One objective, numbered sequentially, per page. Duplicate form as needed.

(1) S.M.A.R.T. Objectives	(2) Work Plan Activities (Responsible Party)	(3) Timelines/ Start/Finish	(4) Performance Measure	(5) Data Source
<p>A-4 (2). By June 30, 2012, all current and new RSCP staff (with patient/consumer/family contact) will attend a minimum of two (2) professional development and/or in-service training(s) related <u>specifically</u> to the provision of culturally and/or linguistically appropriate services.</p> <p><i>Note: A literature search and study (approved in advance by ODH) on the topic of culturally competent provision of services may be substituted as one of the two requirements if SFY 2012 budgeted funds are limited.</i></p>			<p>A-4 (2) (a) The number of professional development and/or in-service training(s) attended by RSCP staff (current and new) related <u>specifically</u> to the provision of culturally and/or linguistically appropriate services.</p> <p>A-4 (2) (b) The number of RSCP staff (current and new) that attends professional development and/or in-service training (s) related <u>specifically</u> to the provision of culturally and linguistically appropriate services.</p>	<p>A-4 (2) (a) Quarterly Performance Reports</p> <p>A-4 (2) (b) Quarterly Performance Reports</p>

SFY 2012
REQUIRED OBJECTIVES and WORKPLAN

Sickle Cell Project: _____ Project #: _____

Component: Performance Improvement and Evaluation Activities

Goal A: Promote the early identification of newborns, children and adults identified with or at risk for sickle cell disease, sickle cell trait and other hemoglobinopathies and facilitate their integration into systems of comprehensive service and care (which include treatment interventions, if applicable) that are available, accessible and culturally and linguistically appropriate.

Expected Outcome/Impact/Result: Hemoglobinopathy services will be improved and reflect the concerns and priorities of all recipient individuals, families and the organizations that serve them.

One objective, numbered sequentially, per page. Duplicate form as needed.

(1) S.M.A.R.T. Objectives	(2) Work Plan Activities (Responsible Party)	(3) Timelines/ Start/Finish	(4) Performance Measure	(5) Data Source
A-5 (1). By the June 30, 2012, the RSCP will convene a Sickle Cell Advisory Committee (SCAC) which meets, at a minimum, semi-annually (<i>refer to the Standards and Criteria for information under <u>Performance Improvement and Evaluation Activities</u></i>).			A-5 (1) The number of SCAC meetings convened during the reporting period.	A-5 (1) Dates of meetings convened documented on Quarterly Performance Reports

SFY 2012
REQUIRED OBJECTIVES and WORKPLAN

Sickle Cell Project: _____ Project #: _____

Component: Performance Improvement and Evaluation Activities

Goal A: Promote the early identification of newborns, children and adults identified with or at risk for sickle cell disease, sickle cell trait and other hemoglobinopathies and facilitate their integration into systems of comprehensive service and care (which include treatment interventions, if applicable) that are available, accessible and culturally and linguistically appropriate.

Expected Outcome/Impact/Result: Hemoglobinopathy services will be improved and reflect the concerns and priorities of all recipient individuals, families and the organizations that serve them.

One objective, numbered sequentially, per page. Duplicate form as needed.

(1) S.M.A.R.T. Objectives	(2) Work Plan Activities (Responsible Party)	(3) Timelines/ Start/Finish	(4) Performance Measure	(5) Data Source
A-5 (2). By June 30, 2012, the composition of the SCAC will represent/reflect the recommended categories of organizational and consumer membership (<i>refer to the Standards and Criteria for information under <u>Performance Improvement and Evaluation Activities</u></i>).			A-5 (2) The number of SCAC members that represent/reflect the recommended categories of membership.	A-5 (2) Recommended organizational and consumer membership documented with Quarter Performance Report(s)

SFY 2012
REQUIRED OBJECTIVES and WORKPLAN

Sickle Cell Project: _____ Project #: _____

Components: Education Activities

Goal B: Increase the awareness, knowledge and skill level of Ohio professionals' about the special health care needs and services related hemoglobinopathies through the promoted use of education, training and outreach.

Expected Outcome/Impact/Result: Ohio professionals' that service children/individuals/families identified with or at risk for hemoglobinopathies will be skilled in recognizing and providing appropriate interventions and knowledgeable about services and referral resources available to them.

One objective, numbered sequentially, per page. Duplicate form as needed.

(1) S.M.A.R.T. Objectives	(2) Work Plan Activities (Responsible Party)	(3) Timelines/ Start/Finish	(4) Performance Measure	(5) Data Source
B-1 (1) By June 30, 2012, establish that 100 percent of the professionals that provide services to the regional newborn population (who receive at least one abnormal hemoglobin NBS result for a patient under their care) will receive information on NBS and RSCP services.			B-1 (1) The number and percent of professionals that provide service to the regional newborn population that receive information on NBS and RSCP services.	B-1 (1) Information documented on the Quarterly Performance Report(s)

SFY 2012
REQUIRED OBJECTIVES and WORKPLAN

Sickle Cell Project: _____ Project #: _____

Components: Education Activities

Goal B: Increase the awareness, knowledge and skill level of Ohio professionals' about the special health care needs and services related to hemoglobinopathies through the promoted use of education, training and outreach.

Expected Outcome/Impact/Result: Ohio professionals' that service children/individuals/families identified with or at risk for hemoglobinopathies will be skilled in recognizing and providing appropriate interventions and knowledgeable about services and referral resources available to them.

One objective, numbered sequentially, per page. Duplicate form as needed.

(1) S.M.A.R.T. Objectives	(2) Work Plan Activities (Responsible Party)	(3) Timelines/ Start/Finish	(4) Performance Measure	(5) Data Source
B-1 (2) By June 30, 2012, the RSCP will provide _____ (insert numerical projection) education and/or awareness activities (e.g. see <i>Glossary for instructional formats: hemoglobinopathy lecture, course, training/rotation/internship, individualized instruction, web-based module and awareness</i>) to professionals in the region that service children/individuals/families identified with or at risk for hemoglobinopathies.			B-1 (2) (a) The number of regional education and/or awareness activities by instructional format provided to professionals by RSCP staff. B-1 (2) (b) The number of individuals by audience type who attend regional education activities provided by RSCP staff.	B-1 (2) (a) Quarterly Performance Report(s) B-1 (2) (b) Quarterly Performance Report(s)

SFY 2012
REQUIRED OBJECTIVES and WORKPLAN

Sickle Cell Project: _____ Project #: _____

Components: Education Activities

Goal C: Expand community education and public awareness of hemoglobinopathies and related programs/services with special emphasis on meeting the needs and culture of unserved, under-served and emerging population groups.

Expected Outcome/Impact/Result: The general public and identified segments of the community will have increased awareness of hemoglobinopathy issues and RSCP locations and services.

One objective, numbered sequentially, per page. Duplicate form as needed.

(1) S.M.A.R.T. Objectives	(2) Work Plan Activities (Responsible Party)	(3) Timelines/ Start/Finish	(4) Performance Measure	(5) Data Source
C-1 (1) By June 30, 2012, the RSCP will identify or create and disseminate culturally and linguistically appropriate educational materials for identified* segments of the community. <i>*Identify the segments of the community that this objective will address.</i>			C-1 (1) The number of culturally and linguistically appropriate education materials identified or created and disseminated for identified* segments of the community.	C-1 (1) Educational materials documented on the Quarterly Report

SFY 2012
REQUIRED OBJECTIVES and WORKPLAN

Sickle Cell Project: _____ Project #: _____

Components: Education Activities

Goal C: Expand community education and public awareness of hemoglobinopathies and related programs/services with special emphasis on meeting the needs and culture of unserved, under-served and emerging population groups.

Expected Outcome/Impact/Result: The general public and identified segments of the community will have increased awareness of hemoglobinopathy issues and RSCP locations and services.

One objective, numbered sequentially, per page. Duplicate form as needed.

(1) S.M.A.R.T. Objectives	(2) Work Plan Activities (Responsible Party)	(3) Timelines/ Start/Finish	(4) Performance Measure	(5) Data Source
<p>C-1 (2) By June 30, 2012, RSCP staff will participate in a minimum of twelve (12) education and/or awareness activities <i>in the counties with the largest estimated number of carriers (HbAS)</i>, with at least three (3) of these being provided to the general public, and at least three (3) provided to identified* segments of the community.</p> <p><i>*Identify the segments of the community that this objective will address.</i></p> <p><i>Note: Excluding September-Sickle Cell Sabbath and Sickle Cell Month activities</i></p>			<p>C-1 (2) (a) The number of regional education and/or awareness activities by instructional format provided by the RSCP to the general public and/or identified* segments of the community.</p> <p>C-1 (2) (b) The number of individuals by audience type that attend regional education and/or awareness activities provided by the RSCP.</p>	<p>C-1 (2) (a) Education Event Reporting</p> <p>C-1 (2) (b) Education Event Reporting</p>

SFY 2012
REQUIRED OBJECTIVES and WORKPLAN

Sickle Cell Project: _____ Project #: _____

Components: Education Activities

Goal C: Expand community education and public awareness of hemoglobinopathies and related programs/services with special emphasis on meeting the needs and culture of unserved, under-served and/or emerging population groups.

Expected Outcome/Impact/Result: The general public and identified segments of the community will have increased awareness of hemoglobinopathy issues and RSCP locations and services.

One objective, numbered sequentially, per page. Duplicate form as needed.

(1) S.M.A.R.T. Objectives	(2) Work Plan Activities (Responsible Party)	(3) Timelines/ Start/Finish	(4) Performance Measure	(5) Data Source
<p>C-1 (3) Between September 1 and September 30, 2011, the RSCP will implement a minimum of three (3) regional education activities to promote “September -Sickle Cell Awareness Month” to individuals from the general public and/or identified * segments of the community.</p> <p><i>*Identify the segments of the community that this objective will address.</i></p> <p><i>Note: Excludes Sickle Cell Sabbath activities.</i></p>			<p>C-1 (3) (a) The number of regional education activities that are implemented by the RSCP to promote “September-Sickle Cell Awareness Month” to individuals from the general public and/or identified* segments of the community.</p> <p>C-1 (3) (b) The number of individuals by audience type that attend/participate in “September-Sickle Cell Awareness Month” activities.</p>	<p>C-1 (3) (a) Education Event Reporting</p> <p>C-1 (3) (b) Education Event Reporting</p>

SFY 2012
REQUIRED OBJECTIVES and WORKPLAN

Sickle Cell Project: _____ Project #: _____

Components: Education Activities

Goal C: Expand community education and public awareness hemoglobinopathies and related programs/services with special emphasis on meeting the needs and culture of unserved, under-served and/or emerging population groups.

Expected Outcome/Impact/Result: The general public and identified segments of the community will have increased awareness of hemoglobinopathy issues and RSCP locations and services.

One objective, numbered sequentially, per page. Duplicate form as needed.

(1) S.M.A.R.T. Objectives	(2) Work Plan Activities (Responsible Party)	(3) Timelines/ Start/Finish	(4) Performance Measure	(5) Data Source
<p>C-1 (4) During September 2011, a minimum of 25 faith-based groups or institutions in the region, of various denominations, will be offered the opportunity to participate in Sickle Cell Sabbath (<i>see Glossary</i>) activities planned and implemented by the RSCP during the state-designated weekend of September 16th through September 18th.</p> <p><i>Note: Excludes Sickle Cell Month activities</i></p>			<p>C-1 (4) (a) The number of faith-based groups or institutions that are offered the opportunity to participate in Sickle Cell Sabbath (SCS) activities during the designated weekend.</p> <p>C-1 (4) (b) The number of faith-based groups or institutions that request SCS-related information/materials from the RSCP during the designated weekend.</p> <p>C-1 (4) (c) The number of individuals from faith-based groups or institutions that attend/participate in SCS activities at their place of worship.</p>	<p>C-1 (4) (a) Education Event Reporting</p> <p>C-1 (4) (b) Education Event Reporting</p> <p>C-1 (4) (c) Education Event Reporting</p>

SFY 2012 - ATTACHMENT #6

SFY 2012
SELECT OBJECTIVES and WORKPLAN

Sickle Cell Project: _____ Project #: _____

Components: Outreach Activities

Goal AA (SELECT): Promote the early identification of newborns, children and adults identified with or at risk for sickle cell disease, sickle cell trait and other hemoglobinopathies and facilitate their integration into systems of comprehensive service and care (which include treatment interventions, if applicable) that are available, accessible and culturally and linguistically appropriate.

Expected Outcome/Impact/Result: “Follow-up” services and/or educational outreach services are available and accessible to children and adults with sickle cell disease, sickle cell trait and other hemoglobinopathies within their demographic and/or geographic catchment area.

One objective, numbered sequentially, per page. Duplicate form as needed.

(1) S.M.A.R.T. Objectives	(2) Work Plan Activities (Responsible Party)	(3) Timelines/ Start/Finish	(4) Performance Measure	(5) Data Source
AA-1 (1) By the June 30, 2012, _____ (insert numerical projection) newborns (resident and non-resident), non-newborns and/or consumers will receive “follow-up” services (excluding hemoglobinopathy testing) and/or educational outreach services at a satellite site (<i>refer to the Standards and Criteria for information under Outreach Activities</i>).			AA-1 (1) The number of newborns, non-newborns and/or consumers that receive “follow-up” services (excluding hemoglobinopathy testing) and/or educational outreach services at a satellite site .	AA-1 (1) Quarterly Performance Report(s)

SFY 2012
SELECT OBJECTIVES and WORKPLAN

Sickle Cell Project: _____ Project #: _____

Component(s): Outreach Activities

Goal AA (SELECT): Promote the early identification of newborns, children and adults identified with or at risk for sickle cell disease, sickle cell trait and other hemoglobinopathies and facilitate their integration into systems of comprehensive service and care (which include treatment interventions, if applicable) that are available, accessible and culturally and linguistically appropriate.

Expected Outcome/Impact/Result: “Follow-up” and/or educational outreach services are available and accessible to children and adults with sickle cell disease, sickle cell trait and other hemoglobinopathies within their demographic and/or geographic catchment area.

One objective, numbered sequentially, per page. Duplicate form as needed.

(1) S.M.A.R.T. Objectives	(2) Work Plan Activities (Responsible Party)	(3) Timelines/ Start/Finish	(4) Performance Measure	(5) Data Source
AA-1 (2) By June 30, 2012, _____ (insert numerical projection) newborns, non-newborns and/or consumers will receive “follow-up” services (excluding hemoglobinopathy testing) and/or educational outreach services at an outreach site <i>(refer to the Standards and Criteria for information under Outreach Activities)</i> .			AA-1 (2) The number of newborns, non-newborns and/or consumers that receive “follow-up” services (excluding hemoglobinopathy testing) and/or educational outreach services at an outreach site .	AA-1 (2) Quarterly Performance Report(s)

SFY 2012 - ATTACHMENT #6

**SFY 2012
SELECT OBJECTIVES and WORKPLAN**

Sickle Cell Project: _____ Project #: _____

Components: Outreach Activities

Goal AA (SELECT): Promote the early identification of newborns, children and adults identified with or at risk for sickle cell disease, sickle cell trait and other hemoglobinopathies and facilitate their integration into systems of comprehensive service and care (which include treatment interventions, if applicable) that are available, accessible and culturally and linguistically appropriate.

Expected Outcome/Impact/Result: “Follow-up” and/or educational outreach services are available and accessible to children and adults with sickle cell disease, sickle cell trait and other hemoglobinopathies within their demographic and/or geographic catchment area.

One objective, numbered sequentially, per page. Duplicate form as needed.

(1) S.M.A.R.T. Objectives	(2) Work Plan Activities (Responsible Party)	(3) Timelines/ Start/Finish	(4) Performance Measure	(5) Data Source
AA-2 (1) By the June 30, 2012, _____ (insert numerical projection) newborns, non-newborns and/or consumers will receive hemoglobinopathy testing services at one of the following locations: 1) RSCP (main site), 2) outreach site or 3) satellite site.			AA-2 (1) The number of newborns, non-newborns and/or consumers that receive hemoglobinopathy testing services at one of the identified locations.	AA-2 (1) Quarterly Performance Report.

SFY 2012
OPTIONAL OBJECTIVES and WORKPLAN

Sickle Cell Project: _____ Project #: _____

Component(s): List the Service Component for this optional objective (*Procedures of Care, Collaboration and Coordination Activities, Culturally and Linguistically Appropriate Services, Performance Improvement and Evaluation Activities, Education Activities, Outreach Activities*)

Goal: List the Goal for this optional objective (*Goal A, Goal B or Goal C*)

Expected Outcome/Impact/Result: List the expected Outcome/Impact/Result for this optional objective

One objective, numbered sequentially, per page. Duplicate form as needed.

(1) S.M.A.R.T. Objectives	(2) Work Plan Activities (Responsible Party)	(3) Timelines/ Start/Finish	(4) Performance Measure	(5) Data Source
<p>The directions for writing S.M.A.R.T. objectives are provided in the RFP guidance under Objectives and Work Plan.</p>	<p>List the specific activities that will be implemented to accomplish the objective listed in column (1). For each activity listed, the PRIMARY staff person/position responsible for implementation of the activity (Responsible Party) must be delineated. Work Plan activities should be numbered sequentially to match the Timeline (Start/Finish) dates in column (3).</p>	<p>Indicate the start/finish date for each activity listed in column (2). Unless the anticipated timeline start/finish dates for a specific activity is the entire grant period, timeline dates should be based on actual completion dates. Timeline (Start/Finish) dates should be numbered sequentially to match the Work plan activities listed in column (2).</p>	<p>Describe how progress toward accomplishing the objectives in column (1) will be will be measured or evaluated.</p>	<p>Insert data sources</p>

**Ohio Department of Health (ODH)
Sickle Cell Services Program (SCSP)**

Assurance That Applicant Meets ODH SCSP Standards & Criteria

As a public health program, the ODH Sickle Cell Services Program, in partnership with the Regional Sickle Cell Projects (RSCPs) works to (1) ensure and enhance the availability and accessibility of quality comprehensive sickle cell services and care for newborns, children and adults; (2) promote patient/consumer/family/professional education to increase awareness and knowledge about hemoglobinopathies and (3) increase collaboration, coordination and utilization of all sickle cell-related services/resources in Ohio.

Each RSCP operates as an identifiable, functional unit or program within an approved tertiary care or community-based facility. It is organized for and capable of ensuring the provision of **regional** comprehensive services and care to newborns, children and adults identified with or at risk for sickle cell disease, sickle cell trait or other hemoglobinopathies in an ODH-defined multi-county service region.

Each RSCP funded by the State of Ohio *must* also meet or exceed the required (“*shall*”) Standards and Criteria and *may* meet many of the optional (“*should*”) Standards and Criteria outlined under the five (5) major service components (Procedures of Care, Education Activities, Collaboration and Coordination Activities, Outreach Activities and Performance Improvement and Evaluation Activities) and the four (4) major Administrative Components (Facility Arrangements and Policies, Staffing Composition and Administration, Culturally and Linguistically Appropriate Services and Guiding Operation Principles).

By signing and dating this document, the _____
(Name of Regional Sickle Cell Project)

Project Director assures that the RSCP meets and will comply with ODH Sickle Cell Services Program Standards and Criteria throughout the **SFY 2012 - SFY 2015** grant funding period.

Signature of Project Director

Title

Date

REGIONAL SICKLE CELL ADVISORY COMMITTEE

Include:

The applicant must describe plans to establish and maintain a **Regional Sickle Cell Advisory Committee** and the efforts that will be undertaken to recruit organization and consumer representatives for membership. Membership composition of the committee should be multidisciplinary, multicultural and reflect a broad spectrum of the regional community who are knowledgeable about the community/agency they represent and who have insight into the recommended “best” practice standards for hemoglobinopathies and the provision of sickle cell services in Ohio. The advisory committee should include an adequate number of patients and family members of those affected with a hemoglobinopathy. **Refer to the Appendix section of the Standards and Criteria for information on the purpose and categories of membership representation for the Advisory Committee.**

Note: All attachments must clearly identify the authorized program name and grant application number.

LETTERS OF SUPPORT

Include:

The applicant must provide a **current** letter of support from a minimum of five (5) partner individuals, groups and/or agency/organizations that support the purpose, scope and work of the applicant agency. One (1) letter must be submitted from at least three (3) of the entities listed below (excluding local county and city health departments/districts):

- Regional Blood Program in Ohio
- Federally Qualifying Health Center (FQHC)
- Organization that addresses health disparities
- Regional Genetics Center
- Faith-based group or Ministerial Alliance
- Local Health District
- Pediatric health care facility (community-based applicants)
- Adult health care facility (community and hospital-based applicants)
- Regional school system
- Volunteer or advocacy group
- Local Help Me Grow Project
- Parent(s) of child with SCD (age 0-18)
- Adult(s) with SCD (age 18+)

Letters of support must be signed, dated and on official letterhead, if applicable (*check entity above and upload all documents in GMIS 2.0*).

Note: All attachments must clearly identify the authorized program name and grant application number.

LETTER OF DOCUMENTATION

Include:

The applicant must identify and provide a letter of documentation from the Medical Director/Medical Advisor that will be responsible for providing guidance and leadership to the project regarding the five (5) service components and the four (4) administrative components of the Standards and Criteria. The letter of documentation must be signed, dated and document the role, responsibility and relationship of the Medical Director/Medical Advisor and the applicant agency (*submit letter of documentation as an upload in GMIS 2.0*). **Refer to the Appendix section of the Standards and Criteria for information on the position of Medical Director/Medical Advisor.**

Note: All attachments must clearly identify the authorized program name and grant application number.

Attachment B
Ohio Department of Health Sub-Awardee
Reporting Form for State Funded Grants

Submission Date ____/____/____

Sub-Awardee Data

1	DUNS #	
2	DUNS # plus 4	
3	Agency Name	
4	Has your Agency registered with CCR?	
5	CCR Expiration Date	

APPLICATION CHECKLIST

Program Name: _____

Grant Application Number: _____

NOTE TO APPLICANT: The following checklist must be completed and *uploaded as an attachment** with your application via GMIS 2.0. **Refer to applicable sections of the RFP for specific details regarding submission requirements.**

Part A: This part is provided to assure that the following components of the RFP have been completed and submitted via GMIS 2.0.

	Included
1. Application Information	<input type="checkbox"/>
2. Project Narrative (<i>Components 1-5</i>)	
<i>Component #1-Project Abstract</i>	<input type="checkbox"/>
<i>Component #2-Description of Applicant Agency/Documentation of Eligibility/Personnel</i>	<input type="checkbox"/>
<i>Component #3-Problem.Need</i>	<input type="checkbox"/>
<i>Component #4-Objectives and Work Plan</i>	<input type="checkbox"/>
<i>Component #5-Additional Requirements</i>	<input type="checkbox"/>
3. Project Contacts	<input type="checkbox"/>
4. Budget (All applicable sections)	<input type="checkbox"/>
5. Civil Rights Review Questionnaire (EEO Survey)	<input type="checkbox"/>
6. Assurances Certification	<input type="checkbox"/>
7. Attachments as required by Program (<i>Attachment #1 – Attachment #13</i>)	
<i>Attachment #1-Public Health Impact Statement of Support from Local Health Districts</i>	<input type="checkbox"/>
<i>Attachment #2-Curricula Vitae/Resumes</i>	<input type="checkbox"/>
<i>Attachment #3-Position Descriptions</i>	<input type="checkbox"/>
<i>Attachment #4-Project Organization Chart</i>	<input type="checkbox"/>
<i>Attachment #5-Required S.M.A.R.T. Objectives and Work Plan</i>	<input type="checkbox"/>
<i>Attachment #6-Select S.M.A.R.T. Objectives and Work Plan</i>	<input type="checkbox"/>
<i>Attachment #7-Optional S.M.A.R.T. Objectives and Work Plan</i>	<input type="checkbox"/>
<i>Attachment #8-Standards and Criteria Assurance Form</i>	<input type="checkbox"/>
<i>Attachment #9-Regional Sickle Cell Advisory Committee</i>	<input type="checkbox"/>
<i>Attachment #10-Letters of Support</i>	<input type="checkbox"/>
<i>Attachment #11-Letter of Documentation</i>	<input type="checkbox"/>
<i>Attachment #12-ODH Sub-Awardee-FFATA Reporting Form</i>	<input type="checkbox"/>
<i>Attachment #13-Application Checklist</i>	<input type="checkbox"/>

Part B: This part is provided to assure that an **original and one copy** of the following forms, available on GMIS 2.0, have been printed, completed (*dated and signed in blue ink with original signatures by the Agency Head or Agency Financial Head*) and mailed to the **Ohio Department of Health, Grants Administration, Central Master Files - 4th Floor, 246 North High Street, Columbus, Ohio 43215.**

1. Electronic Funds Transfer (EFT) Form	<input type="checkbox"/>
2. Internal Revenue Form (IRS) W-9 Form and Vendor Forms	<input type="checkbox"/>

APPLICATION CHECKLIST

Part C: This part is provided to assure that **two copies** of the following documents (if required) have been copied and mailed to the ODH address listed above.

- 1. Public Health Impact Statement
 - 2. Statement of Support from the Local Health Districts
 - 3. Statement of Intent to Pursue Health Equity Strategies
 - 4. Liability Coverage
 - 5. Evidence of Non-Profit Status
-

Part D.: This part is provided to assure that **one copy** of the following documents (if required) have been completed, copied and mailed to the ODH address listed above.

- 1. Current Independent Audit
 - 2. DMA Questionnaire
 - 3. Program Attachments (Non-internet compatible): **None**
-

***All attachments must clearly identify the authorized program name and grant application number.**

APPENDICES

**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)

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

Mail, E-mail or Fax To:

GAIL BYERS
Grants Administration Unit
Ohio Department of Health
246 North High Street
Columbus, Ohio 43215
E-mail: gail.byers@odh.ohio.gov
Fax: 614-752-9783

GMIS 2.0 TRAINING FORM *MUST* BE RECEIVED BY APRIL 15, 2011

SFY 2012 - APPENDIX B

Ohio Department of Health
Bureau of Early Intervention Services
ODH Program Title: Sickle Cell - Direct Service Initiative

GRANT APPLICATION REVIEW FORM
State Fiscal Year: July 1, 2011 to June 30, 2012

APPLICANT AGENCY: _____ **TOTAL PTS.:** _____

Approval and funding of application as submitted (no program special conditions)

Approval and funding of application with applied special conditions. Please list conditions below:

(Attach additional page)

Disapproval of application as submitted. Please state reason(s) below:

(Attach additional page)

Ohio Department of Health
 Bureau for Children with Medical Handicaps
ODH Program Title: Sickle Cell – Direct Service Initiative

State Fiscal Year: July 1, 2011 to June 30, 2012

APPLICANT AGENCY: _____ PROJECT #: _____

REVIEWER NUMBER: _____ REVIEW DATE: _____

TOTAL AMOUNT OF FUNDS REQUESTED: _____ ODH FUNDING ALLOCATION: _____

Instructions: Review the grant application carefully. For each of the sections (1-9) listed below, record the appropriate point value in the Reviewers Score Column. The *total* application score should not exceed the maximum 150 point value. Comments/Strengths/Weaknesses and Special Conditions should be recorded in the middle section.

APPLICATION SECTION	COMMENTS/STRENGTHS/WEAKNESSES SPECIAL CONDITIONS	REVIEWERS SCORE
<p>1. Public Health Impact Statement Summary (Maximum 15 points)</p> <p>Does the applicant:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Include a summary statement listing the Local Health District Improvement Standard(s) to be addressed by grant activities. (Maximum 3 points) <input type="checkbox"/> Describe the demographic characteristics of the target population affected by hemoglobinopathies and the geographical area in which they live. (Maximum 2 points) <input type="checkbox"/> Include a summary of the regional services (county-specific) to be provided or program/activities to be conducted. (Maximum 2 points) 		

SFY 2012 - APPENDIX B

APPLICATION SECTION	COMMENTS/STRENGTHS/WEAKNESSES SPECIAL CONDITIONS	REVIEWERS SCORE
<p>Public Health Impact Statement Summary (continued)</p> <p>Does the applicant:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Describe a plan to coordinate and share information with appropriate local health districts. (Maximum 2 points) <input type="checkbox"/> Adhere to 1 page limit (Maximum 1 point) <input type="checkbox"/> Include as ATTACHMENT #1, a <i>statement of support</i> from <u>each</u> of the local city and/or county health districts in the region with the largest estimated number (greater than 500) of sickle cell (HbAS) carriers (see Sickle Cell Target Population Projections). (Maximum 5 points) 		

SFY 2012 - APPENDIX B

APPLICATION SECTION	COMMENTS/STRENGTHS/WEAKNESSES SPECIAL CONDITIONS	REVIEWERS SCORE
<p>2. Statement of Intent to Pursue Health Equity Strategies (Maximum 15 points)</p> <p>Does the applicant:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Explain the extent in which health disparities are manifested within the health status or health system focus of this application. (Maximum 5 points) <input type="checkbox"/> Identify specific groups(s) who experience a <u>disproportionate burden</u> for the disease or health condition addressed by this application. This includes unserved, under-served and/or emerging populations. (Maximum 5 points) <input type="checkbox"/> Identify specific social and environmental conditions which lead to health disparities (social determinants). This statement must be supported by data.(Maximum 4 points) <input type="checkbox"/> Adhere to the 1 ½ page limit (Maximum 1 point) 		

SFY 2012 - APPENDIX B

APPLICATION SECTION	COMMENTS/STRENGTHS/WEAKNESSES SPECIAL CONDITIONS	REVIEWERS SCORE
<p>3. Budget/Budget Justification (Maximum 30 points)</p> <p>Does the applicant:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Adhere to Unallowable Costs (listed on page 9 of the RFP). (Maximum 1 point) <input type="checkbox"/> Include in the budget narrative, a section describing any “Applicant Share” funds that are committed by the grantee agency and/or contributed by external resources to support grant activities. (Maximum 2 points) <input type="checkbox"/> Adhere to programmatic budgetary restrictions (listed on page 12 of the RFP). (Maximum 1 point) <input type="checkbox"/> Allocate (through either grant request and/or applicant share) funds to purchase educational materials and support travel and per diem, if applicable. (Maximum 1 point) <input type="checkbox"/> Provide a <u>detailed</u> budget justification that describes how the categorical costs are derived (see APPENDIX #10). (Maximum 8 points) <input type="checkbox"/> Discuss the necessity, reasonableness and allocability the proposed costs and how they apply to the program objectives. (Maximum 4 points) <input type="checkbox"/> Describe the specific functions all personnel, consultants and collaborators (including the Medical Director or Medical Advisor). (Maximum 4 points) 		

SFY 2012 - APPENDIX B

APPLICATION SECTION	COMMENTS/STRENGTHS/WEAKNESSES SPECIAL CONDITIONS	REVIEWERS SCORE
<p>Budget/Budget Justification (continued)</p> <p>Does the applicant:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Explain and justify equipment, travel (including any plans for out-of state travel, supplies, trainings costs and/or other line-item costs (see APPENDIX #10). (Maximum 4 points) <input type="checkbox"/> Request line-item costs that are adequate in relation to anticipated scope and nature of project activities. (Maximum 1 point) <input type="checkbox"/> Submit a properly completed subgrantee fiscal application in GMIS 2.0. (Maximum 4 points) 		

SFY 2012 - APPENDIX B

APPLICATION SECTION	COMMENTS/STRENGTHS/WEAKNESSES SPECIAL CONDITIONS	REVIEWERS SCORE
<p>4. Project Abstract (Maximum 5 points)</p> <p>Does the applicant:</p> <ul style="list-style-type: none"> <input type="checkbox"/> State the local health concern(s) that the project will address. (Maximum 1 point) <input type="checkbox"/> Describe the programs/services/activities that will be provided/conducted by the project. (Maximum 1 point) <input type="checkbox"/> Describe segments of the target population that experience a disproportionate burden of the local health status concern(s) that will be serviced by the project. (Maximum 1 point) <input type="checkbox"/> Identify other agencies or subcontractors that will be involved in the provision of programs/services/activities. (Maximum 1 point) <input type="checkbox"/> Adhere to the one page, single spaced limitation. (Maximum 1 point) 		

SFY 2012 - APPENDIX B

APPLICATION SECTION	COMMENTS/STRENGTHS/WEAKNESSES SPECIAL CONDITIONS	REVIEWERS SCORE
<p>5. Description of Applicant Agency/Documentation of Eligibility/Personnel (Maximum 10 points)</p> <p>Does the applicant:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Briefly describe the applicant agency's eligibility to apply addressing each item in the requirements as outlined under <u>Qualified Applicants</u>. (Maximum 2 points) <input type="checkbox"/> Summarize the agency's structure as it relates to this program and, as the lead agency, how it will manage the program. (Maximum 1 point) <input type="checkbox"/> Describe the capacity of the organization, its personnel and contractors to communicate effectively and convey information in a manner that is easily understood by diverse audiences. This includes persons of limited English proficiency, those who are not literate, have low literacy skills and individuals with disabilities. (Maximum 3 points) <input type="checkbox"/> 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 or positions that will be directly involved in project activities. (Maximum 3 points) <input type="checkbox"/> Describe the relationship between project staff members, staff members of the applicant agency, and other partners and agencies that will be working on this project. (Maximum 1 point) 		

SFY 2012 - APPENDIX B

APPLICATION SECTION	COMMENTS/STRENGTHS/WEAKNESSES SPECIAL CONDITIONS	REVIEWERS SCORE
<p>6. Problem/Need (Maximum 20 points)</p> <p>Does the applicant:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Identify and describe the local health status concern that will be addressed by the project. <u>Do not restate national and state data.</u> The specific health status concerns that the project 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. (Maximum 10 points) <input type="checkbox"/> Explicitly describe the segments of the target population who experience a disproportionate burden of the local health status concern. (Maximum 5 points) <input type="checkbox"/> Include a description of the other agencies/organizations also addressing the problem/need and how collaboration/coordination efforts will occur. (Maximum 5 points) 		

SFY 2012 - APPENDIX B

APPLICATION SECTION	COMMENTS/STRENGTHS/WEAKNESSES SPECIAL CONDITIONS	REVIEWERS SCORE
<p>7. Objectives and Work Plan (Maximum 25 points)</p> <p>Does the applicant:</p> <ul style="list-style-type: none"> <input type="checkbox"/> In lieu of a narrative methodology, submit a Work Plan (ATTACHMENT 5 through ATTACHMENT #7) that utilizes the SMART objective format. (Maximum 5 points) <input type="checkbox"/> Describe appropriate work plan activities for the S.M.A.R.T. objectives identified. (Maximum 10 points) <input type="checkbox"/> Identify a staff person who is responsible for the accomplishment of each work plan activity. (Maximum 5 points) <input type="checkbox"/> Specify a timeline (start/finish dates) appropriate for the accomplishment of each work plan activity. (Maximum 5 points) 		

SFY 2012 - APPENDIX B

APPLICATION SECTION	COMMENTS/STRENGTHS/WEAKNESSES SPECIAL CONDITIONS	REVIEWERS SCORE
<p>8. Additional Narrative Requirements (Maximum 20 points)</p> <p>Does the applicant:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Describe (as ATTACHMENT #8) plans to establish and maintain a regional advisory committee and efforts that will be undertaken to recruit organization and consumer representatives for membership. (Maximum 5 points) <input type="checkbox"/> Provide (as ATTACHMENT #9) a current letter of support from a minimum of five (5) partner individuals, groups and/or agency/organizations that support the purpose, scope and work of the applicant agency. A letter representing at least three (3) of the following entities must be submitted: <ul style="list-style-type: none"> <input type="checkbox"/> Regional Blood Program in Ohio <input type="checkbox"/> Federally Qualifying Health Center (FQHC) <input type="checkbox"/> Organization that addresses health disparities <input type="checkbox"/> Regional Genetics Center <input type="checkbox"/> Faith-based group or Ministerial Alliance <input type="checkbox"/> Local Health District <input type="checkbox"/> Pediatric health care facility (community-based applicants) <input type="checkbox"/> Adult health care facility (community and hospital-based applicants) <input type="checkbox"/> Regional school system <input type="checkbox"/> Volunteer or advocacy group <input type="checkbox"/> Local Help Me Grow Project <input type="checkbox"/> Parent(s) of child with SCD (age 0-18) <input type="checkbox"/> Adult(s) with SCD (age 18+) <p>(Maximum 10 points-2 points per letter)</p>		

SFY 2012 - APPENDIX B

APPLICATION SECTION	COMMENTS/STRENGTHS/WEAKNESSES SPECIAL CONDITIONS	REVIEWERS SCORE
<p>Additional Narrative Requirements (continued)</p> <p>Does the applicant:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Provide (as ATTACHMENT # 10) a letter of documentation from the Medical Director/Medical Advisor that will be responsible for providing guidance and leadership to the applicant agency. The letter of documentation must document the relationship between the Medical Director/Medical Advisor and the applicant agency. (Maximum 5 points) 		

SFY 2012 - APPENDIX B

APPLICATION SECTION	COMMENTS/STRENGTHS/WEAKNESSES SPECIAL CONDITIONS	REVIEWERS SCORE
<p>9. Other Programmatic Attachments (Maximum 10 points)</p> <p>Does the applicant:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Include as ATTACHMENT # 2, a curricula vitas/resume for all grant funded and non-granted (in-kind) personnel listed on the Personnel tab in GMIS 2.0. (Maximum 3 points) <input type="checkbox"/> Include as ATTACHMENT #3, a position description* for all personnel in which a curricula vitae/resume has been submitted and/or a description of the recruitment strategies for filling a vacant position if staff has not been selected. (Maximum 3 points) <p>*Note: A position description is not required for the position of Medical Director/Medical Advisor.</p> <ul style="list-style-type: none"> <input type="checkbox"/> Include as ATTACHMENT #4, a one-page figure that depicts the organizational structure of the project, including subcontractors (if applicable) and other significant collaborators. (Maximum 2 points) <input type="checkbox"/> Include as ATTACHMENT # 11, the Application Checklist. (Maximum 2 points) 		
SECTION SCORES (SECTIONS 1-9)		
TOTAL REVIEWERS SCORE		

SFY 2012 - APPENDIX B

APPLICATION SECTION	COMMENTS/STRENGTHS/WEAKNESSES SPECIAL CONDITIONS
<p>REQUIRED RFP DOCUMENTS:</p> <p><i>(To be Completed by ODH Program Staff-No Value Assigned)</i></p> <p>Does the applicant submit the following documents:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Civil Rights Review Questionnaire (EEO Survey) <input type="checkbox"/> Assurances Certification <input type="checkbox"/> IRS (W-9) Form <ul style="list-style-type: none"> <input type="checkbox"/> Vendor New Form <input type="checkbox"/> Vendor Change Form <input type="checkbox"/> Agency Letter <input type="checkbox"/> Electronic Funds Transfer (EFT) Form <input type="checkbox"/> DMA Questionnaire <input type="checkbox"/> Current Certificate of Insurance Liability <input type="checkbox"/> Evidence of Non-Profit Status <input type="checkbox"/> FFATA Reporting Form <input type="checkbox"/> Current Independent Audit 	

SFY 2012 - APPENDIX C

**FUNDING ALLOCATION BY REGION
(Based on Total Target Population)**

REGION	POPULATION 2009	TOTAL TARGET POPULATION	% OF TOTAL TARGET POPULATION	% OF TOTAL FUNDING AVAILABLE
I	1,805,909	22,867	17.39%	\$123,469
II	1,565,112	15,353	11.68%	\$82,928
III	1,045,169	10,092	7.67%	\$54,457
IV	2,910,123	28,917	21.99%	\$156,129
V	2,120,778	34,834	26.49%	\$188,079
VI	2,263,614	19,434	14.78%	\$104,938
TOTAL	11,710,705	131,498	100.00%	\$710,000

Note: Prevalence estimates are rounded to nearest whole number.

(1) Source: Ohio 2009 intercensal population provided by the United States Census

(2) Estimated cases of Sickle Cell Disease (HbSS, HbSC and HbS/β Thalassemia) and estimated carrier (HbAS) for all races: (a) Non-Hispanic American Indian/Alaskan Native; (b) Non-Hispanic Asian; (c) Non-Hispanic Black; (d) Non-Hispanic Native Hawaiian or Pacific Islander; (e) Non-Hispanic White and (f) Hispanic

(3) Based on \$710,000 available funding under the Direct Service Initiative.

SFY 2012 - APPENDIX D

SICKLE CELL TARGET POPULATION PROJECTIONS

REGION I (8 counties)	POPULATION 2009	ESTIMATED CASES OF SC DISEASE (HbSS, HbSC, HbS/β Thal)	ESTIMATED CARRIERS (HbAS)	TOTAL TARGET POPULATION
Adams	28,383	1	84	85
Brown	44,364	3	148	151
Butler	368,031	88	2,794	2,882
Clermont	198,275	14	715	729
Clinton	43,573	5	196	200
Hamilton	867,564	645	16,875	17,520
Highland	42,631	3	165	168
Warren	213,087	29	1,103	1,132
REGION I	1,805,909	788	22,080	22,867

Note: Prevalence estimates are rounded to nearest whole number.

(1) Source: Ohio 2009 intercensal population provided by the United States Census

(2) SC Disease Prevalence - per 100,000 for all races: (a) Non-Hispanic American Indian/Alaskan Native; (b) Non-Hispanic Asian; (c) Non-Hispanic Black; (d) Non-Hispanic Native Hawaiian or Pacific Islander; (e) Non-Hispanic White and (f) Hispanic

(3) Carrier (HbAS) Prevalence - per 100, 000 for all races: (a) Non-Hispanic American Indian/Alaskan Native; (b) Non-Hispanic Asian; (c) Non-Hispanic Black; (d) Non-Hispanic Native Hawaiian or Pacific Islander; (e) Non-Hispanic White and (f) Hispanic

SFY 2012 - APPENDIX E

SICKLE CELL TARGET POPULATION PROJECTIONS

REGION II (17 counties)	POPULATION 2009	ESTIMATED CASES OF SC DISEASE (HbSS, HbSC, HbS/β Thal)	ESTIMATED CARRIERS (HbAS)	TOTAL TARGET POPULATION
Allen	106,334	41	1,168	1,209
Auglaize	47,133	2	143	145
Champaign	40,279	4	184	188
Clark	142,453	42	1,275	1,317
Darke	52,256	3	163	165
Greene	162,853	40	1,245	1,284
Hancock	75,334	6	291	297
Hardin	32,135	2	107	109
Logan	42,287	5	201	205
Mercer	40,939	1	114	115
Miami	102,467	11	453	464
Montgomery	541,783	333	8,901	9,234
Paulding	19,210	1	69	70
Preble	41,730	2	124	126
Putnam	34,548	1	102	103

SFY 2012 - APPENDIX E

SICKLE CELL TARGET POPULATION PROJECTIONS

REGION II (17 counties)	POPULATION 2009	ESTIMATED CASES OF SC DISEASE (HbSS, HbSC, HbS/β Thal)	ESTIMATED CARRIERS (HbAS)	TOTAL TARGET POPULATION
Shelby	49,636	5	213	218
Van Wert	28,735	2	101	103
REGION II	1,565,112	500	14,853	15,353

Note: Prevalence estimates are rounded to nearest whole number.

(1) Source: Ohio 2009 intercensal population provided by the United States Census

(2) SC Disease Prevalence - per 100,000 for all races: (a) Non-Hispanic American Indian/Alaskan Native; (b) Non-Hispanic Asian; (c) Non-Hispanic Black; (d) Non-Hispanic Native Hawaiian or Pacific Islander; (e) Non-Hispanic White and (f) Hispanic

(3) Carrier (HbAS) Prevalence - per 100,000 for all races: (a) Non-Hispanic American Indian/Alaskan Native; (b) Non-Hispanic Asian; (c) Non-Hispanic Black; (d) Non-Hispanic Native Hawaiian or Pacific Islander; (e) Non-Hispanic White and (f) Hispanic

SFY 2012 - APPENDIX F

SICKLE CELL TARGET POPULATION PROJECTIONS

REGION III (11 counties)	POPULATION 2009	ESTIMATED CASES OF SC DISEASE (HbSS, HbSC, HbS/β Thal)	ESTIMATED CARRIERS (HbAS)	TOTAL TARGET POPULATION
Defiance	38,821	3	159	162
Erie	78,348	23	706	729
Fulton	42,756	2	137	139
Henry	28,843	2	98	99
Huron	60,454	4	219	223
Lucas	472,218	261	7,122	7,383
Ottawa	41,273	2	138	140
Sandusky	60,828	7	308	316
Seneca	56,830	5	245	250
Williams	38,099	2	125	127
Wood	126,699	11	513	523
REGION III	1,045,169	323	9,769	10,092

Note: Prevalence estimates are rounded to nearest whole number.

(1) Source: Ohio 2009 intercensal population provided by the United States Census

(2) SC Disease Prevalence - per 100,000 for all races: (a) Non-Hispanic American Indian/Alaskan Native; (b) Non-Hispanic Asian; (c) Non-Hispanic Black; (d) Non-Hispanic Native Hawaiian or Pacific Islander; (e) Non-Hispanic White and (f) Hispanic

(3) Carrier (HbAS) Prevalence - per 100, 000 for all races: (a) Non-Hispanic American Indian/Alaskan Native; (b) Non-Hispanic Asian; (c) Non-Hispanic Black; (d) Non-Hispanic Native Hawaiian or Pacific Islander; (e) Non-Hispanic White and (f) Hispanic

SFY 2012 - APPENDIX G

SICKLE CELL TARGET POPULATION PROJECTIONS

REGION IV (33 counties)	POPULATION 2009	ESTIMATED CASES OF SC DISEASE (HbSS, HbSC, HbS/β Thal)	ESTIMATED CARRIERS (HbAS)	TOTAL TARGET POPULATION
Athens	64,108	7	293	300
Belmont	68,721	11	402	413
Coshocton	36,156	3	130	133
Delaware	171,205	26	940	966
Fairfield	145,704	33	1,053	1,086
Fayette	28,549	3	125	128
Franklin	1,174,070	705	18,893	19,599
Gallia	31,097	4	145	149
Guernsey	40,704	4	165	169
Harrison	15,463	2	73	75
Hocking	29,280	2	102	104
Jackson	33,797	2	109	111
Jefferson	68,571	14	457	471
Knox	60,271	4	206	210
Lawrence	63,472	6	273	279

SFY 2012 - APPENDIX G

SICKLE CELL TARGET POPULATION PROJECTIONS

REGION IV (33 counties)	POPULATION 2009	ESTIMATED CASES OF SC DISEASE (HbSS, HbSC, HbS/β Thal)	ESTIMATED CARRIERS (HbAS)	TOTAL TARGET POPULATION
Licking	160,626	20	783	803
Madison	43,024	10	323	333
Marion	66,385	15	482	496
Meigs	23,105	1	76	78
Monroe	14,172	0	39	39
Morgan	14,830	3	94	97
Morrow	34,912	2	111	113
Muskingum	86,470	14	505	520
Noble	14,384	4	116	120
Perry	35,661	1	104	106
Pickaway	55,375	11	360	370
Pike	28,189	2	98	100
Ross	77,187	18	565	582
Scioto	77,502	9	364	373
Union	49,445	7	264	271

SFY 2012 - APPENDIX G

SICKLE CELL TARGET POPULATION PROJECTIONS

REGION IV (33 counties)	POPULATION 2009	ESTIMATED CASES OF SC DISEASE (HbSS, HbSC, HbS/β Thal)	ESTIMATED CARRIERS (HbAS)	TOTAL TARGET POPULATION
Vinton	13,386	1	41	42
Washington	61,769	4	209	213
Wyandot	22,533	1	68	69
REGION IV	2,910,123	948	27,969	28,917

Note: Prevalence estimates are rounded to nearest whole number.

(1) Source: Ohio 2009 intercensal population provided by the United States Census

(2) SC Disease Prevalence - per 100,000 for all races: (a) Non-Hispanic American Indian/Alaskan Native; (b) Non-Hispanic Asian; (c) Non-Hispanic Black; (d) Non-Hispanic Native Hawaiian or Pacific Islander; (e) Non-Hispanic White and (f) Hispanic

(3) Carrier (HbAS) Prevalence - per 100, 000 for all races: (a) Non-Hispanic American Indian/Alaskan Native; (b) Non-Hispanic Asian; (c) Non-Hispanic Black; (d) Non-Hispanic Native Hawaiian or Pacific Islander; (e) Non-Hispanic White and (f) Hispanic

SFY 2012 - APPENDIX H

SICKLE CELL TARGET POPULATION PROJECTIONS

REGION V (5 counties)	POPULATION 2009	ESTIMATED CASES OF SC DISEASE (HbSS, HbSC, HbS/β Thal)	ESTIMATED CARRIERS (HbAS)	TOTAL TARGET POPULATION
Cuyahoga	1,294,193	1,109	28,686	29,794
Geauga	99,809	7	373	380
Lake	239,229	29	1,168	1,197
Lorain	311,977	87	2,706	2,793
Medina	175,570	13	657	670
REGION V	2,120,778	1,245	33,589	34,834

Note: Prevalence estimates are rounded to nearest whole number.

(1) Source: Ohio 2009 intercensal population provided by the United States Census

(2) SC Disease Prevalence - per 100,000 for all races: (a) Non-Hispanic American Indian/Alaskan Native; (b) Non-Hispanic Asian; (c) Non-Hispanic Black; (d) Non-Hispanic Native Hawaiian or Pacific Islander; (e) Non-Hispanic White and (f) Hispanic

(3) Carrier (HbAS) Prevalence - per 100,000 for all races: (a) Non-Hispanic American Indian/Alaskan Native; (b) Non-Hispanic Asian; (c) Non-Hispanic Black; (d) Non-Hispanic Native Hawaiian or Pacific Islander; (e) Non-Hispanic White and (f) Hispanic

SFY 2012 - APPENDIX I

SICKLE CELL TARGET POPULATION PROJECTIONS

REGION VI (14 counties)	POPULATION 2009	ESTIMATED CASES OF SC DISEASE (HbSS, HbSC, HbS/β Thal)	ESTIMATED CARRIERS (HbAS)	TOTAL TARGET POPULATION
Ashland	55,482	3	185	188
Ashtabula	102,223	13	522	536
Carroll	28,773	1	91	92
Columbiana	108,683	11	465	476
Crawford	43,758	2	140	143
Holmes	42,038	1	118	119
Mahoning	239,919	117	3,233	3,350
Portage	159,640	26	927	953
Richland	126,452	40	1,191	1,231
Stark	358,811	100	3,116	3,216
Summit	550,742	242	6,759	7,001
Trumbull	212,800	57	1,768	1,825

SFY 2012 - APPENDIX I

SICKLE CELL TARGET POPULATION PROJECTIONS

REGION VI (14 counties)	POPULATION 2009	ESTIMATED CASES OF SC DISEASE (HbSS, HbSC, HbS/β Thal)	ESTIMATED CARRIERS (HbAS)	TOTAL TARGET POPULATION
Tuscarawas	91,953	5	299	304
Wayne	115,340	9	437	446
REGION VI	2,263,614	628	19,250	19,878

Note: Prevalence estimates are rounded to nearest whole number.

- (1) Source: Ohio 2009 intercensal population provided by the United States Census
- (2) SC Disease Prevalence - per 100,000 for all races: (a) Non-Hispanic American Indian/Alaskan Native; (b) Non-Hispanic Asian; (c) Non-Hispanic Black; (d) Non-Hispanic Native Hawaiian or Pacific Islander; (e) Non-Hispanic White and (f) Hispanic
- (3) Carrier (HbAS) Prevalence - per 100, 000 for all races: (a) Non-Hispanic American Indian/Alaskan Native; (b) Non-Hispanic Asian; (c) Non-Hispanic Black; (d) Non-Hispanic Native Hawaiian or Pacific Islander; (e) Non-Hispanic White and (f) Hispanic

INSTRUCTIONS FOR COMPLETING THE *LINE-ITEM BUDGET*:

The definitions listed below will help you decide what expenditures should be included in the budget and what level of detail is required for the budget narrative.

INSTRUCTIONS FOR COMPLETING THE *BUDGET NARRATIVE JUSTIFICATION*:

A detailed justification of project expenditures must accompany each grant application submitted in GMIS 2.0. The budget justification must clearly describe each cost element and explain how each cost contributes to meeting the project's objectives/goals.

DEFINITIONS FOR INFORMATION REQUESTED ON *LINE-ITEM BUDGET*:

A. PERSONNEL:

Full or part-time subgrantee agency employee who occupy approved positions to perform program objectives, including employees who are not paid from program funds.

Personnel Costs: Personnel costs should be explained by listing each staff member who will be allocated to the project, name (if possible), position title, percentage of full-time equivalency and annual salary. Include also under this category the position of Medical Director or Medical Advisor. Independent contractors/consultants should be listed under the Contract category.

Fringe Benefits: List the components that comprise the fringe benefit rate, for example health insurance, unemployment insurance, life insurance, retirement plans, workman's compensation and pension plans. The fringe benefits should be directly proportional to that portion of personnel costs allocated for the project.

B. OTHER DIRECT COSTS:

Costs that can be specifically identified with a particular cost objective or program, charged directly as part of the cost of the program

Accounting/Fiscal Human Resources/Secretarial Pool: *Costs related to this line item should be listed for consideration under the category of Personnel or Contract.*

Advertising: Costs associated with purchasing space in the advertising media. Advertising media include magazine, newspapers, radio and television, direct mail, exhibits, billboards/signs, electronic or computer transmittals and the like. This includes advertising for the recruitment of required personnel or the procurement of goods or services necessary for the performance of the grant/award. Specify medium of advertisement and provide unit cost.

Audit Fees: The fair share cost of the single audit is an allowable cost provided that the audit is conducted in accordance with the requirements of OBM Circular A-133, "Audits of States, Local Governments and Non-Profit Organizations".

Client Incentives: *This is an Unallowable Other Direct Cost for the ODH Sickle Cell Services Program Initiatives.*

Client Stipend (For Statewide Family Support Initiative subgrantee ONLY): Includes direct costs for items such as stipends or subsistence allowances, travel allowances and registration fees paid to or on behalf of participants (clients/consumers) in connection with the Empowerment Scholarship Fund. **Note:** *Client Stipend costs must be detailed in the Budget Justification Narrative and approved by the awarding program of ODH.*

Client Transportation: Charges for reimbursing a client/consumer for travel expenses (at OBM state rates) incurred in arriving at or departing from the subgrantee agency or designated location. Reimbursement for client transportation must be related to client/consumer participation in a grant/award activity (e.g. travel mileage reimbursement to clients/consumers who serve in an advisory capacity and are active on a RSCP Sickle Cell Advisory Committee or Statewide Advisory Committee).

Community Forums: Include expenditures for Community Forums under the line-item for Meeting Expense.

Copier Maintenance: Include expenditures for Copier Maintenance under the line-item for Maintenance.

Equipment Maintenance: Include expenditures for Equipment Maintenance under the line-item for Maintenance.

Evaluations: Costs associated with the process of collecting, managing and analyzing information/data to monitor, evaluate and improve the quality of RSCP services/programs. Includes also the costs incurred for the purchase of enhanced survey products and services from companies such as Survey Monkey.

Fiscal Management Services: *Costs related to this line item should be listed for consideration under the category of Personnel or Contract.*

H1N1 (For PH10 PHEP Subgrants ONLY): *This is an Unallowable Other Direct Cost for the ODH Sickle Cell Services Program Initiatives.*

Interpreter: *Costs related to this line item should be listed for consideration under the category for Contract.*

Lab Fees: Include expenditures for Lab Fees under the line item for Testing.

Leadership Conference: Include expenditures for Leadership Conference under the line-item for Meeting Expense.

Liability Insurance: Includes costs for insurance which the organization is required to carry and maintain under the terms of the grant/award. Liability coverage is an ODH requirement of all non-profit agencies/organizations.

MAECS User Fee: *This is an Unallowable Other Direct Cost for the ODH Sickle Cell Services Program Initiatives.*

Maintenance: Includes itemized costs incurred for necessary maintenance, repair or upkeep of items (e.g. copier, equipment) purchased by the subgrantee with ODH funds and used for the performance of the grant/award. Cost of maintenance agreements should also be included under this category.

Media Relations: Costs related to community relations and those activities dedicated to maintaining the image of the agency/organization or maintaining or promoting understanding and favorable relations with the community or public at large or any segment of the public.

Meeting Expense: Includes itemized costs of meetings (including events such as conferences, workshops, town halls, and symposia, community forums, advisory councils/committees) when the primary purpose is the dissemination of information related to particular topic or conducting business necessary to the performance of the grant/award. This includes costs of meals, refreshments, rental of facilities, speakers' fees and other items incidental to the meeting. Identify the meeting purpose in the Budget Narrative Justification. **Note:** *Expenses for "food/meals/refreshments will be carefully scrutinized by the awarding Program of ODH. These expenditures must be clearly identified and justified in the Budget Narrative Justification.*

Newsletter: Include expenditures for Newsletter under the line-item for Publications.

Pedometers: *This is an Unallowable Other Direct Cost for the ODH Sickle Cell Services Program Initiatives.*

Pharmaceuticals: *This is an Unallowable Other Direct Cost for the ODH Sickle Cell Services Program Initiatives.*

Phone Service: Includes itemized costs associated with local and long distance telephone calls and internet service providers. Costs associated with installing/connecting new communication equipment such as telephones and faxes should be included on this line-item. Phone service and internet usage at multiple locations (e.g. main location, satellite and/or outreach site, if applicable) should be separated under this classification.

Postage: Includes itemized costs associated with postage and mailing of correspondence and/or parcel items through carriers such as the United State Post Office (USPS), the United Parcel Service (UPS), FedEx and/or DHL.

Printing: Costs incurred for printing, audiovisual/media/graphic and photocopying services. Select from the classification which best describes the expenditure.

- (1) **Audiovisual/Media and Graphics Services:** Costs associated with services provide to accommodate audiovisual/media and graphics needs.
- (2) **Photocopy:** Includes costs associated with internal photocopies made by subgrantee on department/organization photocopiers. **Note:** *Internal photocopying which is not documented with an invoice or departmental receipt should not be charged to the grant/award.*
- (3) **Printing/Lithography:** Includes costs incurred for typesetting, copying or printing written materials and lithography completed by internal/external vendors. This includes but is not limited to itemized costs for pamphlets, brochures, flyers. **Note:** *Grant funds and/or applicant share resources must be allocated to purchase educational materials (culturally and linguistically sensitive) to be distributed to targeted regional audiences. Refer to Section (II) (B) of the RFP for Budget information related to cost allocations.*
- (4) **Other:** All other charges for printing/audiovisual uses that do not fall under the above line-item classifications.

Professional/Organization Dues (*For Statewide Family Support Initiative subgrantee ONLY*): Charges for the cost of membership fees payable to the Sickle Cell Disease Association of America, Inc. (SCDAA). **Note:** *Refer to Section (I) (Y) of the RFP for Unallowable Costs related to membership fees.*

Promotional Items: Includes costs for articles of merchandise (promotional merchandise, promotional items, promotional products, promotional gifts or advertising gifts) that are branded with a logo/name and used in marketing, communication and/or educational programs. Promotional items are given away to promote a company, corporate image, brand or event (e.g. Sickle Cell Sabbath ribbons, “give-away” book for School Nurse Conferences, etc).

Publications: Costs associated with the purchase and/or distribution of published works or products. This includes, but is not limited to books, newsletters, bulletins, fact sheets, reports, summaries, videotapes, DVDs and other educational materials (consumer/public/professional). **Note:** *Grant funds and/or applicant share resources must be allocated to purchase educational materials (culturally and linguistically sensitive) to be distributed to targeted regional audiences. Refer to Section (II) (B) of the RFP for Budget information related to cost allocations.*

Appendix J

Page 4

Rent: Includes line items for space costs incurred by the project. Identify square footage and costs. **Note:** *Refer to Section (I) (Y) of the RFP for Unallowable Costs related rental of equipment or space owned by the funded agency.*

Signs: Include expenditures for Signs under the line-item for Advertising.

Software License: Charges for the purchase or use of operating and/or application software necessary for the performance of the grant/award.

Subscriptions: *This is an Unallowable Other Direct Cost for the ODH Sickle Cell Services Program Initiatives.*

Supplies-Medical (*For Direct Service Initiative subgrantees ONLY*): Charges for the purchase of items (with a unit cost of less than \$300) intended for use in the medical diagnosis, cure, treatment or prevention of disease. For the ODH Sickle Cell Program-Direct Service Initiative subgrantees, the purchase of thermometers (for parents of newly diagnosed infants) is the ONLY allowable Other Direct Cost under this line-item. **Note:** *Medical supplies specifically related to outreach testing (e.g. lancets, latex gloves) should be listed under the line-item for Testing Materials.*

Supplies-Office: Charges of the purchase of consumable office supplies and materials (with a unit cost of less than \$300) actually used for the performance of the grant/award may only be charged as direct costs. This includes, but is not limited to such items as copy/computer/fax paper, stapler/staples, paper clips, manila folders, forms used for office use, pens, pencils or scissors. This also includes the cost of toner and copier cartridges. Cost of office stationary and envelopes should be included under this category.

Survey: Include expenditures for Survey under the line-item for Evaluations.

Swipers User Fee: *This is an Unallowable Other Direct Cost for the ODH Sickle Cell Services Program Initiatives.*

Testing: Costs associated with testing and laboratory fees charges for hemoglobinopathy testing by a CLIA (Clinical Laboratory Improvement Amendments) certified laboratory. Costs related to materials used for testing should be included under the line item for Testing Materials. **Note:** *This is an allowable cost ONLY for subgrantees performing free outreach testing services (hospital or community-based facilities) and for community-based facilities with phlebotomy services (on-site and/or off-site).*

Testing Materials: Costs for the purchase of materials required to perform testing as necessary for the performance of grant objectives/activities. Testing materials include, but are not limited to such items as: lancet, vacutainer specimen tube, thermal transport container, latex gloves, alcohol swipes and gauze. **Note:** *Itemize materials by unit cost and the approximate number of individuals to be tested (historical usage, if applicable).*

Training: Costs of preparation and/or maintenance of a program of instruction including, but not limited to on-the-job, classroom and apprenticeship training, designed to increase the vocational effectiveness of the personnel on the grant/award. This category also includes training materials, textbooks, and tuition and fees when the training is off-site (e.g. Hemoglobinopathy Counselor Training Program). Identify purpose and attendees in the Budget Narrative Justification. **Note:** *Refer to Section (I) (Y) of the RFP for Unallowable Costs related to training.*

Travel: Travel costs are the expenses for transportation, lodging, subsistence and related items incurred by personnel (listed on the GMIS 2.0 Personnel tab) who are in travel status on official business of the subgrantee agency. Priority is given travel that most directly benefits the program goals/objectives. Travel costs should be itemized under separate line item classifications for in-state and out-of-state travel.

- (1) **In-State Travel:** Includes travel that occurs in the 88 counties of Ohio. Budget must specify destination, mileage, number of trip(s), reason/purpose for trip(s), number and name of traveler(s) and cost per trip as appropriate, along with justifications. For in-state travel, costs are allowable for subgrantee employees listed as grant funded and non-grant funded on the Personnel tab in GMIS 2.0.
- (2) **Out-of-State Travel:** Includes travel outside of Ohio, excluding travel outside of the Continental United States (CONUS). Out-of-state travel must be approved in advance by ODH and include information on the destination and total travel accommodations (e.g. transportation, lodging, meals, per diem) for each traveler. For out-of- state travel, costs are allowable ONLY for subgrantee employees listed as grant funded on the Personnel tab in GMIS 2.0. Normally only one subgrantee employee will be authorized to travel out-of-state with program funds unless extensive justification is presented in the budget request.

Note:

- *All costs related to in-state and out-of-state travel must be in accordance with OBM Travel Rule.*
- *Registration costs/fees for subgrantee employees who are on travel status should be expensed under this line item.*
- *Grant funds and/or applicant share funds must be allocated to support travel and per diem expenses (if applicable) for attendance at all in-state meetings/educational venues as requested/required by ODH. Refer to Section (II) (B) of the RFP for Budget information related to cost allocations.*
- *Refer to Section (I) (Y) of the RFP for Unallowable Costs related to travel and meals over the current state rates and out-of-state travel.*

Utilities: Costs incurred for water, heating, cooling and production of sources of power charged to the subgrantee.

Website: Costs associated with the internal development and maintenance of a website or webpage by the subgrantee agency. **Note:** *List the services of a consultant or contractors (e.g. web site/webpage development and/or maintenance) under the category for Contracts.*

C. CONTRACTS:

Contract personnel are individuals hired to work on the project but who are not regular, salaried or hourly employees of the subgrantee agency. Subgrantee must provide a clear explanation as to the purpose of each contract, how the costs were derived and the specific contract deliverables. The contract line item requires supporting documentation in the form of a CCA submitted via the GMIS 2.0 system. **Note:** *Refer to Section (I) (Y) of the RFP for Unallowable Costs related to contracts for compensation with advisory board members and consulting fees for salaried program personnel to perform activities related to grant objectives.*

D. EQUIPMENT:

List equipment costs for any item of tangible property 1) having a useful life of one year or more; 2) costing \$300 or more and 3) which is purchased in whole or part with program funds. Justification must be provided for the need of the equipment to carry out the program's goals/objectives. Real property, such as land, buildings or improvements other than buildings is not classified as equipment.

GLOSSARY OF TERMS

Allocability: defined as the extent to which something is able to be allocated.

At-Risk Individuals: include persons of African ancestry and also persons with heritage from Spanish-speaking regions in the Western Hemisphere (South America, Cuba and Central America), Saudi Arabia, India and Mediterranean countries such as Turkey, Greece and Italy.

Awareness: an awareness activity is considered an instructional format designed to increase the learner's general understanding (either by perception or by means of information) of a particular subject or service. (Source: Education Event Data Dictionary)

BCMH Provider: a health professional, hospital; medical equipment supplier and any individual, group or agency that is approved by the department of health pursuant to division (C) of section 3701.023 of the Revised Code and rule 3701-43-02 of the Administrative Code and that provides or intends to provide goods or services to an applicant or recipient.

Course: a group of lectures centered on an established curriculum/subject and presented to the same learners. (Source: Education Event Data Dictionary)

Emerging Population: defined as individuals that are affected by sickle cell disease or sickle cell trait in the project's geographic catchment area that are not receiving adequate care due to the lack of information or outreach to these individuals and families. Emerging populations can include racial and ethnic communities not previously viewed as having significant rates of sickle cell disease or sickle cell trait, persons affected by sickle cell disease or trait that do not speak English or who speak sign language and individuals who are illiterate or have low literacy in any language. (Source: HRSA: Sickle Cell Disease Newborn Screening RFP 2010)

Family Member: includes parents/legal guardians, siblings and other extended family relationships (e.g. aunts, cousins).

Follow-Up: active case surveillance on any positive or potentially positive result from the point of physician/hospital/parent/patient/consumer notification to the point of resolution/disposition. (Source: U.S. Newborn Screening System Guidelines - Statement of the Council of Regional Networks for Genetic Services, 1992)

Follow-Up Services: services provided by the RSCP or non-RSCP provider that includes, but are not limited to confirmatory testing, hemoglobinopathy counseling, disease education, resource referrals and/or applicable treatment management.

Hemoglobinopathies: a group of disorders passed down (inherited) through families in which there is abnormal production or structure of the hemoglobin molecule. These disorders include hemoglobin C disease, hemoglobin SC disease, hemoglobin SS disease (sickle cell anemia) and various types of thalassemia (Source: HRSA: Sickle Cell Disease Newborn Screening RFP 2010)

Hemoglobinopathy Counseling: refers to the entire process of interpreting/communicating accurate test results to individuals screened by a competent laboratory. This counseling process involves genetic, medical and psychosocial counseling.

Individualized Instruction: a method of instruction in which the educational content, instructional materials, media, and/or activities is conducted in person or via the telephone with an individual or small group. (Source: Education Event Data Dictionary)

Lecture: a formal speech or talk delivered before an audience and offered as a single event or a part of a conference, seminar, workshop, grand rounds or poster presentation. (Source: Education Event Data Dictionary)

Appendix K
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Lost To Follow-Up: the status of a case when all standardized procedures to establish *direct* contact (e.g. face to face) or indirect contact (e.g. telephone, letter) with an infant's parents/legal guardian/physician of record have been exhausted and a FINAL DIAGNOSIS is unknown.

Non-Newborn: an individual with a birth date prior to the beginning of the SFY (July 1, 2011) that receives follow-up services from an RSCP or non-RSCP provider during the reporting period. *This includes newborns (resident and non-resident) with an abnormal hemoglobin result born prior to July 1, 2011 and their family members that receive follow-up services.*

Non-Resident Newborn: an infant born outside the state of Ohio that receives follow-up services from an RSCP or non-RSCP provider during the reporting period. *Non-resident newborns are not screened by the ODH NBS Laboratory.*

Non-RSCP Provider: a service provider in the region that is external to the RSCP core team or the extended team members.

Patient/Consumer: individuals, including family members, guardians or companions that seek physical, mental or other health-related services.

Reporting Period: the reporting period for SFY 2012 RFP begins July 1, 2011 and ends June 30, 2012.

Resident Newborn: an infant born in the state of Ohio that is screened at birth through the ODH Laboratory and that receives follow-up services from an RSCP or non RSCP provider during the reporting period. *This includes infants born in Ohio to parents with residency outside of Ohio.*

Sickle Cell Sabbath: an interfaith outreach campaign designed to educate and increase awareness within the faith community about sickle cell disease and the need for minority blood donors. A statewide initiative, Sickle Cell Sabbath is a coordinated, cooperative effort between the ODH, state-funded RSCPs, Regional Blood Programs in Ohio (participation may vary) and various statewide and/or local faith-based groups or organizations.

Training: any experience-based work opportunity (e.g. student rotation, placement, internship) that is accomplished through instruction and hands-on practice and supervised by credentialed staff. (Source: Education Event Data Dictionary)

Treatment: the initiation of penicillin prophylaxis for a sickle hemoglobinopathy by an RSCP or non RSCP provider.

Web-Based Module: a standardized or self-contained segment(s) that constitute an educational course or training program delivered through a web browser over any network.

ACRONYMS AND ABBREVIATIONS

BCMh: Bureau for Children with Medical Handicaps

CAP: Corrective Action Plan

CCA: Confirmation of Contractual Agreement

CCIRS: County Central Intake and Referral Sites

CCR: Central Contractor's Number

CFDA: Catalog of Federal Domestic Assistance

CLAS: Culturally and Linguistically Appropriate Services

CLIA: Clinical Laboratory Improvement Amendments

CONUS: Continental United States

DFCHS: Division of Family and Community Health Services

DHL: Dalsey, Hillblom and Lynn (founders of DHL Worldwide Express)

DMA: Declaration Regarding Material Assistance/Non-Assistance to a Terrorist Organization

DUNS: Data Universal Number System

EFT: Electronic Funds Transfer

FFATA: Federal Funding Accountability and Transparency Act

GAPP: Grants Administration Policy and Procedure

GMIS: Grants Management Information System

HMG: Help Me Grow

HRSA: Health Resources and Services Administration

IRS: Internal Revenue Service

LTF: Lost to Follow-up

MDS: Minimum Data Set

NBS: Newborn Screening

NOA: Notice of Award

OBM: Office of Budget and Management

ODH: Ohio Department of Health

PHN: Public Health Nurse

RFP: Request for Proposal

RSCP: Regional Sickle Cell Project

SCAC: Sickle Cell Advisory Committee

SCDAA: Sickle Cell Disease Association of America, Inc.

SCS: Sickle Cell Sabbath

SFY: State Fiscal Year

SMART: Specific, Measurable, Attainable, Realistic and Time-Phased

UPS: United Parcel Service

USPS: United States Post Office

SFY 2012 – APPENDIX M

**OHIO DEPARTMENT OF HEALTH
DIVISION OF FAMILY AND COMMUNITY HEALTH SERVICES
BUREAU FOR CHILDREN WITH MEDICAL HANDICAPS**

SFY 2012 Anticipated Timetable

May 09, 2011	Deadline for GMIS 2.0 Submission of Grant Applications and Materials Not Electronically Filed
July 1, 2011	SFY 2012 Project Funding Period Begins
October 15, 2011	SFY 2012 Quarterly Expenditure Report due via GMIS 2.0 SFY 2012 Quarterly Program Performance Report due via GMIS 2.0 1 st Quarter Education Event Reporting to Program (July-September 2011) MDS Packet due to Program
January 15, 2012	SFY 2012 Quarterly Expenditure Report due via GMIS 2.0 SFY 2012 Quarterly Program Performance Report due via GMIS 2.0 2 nd Quarter Education Event Reporting to Program (October-December 2011)
April 15, 2012	SFY 2012 Quarterly Expenditure Report due via GMIS 2.0 SFY 2012 Quarterly Program Performance Report due via GMIS 2.0 3 rd Quarter Education Event Reporting to Program (January-March 2012) SFY 2007 Minimum Data Set Packet due via Internet MDS Packet due to Program
July 15, 2012	SFY 2012 Quarterly Expenditure Report due via GMIS 2.0 SFY 2012 Quarterly Program Performance Report due via GMIS 2.0 4 th Quarter Education Event Reporting to Program (April-June 2012)
August 15, 2012	SFY 2012 Final Expense Report due via GMIS 2.0

SAVE FOR FUTURE REFERENCE