Request for Application

Illinois Prostate Cancer Communities of Color Initiative Fiscal Year 2010

Illinois Department of Public Health
535 W. Jefferson Street, 5th Floor
Springfield, Illinois 62761
Phone: 217-785-4311
Fax: 217-558-7181

Illinois Department of Public Health
Center for Minority Health Services

Illinois Prostate Cancer Communities of Color Initiative

Request for Application for State Fiscal Year 2010

Application Package Contents:

- Previous Funding Information
- Program Summary
- General Information
- Instructions for Application
- Grant Application Forms
- Budget Forms (Attachment)
- TIN Form (Attachment)
- W9 Form (Attachment)

Additional Illinois Department of Public Health Funding:

Are you currently receiving, have you applied for, or do you anticipate applying for any other grant funds from the Illinois Department of Public Health? If yes, please explain in detail to include amount of grant funding and source. Failure to disclose all applicable information will impact your opportunity to compete for funding.

Please list all funding received from the Illinois Department of Public Health during the period July 1, 2008 to June 30, 2009 to include the amount and funding source. Failure to fully disclose all applicable information will impact your opportunity to compete for funding.

PROGRAM SUMMARY

Title:	Illinois Prostate Cancer Communities of Color Initiative
Issued By:	Illinois Department of Public Health Center for Minority Health Services
Application Processing:	Submit **one signed original and two copies** of application
Who may apply:	Eligible applicants include the following: community-based organizations, non-profits, private associations, religious organizations, voluntary organizations, organizations serving ethnic populations, and collaboratives of government and community-based organizations. Local health departments and other governmental agencies are not eligible to apply; however, may participate as a member of a coalition, partnership, or collaborative. Only organizations based in Illinois are eligible to compete for these funds.
Funding Source:	Illinois General Revenue Funds
Funding Amount:	Grants awards between $5,000 and $25,000
Funding Period:	State Fiscal Year 2010

Note: Please follow all grant application instructions carefully.

GENERAL INFORMATION

Background:

Prostate cancer is the most frequently diagnosed cancer in African American men with a mortality rate 133% high than in white men. Early detection of cancer/cancerous cells increases survival rates.

Purpose:

The Illinois Department of Public Health is requesting proposals for Prostate cancer awareness, education, and screening programs targeted to African American males aged forty and older. The Illinois Department of Public Health is specifically looking for organizations with the capacity to reach African American men through the development of programs that are culturally innovative and unique. Successful applicants will have demonstrated their capacity to successfully collaborate with, and to successfully impact the health outcomes of, the target population.

The Grantee will:

1. Develop and implement strategies that are culturally appropriate and gender-specific to increase the awareness of the incidence of Prostate cancer, the risk factors associated with Prostate cancer, the importance of Prostate cancer screening for men aged forty and over, and where appropriate provide referrals and/or opportunities for Prostate cancer screening.
2. Collaborate with the Illinois Department of Public Health Center for Minority Health Services to document data for formative, process and outcome evaluations for the Prostate cancer programs developed by the grantee.
3. Provide education and awareness for Prostate cancer to target population.
4. Develop and implement prevention and education strategies to target population.
5. Deliver monthly narrative and monthly activity reports to Illinois Department of Public Health Center for Minority Health Services.
6. Submit monthly reimbursement requests to Illinois Department of Public Health Center for Minority Health Services, to include copies of all receipts for expenses incurred.
7. By July 15, 2010, provide a final report that includes, but is not limited to:
    - Findings, limitations, and any recommendations from the program.
    - An outcome study on knowledge, attitudes and behavioral changes based on the implementation of the culturally unique strategy developed by the grantee.

Instructions for Application

How to Apply:

Application may be mailed or hand delivered to:

Doris Turner
Illinois Department of Public Health
Center for Minority Health Services
535 W. Jefferson Street, 5th Floor
Springfield, Illinois 62761

Faxed or electronic submissions will not be eligible for review.

Application:

The completed application must include the following sections:

I. Cover Page (form provided)

II. Application for Public Health Program Grant (form provided)

III. Applicant Contact Information (form provided)

IV. Collaborator List (form provided)

V. Executive Summary **(1 page maximum)**

VI. Organizational Capacity **(1 page maximum)**
Provide a brief review of the applicant's history, mission, services offered and recent accomplishments and discuss the qualifications of project staff to implement the proposed program. Minimally, the applicant must demonstrate that they fulfill the following requirements:

1. Grantee should be an established organization serving the targeted population within the State of Illinois for a minimum of two years.
2. Grantee and/or key staff members should have at least two years of experience serving the target population.
3. Grantee and/or key staff members should have a minimum of two years experience with providing specific public health related programming to the target population
4. Grantee should have experience and documented proof of linkages with appropriate local stakeholders.

VII. Program Plan **(3 page maximum)**
Provide a description of the proposed project including primary objectives and expected outcomes. Provide a detailed time line and a work plan describing when and how the objectives will be met during the grant funding period. Objectives should be measurable and activities supporting attainment of objectives should be described. Program plan should demonstrate innovative or new efforts.

VIII. Program Goals **(1 page maximum)**
Identify how the proposed project will impact the defined health issues of the targeted population.

IX. Program Budget (forms provided on website and/or as an attachment)
Use the forms provided to prepare a budget with sufficient resources to implement the project to include **ALL** materials to be used in conjunction with the project. If needed, additional copies of the forms may be made. The instructions for completion of the forms can be found after each budget page. A list of allowable costs is included.

X. Budget Justification
Use the form provided to submit additional justification for specific line items listed in the program budget. For example, all personal services, contracts and sub-grants must be justified in this section. Justification should clearly indicate why items being requested are essential to the achievement of the project objectives.

XII. Appendices
Provide letters of commitment from collaborators and sub-contractors, letters of support, relevant supporting documents and project coordinator resumes or curriculum vitae.

FORMS:

TIN Form	Completed by applicant and returned with grant application (form provided), filing status must match W9.
W9 Form	Completed by applicant and returned with grant application. Federal Identification Number **must match exactly how applicant is filed with the Internal Revenue System**. (Form provided on website and/or as attachment)

Please note that applications not containing the required number of copies and all of the required information will not be reviewed. No exceptions.

Review Criteria for Applications:

All eligible applications will be competitively evaluated by the Grant Evaluation Committee utilizing the following 100 point scale.

- Organizational capacity (20 points)
- Statement of need and project rationale (20 points)
- Soundness of proposed plan and strategy (40 points)
- Proposed budget, narrative, and potential for matching funds (20 points)
- Bonus – Letter of support for the project from local collaborators (5 points)

Format Requirements:

Applications must be completed using 12 point or larger font and must be both single-spaced and one-sided. Margins may not be less than one inch on all sides.

Proposal Submission Deadline	December 22, 2009
Program Start Date	January 1, 2010
End of Project Funding Period	June 30, 2010
Final Reimbursement Request Deadline	July 15, 2010

Payment Methodology:

Funds awarded to successful applicants will be provided on **a reimbursement basis**. The grantee will document actual expenses incurred for conducting program activities by submitting an Illinois Department of Public Health Reimbursement Certification form with appropriate documentation, i.e. receipts. After review and approval of program expenditures, a voucher will be prepared and processed through the Office of the State Comptroller for payment.

Reimbursement requests must be submitted monthly. The final reimbursement request must be received by July 15, 2010.

For questions related to the content of the grant application, please contact:

Doris Turner
Illinois Department of Public Health
Center for Minority Health Services
535 West Jefferson Street, 5th Floor
Springfield, IL 62761
217-785-4311

Illinois Department of Public Health
Fiscal Year 2010 Illinois Prostate Cancer
Communities of Color Initiative
Mini Grant Application Cover Page

LEAVE BLANK FOR IDPH USE ONLY Number	 Date Received

1. TITLE OF PROJECT (please type or print legibly)

_____

2. Organization Tax Identification Number: _____

3. Total Amount of Funding Requested $ _____

4. Fiscal Contact:

Name (Last, First, Middle) _____

Title _____

Organization _____

Address _____

Phone: _____ Fax: _____ E-Mail _____

Fiscal Officer Assurance: I agree to accept responsibility for the fiscal conduct of this project and to provide required financial reports if a grant is awarded as a result of this application.

Fiscal Officer (signature) _____ Date _____

ILLINOIS DEPARTMENT OF PUBLIC HEALTH
535 West Jefferson Street, 5th Floor, Springfield, Illinois 62761
APPLICATION FOR FISCAL YEAR 2010 ILLINOIS PROSTATE CANCER
COMMUNITIES OF COLOR INITIATIVE

IMPORTANT NOTICE: This state agency is requesting disclosure of information that is necessary to accomplish the statutory purpose outlined under 30 ILCS 105/1 et. seq. Failure to provide this information may prevent this application from being processed.

APPLICANT ORGANIZATION: _____

PROJECT CONTACT: _____

ADDRESS: _____

_____

TELEPHONE:_____ **FAX**: _____ **E-MAIL**: _____

PROJECT TITLE: _____

AMOUNT REQUESTED: $_____

PROJECT PROGRAM: _____

TYPE OF ORGANIZATION (must include documentation in appendix)

Governmental Entity ___ Not-for-Profit Corporation ___ Corporation ____

Medical/Health Care Provider Corp. ___ Tax Exempt Organization _____

Other (please describe) _____

LEGISLATIVE DISTRICT State Senate: _____ State Representative: _____

Congressional: _____

APPLICATION CERTIFICATION
To the best of my knowledge, the data and statements in this application are true and correct. The applicant agrees to comply with all State/Federal statutes and Rules/Regulations applicable to the program. My signature indicates that I have the authority to enter into contracts on behalf of the applying organization.

_____ _____
Typed name of authorized official Signature

Title _____ Date _____

Applicant Contact Information:

Project Title: _____

Organization: _____

Project Contact:

Name: _____

Title: _____

Address: _____

Telephone: _____

FAX: _____

Email: _____

Fiscal Contact:

Name: _____

Title: _____

Address: _____

Telephone: _____

FAX: _____

Email: _____

Authorizing Agent:

Name: _____

Title: _____

Address: _____

Telephone: _____

FAX: _____

Email: _____

Collaborator List

Project Title: _____

Organization: _____

Contact: _____

Title: _____

Address: _____

Telephone: _____

FAX: _____

E-mail: _____

Project Role: _____

_____

_____

Organization: _____

Contact: _____

Title: _____

Address: _____

Telephone: _____

FAX: _____

E-mail: _____

Project Role: _____

_____

_____

(Make copies of form if necessary)

TAXPAYER IDENTIFICATION NUMBER (TIN FORM)

I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), **and**
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding, **and**
3. I am a U.S. person (including a U.S. resident alien).

Name of organization: _____

Taxpayer Identification Number:

Social Security Number _____

or

Employer Identification Number _____

(If you are an individual, enter your name and SSN as it appears on your Social Security Card. If completing this certification for a sole proprietorship, enter the owner's name followed by the name of the business and the owner's SSN or EIN. For all other entities, enter the name of the entity as used to apply for the entity's EIN and the EIN.)

Legal Status (*check one*):

__ Individual

__ Sole Proprietor

__ Partnership/Legal Corporation

__ Tax-exempt

__ Corporation providing or billing medical and/or health care services

__ Corporation NOT providing or billing medical and/or health care services

__ Other: _____

__ Governmental

__ Nonresident alien

__ Estate or trust

__ Pharmacy (Non-Corp.)

__ Pharmacy/Funeral Home/Cemetery (Corp.)

__ Limited Liability Company (select applicable tax classification.)
- □ D = disregarded entity
- □ C = corporation
- □ P = partnership

Signature: _____ **Date:** _____