Illinois Department of Public Health
Center for Minority Health Services
535 West Jefferson, 5th Floor
Springfield, Illinois 62761
Phone: 217-785-4311
Fax: 217-558-7181
Illinois Department of Public Health
Center for Minority Health Services

Illinois HIV/AIDS 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)
# Program Summary

**Title:** Illinois HIV/AIDS 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 youth, organizations serving ethnic populations, schools/school districts, 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, and all applicants must inform their regional HIV prevention lead agency of their participation in the Initiative.  
**Funding Source:** Illinois General Revenue Funds  
**Funding Amount:** Grant Awards To Be Determined  
**Funding Period:** State Fiscal Year 2010  

*Note: Please follow all grant application instructions carefully*
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 fully 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.
Background:

The HIV and AIDS case rates among African Americans and Hispanics/Latinos are the highest among all racial/ethnic groups in Illinois. The current, and continuing, higher rates among these groups indicate that they are disproportionately affected by HIV disease.

Purpose:

The Illinois Department of Public Health Center for Minority Health Services is requesting proposals for HIV prevention, education, testing, and care programs targeted to communities of color. The Center for Minority Health Services is specifically looking for community based and faith based organizations with the capacity to reach African Americans and Hispanics/Latinos by developing and implementing prevention programs that are science-based yet culturally innovative and unique. Successful applicants will have demonstrated their capacity in working with the target population.

Successful applicants should incorporate strategies that will increase the number of high risk individuals from the target population who test for HIV and return for their HIV test results and increase the number of HIV positive individuals from the target population who are linked into HIV/AIDS care and treatment services within forty-eight hours of their HIV diagnosis.

The Grantee will:

1. Develop and implement strategies that are culturally innovative through the solicitation of unique ways of contacting and exposing individuals from the target population to the interventions in both group and individual settings.
2. Develop and implement interventions that are science based and are CDC approved to target communities of color.
3. Collaborate with the Center for Minority Health Services Evaluation Team to document data for formative, process and outcome evaluations for the HIV prevention programs developed by the grantee.
5. Attend mandatory grantee meetings.

Requirements:

1. Grantee and/or key staff members should have at least two years of experience serving the target population.
2. Grantee should be a minority-based organization as defined by the Congressional Black Caucus and provide documentation with proposal.
3. Grantee should have demonstrated the capacity to successfully work with members of the target population and have experience and documented proof of linkages with appropriate local stakeholders.
Scopes of Service:

1. Develop and/or implement HIV prevention, education, and testing strategies to target population.
2. Document the HIV prevention and education program. The final report will include, but not limited to:
   - A final program plan discussing findings, limitations, and any recommendations from the program
   - A complete report offering specific information and presentation of process data
   - A final outcome study on knowledge, attitudes and behaviors based on the implementation of the culturally unique strategy developed by the grantee.

How to Apply:

The Illinois Department of Public Health Center for Minority Health Services has established a two-step process for awarding funds consisting of a letter of intent and a full application package. A letter of intent is requested, but not required.

Letter of Intent

The Illinois Department of Public Health Center for Minority Health Services requests that potential applicants submit a letter, no longer than one page, indicating the applicant’s intention to submit a complete application. Submit letter to:

Doris Turner, Chief
Center for Minority Health Services
Illinois Department of Public Health
535 West Jefferson Street, 5th Floor
Springfield, Illinois 62761-0001

Letters may be faxed to 217-558-7181. These letters will be considered non-binding, but will allow the Center for Minority Health Services to appropriately assemble peer review panels.

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. Also provide documentation of applicant’s status as a minority based organization as defined by the Congressional Black Caucus.

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 relates to the Illinois Department of Public Health Center for Minority Health Services HIV/AIDS Communities of Color Initiative.

IX. Program Budget (forms provided)
Prepare a budget with sufficient resources to implement the project to include ALL materials to be used in conjunction with the project. The instructions for completion of the forms can be found after each budget page. A list of allowable costs is included.

X. Budget Justification
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.

XI. Appendices
Letters of support, relevant supporting documents, project coordinator resumes or curriculum vitae.

FORMS:

TIN Form Completed by applicant and returned with grant application (form provided)
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)

Please note: Applications not containing the required number of copies and all of the above-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 September 15, 2009
Program Start Date October 1, 2009
End of Project Funding Period June 30, 2010
Final Reimbursement Requests Deadline July 15, 2010

Payment Methodology:

Funds awarded to successful applicants will be provided on a reimbursement basis. The grantee will document actual expenditures incurred for conducting program activities by submitting an Illinois Department of Public Health Reimbursement Certification Form with appropriate documentation. 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.
Submission of Applications:

Applications may be mailed or hand-delivered to:

Doris Turner, Chief
Center for Minority Health Services
Illinois Department of Public Health
535 West Jefferson Street, 5th Floor
Springfield, Illinois 62761-0001

Faxed or electronic submissions will not be eligible for review.

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

Doris Turner, Chief
Center for Minority Health Services
Illinois Department of Public Health
535 West Jefferson Street, 5th floor
Springfield, IL 62761
217-785-4311
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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
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: ________________________________
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| **Project Role:**    |
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(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 ______ Governmental
_ Sole Proprietor ______ Nonresident alien
_ Partnership/Legal Corporation ______ Estate or trust
_ Tax-exempt ______ Pharmacy (Non-Corp.)
_ Corporation providing or billing medical and/or health care services ______ Pharmacy/Funeral Home/Cemetery (Corp.)
_ Corporation NOT providing or billing medical and/or health care services ______ Limited Liability Company (select applicable tax classification.)
□ D = disregarded entity
□ C = corporation
□ P = partnership

Signature: ___________________________ Date: _______________