

October 29, 2013

Dear Applicant:

The Illinois Department of Public Health, Office of Women’s Health is pleased to announce the availability of funds for the **Carolyn Adams Ticket for the Cure Grant Program**. These funds support community activities addressing breast cancer awareness and education.

The Office of Women’s Health will fund grant programs during fiscal year 2014/15. These grants will be for eighteen (18) months (January 1, 2014 through June 30, 2015).

We welcome your application. **These grants are extremely competitive.** **Therefore, it is important that you read the application thoroughly. Please remember to use a separate MS Excel document to complete your budget.** Completed applications are due to the Office of Women’s Health no later than **5 p.m. November 25, 2013,** to support program activities from January 1, 2014 through June 30, 2015. For more information, please contact Maureen Pennell Jennings at 217-782-4813.

Sincerely,



Brenda Jones DHSc, RN, MSN, WHNP-BC

Deputy Director

Office of Women's Health

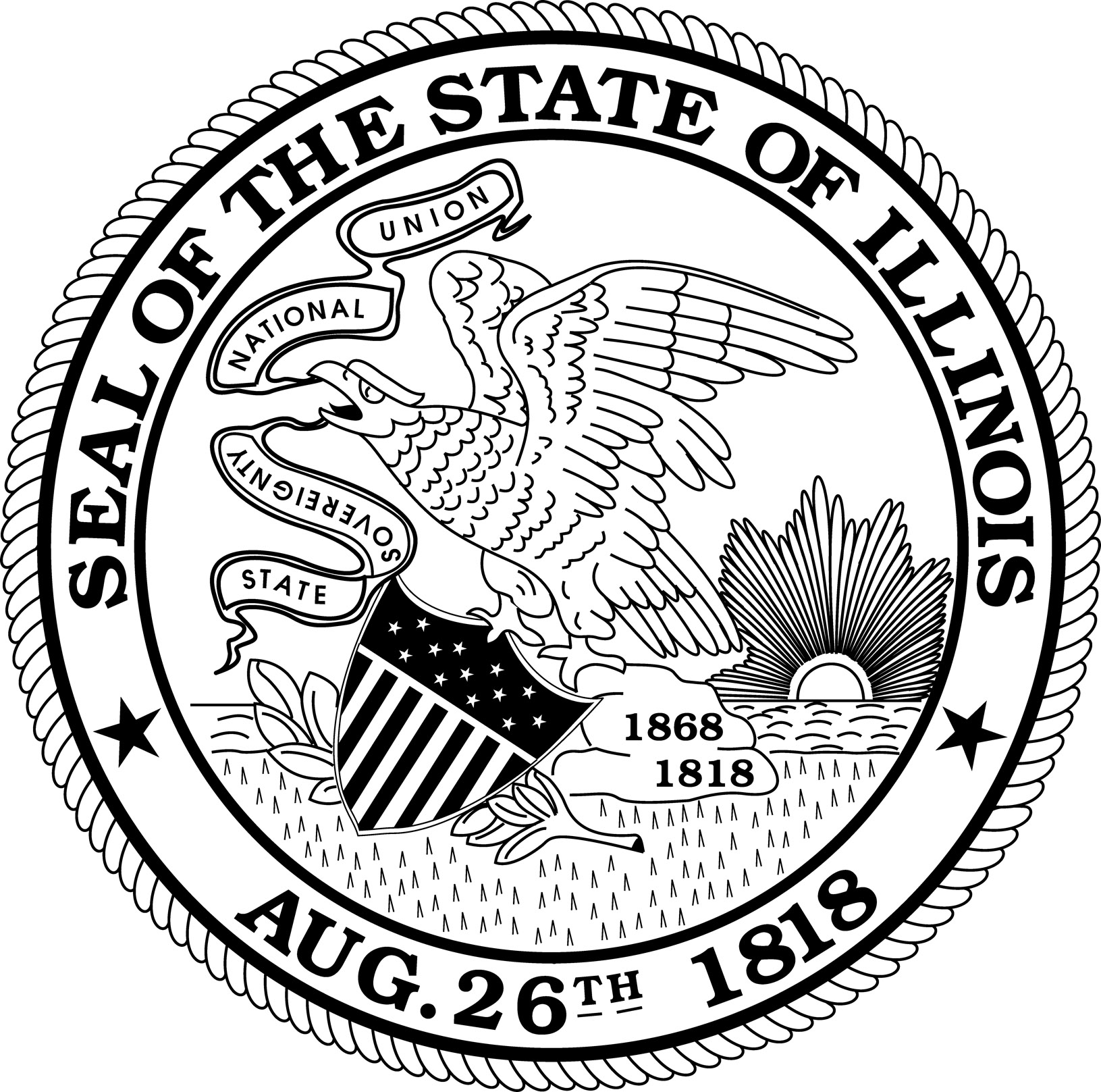
Illinois Department of Public Health

535 West Jefferson Street

Springfield, IL 62761

Enclosure

cc: Maureen Pennell Jennings

 **ILLINOIS DEPARTMENT OF PUBLIC HEALTH** 

For IDPH Use Only

Application No. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date Received \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**APPLICATION FOR PUBLIC HEALTH GRANT**

**Office of Women’s Health**

**Division of Information and Education/Carolyn Adams Ticket for the Cure Community Grant Program**

The Office of Women’s Health will be offering community grant programs during fiscal year 2014/2015. These grants will be for 18 months (January 1, 2014 through June 30, 2015). Descriptions of the programs/projects begin on Page 15 of this application.

|  |  |
| --- | --- |
| **Section 1. APPLICANT INFORMATION** | |
| **Legal Name of Applicant:**  *(Attach copy of W-9)* |  |
| **Name and Title of Chief Officer:**  ***(****If more than one, attach a list of all officers)* | Name:  Title:  Address:  Phone:  Fax:  E-mail: |
| **Applicant Address:** |  |
| **City, State, ZIP Code:** |  |
| **Telephone:** |  |
| **Fax:** |  |
| **E-mail:** |  |
| **Website:** |  |

**Applications must be received no later than**

\* **5 p.m. – Monday, November 25, 2013**

**Applications may be mailed or delivered to:**

**\* 535 W. Jefferson St., First Floor**

**Springfield, IL 62761**

**\* Fax copies will not be accepted**

**\* Submit one signed original and three photocopies of the application.**

**\*Please also email a PDF of your application to** [**maureen.jennings@illinois.gov**](mailto:maureen.jennings@illinois.gov)**\***

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| --- | --- | --- | --- | --- |
| **Section 2. APPLICANT GRANT HISTORY** | | | | |
| **Description of applicant organization:**  *(200 Character Maximum)* |  | | | |
| **Has this applicant received a** **grant from the federal government or the state of Illinois within the last three years?**  **If yes, provide the following:**  *(Add additional rows if needed)* | 🞎  **YES** 🞎 **NO**  Agency providing grant funding:  Grant number:  Grant amount:  Grant term:  Brief description of grant: | | | |
| **How long has applicant been incorporated?** |  | | | |
| **Is the applicant in “good standing” with the Illinois Office of the Secretary of State?** | 🞎  **YES** 🞎 **NO** | | | |
| **Has the applicant or any principal experienced foreclosure, repossession, civil judgment or criminal penalty (or been a party to a consent decree) within the past seven years as a result of any violation of federal, state or local law applicable to its business?** | 🞎  **YES** 🞎 **NO**  If yes, identify the nature of the action and the disposition. If the action/proceeding is still pending or unresolved, provide a status identifying the unresolved issues. Be as descriptive as possible. | | | |
| **Is the applicant or any principal the subject of any proceedings that are pending, or to the best of the applicant’s knowledge threatened against applicant and/or any principal that may result in any adverse change in applicant’s financial condition or materially and adversely affect applicant’s operations?** | 🞎  **YES** 🞎 **NO**  If yes, identify the nature of the proceedings and how they may affect the applicant’s financial situation and/or operations. | | | |
| **Does the applicant or any principal owe any debt to the state of Illinois?** | 🞎  **YES** 🞎 **NO**  If yes, list the amount and reason for the debt. Attach additional documentation to explain the debt owed to the state. | | | |
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| **Section 3. APPLICANT ORGANIZATION INFORMATION**  Only Illinois-based organizations are eligible to receive funding from the Illinois Department of Public Health  (IDPH). They must be a government entity or tax-exempt organization under section 501(c)(3) of the Internal  Revenue Code. The organization applying for funds must have at least one full-time employee. | | | | | |
| **Legal Status:** | | 🞎 Individual  🞎 Sole proprietor  🞎 Partnership/Legal corporation  🞎 Tax exempt  🞎 Corporation providing or billing medical and/or health services  🞎 Corporation NOT providing or billing medical and/or health services  🞎 Other (describe): | | 🞎 Governmental  🞎 Nonresident alien  🞎 Estate or trust  🞎 Pharmacy (non-corporation)  🞎 Pharmacy/Funeral home/Cemetery (Corporation)  🞎 Limited liability company (select applicable tax classification)  🞎 D = Disregarded entity  🞎 C = Corporation  🞎 P = Partnership | |
| **Federal Tax Payer Identification (FEIN) Number or Social Security Number (SSN) of applicant if not an organization:** | |  | | | |
| **If applicable, list all names and FEINS that are registered to your organization or have been registered during the last three years.** | | **Name:** | | **FEIN:** | |
| **Name:** | | **FEIN:** | |
| **Name:** | | **FEIN:** | |
| **DUNS number:** | |  | | | |
| **Illinois Department of Human Rights Number (if applicable):** | |  | | | |
| **Legislative Senate District:** | |  | | | |
| **Legislative House District:** | |  | | | |
| **Congressional District:** | |  | | | |
|  | |  | | | |
| **Section 4. KEY GRANT CONTACT INFORMATION** | | | | |
| **Grant Application Contact/Title:** | | |  | |
| **Telephone:** | | |  | |
| **Fax:** | | |  | |
| **E-mail:** | | |  | |
| **Fiscal Contact/Title:** | | |  | |
| **Telephone:** | | |  | |
| **Fax:** | | |  | |
| **E-mail:** | | |  | |

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| **Section 5. GRANT PROJECT PROPOSAL**  See program descriptions on beginning on Page 5 | | | |
| **Project Title:** |  | | |
| **Brief Project Description:**  *(350 character maximum). Note that the Scope of Work must be completed separately.* |  | | |
| **Project Period:**  *(Include start and end date)* | | January 1, 2014 through June 30, 2015 |
| **Total Amount of Funding Requested from IDPH:** | |  |
| **Total Applicant Match or**  **In-Kind Contribution (you may include match or in-kind, but it is not required for these grants):** | |  |
| **If subcontractors will be used under this grant application, provide name, address and description of services.** | | Subcontractor name:  Address:  City, State, ZIP:  Phone:  Description of services:  Subcontractor name:  Address:  City, State, ZIP:  Phone:  Description of services: |

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| --- | --- | --- |
| **Section 6. GRANT BUDGET SUMMARY**  ***(Note: This section is for summary purposes only. A detailed budget is included and required)*** | | |
| **Budget Line Items Requested** | **Requested Grant Budget Amount** | **Applicant Match of In-Kind Contribution** |
| **Personal Services** *(Includes Salary and Wages)* |  |  |
| **Fringe Benefits** (Percent use for calculation \_\_\_\_\_%) |  |  |
| **Contractual Services (detailed information about the contractual services amount must be submitted on the attached budget Excel form)** |  |  |
| **Travel** |  |  |
| **Commodities/Supplies** |  |  |
| **Printing** |  |  |
| **Equipment** |  |  |
| **Telecommunications** |  |  |
| **Patient/Client Care** |  |  |
| **Grand Total** |  |  |
| **If the proposed budget includes Personal Services (Salary or Wage) related costs, please indicate the type of documentation that will be maintained and used to allocate staff costs to the grant.** | 🞎 Time sheets  🞎 Cost allocation plans  🞎 Certifications of time allocable to grant  🞎 Other, please describe \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  🞎 Not applicable to this grant application | |

**Payments to successful applicants will be made on a reimbursement basis.** The grantee will document actual expenditures incurred for the purchase of goods and services necessary for conducting program activities. The grantee will use the Department’s Reimbursement Certification Form to request reimbursement. Forms and instructions for their use will be mailed with each signed grant agreement. After Departmental review of all submitted Reimbursement Certification Forms received from the grantee and approved for payment, a state of Illinois Invoice Voucher will be prepared and processed through the Office of the Comptroller for payment to the grantee.

**Reimbursement requests will be submitted monthly**. The final reimbursement must be received by the department within 30 days after the close of the grant period (June 30, 2015) to ensure reimbursement.

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### ALLOWABLE COSTS FOR REIMBURSEMENT UNDER IDPH/OWH GRANT AGREEMENT

To be reimbursed under IDPH/OWH Grant Agreement, expenditures must meet the criteria below:

1. Be necessary and reasonable for proper and efficient administration of the program and not be a general expense required to carry out the overall responsibilities of the agency.
2. Be authorized or not prohibited under federal, state or local laws or regulations.
3. Conform to any limitations or exclusions set forth in the applicable rules, program description or grant agreement.
4. Be accorded consistent treatment through application of generally accepted accounting principles appropriate to the circumstances.
5. Not be allocable to or included as a cost of any state or federally financed program in either the current or a prior period.
6. Be net of all applicable credits.
7. Be specifically identified with the provision of a direct service or grant program activity.
8. Be an actual expenditure of funds in support of program activities, documented by check number and/or internal ledger transfer of funds.

Examples of allowable costs are listed below. This is not meant to be a complete list, but rather specific examples of items within each line-item category.

Personal Services:

Gross salary paid to agency employees directly involved in the provision of program services. Employer’s portion of fringe benefits actually paid on behalf of direct services employees; examples include FICA (Social Security), life/health insurance, workers compensation insurance, unemployment insurance and pension/retirement benefits.

Contractual Services:

Contractual employees (requires prior program approval from the Office of Women’s Health)

Repair and maintenance of furniture and equipment

Postage, postal services, UPS or other carrier costs

Software for support of program objectives

Training and education costs

Payments (or pass-through) to subcontractors or subgrantees are to be shown in the Contractual Services section - **all subcontracts or subgrants require an attached detail line item budget supporting this contractual amount**.

Allocation of the applicable portion of the following costs are allowable only if approved by the program and the allocation methodology is approved as part of the application process.

Rent or lease space or facilities

Utility costs

Insurance

Copy machine rental or lease

Costs of improvements to real property

Telecommunications:

Telephone services

Answering services

Installation, repair, parts and maintenance of telephones and other communication equipment

Supplies:

Office supplies

Medical supplies

Educational and instructional materials and supplies, including booklets and reprinted pamphlets

Household, laundry and cleaning supplies

Parts for furniture and office equipment

Equipment items costing less than $100 each

***\*Incentives may not be purchased with IDPH/OWH funds unless they serve an educational purpose related to the grant.***

Printing:

Letterpress, offset printing, binding, lithographing services

Photocopy paper, other paper supplies

Envelopes, letterhead, etc.

Travel:

Mileage (at state rate unless specifically noted otherwise)

Airline or rail transportation expenses

Lodging

Per diem and meal costs

Operation costs of agency owned vehicles

Equipment **(requires prior written approval):**

Items costing more than $100 each with useful life of more than one year

Equipment costs shall include all freight and installation charges

Office equipment and furniture

Allowable medical equipment

Reference and training materials and exhibits

Books and films

**Unallowable costs include**, but are not limited to:

Indirect cost plan allocations

Bad debts

Contingencies or provisions for unforeseen events

Contributions and donations

Entertainment, food, alcoholic beverages and gratuities

Fines and penalties

Interest and financial costs

Legislative and lobbying expenses

Real property payments and purchases

|  |
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| **Section 7. GRANT SCOPE OF WORK** |

The Office of Women’s Health will be offering Carolyn Adams Ticket for the Cure Community Breast Cancer Grant programs during fiscal year 2014/2015. These grants will be for 18 months (January 1, 2014 through June 30, 2015).

1. **Program You are Applying for (based on an evidence-based program):**

|  |  |
| --- | --- |
| 🞎 | Patient Navigation |
| 🞎 | Provider Education |
| 🞎 | Risk Factor Reduction |
| 🞎 | Survivor Support |

1. **Eligibility**

Eligible applicants include local health departments, hospitals, colleges, universities and community organizations and agencies capable of conducting the project, either directly or indirectly through subcontract. Other eligibility requirements are as follows:

* **Only Illinois-based organizations can compete for the grant funds. They must be a government entity or a tax-exempt organization under section 501(c)(3) of the Internal Revenue Code. Subcontractors also must be a government entity or a tax-exempt organization under section 501(c)(3) of the Internal Revenue Code.**
* **Your application must be received by 5 p.m. November 25, 2013.**
* **Submit one (1) original and three (3) copies of the application.**
* **Community-based organizations applying for the grant must obtain a letter of support from their local health department. Include the letter in the appendix.**

**YOUR APPLICATION WILL BE DEEMED INELIGIBLE AND WILL NOT BE REVIEWED IF:**

* **The application is late.**
* **The application does not include original signatures**
* **The required number of copies are not submitted (one original and three copies).**
* **The organizational capacity or status report pages do not follow formatting requirements (two single-spaced pages using 10-point font and ½ inch margins).**
* **The correct forms documenting not-for-profit status are not included (local health departments are excluded).**

1. **Cost Per Participant**

Indicate the cost per program participant. The cost per participant is equivalent to the total cost of program [include funding requested from IDPH and the matching funds (matching funds are not required)] divided by the number of women reached by the program. The OWH wants applicants to take into consideration the number of participants they propose to reach relative to the funds requested. The intent is to encourage targeting an appropriate number of participants for the funding being sought. There are components particular to each model program that impact costs. The cost participant must be reasonable and commensurate to the proposed activities.

1. **Program Descriptions**

**Please submit an evidenced-based program based on your selection. GRANTS WILL BE A MAXIMUM OF $75,000.**

1. **Patient Navigation** – Patient Navigation funding will be for services that will focus on removing barriers to patient care and facilitate access to patient care, enhance services provided for quality of care, disease management and compliance with follow-up care.
2. **Provider Education** – Provider education funding will focus on cancer care plans, better patient management and communication with survivors, as well as timeliness of confirmatory diagnosis.
3. **Risk Factor Reduction** – Risk factor reduction can include nutritional and behavioral opportunities for change – physical fitness, nutrition education, healthy lifestyle, reduce risk of obesity and/or techniques used to reduce the chances of getting breast cancer.
4. **Survivor Support** – Survivor Support funding will be provided to enhance the quality of life as a result of a breast cancer diagnosis including support sessions (to address fatigue, lymphedema, pain, personal emotional changes, relationships, lifestyle behaviors, psychological distress, spiritual effects,), long term survivorship, post cancer care, self-image, body image, communication with family, friends, physicians, etc.

**Organizational Capacity**

Please complete table below for the specific program you are applying for. Please address the following items in no more than FOUR (4) **single-spaced pages using 10-point font.** Front and back is considered two pages.

|  |
| --- |
| 1. **Please describe your detailed plans for conducting the program. How many will be reached? Who will partner with you?** |
| **D 2) Demonstrate the need for this program within the community(ies) your organization serves. (If applicable, describe plans to address underserved populations.) Explain how this program will benefit the population you serve.** |
| **3) What is your plan for publicizing and recruiting participants? How do you plan to encourage program completion?** |
| 1. **How will you know if your program was successful? Please describe your methods for evaluating the program.** |
| 1. **Describe the staff responsible for coordinating the program. Please attach the resumes of all staff working on this grant.** |
| **) 6) Indicate the cost per program participant. The cost per participant is equivalent to the total cost of the program (include funding requested from IDPH and matching funds) divided by the number of women to be reached by the program.** |

**PROJECT WORKPLAN**

Prepare an outline for the event that defines the timeline for the planned activities and person responsible for each activity. You may add additional goals if applicable. The **Project Workplan may not exceed two pages, single-spaced using 10-pt font.**

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| --- | --- | --- | --- | --- |
| **Goal:** | | | | |
| **Objectives** | **Activities** | **Person Responsible** | **Time Frame** | |
|  |  |  | **Start** | **End** |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Goal:** | | | | |
| **Objectives** | **Activities** | **Person Responsible** | **Time Frame** | |
|  |  |  | **Start** | **End** |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Goal:** | | | | |
| **Objectives** | **Activities** | **Person Responsible** | **Time Frame** | |
|  |  |  | **Start** | **End** |

**Illinois Department of Public Health - Office of Women’s Health**

**Ticket for the Cure Community Grant Program**

**18-Month TFC Community Grant Project Timeline**

**Directions: Please complete the template to provide a timeline of events that will result in the completion of the proposed breast cancer community grant within the grant period. You may use additional space as needed.**

|  |  |  |  |
| --- | --- | --- | --- |
| **Quarter** | **Community Grant Activities** | **Target Completion Date** | **Responsible Community Grant Team Member** |
| **Quarter 1 – (January 1, 2014 –**  **March 30, 2014)** |  |  |  |
| **Quarter 2 - (April 1, 2014–**  **June 30, 2014)** |  |  |  |
| **Quarter 3 – (July 1, 2014 –**  **September 30, 2014)** |  |  |  |
| **Quarter 4 – (September, 2014 – December 30, 2014)** |  |  |  |
| **Quarter 5 - (January 1, 2015–**  **March 31, 2015)** |  |  |  |
| **Quarter 6 - (April 1, 2015–**  **June 30, 2015)** |  |  |  |

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| **Section 8. APPLICANT CERTIFICATION** | |
| Under penalty of perjury, I certify that I have examined this application and the document(s), proposal(s), and statement(s) submitted in conjunction herewith, and that to the best of my information and belief, the information contained herein is true, accurate, correct and complete. I represent that I am the person authorized to submit this application on behalf of the applicant, and that I am authorized to execute a legally binding grant agreement on behalf of the applicant if this grant application is approved for funding.  I hereby release to IDPH the rights to use photographs and/or written statements of information, regardless of the format, contained in or provided after the grant application for the purposes of publication on the IDPH website, unless the applicant submits a written request asking that the information not be disclosed. |
| **Signature Printed Name/Title Date** |

**IDPH Program:** Carolyn Adams Ticket for the Cure Community Grant Program  **Applicant: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**FOR DEPARTMENT USE ONLY - DO NOT WRITE BELOW THIS LINE**

|  |  |
| --- | --- |
| **Type of Grant Application** |  |
| Direct Appropriation | 🞎  **Funding Source:**  General Revenue Fund 🞎  State Special Fund 🞎  Federal 🞎 |
| Allocation by Administrative Rule | 🞎 |
| Competitive Request for Application | 🞎 |
| Statutory Board Review Required | 🞎 |
| Formula and/or Caseload Allocation | 🞎 |
| Non-competitive | 🞎 |

**Grant Application Funding Recommendation by Division/Program:**

|  |  |  |
| --- | --- | --- |
| 🞎 | Grant Application Disqualified/Not Eligible for Funding Under This Award | |
| 🞎 | Grant Application Recommended for Funding at Full Request | |
| 🞎 | Grant Application Recommended for Funding at $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_. | |
| Division Chief/Program Manager: | | Date: |

**Grant Application Funding Recommendation Approved by:**

|  |  |
| --- | --- |
| Deputy Director: | Date: |
| Assistant Director: | Date: |