

FOR IDPH Use Only

Application No. _____

Date Received _____



ILLINOIS DEPARTMENT OF PUBLIC HEALTH PUBLIC HEALTH GRANT APPLICATION

Office of

Insert Name of Division/Grant Program

Section 1. APPLICANT INFORMATION

Legal name of applicant <i>(Attach copy of W-9)</i>	
Name and title of chief officer <i>(If more than one, attach a list of all officers)</i>	Name: Title: Address: Phone: Fax: E-mail:
Applicant address	
City, state, ZIP code	
Telephone	
Fax	
E-mail	
Web site	

Section 2. APPLICANT GRANT HISTORY

Description of applicant organization <i>(200 character maximum)</i>	
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: <i>(Add additional rows if needed)</i>	<input type="checkbox"/> YES <input type="checkbox"/> 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?	<input type="checkbox"/> YES <input type="checkbox"/> NO

<p>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?</p>	<p style="text-align: center;"><input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>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.</p>
<p>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?</p>	<p style="text-align: center;"><input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>If yes, identify the nature of the proceedings and how they may affect the applicant's financial situation and/or operations.</p>
<p>Does the applicant or any principal owe any debt to the state of Illinois?</p>	<p style="text-align: center;"><input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>If yes, list the amount and reason for the debt. Attach additional documentation to explain the debt owed to the state.</p>

Section 3. APPLICANT ORGANIZATION INFORMATION			
<p>Legal status:</p>	<table style="width: 100%; border: none;"> <tr> <td style="width: 50%; border: none;"> <input type="checkbox"/> Individual <input type="checkbox"/> Sole proprietor <input type="checkbox"/> Partnership/legal corporation <input type="checkbox"/> Tax exempt <input type="checkbox"/> Corporation providing or billing medical and/or health services <input type="checkbox"/> Corporation NOT providing or billing medical and/or health services <input type="checkbox"/> Other (describe): </td> <td style="width: 50%; border: none;"> <input type="checkbox"/> Governmental <input type="checkbox"/> Nonresident alien <input type="checkbox"/> Estate or trust <input type="checkbox"/> Pharmacy (non-corporation) <input type="checkbox"/> Pharmacy/funeral home/cemetery (corporation) <input type="checkbox"/> Limited liability company (select applicable tax classification) <input type="checkbox"/> D = Disregarded entity <input type="checkbox"/> C = Corporation <input type="checkbox"/> P = Partnership </td> </tr> </table>	<input type="checkbox"/> Individual <input type="checkbox"/> Sole proprietor <input type="checkbox"/> Partnership/legal corporation <input type="checkbox"/> Tax exempt <input type="checkbox"/> Corporation providing or billing medical and/or health services <input type="checkbox"/> Corporation NOT providing or billing medical and/or health services <input type="checkbox"/> Other (describe):	<input type="checkbox"/> Governmental <input type="checkbox"/> Nonresident alien <input type="checkbox"/> Estate or trust <input type="checkbox"/> Pharmacy (non-corporation) <input type="checkbox"/> Pharmacy/funeral home/cemetery (corporation) <input type="checkbox"/> Limited liability company (select applicable tax classification) <input type="checkbox"/> D = Disregarded entity <input type="checkbox"/> C = Corporation <input type="checkbox"/> P = Partnership
<input type="checkbox"/> Individual <input type="checkbox"/> Sole proprietor <input type="checkbox"/> Partnership/legal corporation <input type="checkbox"/> Tax exempt <input type="checkbox"/> Corporation providing or billing medical and/or health services <input type="checkbox"/> Corporation NOT providing or billing medical and/or health services <input type="checkbox"/> Other (describe):	<input type="checkbox"/> Governmental <input type="checkbox"/> Nonresident alien <input type="checkbox"/> Estate or trust <input type="checkbox"/> Pharmacy (non-corporation) <input type="checkbox"/> Pharmacy/funeral home/cemetery (corporation) <input type="checkbox"/> Limited liability company (select applicable tax classification) <input type="checkbox"/> D = Disregarded entity <input type="checkbox"/> C = Corporation <input type="checkbox"/> P = Partnership		
<p>Federal Employer Identification Number (FEIN) or Social Security Number (SSN) of applicant if not an organization:</p>			
<p>If applicable, list all names and FEINs registered to your organization or have been registered during the last three years.</p>	<p>Name</p>	<p>FEIN</p>	
	<p>Name</p>	<p>FEIN</p>	
	<p>Name</p>	<p>FEIN</p>	
<p>D-U-N-S Number</p>			
<p>Illinois Department of Human Rights number (if applicable):</p>			

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	

Section 5. GRANT PROJECT PROPOSAL	
Project title	
Brief project description <i>(350 character maximum). Note that the scope of work must be completed separately.</i>	
Project period <i>(Include start and end date)</i>	
Total amount of funding requested from IDPH	
Total applicant match or in-kind contribution	

If subcontractors will be used under this grant application, provide name, address and description of services.	Subcontractor name: Address: City, state, ZIP code: Phone: Description of services:
	Subcontractor name: Address: City, state, ZIP code: Phone: Description of services:

Section 6. GRANT BUDGET SUMMARY <i>(Note: This section is for summary purposes only. A detailed budget is/may be required. See Section 7)</i>		
Budget line items requested	Requested grant budget amount	Applicant match of in-kind contribution
Personal services <i>(includes salary and wages)</i>		
Fringe benefits <i>(percent use for calculation _____%)</i>		
Contractual services <i>(detailed information about the contractual services amount must be submitted on the attached budget excel form)</i>		
Travel		
Commodities/supplies		
Printing		
Equipment		
Telecommunications		
Patient/client care		
Administrative costs <i>(if applicable/allowable)</i> This line item can be removed by program if not allowable		
TOTAL		
If the proposed budget includes personal services (salary or wage) related costs, indicate the type of documentation that will be maintained and used to allocate staff costs to the grant.	<input type="checkbox"/> Time Sheets <input type="checkbox"/> Cost allocation plans <input type="checkbox"/> Certifications of time allocable to grant <input type="checkbox"/> Other, describe _____ <input type="checkbox"/> Not applicable to this grant application	

Section 7. GRANT SCOPE OF WORK

This section is to be developed by each program use to request information from the grantee that is specific to the grant being issued. Information/data collected **must** include, but not be limited to:

- Detailed description/information about the proposed project
- Expected outcomes
- Description of how outcomes will be measured
- List of goals to be accomplished during the grant period
- Proposed timeline
- Objectives by quarter with a list of tasks that will be implemented to accomplish the objectives. The organization shall specify how the objectives will be measured to determine successful completion.
- Detailed budget by line item and justification. The attached detailed budget spreadsheet can be used or the program may elect to use its own budget worksheet, however, the personal services (salary and wages) information provided by the organization must include: name of position to be funded, projected monthly salary, percent of time on grant, and number of months on grant for each position funded by the grant.

NOTE: Please use the rubric to make sure you include all the necessary components in the statement of work that will be reviewed by the IDPH Grants' Review Committee.

Name of Grant Program _____

Legal Name of Applicant _____

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 Web site, unless the applicant submits a written request asking that the information not be disclosed.

Signature

Printed Name/Title

Date

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Type of Grant Application

- Direct appropriation
- Allocation by administrative rule
- Competitive request for application
- Statutory board review required
- Formula and/or caseload allocation
- Non-competitive

Funding Source:

- General Revenue Fund
- State special fund
- Federal

Grant Application Funding Recommendation by Division/Program

<input type="checkbox"/>	Grant application disqualified/not eligible for funding under this award
<input type="checkbox"/>	Grant application recommended for funding at full request
<input type="checkbox"/>	Grant application recommended for funding at \$_____.

Division Chief/Program Manager _____ Date _____

Grant Application Funding Recommendation Approved by:

Deputy Director: _____ Date: _____

Assistant Director: _____ Date: _____