



Date: December 13, 2023

To: Prospective Applicants

From: Dyane Gogan Turner, MPH, RD/LD, IBCLC [DGT/AS](#)
Chief, Bureau of Child and Family Health
Ohio Department of Health

Subject: Notice of Availability of Funds – Competitive Solicitation for State Fiscal Year 2025
(July 1, 2024 - June 30, 2025) Sickie Cell - Statewide Family Support Initiative

The Ohio Department of Health (ODH), Bureau of Child and Family Health, announces the availability of grant funds.

Qualified applicants for grant funds under this initiative are any community-based 501(c)(3) agency with an identifiable, functional (staffed) program organized for and capable of ensuring the provision of **statewide education, awareness, and empowerment** activities for individuals and groups (adult priority populations) at-risk or affected by sickle cell disease, sickle cell trait and other hemoglobinopathies. Funding consideration will be given to the applicant agency that demonstrates capability, experience and expertise in the three (3) grant service components listed above and whose programmatic activities address the Goals of the Sickie Cell – Statewide Family Support Initiative. **Only one agency will be funded in the state.**

This is a competitive solicitation; a Notice of Intent to Apply for Funding (**NOIAF – Appendix A**) must be submitted by **Wednesday, December 20, 2023** so access to the online application can be established.

To be eligible for funding, all applicant agencies must 1) be a local public or non-profit agency and 2) have the capacity to accept an electronic funds transfer (EFT). If an applicant agency needs GMIS access, then a GMIS Access Request Form must be submitted. (See **Appendix B**).

Potential applicants are encouraged to participate in a Bidders Conference to be held via conference call on **Monday, December 18, 2023 from 1:00 to 2:00 p.m. EST**. The conference call is being offered to allow potential applicants the opportunity to discuss the solicitation and learn about the elements of a successful application. Refer to the solicitation (Section O) for more information regarding accessing the Bidders Conference.

All applications, including any required attachments, must be completed and received by ODH electronically via GMS by **4:00 p.m. on Monday, January 29, 2024**. Applications received after the due date will not be considered for review.

For questions, please contact Allyson VanHorn, Section Administrator by e-mail at Allyson.VanHorn@odh.ohio.gov.

ALL APPLICATIONS MUST BE SUBMITTED THRU THE GRANT MANAGEMENT SYSTEMS

OHIO DEPARTMENT OF HEALTH

BUREAU OF CHILD AND FAMILY HEALTH

Sickle Cell - Statewide Family Support Initiative
SOLICITATION FOR FISCAL YEAR 2025
(07/01/2024 – 06/30/25)

Local Public Applicant Agencies Non-Profit Applicants

COMPETITIVE GRANT APPLICATION INFORMATION
100% Deliverable Funding

Revised 9/29/2023
For grant starts 4/1/2024 and thereafter

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Attachment #6a – Biographical Sketch Instructions

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I. APPLICATION SUMMARY and GUIDANCE

An application for an Ohio Department of Health (ODH) grant consists of several required components including an electronic portion submitted via online and various paper forms and attachments. All the required components of a specific application must be completed and submitted by the application due date. **If any of the required components are not submitted by the due date indicated in sections D, G and R, the entire application will not be considered for review.**

This is a competitive solicitation; a Notice of Intent to Apply for Funding (**NOIAF – Appendix A**) must be submitted by **Wednesday, December 20, 2023** so access to the online application can be established.

NEW AGENCIES ONLY or if UPDATES are needed: For non-profit agencies, the NOIAF must be accompanied by proof of non-profit status. Both non-profit and local public agencies must submit proof of liability coverage. Potential applicants and current subrecipients are required to maintain their current supplier information in the State of Ohio Supplier Portal. This information includes, but is not limited to, Electronic Funds Transfer (EFT), 1099 Form and current address.

This information is maintained on the following website: <http://supplier.ohio.gov/>

Note: Subrecipients future payments will be held for any subrecipient that currently receives a paper check if the EFT information is not updated in the supplier portal.

The application summary information is provided to assist your agency in identifying funding criteria:

- A. Policy and Procedures:** Uniform administration of all the ODH grants is governed by the ODH Grants Administration Policies and Procedures (OGAPP) manual and updates in policies that have been posted on the GMIS Bulletin Board. This manual and GMIS Bulletin Board policy updates must be followed to ensure adherence to the rules, regulations, and procedures for preparation of all subrecipient applications. The OGAPP manual is available on the ODH website (click or copy and paste the following link into your web browser: <https://odh.ohio.gov/wps/portal/gov/odh/about-us/funding-opportunities/resources/grants-administrative-policies-and-procedures-ogapp-manual>).

Updates to policies and procedures can be found on the GMIS bulletin board. All budget justifications must include the following language and be signed by the agency head listed in GMIS. Please refer to the Budget Justification Templates listed on the GMIS bulletin board.

Sickle Cell Program Application Guidance: The budget justification is listed as Deliverable-Objective Descriptions (**Appendix C1**) in the solicitation with the Deliverable-Objective Allocations listed as **Appendix C2**.

Budget Justification Certification language

- Subrecipient understands and agrees that it must follow the federal cost principle that applies to its type of organization (2 CFR, Part 225; 2 CFR, Part 220; or, 2 CFR, Part 230).
- Subrecipient's budgeted costs are reasonable, allowable, and allocable under OGAPP and federal rules and regulations.
- The OGAPP and the rules and regulations have been read and are understood.
- Subrecipient understands and agrees that costs may be disallowed if deemed unallowable or in violation of OGAPP and federal rules and regulations.
- The appropriate programmatic and administrative personnel involved in this application are aware of the agency's policy with regard to subawards and are prepared to establish the necessary inter-institutional agreements consistent with those policies.
- Subrecipient agrees and understands that costs incurred in the fulfillment of the Deliverables must be allowable under OGAPP and federal rules and regulations to qualify for reimbursement.

B. Application Name: Sickle Cell - Statewide Family Support Initiative

- C. **Purpose:** To support the provision of **statewide education, awareness, and empowerment** activities for individuals and groups (adult priority populations) at-risk or affected by sickle cell disease, sickle cell trait, and other hemoglobinopathies and the professionals who serve them.
- D. **Qualified Applicants:** Qualified applicants for grant funds under this initiative are any community-based 501(c)(3) agency organized for and capable of ensuring the provision of **statewide education, awareness, and empowerment** activities (grant service areas) for individuals and groups (adult priority populations) at-risk or affected by sickle cell disease, sickle cell trait and other hemoglobinopathies and the professionals who serve them. Funding consideration will be given to the applicant agency that demonstrates capability, experience, and expertise in the three (3) grant service components (listed above) and whose programmatic activities address the Goals of the Sickle Cell – Statewide Family Support Initiative. **Only one agency will be funded in the state.**

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

Sickle Cell Program Application Guidance: *Applicants that apply for funds under this initiative MAY NOT apply for additional funding under the Sickle Cell Initiative.*

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

1. Must have a history of effective collaboration and cooperation within the state. Shared or cooperative projects involving more than one agency/organization which enhances the ability to cut across geographic or service system boundaries are encouraged.
2. Must have the necessary staff in place for the effective operation of the project. Project staff must have experience and/or expertise in the three (3) grant service components for this initiative. and, at a minimum, include: **Project Director, Education/Outreach Coordinator, and Medical Advisor.**

Sickle Cell Program Application Guidance: *The Project Director for the Sickle Cell Statewide Family Support Initiative must have GMIS access and be listed (at a minimum as a "User") on the GMIS Project Contacts page.*

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 under this initiative to pay for medical services and/or personnel that can be covered by 3rd party payers or other resources.
- Facilities that concurrently apply for funds under the ODH Sickle Cell Initiative and the Statewide Family Support Initiative.

The following criteria must be met for grant applications to be eligible for review:

1. The applicant does not owe funds to ODH and has repaid any funds due within 45 days of the invoice date.
2. The applicant has not been certified to the Attorney General’s (AG’s) office.
3. The applicant has submitted application and all required attachments by **4:00 p.m. on Monday, January 29, 2024.**

E. Service Area: The applicant will provide **statewide** services as identified in the Goals of the Solicitation.

F. Number of Grants and Funds Available: The ODH Sickle Cell Services Program grants are comprised of funds generated from a portion of the state Newborn Screening Fee. **Only one (1) applicant will be funded in the state under this initiative.** The total grant funding available for SFY 2025 budget period (07/01/2024 to 06/30/2025) is anticipated to be approximately \$90,000.00.

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.

G. Due Date: All parts of the application, including any required attachments, must be completed, and received by ODH electronically via GMIS by **4:00 p.m. by Monday, January 29, 2024.** Applications and required attachments received after this deadline will not be considered for review.

Contact Allyson Van Horn, Section Administrator at Allyson.VanHorn@odh.ohio.gov with any questions.

H. Authorization: Authorization of funds for this purpose is contained in Amended Substitute House Bill 166.

- I. **Goals:** In releasing funds for this initiative, the goals of the ODH Sickle Cell Services Program are to:
- A. Increase the visibility of sickle cell services and resources in the state of Ohio through implementation of statewide *education, awareness, and empowerment* activities for individuals and groups (adult priority populations).
 - B. Engage the community to increase the knowledge and support of Ohio individuals and groups at-risk or affected by sickle cell disease, sickle cell trait and other hemoglobinopathies.
 - C. Promote national, statewide, and regional collaboration of groups, programs and organizations that provide information, services, and linkages to Ohio individuals and groups impacted by sickle cell disease, sickle cell trait and other hemoglobinopathies.
- J. **Program Period and Budget Period:** The program period will begin 07/01/2024 and end on 06/30/2028. The budget period for this application is 07/01/2024 through 06/30/2025.
- K. **Public Health Accreditation Board (PHAB) Standard(s):** This grant program will address PHAB standard 4.1: Engage with the Public Health System and the Community in Identifying and Addressing Health Problems through Collaborative Processes. The PHAB standards are available on the following website:

http://www.phaboard.org/wp-content/uploads/PHABSM_WEB_LR1.pdf

- L. **Public Health Impact Statement:** All applicant agencies that are not local health districts must communicate with local health districts regarding the impact of the proposed grant activities on the PHAB Standards.
1. Public Health Impact Statement Summary—Applicants are required to submit a summary (**Attachment #1**) of the proposal to local health districts prior to submitting the grant application to ODH. The program summary, **not to exceed one page**, must include the PHAB Standard to be addressed by grant activities:
 - **Standard 4.1:** Engage with the Public Health System and the Community in Identifying and Addressing Health Problems through Collaborative Processes.

The applicant must submit the above summary as part of the 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 PHAB Standards.

2. Public Health Impact Statement of Support —Include with the grant application a statement of support (**Attachment #2**) from the local health districts, if available. If a statement of support from the local health districts is not obtained, indicate that point when submitting the program summary with the grant application. If an applicant agency has a regional and/or statewide focus, a statement of support should be submitted from at least one local health district, if available.

Sickle Cell Program Application Guidance: A listing of local health districts (city and county) is available at the following website: <https://odh.ohio.gov/find-local-health-districts>. For statements of support not obtained from local health districts, the successful applicant will be required to submit a plan to follow-up with remaining local health districts.

3. Evidence of Health Equity Strategies

The ODH is committed to the elimination of health disparities and achieving health equity for all Ohioans. The items below are requirements for all applicants to ensure health equity is embedded within all components of the application (e.g., Goals, Program Narrative, and Objectives.)

- 1) Identify specific groups who experience a disproportionate burden of disease, health condition or health outcome targeted by this solicitation (See Ohio's State Health Assessment for Ohio's health data) at <https://odh.ohio.gov/wps/portal/gov/odh/explore-data-and-stats/interactive-applications/>.
- 2) Identify geographic reference points (i.e., census tracts, census block groups or zip codes) to specify where program activities are focused. Ohio Health Improvement Zones (OHIZ) refers to the socioeconomic and demographic factors that affect the resilience of individuals and communities – the ability to prevent human suffering and financial loss in a disaster. By understanding where these populations are located and what factors contribute to their levels of risk, Ohio Health Improvement Zones can aid in all phases of improving health in communities. Interactive maps, census tract information and more can be found on the OHIZ Dashboard, here: <https://odh.ohio.gov/wps/portal/gov/odh/know-our-programs/health-equity/health-improvement-zones>.
- 3) Use direct or indirect feedback from the prioritized population, community, group, or community agency to identify specific social and environmental conditions (social determinants of health) associated with health disparities and health inequities.

Sickle Cell Program Application Guidance: *Feedback will be obtained in year one of the grant cycle through the dissemination of the Community Engagement Assessment Tool (CEAT).*

- 4) Identify measurable health equity targets that demonstrate reducing disparities and improving health equity are critical goals to be achieved through program activities. This information must also be supported by data. For guidance on methodology to establish equity targets, review 2030 Target Setting Methodologies for Objectives in Healthy People 2030.
<https://www.healthypeople.gov/sites/default/files/TargetSettingReport-8-6-18%20FINAL.pdf>

Sickle Cell Program Application Guidance: *The measurable health equity targets will be identified in year two of the grant cycle following the dissemination and analysis of the CEAT.*

- 5) Outline specific evaluation strategies to measure the impact of program activities on decreasing and/or eliminating health disparities and health inequities.

Sickle Cell Program Application Guidance: *The evaluation of these strategies will be outlined in year two of the grant cycle.*

The following are best practices toward eliminating disparities and achieving health equity. They are not required, but highly encouraged to use.

- 1) Link proposed activities to health equity strategies identified in local, state, or national planning documents. These documents include, but are not limited to strategies, goals and objectives outlined in [Healthy People](#)

2030, the [State Health Improvement Plan \(SHIP\)](#) and local Community Health Assessments.

- State Health Improvement Plan - <https://odh.ohio.gov/wps/portal/gov/odh/about-us/sha-ship>
- Healthy People 2030 - <https://health.gov/healthypeople>

- 2) Develop staffing plans where board members, leadership and program staff reflect the race, ethnicity, background, and/or culture of the population being served.
- 3) Identify up-and downstream approaches to address social determinants of health and reduce disparities. Upstream factors like food, housing and income insecurity that focus on addressing social determinants of health decrease barriers and improve supports that provide opportunity for people to achieve their full health potential. Downstream approaches focus on providing equitable access to care and services to reduce the negative impact of social determinants on health outcomes.
- 4) Establish non-traditional partnerships among different sectors of the community (e.g., faith-based organizations, community organizations, businesses, universities, healthcare) that can provide valuable insight, new perspective, and more effective ways to achieve program goals. Non-traditional partners create opportunities to collaborate across sectors and may serve as a new source of support for the program.

Understanding Health Disparities, Health Inequities, Social Determinants of Health & Health Equity: The following information is provided to explain key health equity concepts and terms.

Racial and ethnic minorities, those living in rural communities, people with disabilities, the LGBTQ community and Ohio's economically disadvantaged residents do not have the same opportunities as other groups to achieve and sustain optimal health. Health disparities occur when these groups experience more diseases, death, or disability beyond what would normally be expected based on their relative size of the population. Health disparities are often characterized by such measures as disproportionate incidence, prevalence and/or mortality rates of diseases or health conditions. Health is largely determined by where people live, learn, work, play, and age. Health disparities are unnatural and occur because of low socioeconomic status, race/ethnicity, sexual orientation, gender, disability status, geographic location, or some combination of these factors. Those most impacted by health disparities also tend to have less access to resources like healthy food, safe housing, quality education, safe neighborhoods and freedom from racism and other forms of discrimination. These are referred to as **social determinants of health (SDOH)**. SDOH is a root cause of health disparities. The systematic nature of health disparities is considered unjust and is referred to as **health inequities**. The ability of everyone to have the same opportunity to achieve the best health possible is referred to as **health equity**. Programs that incorporate social determinants into the planning and implementation of interventions will greatly contribute to advancing health equity.

- M. Human Trafficking:** Human trafficking is defined by the use of force, fraud, or coercion to compel victims into performing labor or commercial sex acts. Populations at increased risk include but are not limited to lesbian-gay-bisexual-transgender-questioning individuals, individuals with disabilities, undocumented immigrants, runaway and homeless youth, temporary guest workers, and low-income individuals.

ODH is committed to the elimination of human trafficking in Ohio. If applicable to the subrecipient program, ODH will give priority consideration to those subrecipients who can demonstrate the following:

- a. Victims of human trafficking are included in your agency's target population.

1. At-risk population
2. Mental health population
3. Homeless population

Agency promotes the expansion of services to identify and serve those affected by human trafficking.

____ Applicable X Not Applicable to **Sickle Cell – Statewide Family Support Initiative**

- N. Appropriation Contingency:** Any award made through this program is contingent upon the availability of funds for this purpose. **The subrecipient agency must be prepared to support the costs of operating the program in the event of a delay in grant payments.**
- O. Programmatic, Technical Assistance and Authorization for Internet Submission:** Agencies will receive their authorization after the posting of the Solicitation to the ODH website and the receipt of the NOI AF. Please contact Allyson VanHorn, Section Administrator at Allyson.VanHorn@odh.ohio.gov or (614) 728-6785 for questions regarding this Solicitation.

Bidders Conference

A Bidders Conference is being offered via conference call to allow potential applicants the opportunity to discuss the ODH Sickle Cell Initiative Competitive Solicitation and learn the elements of a successful application. Attendance is recommended, but not required for submission of an application.

The conference call will be held via Microsoft Teams on **Monday, December 18, 2023 from 1:00 to 2:00 p.m. EST** as follows:

Join on your computer, mobile app or room device

[Click here to join the meeting](#)

Meeting ID: 265 379 679 088

Passcode: XaVivB

[Download Teams](#) | [Join on the web](#)

Join with a video conferencing device

[682042763@t.plcm.vc](tel:682042763@t.plcm.vc)

Video Conference ID: 117 288 225 7

[Alternate VTC instructions](#)

Or call in (audio only)

[+1 614-721-2972,,313520486#](tel:+16147212972,313520486#) United States, Columbus

Phone Conference ID: 313 520 486#

Sickle Cell Program Application Guidance: *Please note that Sickle Cell Services Program staff are unable to assist with the actual writing of an application or critique of an application draft during the Competitive cycle.*

- P. Acknowledgment:** An application submitted status will appear in GMIS that acknowledges ODH system receipt of the application submission.
- Q. Late Applications:** GMIS automatically provides a time and date system for grant application submissions. Required attachments and/or forms must be uploaded in GMIS by **Monday, January 29, 2024 at 4:00 p.m.**

- R. Successful Applicants:** Successful applicants will receive official notification in the form of a Notice of Award (NOA). The NOA, issued over the signature of the Director of the Ohio Department of Health, allows for expenditure of the funds.
- S. Unsuccessful Applicants:** Within 30 days after a decision to disapprove or not fund a grant application, a written notification, issued over the signature of the Director of Health, or his designee, shall be sent to the unsuccessful applicant via GMIS.
- T. Review Criteria:** All proposals will be graded on the quality, clarity, and completeness of the application. Applications will be graded according to the extent to which the proposal:
1. Workplan and/or logic model demonstrate how activities reduce health disparities and inequities.
 2. Is responsive to policy concerns and program objectives of the initiative/program/activity for which grant dollars are being made available.
 3. Is well executed and can attain program objectives.
 4. Describe Specific, Measurable, Attainable, Realistic & Time-Phased (S.M.A.R.T.I.E) objectives, activities, (SMARTIE) milestones and outcomes with respect to timelines and resources.
 5. Estimate reasonable cost to the ODH, considering the anticipated results.
 6. Show that program personnel are well qualified by training and/or experience for their roles in the program, and the applicant organization has adequate facilities and personnel to reflect the communities served through grant funds.
 7. Have an evaluation plan, including a design for determining program success and demonstrates that the community being served will be meaningfully engaged in formative and outcome evaluations.
 8. Respond to the special concerns and program priorities specified in the Solicitation.
 9. Has acceptable past performance in areas related to programmatic and financial stewardship of grant funds.
 10. Are compliant with OGAPP.
 11. Explicitly identify specific groups in the service area who experience a disproportionate burden of the diseases; health condition(s); or who are at an increased risk for problems addressed by this funding opportunity.
 12. Describe activities which support the requirements outlined in Sections I. through M. of this Solicitation.

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 Sickle Cell – Statewide Family Support Initiative. Responses to the Solicitation, which are determined to be complete and in compliance with these requirements, will be reviewed in accordance with the Point Values on the Application Review Form. (See **Appendix D**).

ODH will make the final determination and selection of successful/unsuccessful applicants and reserves the right to reject any or all applications for any given solicitations. **There will be no appeal of the Department's decision.**

Sickle Cell Program Application Guidance: *Applicants must score greater than or equal to 70 percent on the Application Review Form to be eligible for funding under this Initiative.*

U. Freedom of Information Act: The Freedom of Information Act (5 U.S.C.552) and the associated Public Information Regulations 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 being an unwarranted invasion of personal privacy will not be disclosed. For guidance regarding specific funding sources, refer to: 45 CFR Part 5 for funds from the U.S. Department of Health and Human Service; 34 CFR Part 5 for funds from the U.S. Department of Education or, 7 CFR Part 1 for funds from the U.S. Department of Agriculture.

V. Ownership Copyright: Any work produced under this grant, including any documents, data, photographs and negatives, electronic reports, records, software, source code, or other media, shall become the property of ODH, which shall have an unrestricted right to reproduce, distribute, modify, maintain, and use the work produced. If this grant is funded in whole, or in part, by the federal government, unless otherwise provided by the terms of that grant or by federal law, the federal funder also shall have an unrestricted right to reproduce, distribute, modify, maintain, and use the work produced. No work produced under this grant shall include copyrighted matter without the prior written consent of the owner, except as may otherwise be allowed under federal law.

ODH must approve, in advance, the content of any work produced under this grant. All work must clearly state:

“This work is funded either in whole or in part by a grant awarded by the Ohio Department of Health, Bureau of Child and Family Health, Sickle Cell Services Program.”

W. Reporting Requirements: Successful applicants are required to submit subrecipient program and expenditure reports. The reports must be received in accordance with the requirements of the OGAPP manual and this solicitation before the department releases any additional funds.

Note: Failure to ensure the quality of reporting by submitting incomplete and/or late program or expenditure reports will jeopardize the receipt of future agency payments.

Reports shall be submitted as follows:

a. Program Reports: Subrecipients program reports must be completed and submitted via GMIS, as required by the subgrant program by the following dates. **Program reports that do not include required attachments will not be approved.** All program report attachments must clearly identify the authorized program name and grant number.

☒ Program Reports Required ☐ No Program Reports Required

Subrecipient Program Performance Reports

Subrecipient **Monthly** Program Performance Reports **must** be completed and submitted via GMIS by the following dates:

Period	Report Due Date
July 1 – 31, 2024	August 10, 2024
August 1 – 31, 2024	September 10, 2024
September 1 – 30, 2024	October 10, 2024

October 1 – 31, 2024	November 10, 2024
November 1 – 30, 2024	December 10, 2024
December 1 – 31, 2024	January 10, 2025
January 1 – 31, 2025	February 10, 2025
February 1 – 28, 2025	March 10, 2025
March 1 – 31, 2025	April 10, 2025
April 1 – 30, 2025	May 10, 2025
May 1 – 31, 2025	June 10, 2025
June 1 – 30, 2025	July 10, 2025

Subrecipient **Quarterly** Program Performance Reports **must** be completed and submitted via GMIS by the following dates:

Period	Report Due Date
July 1 - September 30, 2024	October 10, 2024
October 1 - December 31, 2024	January 10, 2025
January 1 - March 31, 2025	April 10, 2025
April 1 - June 30, 2025	July 10, 2025

Submission of Subrecipient program reports via GMIS indicates acceptance of the OGAPP.

Other Program-Specific Forms and Reporting Documentation

Subrecipient Forms **must** be completed and **submitted as specified by ODH Program**:

Subrecipient Forms	Submission Date
Deliverable-Objectives and Work Plan	Submitted with application
Letter of Documentation	Submitted with application
Deliverable Staff Contact Information Form	Submitted with application
Biographical Sketch Form	Submitted with application
Position Descriptions	Submitted with application
Data Assurances	Submitted with application
User Access Form	Submitted with application

Subrecipient Forms **must** be completed and **submitted monthly or quarterly based on subrecipient reimbursement type (*expenditure report submission*)**:

Subrecipient Forms	Submission Date
External Meeting Verification Form	Monthly or Quarterly
Professional Development Verification Form	Monthly or Quarterly
Deliverable Reimbursement Form	Monthly or Quarterly
Media Metrics Form	Monthly or Quarterly
OSCAFA Funding Disbursement/Activity Letter	Monthly or Quarterly

Subrecipient Data Documents **must** be completed and **submitted as specified by ODH Program**:

Subrecipient Data Documents and Reports	Submission Date
Annual Report Worksheet	By June 30, 2025
Maternal and Child Health Integrated Data System(MCHIDS)/Sickle Cell Education Database (SCED)	Within 10 days of the event
Community Engagement Assessment Tool (CEAT)	January 10, 2025
Community Engagement Action Plan	April 10, 2025

Sickle Cell Program Application Guidance: *Formats for submission of the above listed program performance reports, subrecipient forms and data documents and reports will be provided to the successful applicant subsequent to official notification from ODH. Refer to Section G for information on submission of attachments.*

In addition to submission of the above-listed forms and reports, subrecipient staff are **required** to participate in the meeting formats (*in-person or virtual*) as indicated below:

Subrecipient Communication with ODH Program		
Meeting Formats	Meeting Dates	Reimbursement
Bi-Annual Sickle Cell Project Staff Meeting	July 12, 2024 December 13, 2024	\$150.00/per meeting
Stakeholder Meeting (including Medical Director/Medical Advisor)	To Be Determined	\$500.00/per meeting
Grant Check-in Meeting (subrecipient-specific)	August 2024 November 2024 February 2025 May 2025	\$100.00/per meeting

- b. Subrecipient Reimbursement Expenditure Reports:** Subrecipients can choose monthly or quarterly reimbursement (expenditure report submission) from ODH (please check the reimbursement type on the attached NOI AF). Please note that no changes can be made to the reimbursement type during the fiscal year once the project numbers have been established in GMIS.

Subrecipient **Monthly** Reimbursement Expenditure Reports **must** be completed and submitted **via GMIS** by the following dates:

Period	Report Due Date
July 1 – 31, 2024	August 10, 2024
August 1 – 31, 2024	September 10, 2024
September 1 – 30, 2024	October 10, 2024
October 1 – 31, 2024	November 10, 2024
November 1 – 30, 2024	December 10, 2024
December 1 – 31, 2024	January 10, 2025
January 1 – 31, 2025	February 10, 2025

February 1 – 28, 2025	March 10, 2025
March 1 – 31, 2025	April 10, 2025
April 1 – 30, 2025	May 10, 2025
May 1 – 31, 2025	June 10, 2025
June 1 – 30, 2025	July 10, 2025

Subrecipient **Quarterly** Reimbursement Expenditure Reports **must** be completed and submitted **via GMIS** by the following dates:

Period	Report Due Date
July 1 – September 30, 2024	October 10, 2024
October 1 – December 31, 2024	January 10, 2025
January 1 – March 31, 2025	April 10, 2025
April 1 – June 30, 2025	July 10, 2025

Sickle Cell Program Application Guidance: *The format for submission of the Expenditure Report “Deliverable Reimbursement Form” will be provided to successful applicants subsequent to official award notification from ODH.*

Note: Obligations not reported on the final monthly or 4th quarter expenditure report will not be considered for payment with the final expenditure report.

- c. **Final Expenditure Reports:** A Subrecipient final expenditure Report reflecting total expenditures for the fiscal year must be completed and submitted **via GMIS by 4:00 p.m.** on or before **August 5, 2025**. The information contained in this report must reflect the program’s accounting records and supportive documentation. Any cash balances must be returned with the Subrecipient final expense report, which serves as an invoice to return unused funds.

- *Submission of the Monthly/Quarterly and Final subrecipient expenditure reports via the GMIS system indicates acceptance of OGAPP. Clicking the “Approve” button constitutes an authorization of the submission the agency official and serves as an electronic acknowledgment and acceptance of OGAPP rules and regulations.*

- X. **Special Condition(s):** A Special Conditions link is available for viewing and responding to special conditions within GMIS. The 30-day time period, in which the subrecipient must respond to special conditions will begin when the link is viewable. Subsequent payments will be withheld until satisfactory responses to the special conditions or a plan describing how those special conditions will be satisfied is submitted to GMIS.

- 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.
2. To disseminate factually incorrect or deceitful information.
3. Consulting fees for salaried program personnel to perform activities related to grant objectives.
4. Bad debts of any kind.
5. Contributions to a contingency fund.
6. Entertainment.

7. Fines and penalties.
8. Membership fees — unless related to the program and approved by ODH.
9. Interest or other financial payments (including but not limited to bank fees).
10. Contributions made by program personnel.
11. Costs to rent equipment or space owned by the funded agency.
12. Inpatient services.
13. The purchase or improvement of land; the purchase, construction, or permanent improvement of any building; unless allowable by the grant.
14. Satisfying any requirement for the expenditure of non-federal funds as a condition for the receipt of federal funds.
15. 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 and Other Unallowable Costs

16. Advertisement – other than for recruitment or procurement or if required by the program’s Solicitation.
17. All costs related to out-of-state travel.
18. Client Incentives (gas cards/vouchers) and Client Enablers.
19. Contracts, for compensations, with advisory board members.
20. Costs associated with any work produced under this grant, including documents, data, photographs, and negatives, electronic reports, records, software, source code, or other media that is not pre-approved in advance by ODH Program (Refer to Section V - Ownership Copyright for additional requirements).
21. Costs associated with clinical services.
22. Reimbursement for physician(s) who serve on the grant as Medical Director or Medical Advisor.
23. First class travel.
24. Food, refreshments and beverages (including alcoholic beverages).
25. Funds requested to reduce, replace or supplant existing applicant agency funds for sickle cell and other hemoglobinopathy services.
26. Grant-related equipment costs greater than \$1,000.00, unless justified and approved by ODH Program.
27. Honorariums and speaker fees.
28. Instructional supplies (including, but not limited to thermometers)
29. In-state lodging, travel and meals over the current state rates (see Ohio Shared Services website for travel and expense reimbursements at: <https://obm.ohio.gov/areas-of-interest/obm-shared-services/travel-and-expense-reimbursements>).
30. Office furniture (Refer to OGAPP Manual).
31. Promotional items (include items with slogans, logos, agency name/address, messaging). Promotional like items must be preapproved prior to submitting in agency subgrant program budget (e.g., sickle cell awareness fans, sickle cell awareness ribbons, sickle cell awareness silicone bracelets that do not include slogans, logos, agency name/address, messaging).
32. Subscriptions.
33. Staff development and/or training longer than one week in duration, unless prior approved by ODH Program.
34. Unapproved educational or training activities.

Subrecipients will not receive payment from ODH grant funds used for prohibited purposes. ODH has the right to recover funds paid to Subrecipients for purposes later discovered to be prohibited.

AA. Audit: Subrecipients currently receiving funding from the ODH are responsible for submitting an independent audit report. Every subrecipient will fall into one of two categories which determine the type of audit documentation required.

Subrecipients that spend \$750,000 or more in federal awards per fiscal year are required to have a single audit which meets OMB's Federal Uniform Administrative Requirements. The subrecipient must submit, 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 nine months after the end of the Subrecipient's fiscal year. 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's Federal Uniform Administrative Requirements.

Subrecipients that expend less than the \$750,000 threshold require a financial audit conducted in accordance with Generally Accepted Government Auditing Standards. The Subrecipient must submit a copy of the audit report, the auditor's management letter, and a corrective action plan (if applicable) within 30 days of the receipt of the auditor's report, but no later than nine months after the end of the subrecipient's fiscal year. **The financial audit is not an allowable cost to the program.**

Once an audit is completed, a copy must be sent to <https://harvester.census.gov/facweb/> or to the ODH Grants Services Unit, (GSU) within 30 days. Reference:

OGAPP and OMB's Omni Circular Federal Uniform Administrative Requirements regarding Audits of States, Local Governments, and Non-Profit Organizations for additional audit requirements.

Subrecipient audit reports (finalized and published, and including the audit Management Letters, if applicable) **which include internal control findings, questioned costs or any other material 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.

AB. Submission of Application: Formatting Requirements:

- Properly label each item of the application packet (e.g., Budget Narrative, Program Narrative).
- Each section should use 1.5 spacing with one-inch margins.
- Program and budget narratives must be submitted in portrait orientation on 8 ½ by 11 paper.
- Number all pages (print on one side only).
- Program narrative should not exceed 25 pages (**excludes** appendices, attachments, budget and budget narrative).
- Use a 12-point Calibri font.
- Forms must be completed and submitted in the format provided by ODH.

The GMIS application submission must consist of the following:

**Complete &
Submit via
Internet**

1. Application Information
2. Project Narrative
3. Project Contacts
4. Budget
5. Civil Rights Review Questionnaire
6. Assurances Certification
7. Federal Funding Accountability and Transparency Act (FFATA) reporting form. Must have an active SAM.gov registration.
8. Change request in writing on agency letterhead **(Existing agency with tax identification number, name and/or address change(s))**.
9. If not previously submitted, if all federal funding expensed equals or exceeds \$750,000, upload the current audit to <https://harvester.census.gov/facweb/> or if less than \$750,000, email audit to audits@odh.ohio.gov.
10. Public Health Impact Statement Summary (non-health department only).
11. Statement of Support from the Local Health Districts (non-health department only).
12. Program-Specific Attachments:
 - Attachment #1 – Public Health Impact Statement Summary
 - Attachment #2 – Public Health Statement of Support from Local Health Districts
 - Attachment #3 – Deliverable-Objectives and Work Plan
 - Attachment #4 – Letter of Documentation
 - Attachment #5 – Deliverable Staff Contact Information Form
 - Attachment #6a– Biographical Sketch Instructions
 - Attachment #6b – Biographical Sketch Form
 - Attachment #7 – Position Descriptions
 - Attachment #8 – Data Assurances Form
 - Attachment #9 – User Access Form

II. APPLICATION REQUIREMENTS AND FORMAT

Agencies will receive GMIS access after the Notice of Intent to Apply for Funding is submitted to ODH.

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

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 ODH.

B. Budget: Prior to completion of the budget section, please review page 14-15 of the Solicitation for unallowable cost.

A 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 narrative may be used to identify additional funding information from other resources.

- 1. Primary Reason and Justification Pages:** For deliverable subgrants, provide a budget justification narrative (**Appendix C1**) outlining how the deliverables will be met.
- 2. Other Direct Costs:** Submit a budget for this section and the necessary form(s) to support costs for the period 07/01/2024 to 06/30/2025.

Funds may be used to support personnel, their training, travel (see OBM website)

<https://obm.ohio.gov/wps/portal/gov/obm/areas-of-interest/agency-overview/obm-travel-rule/obm-travel-rule> and supplies directly related to planning, organizing, and conducting the initiative/program/activity described in this announcement.

All subrecipient personnel paid using any portion of this subgrant must complete daily timesheets. Time & Effort reporting must be completed if staff are charged to multiple funding sources.

The applicant shall retain all original fully executed contracts on file. A completed “Confirmation of Contractual Agreement” (CCA) must be submitted via GMIS for each contract once it has been signed by both parties. All contracts must be signed and dated by all parties prior to any service being rendered and must be attached to the CCA section in GMIS. The submitted CCA and attached contract must be approved by ODH before contractual expenditures are authorized. CCAs and attached contracts cannot be submitted until the first quarter grant payment has been issued.

The applicant shall retain all original fully executed contracts on file.

- 3. Compliance Section:** Answer each question on this form in GMIS as accurately as possible. *Completion of the form ensures your agency’s compliance with the administrative standards of ODH and federal grants.*
- C. Assurances Certification:** Each subrecipient must submit the assurances (Federal and State Assurances for subrecipients) form within GMIS. This form is submitted as a part of each application via GMIS. The Assurances Certification sets forth 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 subrecipient agency acknowledges the financial standards of conduct as stated herein.

D. Project Narrative:

1. Executive Summary:

- Identify the target population, services, and programs to be offered and what agency or agencies will provide those services.
- Describe the burden of health disparities and health inequities related to this grant funding.
- Describe the public health problem(s) that the program will address.

Sickle Cell Program Application Guidance: *The Executive Summary should be no longer than ten (10) pages, using the grant formatting requirements described on page 16. Each response should reference the bullet to which they correspond.*

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

- Briefly discuss the applicant agency's eligibility to apply.
- Summarize the agency's structure as it relates to this program and, as the lead agency, how it will manage the program.
- Describe the capacity of your organization, its personnel, or contractors to communicate effectively and convey information in accordance with National Standards for Culturally and Linguistically Appropriate Services (CLAS) and Americans with disabilities Act (ADA) Standards for Effective Communication in a manner and method 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 (see standards below).
 - National CLAS Standards:
<https://thinkculturalhealth.hhs.gov/clas#:~:text=The%20National%20CLAS%20Standards%20are,cultural%20and%20linguistically%20appropriate%20services>.
 - ADA Standards for Effective Communication: <https://www.ada.gov/effective-comm.htm>.

Sickle Cell Program Application Guidance: *The Description of Applicant Agency/Documentation of Eligibility/Personnel should be no longer than five (5) pages, using the grant formatting requirements described on page 16. Each response should reference the bullet to which they correspond.*

3. Problem/Need:

- Identify and describe the local health status concern(s) that will be addressed by the program. Only provide national and state data if local data is not available. The specific health status concerns that the program intends to address may be stated in terms of disparity (e.g., population, location); health status (morbidity and/or mortality); or health system (e.g., accessibility, availability, affordability, appropriateness, quality of health services) indicators. The indicators should be measurable in order to serve as baseline data upon which evaluation will be based. Clearly identify the target population.
- Explicitly describe segments of the target population who experience a disproportionate burden for the health concern or issue; or who are at an increased risk for the problem addressed by this funding opportunity.
- Include a description of other agencies/organizations, in your area, also addressing this problem/need.

Sickle Cell Program Application Guidance: *The Problem/Need should be no longer than five (5) pages, using the grant formatting requirements described on page 16. Each response should reference the bullet to which they correspond.*

4. Methodology:

- In narrative form, identify the program goals, **SMARTIE** process, impact, or outcome objectives and activities. Indicate how they will be evaluated to determine the level of success of the program.
- If health disparities and/or health inequities have been identified, describe how program activities are designed to address these issues.
- Complete a Deliverable-Objective and Work plan (**Attachment #3**) to identify program deliverable-objectives, activities, person responsible for the implementation of each activity and the start/finish completion dates for each activity.

Sickle Cell Program Application Guidance: *The Methodology should be no longer than ten (10) pages (excluding the Deliverable-Objectives and Work Plan), using the grant formatting requirements described on page 16. Each response should reference the bullet to which they correspond.*

- E. Civil Rights Review Questionnaire — EEO Survey:** The Civil Rights Review Questionnaire Survey is a part of the Application Section of GMIS. Subrecipients must complete the questionnaire as part of the application process. This questionnaire is submitted online automatically with each application online.
- F. Federal Funding Accountability and Transparency Act (FFATA):** All applicants applying for ODH grants are required to complete the FFATA reporting form in GMIS. Applicants must ensure that the information contained in SAM.gov, and the FFATA reporting form match. ODH will hold all payments if an applicant's information does not successfully upload into the federal system.

All new applicants for ODH grants are required to register in SAM.gov and submit the information in the grant application. For information about System for Award Management (SAM) go to <https://beta.sam.gov/>.

Information on Federal Spending Transparency can be located at www.usaspending.gov.

Required by all applicants, the FFATA form is located on the GMIS Application page and must be completed to submit the application.)

- G. Attachment(s):** Attachments are documents which are not part of the standard GMIS application but are deemed necessary to a given grant program. All attachments must clearly identify the authorized program name and program number. All attachments submitted to GMIS must be attached in the "Project Narratives" section and be in one of the following formats: PDF, Microsoft Word or Microsoft Excel. Please see the GMIS bulletin board for instructions on how to submit attachments in GMIS. Attachments must be uploaded in GMIS **by 4:00 p.m. on or before Monday, January 29, 2023.**

Program Specific Documents

- **Medical Director/Medical Advisor:** Each subrecipient must identify and provide a signed *Letter of Documentation (Attachment #4)* for the Medical Director/Medical Advisor that will provide medical expertise and leadership to the deliverable team staff. A position description example for the Medical Director/Medical Advisor is provided as **Appendix E**.
- **Personnel:** Submit as an attachment with this application, a copy of the following:
 - *Deliverable Staff Contact Information Form (Attachment #5)* for all deliverable team staff who will be directly involved in project activities.
 - *Biographical Sketch Instructions (Attachment #6a)* and *Biographical Sketch Form (Attachment 6b)* for all staff listed on the *Deliverable Staff Contact information Form*.
 - *Position Description (Attachment #7)* for all staff in which a *Biographical Sketch* is submitted. If staff has not been selected for a vacant position, a description of the recruitment strategies for filling the position must be submitted.
- **Data Assurances Form (Attachment #8):** To provide signed assurance that the ODH Sickle Cell Program statements of data assurance will be in place by July 1, 2024.
- **User Access Form (Attachment #9):** To identify deliverable team staff who will need access to GMIS and/or access to the Maternal and Child Health Integrated Data System (MCHIDS)/Sickle Cell Event Database (SCED).

III APPENDICES

- A. Notice of Intent to Apply For Funding
- B. GMIS Access Request Form
- C. C1 Deliverable – Objective Descriptions
C2 Deliverable – Objective Allocations
- D. Application Review Form
- E. Medical Director/Medical Advisor Position Description Example
- F. Other Program Documents
 - Attachment #1 - Public Health Impact Statement Summary (*to be submitted with application*)
 - Attachment #2 – Statement of Support from Local Health Districts (*to be submitted with application*)
 - Attachment #3 - Deliverable-Objectives and Work Plan (*to be submitted with application*)
 - Attachment #4 – Letter of Documentation (*to be submitted with application*)
 - Attachment #5 – Deliverable Staff Contact Information Form(*to be submitted with application*)
 - Attachment #6a – Biographical Sketch Instructions
 - Attachment #6b – Biographical Sketch (*to be submitted with application*)
 - Attachment #7 – Position Descriptions (*to be submitted with application*)
 - Attachment #8 – Data Assurances Form (*to be submitted with application*)
 - Attachment #9 - User Access Form (*to be submitted with application*)

Appendix A

Reimbursement
Type

Select one of the
options below:

☐ Monthly

OR

☐ Quarterly

NOTICE OF INTENT TO APPLY FOR FUNDING

Ohio Department of Health Office of
Bureau of Child and Family Health

ODH Program Title:
Sickle Cell Initiative

Submission Required

See due date below.

New Applicants must submit the
GMIS Access form with the Notice of
Intent to Apply for Funding Form

ALL INFORMATION REQUESTED MUST BE COMPLETED.

County of Applicant Agency _____ Federal Tax Identification Number _____

Geographic Area Applying to Cover _____

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.

Type of Applicant Agency
(Check One)

☐

County Agency

☐

Hospital

☐

Local Schools

☐

City Agency

☐

Higher Education

☐

Not-for Profit

Applicant Agency/Organization _____

Applicant Agency Address _____

Agency Contact Person Name and Title _____

Telephone Number _____ E-mail Address _____

Agency Head (Print Name)

Agency Head (Signature)

Please note that the agency head listed above must match the agency head listed in GMIS. Unless a new agency, NOIAF's will not be accepted if name doesn't match what is listed in GMIS. If the agency head needs updated in GMIS, please include a letter on agency letterhead outlining the change. The new agency head's signature will be accepted with receipt of the update letter.

Does your agency have at least two staff members who currently have access to the ODH GMIS system? ☒ YES ☐ NO

If yes, no further action is needed. If no, ODH Grants Services Unit staff will email the GMIS reference guide to the email addresses listed on the GMIS Access Request form.

The NOIAF must be accompanied by the agency's Proof of Non-Profit status (if applicable) and Proof of Liability Coverage (if applicable). Potential applicants and current subrecipients are required to set-up and maintain their current supplier information in the State of Ohio Supplier Portal. This information includes, but is not limited to, Electronic Funds Transfer (EFT), 1099 Form and current address.

This information must be set-up and maintained in the following website: <http://supplier.ohio.gov/>.

Note: Subrecipients' future payments will be held if the agency receives a paper check due to the EFT information not being properly maintained in the supplier portal.

Forms are only required for NEW AGENCIES or if UPDATES are needed for current agencies. THE NOIAF AND REQUIRED FORMS MUST BE EMAILED TO Allyson.VanHorn@odh.ohio.gov BY **December 20, 2023**.

NOTE: NOIAF's will be considered late if any of the required forms listed above are not received by NEW AGENCIES by the due date. NOIAF's considered late will not be accepted.

Appendix B

This form must be submitted with the Notice of Intent to Apply for Funding Form for all new ODH applicants.

GMIS Training, User Access, Access Change or Deactivation Request

One request per person. Requests will only be honored when signed by your **Agency Head** or **Agency Financial Head** and complete. In addition, if a user leaves your agency, you are to notify ODH so that their account is rendered inactive and submit a form for the replacement. The user will receive his/her username and password via e-mail once the request is processed. *Refresher guides can be found on the ODH web site: <https://odh.ohio.gov/wps/portal/gov/odh/about-us/funding-opportunities/ODH-Grants/>. ODH Grants Page – “GMIS Training Resource” Section.*

Date: _____

Check the type of access and complete the information requested:

☐ Employee —needs GMIS Training

☐ New Employee —needs GMIS Access. Effective Date of Activation: _____

☐ Existing Employee —New GMIS User or GMIS User Access Change.

Effective/Change Date: _____

☐ Deactivation —User no longer needs access to ODH Application Gateway/GMIS 2.0 or GMIS 2.0 only: Effective Date of Deactivation (ODH Application Gateway/GMIS 2.0): _____

Or Effective Date of Deactivation (GMIS 2.0 access only): _____

Agency Name & Address: _____

Employee Name (no nicknames):

Employee Job Title:

Employee Office Phone Number:

Employee Office Fax Number:

Employee Office Email Address:

User Access Section: Please check all that applies and enter requested information: Email

Notifications: ☐ Yes ☐ No

GMIS Project Number(s) user needs access to: _____

Authorization Signature for User Access/Change/Deactivation:

Signature of Agency Head or Agency Financial Head

Printed Name of Agency Head or Agency Financial Head

To be completed by Grants System Officer ONLY—Date Received: _____ Date Processed: _____

Deliver Requests to Maria Kapenda, Data System Administrator, 614-620-5184

Scan & Email: Maria.Kapenda@odh.ohio.gov

Appendix C1

Name of Subgrant Program: Sickie Cell - Statewide Family Support Initiative

Budget Period: July 1, 2024 to June 30, 2025

of Deliverable-Objectives: 17

Use Budget Justification Scenario#: 3

100% Deliverables

Deliverable - Objective 1: Ensure Statewide Sickie Cell Services are Available to Ohioans

Total Amount Available: \$18,000.00

- **Deliverable 1.1** - By June 30, 2025, the subrecipient shall have an identifiable, functional (staffed) program organized for and capable of ensuring the provision of **statewide education, awareness and empowerment** activities to public/community, professional and adult priority population audiences related to sickie cell disease, sickie cell trait and other hemoglobinopathies. For staff in-office and/or "off-site" options, the purchase of expendable office supplies and equipment – necessary and reasonable for proper and efficient performance and administration of the program - are allowable costs under this deliverable. Reimbursement for this deliverable is \$1,500.00 per month or \$4,500.00 per quarter (*specify subrecipient reimbursement type*). **For reimbursement purposes, subrecipient staff under this deliverable must be listed on the Deliverable Staff Contact Information Form.** Total reimbursement for this deliverable is not to exceed the annual amount of \$18,000.00 per subrecipient.

NOTE: Subrecipient must follow the OGGAPP guidelines for purchase of office supplies and equipment. Reference Chapter 2, Section B2.5 - Other Directs Costs (page 40) and Section B2.6 - Equipment Costs (page 43) for more information. Failure to follow these guidelines may result in disallowance of costs.

ODH Validation: Submission of the *Deliverable Reimbursement Form* will be the initial documentation to release funds for this deliverable. To validate reimbursement for this deliverable, the subrecipient must submit (1) required SFY 2025 documents as specified by ODH Program and (2) vendor purchase invoice(s).

Deliverable - Objective 2: Statewide Outreach and Awareness Messages/Campaigns

Total Amount Available: \$24,000.00

- **Deliverable 2.1** - By June 30, 2025, subrecipient deliverable staff will implement/promote a minimum of one (1) statewide outreach and awareness message/campaign, *per month*, utilizing electronic and/or print mediums (*specify electronic and/or print mediums*) to increase the visibility of sickie cell services and empowerment resources in Ohio. For National Sickie Cell Awareness Month (*September 2024*) and World Sickie Cell Awareness Day (*June 19, 2025*), the subrecipient will also be required to develop (in collaboration with ODH Program) a social media toolkit for posting/distribution to public/community/professional/adult priority population stakeholders. The toolkit, at a minimum, must follow CLAS standards and include suggested organizations to like or follow, relevant hashtags, links to other resources, and template social media posts. Reimbursement for this deliverable is up to \$2,000.00 per month or \$6,000.00 per quarter (*specify subrecipient reimbursement type*). The subrecipient will be required to enter data into the Maternal and Child Health Integrated Data System (MCHIDS)/Sickie Cell Education Event Database (SCED) within ten (10) days of the message/campaign event. Total reimbursement for this deliverable is not to exceed the annual amount of \$24,000.00 per subrecipient.

NOTES:

1. *Messages/campaigns for hemoglobinopathies must adhere to the ownership copyright and verbiage/logo requirements as outlined in the Solicitation.*
2. *This is a flat rate deliverable. There is no additional reimbursement for MCHIDS/SCED data entry.*

ODH Validation: Submission of the *Deliverable Reimbursement Form* will be the initial documentation to release funds for this deliverable. To validate reimbursement for this deliverable, the subrecipient must submit the following documentation: (1) *Subrecipient Media Metrics Form* in GMIS under Expenditure Report Comments, and (2) social media toolkits to ODH Program.

Deliverable - Objective 3: Sickle Cell Events Targeting Adult Priority Populations

Total Amount Available: \$13,000.00

- **Deliverable 3.1** - By June 30, 2025, subrecipient deliverable staff will implement/participate in a minimum of twelve (12) sickle cell events (education and/or awareness) (*utilizing various instructional formats*) targeting adult priority populations to increase visibility and promote awareness of sickle cell services and resources in Ohio. At least six of these events must occur in areas with .75 SVI score or higher. This includes, but is not limited to, select Ohio Festivals and Annual Events (*e.g., Columbus Asian Festival, Ohio Black Expo*) and select National Health Observance Months/Days (*e.g., April/National Minority Health Month; May/National Stroke Awareness Month; June/World Sickle Cell Awareness Day; September/National Sickle Cell Awareness Month; November/American Diabetes Month*) to highlight hemoglobinopathies and their association/link with other health concerns. Reimbursement for this deliverable is up to \$1,000.00 per event and includes staff preparation, set-up and participation time, staff travel (as necessary), event materials, registration fees, exhibit/booth rental costs (*if applicable*), post-event follow-up and data entry into the MCHIDS/SCED within ten (10) days of the event. Total reimbursement for this deliverable is not to exceed the annual amount of \$13,000.00 per subrecipient.

ODH Validation: Submission of the *Deliverable Reimbursement Form* will be the initial documentation to release funds for this deliverable. To validate reimbursement for this deliverable, the subrecipient must enter data into the MCHIDS/SCED within ten (10) days of the event.

Deliverable - Objective 4: Sickle Cell Events Targeting Professionals and Providers

Total Amount Available: \$8,000.00

- **Deliverable 4.1** - By June 30, 2025, subrecipient deliverable staff will implement/participate in **statewide** sickle cell events (education and/or awareness), *utilizing various instructional formats*, targeting healthcare and non-healthcare professionals and providers (including professional associations and/or organizations) to increase the visibility of sickle cell services and resources in Ohio. Reimbursement for this deliverable is up to \$1,000.00 per event and includes staff preparation, set-up and participation time, staff travel (as necessary), event materials, registration fees, exhibit/booth rental costs (*if applicable*), post-event follow-up and data entry into the MCHIDS/SCED within ten (10) days of the event. Total reimbursement for this deliverable is not to exceed the annual amount of \$8,000.00 per subrecipient.

ODH Validation: Submission of the *Deliverable Reimbursement Form* will be the initial documentation to release funds for this deliverable. To validate reimbursement for this deliverable, the subrecipient must enter data into the MCHIDS/SCED within ten (10) days of the event.

Deliverable - Objective 5: Administrative Oversight and Subgrant Funding to the Ohio Sickle Cell Affected Families Association

Total Amount Available: \$8,250.00

- **Deliverable 5.1** - By June 30, 2025, the subrecipient will provide administrative oversight and distribute sub-grant funding to the Ohio Sickle Cell Affected Families Association (OSCAFA) for eligible Adult Sickle Cell Affected Family Support Groups (ASCAFSGs) in each of the six (6) ODH defined multi-county sickle cell services regions. This deliverable allows for sub-grant funding to be distributed to multiple eligible ASCAFSGs in the state. Each funded ASCAFSG will be required to implement a minimum of one (1) capacity-building activity during the reporting period. Reimbursement for this deliverable is as follows: (a) \$6,250.00 allocated to the OSCAFA for eligible ASCAFSGs and (b) \$2,000.00 allocated for administrative oversight. Total reimbursement for this deliverable is not to exceed the annual amount of \$8,250.00 per subrecipient.

NOTES:

1. *It will be the responsibility of the subrecipient to monitor the compliance of all ASCAFSGs that receive sub-grant funding.*
2. *This deliverable allows for sub-grant funding to be distributed to multiple ASCAFSGs in the state.*

ODH Validation: Submission of the *Deliverable Reimbursement Form* will be the initial documentation to release funds for this deliverable. To validate reimbursement for this deliverable, the subrecipient must submit the following documentation: (1) *Subrecipient Disbursement/Activity Form* in GMIS under Expenditure Report Comments and (2) list of eligible Ohio Adult Sickle Cell Affected Family Support Groups to ODH Program.

Deliverable - Objective 6: Ensure Empowerment Resources for Adults Living with Sickle Cell Disease

Total Amount Available: \$6,500.00

- **Deliverable 6.1** - By June 30, 2025, the subrecipient will ensure that empowerment resources are available to adults living with sickle cell disease. This deliverable requires the subrecipient to administrate the Empowerment Scholarship Fund (ESF). The ESF, through scholarship assistance, enables eligible individuals and/or families impacted by sickle cell disease to attend/participate in sickle cell-specific educational events. Total reimbursement for this deliverable is not to exceed the annual amount of \$6,500.00 per subrecipient.

ODH Validation: Submission of the *Deliverable Reimbursement Form* will be the initial documentation to release funds for this deliverable. To validate reimbursement for this deliverable, the subrecipient must document the following information (located in the ESF Guidelines) to ODH Program: (1) ESF Application Form, (2) ESF Scholarship Approval Form and (3) ESF Outcome Report Form.

Deliverable - Objective 7: Participation on External Groups, Programs or Organizations Representing Sickle Cell

Total Amount Available: \$1,500.00

- **Deliverable 7.1** - By June 30, 2025, subrecipient deliverable staff will actively participate (*virtually and/or in-person*) on a minimum of one (1) national and/or statewide group, program or organization (*external to the subrecipient agency*) that serves to impact the specific health disparity (*e.g., population, location*); health status (*e.g., morbidity and/or mortality*) or health system (*e.g., accessibility, availability, affordability, appropriateness, quality of health services*) concerns and/or priorities of Ohio individuals affected by sickle cell disease and other hemoglobinopathies. Reimbursement for this deliverable is up to \$83.34 per month/per staff member or \$250.00 per quarter/per staff member (*specify subrecipient reimbursement type*). **For reimbursement purposes, subrecipient deliverable staff must be listed on the *Deliverable Staff Contact Information Form*.** Total reimbursement for this deliverable is not to exceed the annual amount of \$1,000.00 per subrecipient.

ODH Validation: Submission of the *Deliverable Reimbursement Form* will be the initial documentation to release funds for this deliverable. To validate reimbursement for this deliverable, the subrecipient must submit the *External Meeting Verification Form* (with supporting documentation) in GMIS under Expenditure Report Comments.

- **Deliverable 7.2** - By June 30, 2025, the subrecipient will serve (*through yearly membership fees*) as the Sickle Cell Disease Association of America (SCDAA) – Ohio affiliate and keep ODH Program, Regional Sickle Cell Projects and Ohio Adult Sickle Cell Affected Family Support Groups apprised of SCDAA related information (via email) including, but not limited to: Updates, News, Advisories, Trainings and Program Announcements. Total reimbursement for this deliverable is not to exceed the annual amount of \$500.00 per subrecipient.

ODH Validation: Submission of the Deliverable Reimbursement Form will be the initial documentation to release funds for this deliverable. To validate reimbursement for this deliverable, the subrecipient must submit the following documentation in GMIS: (1) SCDAA membership fee invoice under Expenditure Report Comments and (2) tracking information on SCDAA sickle cell related emails on the Program Performance Report under Program Report Comments.

Deliverable - Objective 8: Statewide Sickle Cell Sabbath Event

Total Amount Available: \$1,037.50

- **Deliverable 8.1** - During the state designated Sickle Cell Sabbath (SCS) weekend (*September 21-22, 2024*), the subrecipient will plan and implement a minimum of one (1) **statewide** SCS activity (*utilizing various instructional formats*), in coordination and collaboration with ODH Program and **statewide** faith-based leaders of various denominations (*e.g., ministerial alliances/associations/headquarters*). The subrecipient will be required to enter data into the MCHIDS/SCED within ten (10) days of the Sabbath events(s). Total reimbursement for this deliverable is not to exceed the annual amount of \$1,037.50 per subrecipient.

ODH Validation: Submission of the *Deliverable Reimbursement Form* will be the initial documentation to release funds for this deliverable. To validate reimbursement for this deliverable, the subrecipient must enter data into the MCHIDS/SCED within ten (10) days of the SCS event.

Deliverable - Objective 9: Procurement of Educational Materials to Maintain a Statewide Hemoglobinopathy Clearinghouse and Resource Center

Total Amount Available: \$2,500.00

- **Deliverable 9.1** - By June 30, 2025, the subrecipient will establish and maintain a clearinghouse and resource center of hemoglobinopathy education materials for **statewide** distribution to public/community, professional and adult priority population audiences. Education materials must be current, of professional quality, culturally, age, language, and literacy appropriate and available upon request. This deliverable includes materials that are purchased and/or printed through external vendors (*including digital and audio materials*) and internal departmental printing costs. The subrecipient will be required to (a) develop/maintain informative content which outlines available newborn screening and outreach education services/activities/programs funded by ODH Program and (b) submit a source listing document of hemoglobinopathy education materials available for statewide distribution. Total reimbursement for this deliverable is not to exceed the annual amount of \$2,500.00 per subrecipient.

NOTES:

1. *It is recommended that education materials comply with [CDC Clear Communication Index](#) criteria, [Federal Plain Language Guidelines](#) and/or agency standards for the development of public communication materials.*
2. *Costs associated with the content of any work produced under this grant (project specific) must be pre-approved by ODH Program. Failure to follow these approval guidelines may result in the disallowance of costs.*
3. *All educational material purchases (through external vendors) must be completed in the first three quarters of the grant period (as applicable). Any purchases outside of the prescribed time must be pre-approved by ODH Program.*

ODH Validation: Submission of the *Deliverable Reimbursement Form* will be the initial documentation to release funds for this deliverable. To validate reimbursement for this deliverable, the subrecipient must submit the following documentation in GMIS under Expenditure Report Comments: (1) ODH approved subrecipient informative content; (2) source listing of hemoglobinopathy education materials; and (3) vendor purchase/print invoice(s).

Deliverable - Objective 10: Professional Development

Total Amount Available: \$2,562.50

- **Deliverable 10.1** - By June 30, 2025, subrecipient deliverable staff will complete a minimum of one (1) professional development activity to advance their knowledge in the following priority focus areas: health equity and/or culturally and linguistically appropriate service (CLAS) delivery. Type of activities under this deliverable include conference sessions, seminars/presentations, workshops, and/or course. Reimbursement for this deliverable is up to \$150.00 per activity/per staff member. **For reimbursement purposes, subrecipient staff under this deliverable must be listed on the *Deliverable Staff Contact Information Form*.** Total reimbursement for this deliverable is not to exceed the annual amount of \$600.00 per subrecipient.

NOTE: *Includes online and virtual fee-based activities. Physical attendance is limited to activities in Ohio. Subrecipient agency mandated professional development and/or in-service trainings may also count towards this professional development requirement, as long the activity meets the criteria for the priority focus areas identified in the deliverable.*

ODH Validation: Submission of the *Deliverable Reimbursement Form* will be the initial documentation to release funds for this deliverable. To validate reimbursement for this deliverable, the subrecipient must submit the *Professional Development Verification Form* (with supporting documentation) in GMIS under Expenditure Report Comments.

- **Deliverable 10.2** – During year one (1) of the grant cycle (SFY 2025), subrecipient deliverable staff will complete the Cincinnati Hemoglobinopathy Counselor Training Course (*presented by the Cincinnati Comprehensive Sickle Cell Center*). **For reimbursement purposes, subrecipient deliverable staff must be listed on the *Deliverable Staff Contact Information Form*.** Total reimbursement for this deliverable is not to exceed the annual amount of \$1,962.50 per subrecipient.

ODH Validation: Submission of the *Deliverable Reimbursement Form* will be the initial documentation to release funds for this deliverable. To validate reimbursement for this deliverable, subrecipient deliverable staff must submit the following documentation in GMIS: (1) certificate of course completion and (2) course registration receipt under Expenditure Report Comments.

Deliverable - Objective 11: Data Collection and Reporting

Total Amount Available: \$1,450.00

- **Deliverable 11.1** - By June 30, 2025, the subrecipient will prepare and submit a Program Performance Report (PPR). The PPR will report progress on program performance measures. The PPR must be submitted electronically, either monthly or quarterly (*specify subrecipient reimbursement type*), by the due date and in the format specified by ODH Program. Reimbursement for this deliverable is \$100.00 per month or \$300.00 per quarter (*specify subrecipient reimbursement type*). Total reimbursement for this deliverable is not to exceed the annual amount of \$1,200.00 per subrecipient.

ODH Validation: Submission of the *Deliverable Reimbursement Form* will be the initial documentation to release funds for this deliverable. To validate reimbursement for this deliverable, the subrecipient must submit the PPR in GMIS under Program Report Comments.

- **Deliverable 11.2** – By June 30, 2025, the subrecipient will prepare and submit an Annual Report Worksheet (ARW) to report project profile information and/or significant accomplishments/achievements. The ARW must be submitted electronically by the due date and in the format specified by ODH Program. Total reimbursement for this deliverable is not to exceed the annual amount of \$250.00 per subrecipient.

ODH Validation: Submission of the *Deliverable Reimbursement Form* will be the initial documentation to release funds for this deliverable. To validate reimbursement for this deliverable, the subrecipient must submit the ARW electronically by the due date and in the format specified by ODH Program.

Deliverable - Objective 12: Subrecipient Communication with ODH Program

Total Amount Available: \$1,200.00

- **Deliverable 12.1** - By June 30, 2025, subrecipient will participate in meeting formats as required by ODH Program. In-person meetings will be held Columbus. Virtual meetings will be held on the Microsoft (MS) Teams communication platform. Subrecipient deliverable staff will be required to engage in the full functionality of the Teams platform, including but not limited to, the ability to: 1) speak or share video; 2) view and participate in meeting chat; 3) respond to meeting polls; 4) share content (*if presenter*); 5) view a PowerPoint file (*if shared by someone else*); and 6) collaborate interactively in a shared space (*e.g., Whiteboard, Mentimeter*). **Call in (audio only) participation for MS Teams meetings will not be a reimbursable option under this deliverable.** Reimbursable options will include meeting participation via the Teams app or Teams on the web. Meeting formats for this deliverable will include quarterly check-in meetings (\$100.00 per meeting), bi-annual deliverable staff meeting (\$150.00 per meeting) and a stakeholder meeting (\$500.00). **For reimbursement purposes, subrecipient staff under this deliverable must be listed on the *Deliverable Staff Contact Information Form*.** Total reimbursement for this deliverable is not to exceed the annual amount of \$1,200.00 per subrecipient.

ODH Validation: Submission of the *Deliverable Reimbursement Form* will be the initial documentation to release funds for this deliverable. To validate reimbursement for this deliverable, attendance will be taken during meeting formats. Subrecipient deliverable staff representation or an ODH approved designee is required at all meeting formats. Attendance verification methods include a sign-in sheet (*for in-person meetings*) and roll call via MS Teams chat and/or MS Teams Participant Attendance Report (*for virtual meetings*).

Deliverable - Objective 13: Engaging the Community

Total Amount Available: \$2,500.00

- **Deliverable 13.1** - By January 10, 2025, the subrecipient will submit the results of the **Community Engagement Assessment Tool** (CEAT) and provide a list of community stakeholders (*adults living with sickle cell disease*) who were invited to participate in the survey. Total reimbursement for this deliverable is not to exceed the annual amount of \$1,500.00 per subrecipient.

ODH Validation: Submission of the *Deliverable Reimbursement Form* will be the initial documentation to release funds for this deliverable. To validate reimbursement for this deliverable, the subrecipient must (1) submit the list of community stakeholders (*adults living with sickle cell disease*) invited to participate in the CEAT survey and (2) submit the results of the CEAT survey.

Deliverable - Objective 13: Engaging the Community

Total Amount Available: \$1,000.00

- **Deliverable 13.2** - By April 10, 2025, the subrecipient will submit a **Community Engagement Action Plan** that will improve and enhance the engagement with community stakeholders (*adults living with sickle cell disease*) in one (1) identified area (as determined by the survey tool). Total reimbursement for this deliverable is not to exceed the annual amount of \$1,000.000 per subrecipient.

ODH Validation: Submission of the *Deliverable Reimbursement Form* will be the initial documentation to release funds for this deliverable. To validate reimbursement for this deliverable, the subrecipient must submit an action plan focusing on one (1) indicator from the CEAT.

Appendix C2

Name of Subgrant Program: Sickie Cell Family Support

Budget Period: 07/01/2024 to 06/30/2025

of Deliverables: 17

Use Budget Justification Scenario #: 3

X Deliverables Only

	Deliverable 1.1 Ensure Statewide Sickie Cell Services are Available to Ohioans	Deliverable 2.1 Objective 2: Statewide Outreach and Awareness Messages/Campaigns	Deliverable 3.1 Sickie Cell Events Targeting Adult Priority Populations	Deliverable 4.1 Sickie Cell Events Targeting Professionals and Providers	Deliverable 5.1 Administrative Oversight and Subgrant Funding to the Ohio Sickie Cell Affected Families Association	Deliverable 6.1 Ensure Empowerment Resources for Adults Living with Sickie Cell Disease	Deliverable 7.1 Participation on External Groups, Programs or Organizations Representing Sickie Cell	Deliverable 7.2 Participation on External Groups, Programs or Organizations Representing Sickie Cell	Deliverable 8.1 Statewide Sickie Cell Sabbath Event
Statewide Family Support	\$18,000.00	\$24,000.00	\$13,000.00	\$8,000.00	\$8,250.00	\$6,500.00	\$1,000.00	\$500.00	\$1,037.50
TOTAL	\$18,000.00	\$24,000.00	\$13,000.00	\$8,000.00	\$8,250.00	\$6,500.00	\$1,000.00	\$500.00	\$1,037.50

	Deliverable 9.1 Procurement of Educational Materials to Maintain a Statewide Hemoglobinopathy Clearinghouse and Resource Center	Deliverable 10.1 Professional Development	Deliverable 10.2 Professional Development	Deliverable 11.1 Data Collection and Reporting	Deliverable 11.2 Data Collection and Reporting: Annual Report Worksheet	Deliverable 12.1 Subrecipient Communication with ODH Program	Deliverable 13.1 Engaging the Community: Community Engagment Tool	Deliverable 13.2 Engaging the Community: Community Engagment Action Plan	Total
Statewide Family Support	\$2,500.00	\$600.00	\$1,962.50	\$1,200.00	\$250.00	\$1,200.00	\$500.00	\$1,500.00	\$90,000.00
TOTAL	\$2,500.00	\$600.00	\$1,962.50	\$1,200.00	\$250.00	\$1,200.00	\$500.00	\$1,500.00	\$90,000.00

Appendix D

APPLICATION REVIEW FORM
State Fiscal Year: July 1, 2024 to June 30, 2025

ODH Program: Sickle Cell – Statewide Family Support Initiative

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 (1-7) listed below, record the appropriate point value in the Reviewers Score Column. Individual section scores should not exceed the maximum points. Strengths/Weaknesses and Special Conditions should be recorded in the appropriate areas.

	Max	Reviewer Score	Comments: Strengths/Weaknesses
Section 1. <u>Public Health Impact Statement Summary</u>(not to exceed one page)			
Applicant identifies the Public Health Accreditation Board (PHAB) Standard(s) to be addressed by grant activities.	1		
Applicant describes the demographic characteristics of the target population and the geographic area in which they live.	2		
Applicant includes a summary of the services to be provided or activities to be conducted.	1		
Applicant includes a plan to coordinate and share information with appropriate local health district(s).	1		
Public Health Impact Statement Summary Total	5		
Public Health Impact Statement Summary Special Condition(s): 			

Appendix D

APPLICATION REVIEW FORM State Fiscal Year: July 1, 2024 to June 30, 2025

ODH Program: Sickle Cell – Statewide Family Support Initiative

	Max	Reviewer Score	Comments: Strengths, Weaknesses
Section 2. <u>Formatting Requirements</u>			
Applicant properly labeled each item of the application packet (e.g., <i>Budget Narrative, Program Narrative</i>),	2		
Applicant uses 1.5 spacing with one-inch margins for each section.	2		
Applicant submits the program and budget narratives in portrait orientation on 8 ½ by 11 paper.	1		
Applicant numbers all pages (print on one side only).	1		
Applicant does not exceed the maximum twenty (20) pages in the Program Narrative section (excludes appendices, attachments, budget, and budget narrative).	2		
Applicant uses a 12-Calibri point font.	1		
Applicant completes and submits forms in the format provided by ODH.	1		
Formatting Requirements Total	10		
Formatting Requirements Special Condition(s):			

Appendix D

APPLICATION REVIEW FORM State Fiscal Year: July 1, 2024 to June 30, 2025

ODH Program: Sickle Cell – Statewide Family Support Initiative

	Max	Reviewer Score	Comments: Strengths, Weaknesses
Section 3. <u>Primary Reason and Justification Pages</u>			
Applicant provides a budget justification narrative (Appendix C1) outlining how the deliverable(s) will be met.	8		
Applicant includes the required certification language on the budget justification narrative. Budget justification narrative is also signed by the agency head.	2		
Applicant submits in GMIS a biographical sketch (Attachment #6b) for all core team staff working on project deliverables. Program staff are well qualified by training and/or experience for their roles in the program.	5		
Applicant submits position descriptions (Attachment #7) for all deliverable staff in which a biographical sketch is submitted.	5		
Primary Reason and Justification Pages Total	20		
Primary Reason and Justification Pages Special Condition(s):			

Appendix D

APPLICATION REVIEW FORM
State Fiscal Year: July 1, 2024 to June 30, 2025

ODH Program: Sickle Cell – Statewide Family Support Initiative

	Max	Reviewer Score	Comments: Strengths, Weaknesses
Section 4. Project Narrative: <i>Executive Summary (not to exceed 5 pages)</i>			
Applicant identifies the target population, services and programs to be offered.	4		
Applicant identifies what agency or agencies will provide those services.	2		
Applicant describes the burden of health disparities and health inequities related to grant funding.	2		
Applicant describes the public health problem(s) that the program will address.	2		
Executive Summary Total	10		
Executive Summary Special Condition(s):			

Appendix D

APPLICATION REVIEW FORM State Fiscal Year: July 1, 2024 to June 30, 2025

ODH Program: Sickle Cell – Statewide Family Support Initiative

	Max	Reviewer Score	Comments: Strengths, Weaknesses
Section 5. <i>Description of Applicant Agency/Documentation of Eligibility/Personnel</i> (not to exceed 5 pages)			
Applicant briefly discusses the applicant agency's eligibility to apply.	2		
Applicant summarizes the agency's structure as it relates to this program and, as the lead agency, how it will manage the program.	3		
Applicant describes the capacity of the organization, its personnel, or contractors to communicate effectively and convey information in accordance with CLAS and ADA Standards for Effective Communication manner in a manner and method 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.	10		
Description of Applicant Agency/Documentation of Eligibility/Personnel Total	15		
Description of Applicant Agency/Documentation of Eligibility/Personnel Special Condition(s):			

Appendix D

APPLICATION REVIEW FORM State Fiscal Year: July 1, 2024 to June 30, 2025

ODH Program: Sickle Cell – Statewide Family Support Initiative

	Max	Reviewer Score	Comments: Strengths, Weaknesses
Section 6. Project Narrative: <i>Problem/Need</i> (not to exceed 5 pages)			
Applicant identifies and describes the local health status concern(s) that will be addressed by the program.	5		
Applicant only restates national and state data if local data is not available.	3		
Applicant discusses the specific health status concerns that the program intends to address in terms of <u>disparity</u> (e.g., population, location), <u>health status</u> (e.g., morbidity and/or mortality) <u>or health system</u> (e.g., accessibility, availability, affordability, appropriateness, quality of health services) indicators.	10		
Applicant explicitly describes segments of the target population who experience a <u>disproportionate</u> burden for the health concern or issue; or who are at an increased risk for the problem addressed by this funding opportunity.	5		
Applicant includes a description of other agencies/organizations, in the state, also addressing this problem/need.	2		
Problem/Need Total	25		
Problem/Need Special Condition(s):			

Appendix D

APPLICATION REVIEW FORM
State Fiscal Year: July 1, 2024 to June 30, 2025

ODH Program: Sickle Cell – Statewide Family Support Initiative

	Max	Reviewer Score	Comments: Strengths, Weaknesses
Section 7. Project Narrative: <u>Methodology Section</u> (not to exceed 10 pages, excluding Deliverable-Objectives and Work Plan)			
In narrative form, applicant identifies the program goals, S.M.A.R.T.I.E process, impact or outcome objectives and activities and indicates how they will be evaluated to determine the level of success of the program.	5		
Applicant describes how program activities are designed to address health disparities and/or health inequities issues, if they have been identified.	10		
Applicant completes a Deliverable - Objectives and Work Plan (Attachment #3) to identify program objectives, activities, person responsible for the implementation of each activity and the start/finish completion dates for each activity.	15		
Methodology Total	30		
Methodology Section Special Condition(s):			
POINT VALUES (1-7)	115	/115	
TOTAL SCORES	115	/115	

Appendix D

APPLICATION REVIEW FORM State Fiscal Year: July 1, 2024 to June 30, 2025

ODH Program: Sickie Cell – Statewide Family Support Initiative

	Max	Reviewer Score	Comments: Strengths, Weaknesses
Section 8. Additional Requirements/Documentation <i>(To be completed by ODH Program Staff-No Point Value Assigned)</i>			
Applicant submits the Letter of Documentation (Attachment #4) from the Medical Director/Medical Advisor to be associated with the agency.	Yes	No	
Applicant submits the Deliverable Staff Information Contact Form (Attachment #5).	Yes	No	
Applicant submits a Biographical Sketch for all core team staff (Attachment #6b)	Yes	No	
Applicant submits Position Descriptions (Attachment #7).	Yes	No	
Applicant submits a signed Data Assurances Form (Attachment #8).	Yes	No	
Applicant submits a User Access Form (Attachment #9).	Yes	No	
Applicant lists Project Director as a “User” in GMIS on the Project Contacts page.	Yes	No	
Additional Requirements/Documentation Special Condition(s)			

Appendix E

POSITION DESCRIPTION EXAMPLE Medical Director/Medical Advisor

PURPOSE

The role of the Medical Director/Medical Advisor is to provide medical leadership and expertise to the sickle cell project staff under this initiative. The position of Medical Director is associated with hospital-based projects. The Medical Advisor position is associated with community-based projects. This is an in-kind position.

RESPONSIBILITIES OF THE MEDICAL DIRECTOR/MEDICAL ADVISOR

Pursuant to the purpose of the ODH Sickle Cell Services Program, the Medical Director/Medical Advisor may function directly or consultatively as follows:

- A. Provide guidance for the medical referral and follow-up process of individuals diagnosed with hemoglobinopathy.
- B. Serve as a medical consultant to subrecipient staff regarding the interpretation of laboratory test results for hemoglobinopathies (*if applicable*).
- C. Provide medical expertise about hemoglobinopathies and represent the subrecipient within the medical community.
- D. Review and approve (in accordance with ODH ownership copyright guidelines) medical content in educational presentations and materials.
- E. Provide education to healthcare and non-healthcare professionals, the public/community and adult priority populations on hemoglobinopathies.
- F. Attend ODH Medical Director/Medical Advisor meeting, as required by ODH Program.
- G. Participate in ODH monitoring activities (e.g., project self-assessment, desk review, site visit, etc.), as required by ODH Program.
- H. Serve as a medical liaison between the statewide project and the community of individuals affected by hemoglobinopathies.

EXAMPLE QUALIFICATIONS

- The Medical Director/Medical Advisor should be a board-certified hematologist with expertise in the management of individuals with sickle cell disease and treatment-related complications.
- If the Medical Director/Medical Advisor is not a board-certified hematologist, at a minimum, he/she must be a licensed physician with expertise in the management of individuals with sickle cell disease.

Program-Specific Attachments

Attachment #1

SFY 2025 PUBLIC HEALTH IMPACT STATEMENT SUMMARY

Include:

Applicants are required to submit a summary of the proposal to local health districts prior to submitting the grant application to ODH. The program summary, **not to exceed one page**, must include PHAB Standard to be addressed by grant activities.

- **Standard 4.1:** Engage with the Public Health System and the Community in Identifying and Addressing Health Problems through Collaborative Processes.

The applicant must submit the above summary as part of the 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 PHAB Standards.

Submit the Public Health Impact Statement Summary as an upload in GMIS under Program Narrative Attachments.

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

Attachment #2

SFY 2025 PUBLIC HEALTH IMPACT STATEMENT OF SUPPORT FROM LOCAL HEALTH DISTRICTS

Include:

A statement of support was obtained from the following local health districts (*list name of health districts below*) in the region. Statements of support must be signed, dated and on official letterhead.

- 1.
- 2.
- 3.
- 4.

Include:

A statement of support was not obtained from the following local health districts (*list name of health districts below*) in the region.

- 1.
- 2.
- 3.
- 4.

Include:

The number of local (city and county) health districts in the state: _____

A listing of health districts is available at the following website: <https://odh.ohio.gov/find-local-health-districts>.

Submit the Public Health Impact Statement(s) of Support obtained from the local health districts as an upload in GMIS under Project Narrative Attachments.

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

Attachment #3

ODH Program Title: Sickle Cell - Statewide Family Support Initiative

DELIVERABLE-OBJECTIVES AND WORK PLAN

State Fiscal Year: July 1, 2024 to June 30, 2025

Applicant Agency: _____

GMIS Project #: _____

Deliverable – Objective (1): Ensure Statewide Sickle Cell Services are Available to Ohioans.

One deliverable, numbered sequentially, per page. Submit in format provided by ODH Program. Number each page.

(1) Deliverable-Objective	(2) Work Plan Activities (Responsible Party)	(3) Timelines/ Start/Finish	(4) Performance Measures	(5) ODH Program Validation/Data Source
<p>Deliverable 1.1 - By June 30, 2025, the subrecipient shall have an identifiable, functional (staffed) unit or program organized for and capable of ensuring the provision of statewide education, awareness and empowerment activities to public/community, professional, and adult priority population audiences related to sickle cell disease, sickle cell trait and other hemoglobinopathies. For staff in-office and/or “off-site” options, the purchase of expendable office supplies and/or equipment – necessary and reasonable for proper and efficient performance and administration of the program - are allowable costs under this deliverable.</p> <p>Refer to Appendix C1 for complete deliverable language and reimbursement information.</p> <p>NOTE: <i>This is a required deliverable (Deliverable 1.1).</i></p>			<p>1.1 (a) Subrecipient submits the SFY 2025 Deliverable Reimbursement Form (with the days per week/month/quarter and deliverable staff information) together with the GMIS Expenditure Report and SFY 2025 Program Performance Report <i>(submitted either monthly or quarterly based on subrecipient reimbursement type)</i>.</p> <p>1.1 (b) Subrecipient purchases expendable office supplies and/or equipment <i>(if applicable)</i>.</p>	<ul style="list-style-type: none">• SFY 2025 documents to be submitted with application:<ul style="list-style-type: none">○ Deliverable Reimbursement Form○ Deliverable Staff Contact Information Form○ Data Assurances Form○ User Access Form○ Biographical Sketch○ Position Descriptions○ Letter of Documentation• SFY 2025 Deliverable Reimbursement Form• SFY 2025 Program Performance Report• Vendor purchase invoice(s)

Attachment #3

ODH Program Title: Sickle Cell - Statewide Family Support Initiative

DELIVERABLE-OBJECTIVES AND WORK PLAN

State Fiscal Year: July 1, 2024 to June 30, 2025

Applicant Agency: _____

GMIS Project #: _____

Deliverable – Objective (2): Statewide Outreach and Awareness Messages/Campaigns

One deliverable, numbered sequentially, per page. Submit in format provided by ODH Program. Number each page.

(1) Deliverable-Objective	(2) Work Plan Activities (Responsible Party)	(3) Timelines/ Start/Finish	(4) Performance Measures	(5) ODH Program Validation/Data Source
<p>Deliverable 2.1 -By June 30, 2025, subrecipient deliverable staff will implement/promote a minimum of one (1) statewide outreach and awareness message/campaign, <i>per month</i>, utilizing electronic and/or print mediums (<i>specify electronic and/or print mediums</i>) to increase the visibility of sickle cell services and empowerment resources in Ohio. For National Sickle Cell Awareness Month (<i>September 2024</i>) and World Sickle Cell Awareness Day (<i>June 19, 2025</i>), the subrecipient will also be required to develop (in collaboration with ODH Program) a social media toolkit for posting/distribution to public/community/professional/adult priority population stakeholders. The toolkit, at a minimum, must include suggested organizations to like or follow, relevant hashtags, links to other resources, and template social media posts.</p> <p>Refer to Appendix C1 for complete deliverable language and reimbursement information.</p> <p>NOTE: <i>This is a required deliverable (Deliverable 2.1).</i></p>			<p>2.1 (a) The number of statewide outreach and awareness messages/campaigns implemented/promoted, <i>per month</i>, utilizing electronic and print mediums entered into Maternal Child Health Integrated Data System (MCHIDS)/Sickle Cell Event Database (SCED) within 10 days of the event.</p> <p>2.1 (b) The audience numbers (<i>reach and frequency</i>) generated by statewide outreach messages/campaigns.</p> <p>2.1 (c) The number of social media tool kits developed (in collaboration with ODH Program)</p>	<ul style="list-style-type: none">• MCHIDS/SCED• SFY 2025 MCHIDS/SCED User Guide• SFY 2025 Deliverable Reimbursement Form• SFY 2025 Subrecipient Media Metrics Form (<i>reach and frequency report</i>)• Social media tool kit(s) for National Sickle Cell Awareness Month (September 2024) and World Sickle Cell Day (June 2025)• SFY 2025 Program Performance Report

Attachment #3

ODH Program Title: Sickie Cell - Statewide Family Support Initiative

DELIVERABLE-OBJECTIVES AND WORK PLAN

State Fiscal Year: July 1, 2024 to June 30, 2025

Applicant Agency: _____

GMIS Project #: _____

Deliverable – Objective (3): Sickie Events Targeting Adult Priority Populations

One deliverable, numbered sequentially, per page. Submit in format provided by ODH Program. Number each page.

(1) Deliverable-Objective	(2) Work Plan Activities (Responsible Party)	(3) Timelines/ Start/Finish	(4) Performance Measures	(5) ODH Program Validation/Data Source
<p>Deliverable 3.1 - By June 30, 2025, subrecipient deliverable staff will implement/participate in a minimum of twelve (12) sickie cell events (education and/or awareness) (<i>utilizing various instructional formats</i>) <u>targeting</u> adult priority populations to increase visibility and promote awareness of sickie cell services and resources in Ohio. At least six of these events must occur in areas with .75 SVI score or higher. This includes, but is not limited to, select Ohio Festivals and Annual Events (<i>e.g., Columbus Asian Festival, Ohio Black Expo</i>) and select National Health Observance Months/Days (<i>e.g., April/National Minority Health Month; May/National Stroke Awareness Month; June/World Sickie Cell Day; September/National Sickie Cell Awareness Month; November/American Diabetes Month</i>) to highlight hemoglobinopathies and their association/link with other health concerns.</p> <p>Refer to Appendix C1 for complete deliverable language and reimbursement information.</p> <p>NOTE: <i>This is a required deliverable (Deliverable 3.1).</i></p>			<p>3.1 (a) The number of statewide sickie cell events <u>targeting</u> the adult priority populations (during select Ohio Festivals and Annual Events) entered into MCHIDS/SCED within 10 days of the event.</p> <p>3.1 (b) The audience numbers generated by participation in select Ohio Festivals and Annual Events.</p> <p>3.1 (c) The number of statewide sickie cell events <u>targeting</u> the adult priority populations (during select National Health Observance Months/Days) entered into MCHIDS/SCED within 10 days of the event.</p> <p><i>Continued on next page</i></p>	<ul style="list-style-type: none"> • MCHIDS/SCED • SFY 2025 Deliverable Reimbursement Form • SFY 2025 Program Performance Report <p><i>Continued on next page</i></p>

ODH Program Title: Sickle Cell - Statewide Family Support Initiative

DELIVERABLE-OBJECTIVES AND WORK PLAN
State Fiscal Year: July 1, 2024 to June 30, 2025

Applicant Agency: _____ GMIS Project #: _____

Deliverable – Objective (3): Sickle Events Targeting Adult Priority Populations

One deliverable, numbered sequentially, per page. Submit in format provided by ODH Program. Number each page.

(1) Deliverable-Objective	(2) Work Plan Activities (Responsible Party)	(3) Timelines/ Start/Finish	(4) Performance Measures	(5) ODH Program Validation/Data Source
Deliverable 3.1 (continued)			3.1 (d) The audience numbers generated by participation in select National Health Observance Months..	<ul style="list-style-type: none">• MCHIDS/SCED• SFY 2025 Deliverable Reimbursement Form• SFY 2025 Program Performance Report

ODH Program Title: Sickie Cell - Statewide Family Support Initiative

DELIVERABLE-OBJECTIVES AND WORK PLAN
State Fiscal Year: July 1, 2024 to June 30, 2025

Applicant Agency: _____ GMIS Project #: _____

Deliverable- Objective (4): Sickie Cell Events Targeting Professionals and Providers

One deliverable, numbered sequentially, per page. Submit in format provided by ODH Program. Number each page.

(1) Deliverable-Objective	(2) Work Plan Activities (Responsible Party)	(3) Timelines/ Start/Finish	(4) Performance Measures	(5) ODH Program Validation/Data Source
<p>Deliverable 4.1 - By June 30, 2025, subrecipient deliverable staff will implement/participate in statewide sickie cell events (education and/or awareness), <i>utilizing various instructional formats, <u>targeting</u> health care and non-healthcare professionals and providers</i> (including professional associations and/or organizations) to increase the visibility of sickie cell services and resources in Ohio.</p> <p>Refer to Appendix C1 for complete deliverable language and reimbursement information.</p> <p>NOTE: <i>This is a required deliverable (Deliverable 4.1).</i></p>			<p>4.1 (a) The number of statewide sickie cell events <u>targeting</u> health care and non-healthcare professionals and providers entered into MCHIDS/SCED within 10 days of the event.</p> <p>4.1 (b) The audience numbers generated by participation in sickie cell events to health care and non-healthcare professionals and providers.</p>	<ul style="list-style-type: none">• MCHIDS/SCED• SFY 2025 Deliverable Reimbursement Form• SFY 2025 Program Performance Report

Attachment #3

ODH Program Title: Sickie Cell - Statewide Family Support Initiative

DELIVERABLE-OBJECTIVES AND WORK PLAN

State Fiscal Year: July 1, 2024 to June 30, 2025

Applicant Agency: _____

GMIS Project #: _____

Deliverable- Objective (5): Administrative Oversight and Subgrant Funding to the Ohio Sickie Cell Affected Families Association

One deliverable, numbered sequentially, per page. Submit in format provided by ODH Program. Number each page.

(1) Deliverable-Objective	(2) Work Plan Activities (Responsible Party)	(3) Timelines/ Start/Finish	(4) Performance Measures	(5) ODH Program Validation/Data Source
<p>Deliverable 5.1 - By June 30, 2025, the subrecipient will provide administrative oversight and distribute sub-grant funding to the Ohio Sickie Cell Affected Families Association (OSCAFA) for <u>eligible</u> Adult Sickie Cell Affected Family Support Groups (ASCAFSGs) in each of the six (6) ODH defined multi-county sickie cell service regions. Each funded ASCAFSG will be required to implement a minimum of one (1) capacity building activity during the reporting period.</p> <p>Refer to Appendix C1 for complete deliverable language and reimbursement information.</p> <p>NOTE: <i>This is a required deliverable (Deliverable 5.1).</i></p>			<p>5.1 (a) The number of eligible ASCAFSGs that <u>request, apply and receive</u> subgrant funding.</p> <p>5.1 (b) The number of sub-grant funded ASCAFSGs that implement a minimum of one (1) capacity building activity in each of the six (6)ODH-defined multi-county service regions.</p> <p>5.1 (c)The number (including dates) of administrative meetings, site visits and/or conference calls implemented by the subrecipient with sub-grant funded ASCAFSGs.</p>	<ul style="list-style-type: none">• SFY Deliverable Reimbursement Form• SFY 2025 OSCAFA Guidelines• OSCAFA Funding Disbursement/Activity letter• SFY 2025 list of eligible Adult Sickie Cell Affected Family Support Groups• SFY 2025 Program Performance Report

Attachment #3

ODH Program Title: Sickie Cell - Statewide Family Support Initiative

DELIVERABLE-OBJECTIVES AND WORK PLAN

State Fiscal Year: July 1, 2024 to June 30, 2025

Applicant Agency: _____

GMIS Project #: _____

Deliverable- Objective (6): Ensure Empowerment Resources for Adults Living with Sickie Cell Disease

One deliverable, numbered sequentially, per page. Submit in format provided by ODH Program. Number each page.

(1) Deliverables-Objective	(2) Work Plan Activities (Responsible Party)	(3) Timelines/ Start/Finish	(4) Performance Measures	(5) ODH Program Validation/Data Source
<p>Deliverable 6.1 – By June 30, 2025, the subrecipient will ensure that empowerment resources are available to adults living with sickie cell disease. This deliverable requires the subrecipient to administrate the Empowerment Scholarship Fund (ESF). The ESF, through scholarship assistance, enables <u>eligible</u> individuals and/or families impacted by sickie cell disease to attend/participate in sickie cell-specific educational events.</p> <p>Refer to Appendix C1 for complete deliverable language and reimbursement information.</p> <p>NOTE: <i>This is a required deliverable (Deliverable 6.1)</i></p>			<p>6.1 (a) The number of eligible individuals/families impacted by sickie cell disease who <u>request</u> scholarship assistance to attend/participate in a sickie cell-specific educational event funded through the ESF.</p> <p>6.1 (b) The number of eligible individuals /families impacted by sickie cell disease who <u>receive</u> scholarship assistance to attend/participate in a sickie cell-specific educational event funded through the ESF.</p> <p>6.1 (c) The number of individuals/families who complete and submit Outcome Report Forms as per ESF guidelines.</p>	<ul style="list-style-type: none">• SFY 2025 Deliverable Reimbursement Form• SFY 2025 Empowerment Scholarship Fund Guidelines• SFY 2025 Program Performance Report

Attachment #3

ODH Program Title: Sickie Cell - Statewide Family Support Initiative

DELIVERABLE-OBJECTIVES AND WORK PLAN

State Fiscal Year: July 1, 2024 to June 30, 2025

Applicant Agency: _____

GMIS Project #: _____

Deliverable- Objective (7): Participation in External Groups, Programs or Organizations Representing Sickie Cell

One deliverable, numbered sequentially, per page. Submit in format provided by ODH Program. Number each page.

(1) Deliverable-Objective	(2) Work Plan Activities (Responsible Party)	(3) Timelines/ Start/Finish	(4) Performance Measures	(5) ODH Program Validation/Data Source
<p>Deliverable 7.1 By June 30, 2025, subrecipient deliverable staff will <u>actively participate</u> (<i>virtually and/or in-person</i>) on a minimum of one (1) national and/or statewide group, program or organization (<i>external to the subrecipient agency</i>) that serves to impact the specific health disparity (<i>e.g., population, location</i>); health status (<i>e.g., morbidity and/or mortality</i>); or health system (<i>e.g., accessibility, availability, affordability, appropriateness, quality of health services</i>) concerns and/or priorities of Ohio individuals affected by sickie cell disease and other hemoglobinopathies.</p> <p>Refer to Appendix C1 for complete deliverable language and reimbursement information.</p> <p>NOTE: Excludes the subrecipient Medical Director/Medical Advisor</p> <p>NOTE: <i>This is a required deliverable (Deliverable 7.1).</i></p>			<p>7.1 (a) The number of national and/or statewide groups, programs, or organizations that subrecipient deliverable staff have <u>active participation</u> in during the reporting period.</p> <p>7.1 (b) The number and percent of meetings attended by subrecipient deliverable staff.</p>	<ul style="list-style-type: none">• SFY 2025 Deliverable Reimbursement Form• SFY 2025 External Meeting Verification Form (with supporting documentation)• SFY 2025 Program Performance Report

Attachment #3

ODH Program Title: Sickle Cell - Statewide Family Support Initiative

DELIVERABLE-OBJECTIVES AND WORK PLAN

State Fiscal Year: July 1, 2024 to June 30, 2025

Applicant Agency: _____

GMIS Project #: _____

Deliverable- Objective (7): Participation in External Groups, Programs or Organizations Representing Sickle Cell

One deliverable, numbered sequentially, per page. Submit in format provided by ODH Program. Number each page.

(1) Deliverable-Objective	(2) Work Plan Activities (Responsible Party)	(3) Timelines/ Start/Finish	(4) Performance Measures	(5) ODH Program Validation/Data Source
<p>Deliverable 7.2 - By June 30, 2025, the subrecipient will serve <i>(through yearly membership fees)</i> as the Sickle Cell Disease Association of America (SCDAA) – Ohio affiliate and keep ODH Program, Regional Sickle Cell Projects and Ohio Adult Sickle Cell Affected Family Support Groups (OASCAFSGs) apprised of SCDAA related information (via email) including, but not limited to: Updates, News, Advisories, Trainings, and Program Announcements.</p> <p>Refer to Appendix C1 for complete deliverable language and reimbursement information.</p> <p>NOTE: <i>This is a required deliverable (Deliverable 7.2).</i></p>			<p>7.2 (a) The subrecipient is a member of the National Organization - SCDAA. Inc.</p> <p>7.2 (b) The number of SCDAA sickle cell-related emails sent to ODH Program, Regional Sickle Cell Projects, and OASCAFSGs.</p>	<ul style="list-style-type: none">• SFY 2025 Deliverable Reimbursement Form• SCDAA membership fee invoice• SFY 2025 Program Performance Report• Tracking information on SCDAA sickle cell related emails.

ODH Program Title: Sickle Cell - Statewide Family Support Initiative

DELIVERABLE-OBJECTIVES AND WORK PLAN
State Fiscal Year: July 1, 2024 to June 30, 2025

Applicant Agency: _____ GMIS Project #: _____

Deliverable- Objective (8): Statewide Sickle Cell Sabbath Event

One deliverable, numbered sequentially, per page. Submit in format provided by ODH Program. Number each page.

(1) Deliverable-Objective	(2) Work Plan Activities (Responsible Party)	(3) Timelines/ Start/Finish	(4) Performance Measures	(5) ODH Program Validation/Data Source
<p>Deliverable 8.1 - During the state designated Sickle Cell Sabbath (SCS) weekend (<i>September 21-22, 2024</i>), the subrecipient will plan and implement a minimum of one (1) statewide SCS activity (<i>utilizing various instructional formats</i>), in coordination and collaboration with statewide faith-based leaders of various denominations (e.g., ministerial alliances/associations/headquarters).</p> <p>Refer to Appendix C1 for complete deliverable language and reimbursement information.</p> <p>NOTE: <i>This is a select deliverable (Deliverable 8.1).</i></p>	4		<p>8.1 (a) The number of statewide SCS events <u>targeting</u> statewide faith-based leaders/headquarters entered into MCHIDS/SCED within 10 days of the event.</p> <p>8.1 (b) The audience numbers generated by statewide SCS events to faith-based leaders/headquarters.</p>	<ul style="list-style-type: none">• MCHIDS/SCED• SFY 2025 Deliverable Reimbursement Form• SFY 2025 Program Performance Report

Attachment #3

ODH Program Title: Sickie Cell - Statewide Family Support Initiative

DELIVERABLE-OBJECTIVES AND WORK PLAN

State Fiscal Year: July 1, 2024 to June 30, 2025

Applicant Agency: _____

GMIS Project #: _____

Deliverable- Objective (9): Procurement of Educational Materials to Maintain a Statewide Hemoglobinopathy Clearinghouse and Resource Center

One deliverable, numbered sequentially, per page. Submit in format provided by ODH Program. Number each page.

(1) Deliverable-Objective	(2) Work Plan Activities (Responsible Party)	(3) Timelines/ Start/Finish	(4) Performance Measures	(5) ODH Program Validation/Data Source
<p>Deliverable 9.1 - By June 30, 2025, the subrecipient will establish and maintain a clearinghouse and resource center of hemoglobinopathy education materials for statewide distribution to public/community, professional and adult priority population audiences. Education materials must be current, of professional quality, culturally, age, language, and literacy appropriate and available upon request. This deliverable includes materials that are purchased and/or printed through external vendors (<i>including digital and audio materials</i>) and internal departmental printing costs. The subrecipient will also be required to (a) develop/maintain informative content which outlines available newborn screening and outreach education services/activities/programs funded by ODH Program and (b) submit a source listing document of education materials available for statewide distribution.</p> <p>Refer to Appendix C1 for complete deliverable language and reimbursement information.</p> <p>NOTE: <i>This is a required deliverable (Deliverable 9.1).</i></p>			<p>9.1 (a) Educational materials are purchased, maintained and readily available for distribution to public/community, professional and adult priority population audiences.</p> <p>9.1 (b) Informative content is developed and maintained by subrecipient that outlines services/activities/programs funded by ODH Program.</p> <p>9.1 (c) Subrecipient submits a Source Listing document of educational materials (project-specific and public domain) available for distribution.</p>	<ul style="list-style-type: none">• SFY 2025 Deliverable Reimbursement Form• ODH approved informative content submitted as specified by ODH program• SFY 2025 Source listing document submitted as specified by ODH• Vendor purchase/print invoices(s)• SFY 2025 Program Performance Report

Attachment #3

ODH Program Title: Sickie Cell - Statewide Family Support Initiative

DELIVERABLE-OBJECTIVES AND WORK PLAN

State Fiscal Year: July 1, 2024 to June 30, 2025

Applicant Agency: _____

GMIS Project #: _____

Deliverable- Objective (10): Professional Development

One deliverable, numbered sequentially, per page. Submit in format provided by ODH Program. Number each page.

(1) Deliverable-Objective	(2) Work Plan Activities (Responsible Party)	(3) Timelines/ Start/Finish	(4) Performance Measures	(5) ODH Program Validation/Data Source
<p>Deliverable 10.1 - By June 30, 2025, subrecipient deliverable staff will complete a minimum of one (1) professional development activity to advance their knowledge in the following grant <u>priority focus areas</u>: health equity and/or culturally and linguistically appropriate service (CLAS) delivery. Type of activities under this deliverable include conference sessions, seminars/presentations, workshops, and/or course.</p> <p>Refer to Appendix C1 for complete deliverable language and reimbursement information.</p> <p>NOTE: <i>This is a required deliverable (Deliverable 10.1).</i></p>			<p>10.1 100% of the deliverable staff complete the minimum requirement of one (1) professional development activity related to priority <u>focus areas</u>.</p>	<ul style="list-style-type: none">• SFY 2025 Deliverable Reimbursement Form• SFY 2025 Professional Development Verification Form (with supporting documentation)• Vendor purchase receipt/invoice(s)• SFY 2025 Program Performance Report

ODH Program Title: Sickie Cell - Statewide Family Support Initiative

DELIVERABLE-OBJECTIVES AND WORK PLAN
State Fiscal Year: July 1, 2024 to June 30, 2025

Applicant Agency: _____ GMIS Project #: _____

Deliverable- Objective (10): Professional Development

One deliverable, numbered sequentially, per page. Submit in format provided by ODH Program. Number each page.

(1) Deliverables	(2) Work Plan Activities (Responsible Party)	(3) Timelines/ Start/Finish	(4) Performance Measures	(5) ODH Program Validation/Data Source
<p>Deliverable 10.2 – During year one (1) of the grant cycle (SFY 2025), subrecipient deliverable staff will complete the Hemoglobinopathy Counselor Training Course <i>(presented by the Cincinnati Comprehensive Sickie Cell Center)</i>.</p> <p>Refer to Appendix C1 for complete deliverable language and reimbursement information.</p> <p>NOTE: <i>This is a required deliverable (Deliverable 10.2).</i></p>	.		10.2 100% of the deliverable staff complete the Hemoglobinopathy Counselor Training Course during year one (1) of the grant cycle.	<ul style="list-style-type: none">• SFY 2025 Deliverable Reimbursement Form• SFY 2025 Professional Development Verification Form (with supporting documentation)• Certificate of course completion• Course registration receipt• SFY 2025 Program Performance Report

Attachment #3

ODH Program Title: Sickle Cell - Statewide Family Support Initiative

DELIVERABLE-OBJECTIVES AND WORK PLAN
State Fiscal Year: July 1, 2024 to June 30, 2025

Applicant Agency: _____

GMIS Project #: _____

Deliverable- Objective (11): Data Collection and Reporting

One deliverable, numbered sequentially, per page. Submit in format provided by ODH Program. Number each page.

(1) Deliverable-Objective	(2) Work Plan Activities (Responsible Party)	(3) Timelines/ Start/Finish	(4) Performance Measures	(5) ODH Program Validation/Data Source
<p>Deliverable 11.1 - By June 30, 2025, the subrecipient will prepare and submit a <u>Program Performance Report</u> (PPR) to report progress on program performance measures. The PPR must be submitted electronically in GMIS, either monthly or quarterly (<i>specify subrecipient reimbursement type</i>), by the due date and in the format specified by ODH Program.</p> <p>Refer to Appendix C1 for complete deliverable language and reimbursement information.</p> <p>NOTE: <i>This is a required deliverable (Deliverable 11.1).</i></p>			<p>11.1 The subrecipient submits the completed PPR electronically in GMIS, either monthly or quarterly (<i>specify subrecipient reimbursement type</i>) to report progress on program performance measures.</p>	<ul style="list-style-type: none">• SFY 2025 Deliverable Reimbursement Form• SFY 2025 Program Performance Report

Attachment #3

ODH Program Title: Sickie Cell - Statewide Family Support Initiative

DELIVERABLE-OBJECTIVES AND WORK PLAN

State Fiscal Year: July 1, 2024 to June 30, 2025

Applicant Agency: _____

GMIS Project #: _____

Deliverable- Objective (11): Data Collection and Reporting

One deliverable, numbered sequentially, per page. Submit in format provided by ODH Program. Number each page.

(1) Deliverable-Objective	(2) Work Plan Activities (Responsible Party)	(3) Timelines/ Start/Finish	(4) Performance Measures	(5) ODH Program Validation/Data Source
<p>Deliverable 11.2 – By June 30, 2025, the subrecipient will prepare and submit an <u>Annual Report Worksheet</u> (ARW) to report project profile information and/or significant accomplishments/achievements. The ARW must be submitted electronically by the due date and in the format specified by ODH Program.</p> <p>Refer to Appendix C1 for complete deliverable language and reimbursement information.</p> <p>NOTE: <i>This is a required deliverable (Deliverable 11.2).</i></p>			11.2 The subrecipient submits the completed ARW to report project profile information and/or significant accomplishments/achievements	<ul style="list-style-type: none">• ARW (<i>Submit with the June Expenditure Report or the 4th Quarter Expenditure Report – based on subrecipient reimbursement type</i>)• SFY 2025 Deliverable Reimbursement Form• SFY 2025 Program Performance Report

ODH Program Title: Sickle Cell - Statewide Family Support Initiative

DELIVERABLE-OBJECTIVES AND WORK PLAN
State Fiscal Year: July 1, 2024 to June 30, 2025

Applicant Agency: _____ GMIS Project #: _____

Deliverable- Objective (12): Subrecipient Communication with ODH Program

One deliverable, numbered sequentially, per page. Submit in format provided by ODH Program. Number each page.

(1) Deliverables	(2) Work Plan Activities (Responsible Party)	(3) Timelines/ Start/Finish	(4) Performance Measures	(5) ODH Program Validation/Data Source
<p>Deliverable 12.1 - By June 30, 2025, subrecipient deliverable staff will participate in meeting formats as required by ODH Program. <u>In-person meetings</u> will be held in Columbus. <u>Virtual meetings</u> will be held on the Microsoft Teams communication platform. Meeting formats for this deliverable include quarterly check-in meetings, bi-annual deliverable staff meetings and a stakeholder meeting.</p> <p>Refer to Appendix C1 for complete deliverable language and reimbursement information.</p> <p>NOTE: <i>This is a required deliverable (Deliverable 12.1).</i></p>			12.1 Subrecipient deliverable staff representation or an ODH approved designee at all meeting formats.	<ul style="list-style-type: none">• Sign-in sheet (<i>for in-person meetings</i>)• Roll call via MS Teams chat and/or MS Teams Participant Attendance Report (<i>for virtual meetings</i>)• SFY 2025 Deliverable Reimbursement Form• SFY 2025 Program Performance Report

ODH Program Title: Sickie Cell - Statewide Family Support Initiative

DELIVERABLE-OBJECTIVES AND WORK PLAN
State Fiscal Year: July 1, 2024 to June 30, 2025

Applicant Agency: _____ GMIS Project #: _____

Deliverable- Objective (13): Engaging the Community

One deliverable, numbered sequentially, per page. Submit in format provided by ODH Program. Number each page.

(1) Deliverables	(2) Work Plan Activities (Responsible Party)	(3) Timelines/ Start/Finish	(4) Performance Measures	(5) ODH Program Validation/Data Source
<p>Deliverable 13.1 - By January 10, 2025, the subrecipient will submit the results of the Community Engagement Assessment Tool (CEAT) and provide a list of community stakeholders (<i>adults living with sickle cell disease</i>) who were invited to participate in the survey.</p> <p>Refer to Appendix C1 for complete deliverable language and reimbursement information.</p> <p>NOTE: <i>This is a required deliverable (Deliverable 13.1).</i></p>			<p>13.1 (a) The subrecipient submits the list of community stakeholders (<i>adults living with sickle cell disease</i>) who were invited to participate in the CEAT survey as specified by ODH Program.</p> <p>13.1 (b) The subrecipient submits the results of the CEAT survey (in Survey Monkey) as specified by ODH Program.</p>	<ul style="list-style-type: none">• SFY 2025 Deliverable Reimbursement Form• SFY 2025 Subrecipient Survey Monkey CEAT results• SFY 2025 Deliverable Reimbursement Form• SFY 2025 Program Performance Report

ODH Program Title: Sickie Cell - Statewide Family Support Initiative

DELIVERABLE-OBJECTIVES AND WORK PLAN
State Fiscal Year: July 1, 2024 to June 30, 2025

Applicant Agency: _____ GMIS Project #: _____

Deliverable- Objective (13): Engaging the Community

One deliverable, numbered sequentially, per page. Submit in format provided by ODH Program. Number each page.

(1) Deliverable-Objective	(2) Work Plan Activities (Responsible Party)	(3) Timelines/ Start/Finish	(4) Performance Measures	(5) ODH Program Validation/Data Source
<p>Deliverable 13.2 - By April 10, 2025, the subrecipient will submit a Community Engagement Action Plan that will improve and enhance the engagement with community stakeholders (<i>adults living with sickle cell disease</i>) in one (1) identified area (as determined by the survey tool).</p> <p>Refer to Appendix C1 for complete deliverable language and reimbursement information.</p> <p>NOTE: <i>This is a required deliverable (Deliverable 13.2).</i></p>			<p>13.2 The subrecipient submits an action plan focusing on one (1) indicator from the CEAT.</p>	<ul style="list-style-type: none">SFY 2025 Deliverable Reimbursement FormSubrecipient Community Engagement Plan

Attachment #4

**SFY 2025
LETTER OF DOCUMENTATION**

Include:

The applicant must identify and provide a letter of documentation from the Medical Director/Medical Advisor that will provide medical leadership and expertise to the sickle cell project under this initiative. The position of Medical Director is associated with hospital-based projects. The Medical Advisor position is associated with community-based projects. This is an in-kind position.

The letter of documentation must be **signed, dated on official letterhead and document the relationship – including roles and responsibilities - of the Medical Director/Medical Advisor and the applicant.**

Refer to Appendix E for an example of the Medical Director/Medical Advisor position.

Submit the Letter of Documentation as an upload in GMIS under Project Narrative Attachments.

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

Attachment #5

**SFY 2025
DELIVERABLE STAFF CONTACT INFORMATION FORM**

Agency Name *(as listed n GMIS)* _____

GMIS Project # _____

Deliverable Staff Position	Staff Name	Staff Credentials	Telephone Number (<u>include</u> extension)	Work E-mail Address

Person Completing Form: _____

Signature of Project Director: _____

Attachment #6a

**SFY 2025
BIOGRAPHICAL SKETCH**

Include:

The applicant must submit a biographical sketch for all staff listed on the *Deliverable Staff Contact Information Form (Attachment #5)*. Each biographical sketch, **not to exceed four (4) pages**, must include:

- Education/Training
- Personal Statement
- Positions and Honors
- Professional Appointments and Memberships
- Certifications

A biographical sketch is not required for the Medical Director/Medical Advisor.

Submit Biographical Sketches as an upload in GMIS under Project Narrative Attachments.

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

Attachment #6b

SFY 2025
BIOGRAPHICAL SKETCH

Provide the following information for all project staff.
Follow this format for each person. **DO NOT EXCEED FOUR PAGES.**

NAME:		POSITION TITLE:	
EDUCATION/TRAINING <i>(Begin with baccalaureate or other initial professional education, include postdoctoral training, if applicable). Add/delete rows as necessary.</i>			
INSTITUTION AND LOCATION	DEGREE	COMPLETION DATE MM/YYYY	FIELD OF STUDY

- A. Personal Statement**
Briefly describe why your experience and qualifications make you particularly well-suited for your role in the project that is the subject of this application.
- B. Positions and Honors**
Begin with current position, then list in reverse chronological order, relevant previous employment and experience. List any honors under a separate category.
- C. Professional Appointments and Memberships**
Begin with current appointments and/or memberships, then list in reverse chronological order, relevant professional appointments and/or memberships.
- D. Certifications**
List any current certifications that would be applicable to your role in the project (*e.g., Certified Health Education Specialist – CHES*).

Attachment #7

**SFY 2025
POSITION DESCRIPTIONS**

Include:

The applicant must provide a position description for all project staff in which a biographical sketch is submitted.

If a staff member has not been selected for a vacant position, a narrative description of the job information and responsibilities must be documented and submitted in GMIS.

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

Submit Position Descriptions as an upload in GMIS under Project Narrative Attachments.

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

Attachment #8

Ohio Department of Health
Bureau of Child and Family Health
Sickle Cell Services Program

SFY 2025 Data Assurances

Sickle Cell – Statewide Family Support initiative

1. Assurance that all data obtained and generated under this grant will be owned by ODH.
2. Assurance that the Health Insurance Portability and Accountability Act (HIPAA) is instituted in the agency.
3. Assurance that appropriate safeguards are in place to secure confidential and sensitive information if/when teleworking. The teleworker(s) must effectively safeguard information and obtain necessary software and/or physical equipment to secure confidential and sensitive information.
4. Assurance that disclosing information and records received from ODH, including patient identifying health information and protected health information, is strictly prohibited, unless authorized by state or federal law.
5. Assurance that notice will be provided to ODH upon receiving any requests for records provided by ODH.
6. Assurance that prior approval must be provided by ODH in order to utilize secure ODH data in any type of published journal articles, research, posters, presentations, etc.
7. Assurance that, except for as stated herein, no third-party entity will have access to the records and information provided by ODH.
8. Assurance of compliance with confidentiality provisions in accordance with federal and state laws, federal regulations, and the administrative rules of ODH. Further, assurance that data will be accessed only by authorized employees and officials.
9. Assurance that information and records provided by ODH will be stored in an area where access by unauthorized persons is restricted during duty hours, as well as non-duty hours or when not in use. ODH records will be processed and utilized in a manner that will protect the confidentiality of the records and stored on a secure server and/or in a secure system in such a way that unauthorized persons cannot retrieve any such data by computer, remote terminal, or other means.

Agency Name (as listed in n GMIS):	GMIS Project Number:
Institutional Signatory:	
<hr/>	
[Signature]	
<hr/>	
[Print Name & Title]	
<hr/>	
[Date]	

Attachment #9

**SFY 2025
USER ACCESS FORM**

Agency Name (as listed in GMIS): _____

GMIS Project Number: _____

(A) First Name, Last Name	(B) Deliverable Staff Position <i>(as listed in the Standards and Criteria)</i>	(C) Work Email Address	(D) User access to GMIS 2.0? ¹ (✓ Check one)		(E) User access to MCHIDS/SCED? ² (✓ Check one)	
			YES	NO	YES	NO

¹For access to GMIS, complete and upload the GMIS Access Request Form (Appendix B).
²Access to MCHIDS/SCED will be provided to successful applicants subsequent to official notification from ODH Program.