OHIO DEPARTMENT OF HEALTH

246 North High Street
Columbus, Ohio 43215

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John R. Kasich/Governor

Lance Himes/Director of Health

Date: December 21, 2018

To: Hospital Preparedness Program (HPP) Grant Applicants

From: Tamara McBride, Chief
Office of Health Preparedness
Ohio Department of Health

Subject: HPP Competitive Solicitation FY20-July 1, 2019-June 30, 2024

The Ohio Department of Health (ODH), Office of Health Preparedness (OHP), is announcing the availability of grant funds to support the HPP Program. The goal of the HPP Program is to help address bioterrorism, infectious disease outbreaks, other public health threats, and emergencies at the county and regional public health level.

The total amount of funds to be awarded is **$4,817,191**. The funds will be awarded regionally as follows:

1.	Northeast Region	$750,068
2.	Northwest Region	$706,188
3.	Northeast Central Region	$867,735
4.	West Central Region	$450,047
5.	Southwest Region	$675,267
6.	Central Region	$886,965
7.	Southeast Region	$258,018
8.	Southeast Central Region	$222,903

These funding levels are determined by the Assistant Secretary of Preparedness and Response (ASPR) and are contingent upon the availability of funds.

All interested parties must submit a Notice of lntent to Apply for Funding (NOIAF) form, by **Monday, December 31, 2018** to be eligible to apply for funding (attached to the solicitation).

All potential applicants are encouraged to attend a Bidder's Conference call on **December 27, 2018 from 2:00 pm to 4:00pm**. The Bidder's Conference will provide an opportunity for interested parties to learn more about the solicitation. Information regarding date, time and instructions will be provided to those who submit a Notice of Intent to Apply for Funding (NOIAF).

All grant applications must be submitted online using the Grant Management Information System (GMIS 2.0) Interested applicants who have not completed the GMIS 2.0 training previously must do so to be eligible for funding. To sign up for the GMIS 2.0 training, complete and return the training form that is attached to the solicitation. This training will allow you to submit an application online.

The solicitation will provide detailed information about the background, intent and scope of the grant, policies, procedures, performance expectations, and general information and requirements associated with the administration of the grant.

Please contact Monique Witherspoon, Preparedness Monitoring Program Unit manager at (614) 644-1912,
or by e-mail at monique.witherspoon@odh.ohio.gov, if you have any questions regarding this application.

Mail the original and two (2) copies of the material not electronically filed to:

Ohio Department of Health
Grants Services Unit
Central Master Files, 4th Floor
246 N. High Street

ALL APPLICATIONS MUST BE SUBMITTED VIA THE INTERNET

OHIO DEPARTMENT OF HEALTH

OFFICE OF HEALTH PREPAREDNESS

REGIONAL HEALTHCARE SYSTEM COORDINATION FOR DISASTER PREPAREDNESS PROGRAM-HPP

FOR

FISCAL YEAR 2020

07/01/2019 – 06/30/2024

Local Public Applicant Agencies
Non-Profit Applicants

COMPETITIVE GRANT APPLICATION INFORMATION

100% Deliverable Funding

Revised 09/11/2017
For grant starts 4/1/2018 and thereafter

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I. APPLICATION SUMMARY AND GUIDANCE

An application for an Ohio Department of Health (ODH) grant consists of a number of required components including an electronic portion submitted via the Internet website "ODH Application Gateway" and various paper forms and attachments. All of 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 **Monday, December 31, 2018** so access to the application via the Internet website "ODH Application Gateway" 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. Request for Taxpayer Identification Number and Certification (W-9), and Authorization Agreement for Direct Deposit of EFT Payments Form (EFT).

The above-mentioned forms are located on the Ohio Department of Administrative Services website at: http://ohiosharedservices.ohio.gov/SupplierOperations/Forms.aspx
or directly at the following websites:

- **Request for Taxpayer Identification Number and Certification (W-9)**
  https://www.irs.gov/pub/irs-pdf/fw9.pdf
- **Authorization Agreement for Direct Deposit of EFT Payment Form (EFT)**
  http://www.ohiosharedservices.ohio.gov/SupplierOperations/doc/EFT_Payment_Authorization_OBM4310.pdf
- **Supplier Information Form**
  http://www.ohiosharedservices.ohio.gov/SupplierOperations/doc/Supplier_Information_Form_OBM5657.pdf

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

A. Policy and Procedure: 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: *http://www.odh.ohio.gov*.
(Click on Grant/Contracts, ODH Grants, Grants Administrative Policies and Procedures Manual (OGAPP)) or copy and paste the following link into your web browser: *https://odh.ohio.gov/odh/about-us/funding-opportunities/resources/grants-administrative-policies-and-procedures-manual*.

Refer to Policy and Procedure updates found on the GMIS bulletin board.

All budget justifications must include the following language and be signed by the agency head listed in GMIS. Refer to the budget justification examples listed on the GMIS bulletin board.

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 agency policy regarding 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: Regional Healthcare System Coordination for Disaster Preparedness (Also known as HPP)

C. Purpose: The Ohio Department of Health is the state agency responsible for oversight of the Hospital Preparedness Program (HPP) which is funded through the Assistant Secretary for Preparedness and Response (ASPR). HPP funding enables the healthcare delivery system to save lives during emergencies and disaster events that exceed the day-to-day capacity and capability of existing health and emergency response systems. HPP is the only source of federal funding for healthcare delivery readiness, intended to improve patient outcomes, minimize the need for federal and supplemental state resources during emergencies, and enable rapid recovery.

HPP prepares the healthcare delivery system to save lives through the development of Healthcare Coalitions (HCCs) that incentivize diverse and often competitive healthcare organizations with differing priorities and objectives to work together.

A **Healthcare Coalition (HCC)** is a group of individual healthcare and response organizations (e.g., hospitals, emergency medical services (EMS), emergency management agencies (EMA), public health agencies, etc.) in a defined geographic location. HCCs play a critical role in developing healthcare delivery system preparedness and response capabilities. HCCs serve as a multi-agency coordinating group that supports and integrates ESF-8 activities in the context of incident command system (ICS) responsibilities.

HCCs coordinate activities among healthcare organizations and other stakeholders in their communities; these entities comprise HCC members that actively contribute to HCC strategic planning, operational planning and response, information sharing, and resource coordination and management. As a result, HCCs collaborate to ensure each member has what it needs to respond to emergencies and planned events, including medical equipment and supplies, real-time information, communication systems, and educated and trained healthcare personnel.

An **Assistant Secretary for Preparedness and Response (ASPR)** funded hospital in Ohio is defined as:

- A general, specialty heart, pediatric, or burns hospital under the Ohio Revised Code 3701.07,
- A Healthcare Coalition member active in their Regional Healthcare Coalition,
- A hospital with a demonstrated commitment to improving the preparedness capabilities of their healthcare delivery system to save lives during emergencies and disaster events by:
    1. Attending Regional Healthcare Coalition meetings hosted by the Regional Healthcare Coordinator,
    2. Ensuring processes are in place to request, receive, and dispense medical countermeasures (MCM) received from the Ohio Department of Health (ODH),
    3. Completing Multi-Agency Radio Communication System (MARCS) radio checks as facilitated by ODH,
    4. Completing information required through the Ohio Points of Dispensing (OPOD) online system and ensures that information is regularly updated and maintained,
    5. Ensuring information is accurate within the Ohio Public Health Communication System (OPHCS), and regularly participates in any drills.

This grant will provide funds to Regional Healthcare Coalitions to coordinate Ohio's healthcare delivery system to effectively plan for and coordinate a surge response during an emergency that may impact the public's health, including training and exercising for such a response. Funds will continue to support existing infrastructure while improving, where needed, additional opportunities to enhance planning and coordination, interoperable communications, and increased situational awareness. **A portion of the grant funding must be distributed among all ASPR funded hospitals and all members of the healthcare coalition executive steering committee, with no agency receiving less than $1,000.**

D. Qualified Applicants: *Eligible applicants must meet the following criteria:*

- Be a public or non-profit agency located within Ohio

- With the application, submit no less than 10 letters of support from members of the Regional Healthcare Coalition. There must be at least one letter of support from each of the core member disciplines (hospitals, emergency medical services (EMS), emergency management agencies (EMA), and public health agencies).

Applicant agencies must attend or document in writing prior attendance at Grants Management Information System (GMIS) training and must have the capacity to accept an electronic funds transfer (EFT). If an applicant agency needs GMIS training prior to the establishment of access to the application, then a GMIS training form must be submitted (Appendix B). GMIS training must occur no later than, January 15, 2019.

Upon notification of award (receipt of NOA) for the Regional Healthcare System Coordination for Disaster Preparedness grant, agencies must adhere to the following requirements:

- Identify an individual to fulfill the Regional Healthcare Coordinator (RHC) role within 60 days.
- Submit an updated Attachment #1 immediately upon filling the RHC position.
- The identified RHC must demonstrate NIMS compliance through the completion of, at a minimum IS100, IS200, IS700, and IS800 and submit certificates to the ODH Public Health Consultant within 30 days of hire.

Additionally, the agency agrees to adhere to the requirements as identified in the Regional Healthcare Coordination Subrecipient Expectations. (See Appendix E) and the Regional Healthcare Coalition Requirements (See Appendix L).

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

1. Applicant does not owe funds to ODH and has repaid any funds due within 45 days of the invoice date.
2. Applicant has not been certified to the Attorney General's (AG's) office.
3. Applicant has submitted application and all required attachments by 4:00 PM on February 4, 2019.

E. Service Area: See Appendix I

F. Number of Grants and Funds Available: A total of **$4,817,191** will be awarded for up to (8) Homeland Security regions for Regional Healthcare Coordination (see Appendix I).

Funding is based on the current number of ASPR funded hospitals as of 10/1/2018 (see Appendix F), the regional population, and the number of counties within the region. The funds will be awarded as follows:

Region	Funding
1. Northeast Region	$750,068.00
2. Northwest Region	$706,188.00
3. Northeast Central Region	$867,735.00
4. West Central Region	$450,047.00
5. Southwest Region	$675,267.00
6. Central Region	$886,965.00
7. Southeast Region	$258,018.00
8. Southeast Central Region	$222,903.00

- Funds may not be distributed to an ASPR funded hospital who does not meet the requirements identified in Section C.
- HPP funding cannot be used for entities covered under the Centers for Medicare & Medicaid Emergency Preparedness Rule (CMS) to meet conditions of participation (i.e., writing plans and developing exercises).

*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 or via ground delivery by **4:00 p.m. on February 4, 2019.** Applications and required attachments received after this deadline will not be considered for review. Contact Monique Witherspoon at (614) 644-1912 or Monique.Witherspoon@odh.ohio.gov with any questions.

H. Authorization: Authorization of funds for this purpose is contained in The Public Health Security and Bioterrorism Preparedness and Response Act of 2002. Public Law 107-188, Section 319C-1 of the Public Health Service Act, 42 U.S.C. 247d-3a and the Catalog of Federal Domestic Assistance (CFDA) Number 93.

I. Goals: The Four Healthcare Preparedness and Response Capabilities are:

- **Capability 1:** Foundation for Healthcare and Medical Readiness
  Goal of Capability 1: The community's healthcare organizations and other stakeholders—coordinated through a sustainable HCC—have strong relationships, identify hazards and risks, and prioritize and address gaps through planning, training, exercising, and managing resources.
- **Capability 2:** Healthcare and Medical Response Coordination
  Goal of Capability 2: Healthcare organizations, the HCC, their jurisdiction(s), and the ESF-8 lead agency plan and collaborate to share and analyze information, manage and share resources, and coordinate strategies to deliver medical care to all populations during emergencies and planned events.
- **Capability 3:** Continuity of Healthcare Service Delivery
  Goal of Capability 3: Healthcare organizations, with support from the HCC and the ESF-8 lead agency, provide uninterrupted, optimal medical care to all populations in the face of damaged or disabled healthcare infrastructure. Healthcare workers are well-trained, well-educated, and well-equipped to care for patients during emergencies. Simultaneous response and recovery operations result in a return to normal or, ideally, improved operations.
- **Capability 4:** Medical Surge
  Goal of Capability 4: Healthcare organizations—including hospitals, EMS, and out-of-hospital providers—deliver timely and efficient care to their patients even when the demand for healthcare services exceeds available supply. The HCC, in collaboration with the ESF-8 lead agency, coordinates information and available resources for its members to maintain conventional surge response. When an emergency overwhelms the HCC's collective resources, the HCC supports the healthcare delivery system's transition to contingency and crisis surge response and promotes a timely return to conventional standards of care as soon as possible.

These four capabilities were developed based on guidance provided in the 2017-2022 **Healthcare Preparedness Capabilities: National Guidance for Healthcare System Preparedness** document. They support and cascade from guidance documented in the National Response Framework, National Preparedness Goal, and the National Health Security Strategy to build community health resilience and integrate healthcare organizations, emergency management organizations, and public health agencies.

In addition:

1. Partner with stakeholders whose capabilities and services may support public health response, including reaching individuals with access and functional needs.

2. Develop and mature healthcare coalitions (HCCs).

3. Ensure plans incorporate an accurate hazard analysis and risk assessment, including identifying areas with individuals with access and functional needs, and ensure capabilities.

J. Program Period and Budget Period: The program period will begin July 1, 2019 and end on June 30, 2024. The budget period for this application is July 1, 2019 through June 30, 2020.

K. 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* - Applicant agencies 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:
   The Public Health Accreditation Board (PHAB) Standard(s) to be addressed by grant activities:
   - A description of the demographic characteristics (e.g., age, race, gender, ethnicity, socio-economic status, educational levels) of the target population and the geographical area in which they live (e.g., census tracts, census blocks, block groups;
   - A summary of the services to be provided or activities to be conducted; and,
   - A plan to coordinate and share information with appropriate local health districts.

   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 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**.** The current letters of support from no less than 10 members of the Regional Healthcare Coalition submitted with the application will satisfy this requirement.

L. Incorporation of Strategies to Eliminate Health Inequities

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The Ohio Department of Health is committed to the elimination of health inequities. Racial and ethnic minorities, people with disabilities, the LGBTQ community and Ohio's economically disadvantaged residents experience health inequities and do not have the

same opportunities as other groups to achieve and sustain optimal health.

Throughout the various components of this application (e.g., Program Narrative, Objectives) applicants are required to:

1. Explain the extent to which health disparities and/or health inequities are manifested within the problem addressed by this funding opportunity. This includes the identification of specific group(s) who experience a disproportionate burden of disease or health condition (this information must be supported by data).

2. Explain and identify how specific social and environmental conditions (social determinants of health) put groups who are already disadvantaged at increased risk for health inequities.

3. Explain how proposed program interventions will mitigate and prevent this problem.

4. Link health equity interventions in the grant proposal to national health equity strategies using the GMIS Health Equity Module.

The following section will provide basic framework, links and guidance to information to understand and apply health equity concepts.

Understanding Health Disparities, Health Inequities, Social Determinants of Health & Health Equity:

Certain groups in Ohio face significant barriers to achieving the best health possible. These groups include Ohio's poorest residents, people with disabilities, and racial and ethnic minority groups. Health disparities occur when these groups experience more disease, 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, work and play. Health disparities are unnatural and can occur because of 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, good housing, good education, safe neighborhoods, freedom from racism and other forms of discrimination. These are referred to as **social determinants of health**. *Social determinants are the root causes of health disparities. The systematic and unjust distribution of social determinants resulting in negative health outcomes is referred to as* **health inequities**. *As long as health inequities persist, those aforementioned groups will not achieve their best possible health. The ability of marginalized groups to achieve optimal health (like those with access to social determinants) is referred to as* **health equity**. *Public health programs that incorporate social determinants into the planning and implementation of interventions will greatly contribute to the elimination of health inequities.*

GMIS Health Equity Module:
The GMIS Health Equity Module links health equity initiatives in grant proposals to national health equity strategies such as those found in ***Healthy People 2020*** or the ***National Stakeholder Strategy for Achieving Health Equity***.

Applicants are required to select the goals and strategies from the module that best reflect how their particular grant proposal addresses health disparities and/or health inequities. Applicants can choose more than one goal and/or strategy. *For more resources on health equity, please visit the ODH website at:*
https://odh.ohio.gov/wps/portal/gov/odh/know-our-programs/health-equity/health-equity

M. 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.**

N. Programmatic, Technical Assistance and Authorization for Internet Submission*:* Initial authorization for Internet submission, for new agencies, will be granted after participation in the GMIS training session. All other agencies will receive their authorization after the posting of the Solicitation to the ODH website and the receipt of the NOIAF. Please Contact Monique Witherspoon at (614) 644-1912, or Monique.Witherspoon@odh.ohio.gov with any questions regarding this solicitation.

Applicant must attend or must document in the NOIAF prior attendance at GMIS training in order to receive authorization for internet submission.

O. Acknowledgment: An Application Submitted status will appear in GMIS that acknowledges ODH system receipt of the application submission.

P. Late Applications: GMIS automatically provides a time and date system for grant application submissions. Required attachments and/or forms sent electronically must be transmitted by the application due date. Required attachments and/or forms mailed that are non-Internet compatible must be postmarked or received on or before the application due date of **February 4, 2019.**

Applicants should request a legibly dated postmark or obtain a legibly dated receipt from the U.S. Postal Service or a commercial carrier. Private metered postmarks shall **not** be acceptable as proof of timely mailing. Applicants can hand-deliver attachments to ODH, Grants Services Unit (GSU), via the front desk at 246 N. High St., Columbus, Ohio; but they must be delivered by **4:00 p.m**. on the application due date. Fax attachments will not be accepted**. GMIS applications and required application attachments received late will not be considered for review.**

Q. 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 grant funds.

R. Unsuccessful Applicants: Within 30 days after a decision to disapprove or not fund a grant application, written notification, issued over the signature of the Director of Health, or his designee, shall be sent to the unsuccessful applicant.

S. Review Criteria: All proposals will be judged on the quality, clarity and completeness of the application. Applications will be judged according to the extent to which the proposal:

1. Contributes to the advancement and/or improvement of the health of Ohioans;

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 capable of attaining program objectives;
4. Describe Specific, Measurable, Attainable, Realistic & Time-Bound (S.M.A.R.T.) objectives, activities, milestones and outcomes with respect to time-lines and resources;
5. Estimates reasonable cost to the ODH, considering the anticipated results;
6. Indicates 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;
7. Provides an evaluation plan, including a design for determining program success;
8. Is responsive to the special concerns and program priorities specified in the Solicitation;
9. Has demonstrated acceptable past performance in areas related to programmatic and financial stewardship of grant funds;
10. Has demonstrated compliance to OGAPP;
11. Explicitly identifies 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. thru M. of this Solicitation.
13. Achieve a minimum score of 43 points on the Application Review Score Sheet (See Appendix D).

The 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.**

T. 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.

U. 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, Office of Health Preparedness, Hospital Preparedness Program (HPP) and as a sub-award of a grant issued under the Hospital Preparedness Program (HPP) and PHEP Cooperative Agreements CDC-RFA-TP12-*

1201, and CFDA number 93.074."

V. Reporting Requirements: Successful applicants are required to submit Subrecipient Expenditure Reports. Expenditure reports must be received in accordance and adhere to the requirements of the OGAPP manual and this Solicitation before the department will release any additional funds.

Mid-Year and End-of-Year program reports ARE NOT required but subrecipients are required to submit any and all forms of documentation and/or reports as requested by ODH.

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.

Expenditure reports shall be submitted as follows:

1. **Subrecipient Reimbursement Expenditure Reports:** Subrecipients can choose monthly or quarterly reimbursement (expenditure report submission) from ODH (indicate the reimbursement type on the attached NOIAF). 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 10th unless it is a Saturday or Sunday:

Period	***Report Due Date***
July 1 – 31, 2019	*August 9, 2019*
August 1 – 28, 2019	*September 10, 2019*
September 1 – 31, 2019	*October 10, 2019*
October 1 – 30, 2019	*November 8, 2019*
November 1 – 31, 2019	*December 10, 2019*
December 1 – 30, 2019	*January 10, 2020*
January 1 – 31, 2020	*February 10, 2020*
February 1 –29, 2020	*March 10, 2020*
March 1 – 30, 2020	*April 10, 2020*
April 1 – 31, 2020	*May 8, 2020*
May 1 – 30, 2020	*June 10, 2020*
June 1 – 31, 2020	*July 10, 2020*

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

Period	***Report Due Date***
July 1 – September 31, 2018	*October 10, 2018*
October 1 – December 30, 2019	*January 10, 2019*
January 1 – March 30, 2020	*April 10, 2020*
October 1 – June 31, 2020	*July 10, 2020*

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

2. **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, 2020**. 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. The Subrecipient Final Expense Report 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 signifies authorization of the submission by an agency official and constitutes electronic acknowledgment and acceptance of OGAPP rules and regulations.

W. 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 in GMIS.

X. Unallowable Costs: Funds **may not** be used for the following:

1. Advancement of political or religious points of view
2. Fund raising and investment management costs
3. Dissemination of factually incorrect or deceitful information
4. Consulting fee for salaried program personnel to perform activities related to grant objectives
5. Advertisement – other than for recruitment or procurement or if required by the specified program's Solicitation
6. Bad debts of any kind
7. Contributions to a contingency fund or reserve
8. Entertainment
9. Alcoholic Beverages
10. Fines and penalties
11. Legal fees incurred in defense of any civil or criminal fraud proceeding
12. Membership fees -- unless related to the program and approved by ODH
13. Loan or the principle amount of mortgage payments
14. Contributions made by program personnel
15. Costs to rent equipment or space owned by the funded agency
16. Inpatient services
17. Purchase or improvement of land; the purchase, construction, or permanent improvement of any building
18. Satisfying any requirement for the expenditure of non-federal funds as a condition for the receipt of federal funds
19. Lodging, travel and meals over the current state rates. See Ohio Shared Services Website for hotel rates and Meals Per Diem at: http://www.ohiosharedservices.ohio.gov/TravelExpense
20. All costs related to out-of-state travel, unless prior approved by ODH
21. Training longer than one week in duration, unless prior approved by ODH
22. Contracts, for compensation, with advisory board members

23. Goods or services for personal use regardless if reported as taxable income to employee
24. Grant-related equipment costs greater than $1,000, unless justified and approved by ODH
25. Payments to any person for influencing or attempting to influence members of Congress or the Ohio General Assembly in connection with awarding of grants
26. Gas Card/Vouchers unless specified in the Federal program guidelines and included in the Solicitation
27. 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., to water bottles, t-shirts, totes that do not include slogans, logos, agency name/address, messaging).
28. Office furniture (Refer to OGAPP Manual)
29. Additional program specific Unallowable Costs per the CFDA, program regulations and directives or state law specifications, which may be provided in the Solicitation.

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.

Y. Client Incentives and Cost Enablers Client Incentives and Cost Enablers are an unallowable cost.

Z. 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 expend $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 audits@odh.ohio.gov 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 serious 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.

AA. 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 10 pages (**excludes** appendices, attachments, budget and budget narrative).
- Use a 12-point 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
   - Primary Reason
   - Funding
   - Other Direct Costs
   - Compliance Section
   - Summary
5. Civil Rights Review Questionnaire
6. Assurances Certification
7. Federal Funding Accountability and Transparency Act (FFATA) reporting form
8. Change request in writing on agency letterhead **(Existing agency with tax identification number, name and/or address changes)**
9. Health Equity Module
10. Public Health Impact Statement Summary (non-health department only)
11. Statement of Support from the Local Health Districts (non-health department only)
12. Required Attachments
    - Contact Information Sheet (Attachment #1)
    - Match Letter (Attachment #2)
    - 10 Letters of Support
    - Table of Organization
    - Regional Coordination Subrecipient Expectations

(Appendix E)

One copy of the following document(s) must be e-mailed to https://harvester.census.gov/facweb/ or mailed to the address listed below:

Complete Copy & E-mail or Mail to ODH

Current Independent Audit (latest completed organizational fiscal period; **only if not previously submitted**)

Ohio Department of Health
Grants Services Unit
Central Master Files, 4th Floor
35 E. Chestnut Street
Columbus, Ohio 43215

II. APPLICATION REQUIREMENTS AND FORMAT

GMIS access will be provided to an agency after it has completed the required ODH sponsored training. Agencies who have previously completed GMIS training will receive access after the Solicitation is posted to the ODH website.

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 signifies authorization by an agency official and constitutes 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 the ODH.

B. Budget: Prior to completion of the budget section, please review page 12 of the Solicitation for **Unallowable Costs**. The subrecipient must submit the Budget Justification (see Attachment #3) signed by the Agency Head.

A match of 7.7% is required by this program contingent upon the federal award. This match amount must be included in the applicant share column of the Budget Summary page with a match plan in the narrative. (See Appendix K) for additional information regarding Match requirements. The subrecipient must submit the Match Letter (Attachment #2) with the grant application. The letter must be on agency letterhead and signed by the Agency Head.

Funds may be used to support personnel, their training, travel (see OBM Website https://obm.ohio.gov/TravelRule/) and supplies directly related to planning, organizing and conducting the initiative/program/activity described in this announcement.

1. **Primary Reason and Justification Pages:** Provide a budget justification narrative outlining how the deliverable will be met. (A budget justification example can be found on GMIS).

2. **Other Direct Costs: July 1, 2019 – June 30, 2020**
   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 agrees by electronic acknowledgment to the financial standards of conduct as stated therein.

D. Project Narrative:

1. **Executive Summary:** Identify the target populations, services and programs to be offered and what agency or agencies will provide those services, burden of health disparities and health inequities. Describe the public health problem(s) that the program will address.

2. **Description of Applicant Agency/Documentation of Eligibility:**
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 a manner 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.

3. **Problem:** Identify and describe the local health status concern(s) that will be addressed by the program. Only restate 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 term**s** of health status (e.g., morbidity and/or mortality) or health system (e.g., accessibility, availability, affordability, appropriateness of health services) indicators. The indicators should be measurable in order to serve as baseline data upon which the 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.

   Methodology: In narrative form, identify the program goals, **SMART** 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 program activities timeline to identify program objectives and activities and the start and completion dates for each.

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 automatically with each application via the Internet.

F. Federal Funding Accountability and Transparency Act (FFATA): All applicants applying for Ohio Department of Health grant funds are required to complete the FFATA reporting form in GMIS. Applicants must ensure that the information contained in SAM.gov, DUN & Bradstreet 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 applicants for grants are required to obtain a Data Universal Number System (DUNS), Register in SAM.gov and submit the information in the grant application. For information about the DUNS, go to https://fedgov.dnb.com/webform. For more information about system for Award Management (SAM) go to http://www.sam.gov.

Information on Federal Spending Transparency can be located at http://www.USAspending.gov or the Office of Management and Budget's website for Federal Spending Transparency at http://www.whitehouse.gov/omb.

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

G. Public Health Impact: Applicants that are not local health departments are to attach in GMIS the statement(s) of support from the local health district(s) regarding the impact of your proposed grant activities on the PHAB Standards. If a statement of support from the local health districts is not available, indicate that and submit a copy of the program summary that your agency forwarded to the local health district(s).

H. 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 that are non-Internet compatible must be postmarked or received on or before the application due date. An original and the required number of copies of non-Internet compatible attachments must be mailed to the ODH, Grants Services Unit, Central Master Files address by **4:00 p.m. on or before February 4, 2019.** A minimum of an original and the indicated number of copies of non-Internet attachments are required.

II. ATTACHMENTS (The following will be uploaded into OPHCS by December 21st, 2018*)

1. Contact Information Sheet (Attachment #1)*
2. Match Letter (Attachment #2)*
3. Budget Justification Scenario 3 (Attachment #3)*
4. Letters of Support
5. Table of Organization
6. Public Health Impact Statement Summary
7. Regional Healthcare Coordination Subrecipient Expectations (Appendix E)*

Reimbursement Type Select one of the options below: ☐ Monthly OR ☐ Quarterly

Appendix A

NOTICE OF INTENT TO APPLY FOR FUNDING

Ohio Department of Health

Office of Health Preparedness

Regional Healthcare System Coordination for Disaster Preparedness (HPP)

Submission Required

See Due Date Below

ALL INFORMATION REQUESTED MUST BE COMPLETED.

County of Applicant Agency _____ **Federal Tax Identification Number** _____

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 ☐ City Agency ☐ Hospital ☐ Higher Education ☐ Local Schools ☐ 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 have been trained in and currently have access to the ODH GMIS system? ☐ YES ☐ NO

If yes, no further action is needed.

If no, at least two people from your agency are **REQUIRED** to complete the training before you will be able to access the ODH GMIS system and submit a grant proposal. Complete the GMIS training request form in the Request for Proposal.

The NOIAF must be accompanied by the agency's Proof of Non-Profit status (if applicable); Proof of Liability Coverage (if applicable); Request for Taxpayer Identification Number and Certification (W-9), Authorization Agreement for Direct Deposit of EFT Payments Form (EFT), (New Agency Only) Vendor Information Form. These forms are located on the Ohio Department of Administrative Services website at: http://ohiosharedservices.ohio.gov/SupplierOperations/Forms.aspx. **You can also access these forms at the following websites:**

- **Request for Taxpayer Identification Number and Certification (W-9),** http://ohiosharedservices.ohio.gov/SupplierOperations/Forms.aspx
- **Authorization Agreement for Direct Deposit of EFT Payments Form (EFT)** http://www.ohiosharedservies.ohio.gov/SupplierOperations/doc/EFT_Payment_Authorization_OBM4310.pdf
- **Supplier Information Form** http://www.ohiosharedservices.ohio/SupplierOperations/doc/Supplier_Information_Form_OBM5657.pdf

Forms are only required for NEW AGENCIES or if UPDATES are needed for current agencies. ODH will forward the forms to Ohio Shared Services. FORMS MUST BE RECEIVED BY December 31, 2019.

Mail, E-mail: Monique.Witherspoon/Monique.Witherspoon@odh.ohio.gov
Ohio Department of Health REGIONAL HEALTHCARE SYSTEM COORDINATION
35 East Chestnut Street, 7th Floor
Columbus, OH 43215

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

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. *Please note: GMIS Training is only required for New Agencies to ODH. If you are new to your agency someone there should train you. Refresher guides can be found on the ODH web site: http://www.odh.ohio.gov/en/about/grants/aspx ODH Grants Page – "GMIS Training Resource" Section.* Confirmation of your GMIS training session will be e-mailed once a date has been assigned by ODH. Also use this form when user changes are needed.

`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 Karen Tinsley, Grants System Officer, 614-644-7546
Mail: ODH/OFA, 35 E. Chestnut St.,4th Floor, Columbus, Ohio 43215 *Or*
Scan & Email: karen.tinsley@odh.ohio.gov

C1.1 HPP
Hospital Preparedness Program

- **Budget Period: 1**
- **# of Deliverables: 13**
- **Use Budget Justification Scenario**

DELIVERABLE SUBMISSIONS:
All deliverables to be submitted through GMIS, unless noted otherwise.

Deliverable – Objective 1– Coalition Membership Roster
CDC Preparedness Domain: Community Resilience
Capability: #1

Description: The Healthcare Coalition is useful for all phases of Comprehensive Emergency Management, but its primary mission should be to support healthcare organizations during emergency response and recovery. An element of this mission is promoting integration of Coalition member organizations into the broader community response. The roster submission must demonstrate Regional Healthcare Coalition compliance with all ODH-provided ***BP1/SFY20 Coalition Requirements.***

Successful Completion of the Deliverable(s) Includes:

- **Objective 1.1**: By September 6, 2019, the subrecipient will submit a current Coalition Membership Roster using the ***BP1/SFY20 Coalition Membership Roster*** via GMIS._____**3%**

Deliverable – Objective 2– Regional Healthcare Coalition Meetings
CDC Preparedness Domain: Community Resilience
Capability: #1

Description: The Regional Healthcare Coordinators will lead bi-monthly Regional Healthcare Coalition meetings. Bi-monthly coalition meetings serve to bring coalition members together to plan, build relationships, and promote inter-agency communication, information sharing, and collaboration across various coalition member agencies, partners, and disciplines. The organizations represent all counties within the region. The HCC Spend Plan needs to include the total HPP funding allocation and how it will be disbursed.

Successful Completion of the Deliverable(s) Includes:

- **Objective 2.1**: By July 30, 2019, the subrecipient will submit a calendar schedule for six HCC meetings within the grant year via GMIS. _____**6.87%**

- **Objective 2.2:** By January 3, 2020, the subrecipient will submit, via GMIS, three Regional Healthcare Coalition Meeting agenda, minutes, presentations, and sign-in sheets from each meeting within 21 days of the meeting occurrence. During the first scheduled HCC meeting, the HCC spend plan must be disseminated to all HCC members. Sign-in-sheets must identify name of the participating individuals and the agencies represented. The meeting materials must also be distributed to the meeting attendees, including the Regional Public Health Coordinator. **_6.87 %**

- **Objective 2.3:** By May 29, 2020, the subrecipient will submit, via GMIS, three additional Regional Healthcare Coalition Meeting agenda, minutes, presentations, and sign-in sheets from each meeting within 21 days of the meeting occurrence. The subrecipient must conduct, complete, and submit a Hazard Vulnerability Analysis (HVA) during one of these meetings. Sign-in-sheets must identify name of the participating individuals and the agencies represented. The meeting materials must also be distributed to the meeting attendees, including the Regional Public Health Coordinator. _____**6.87%**

Deliverable – Objective 3– Monthly ODH Meetings
CDC Preparedness Domain: Community Resilience
Capability: #1

Description: The specific objectives for a Healthcare Coalition during emergency response and recovery may vary from one Coalition to another. Monthly coordination meetings with ODH will ensure that all Regional Healthcare Coordinators and ODH are working to establish what the Coalitions should achieve during preparedness and response. The August 2019 meeting will be the TEPW and must be attended in-person.

Successful Completion of the Deliverable(s) Includes:

- **Objective 3.1:** By June 3, 2020 the Regional Healthcare Coordinator or his/her designee will attend ALL monthly ODH-sponsored meetings. 50% of these meetings must be attended in person, in Columbus, Ohio, as evidenced by the ODH Sign-in Sheet. _____**4%**

Deliverable – Objective 4 – HCC Response Plan
Domain: Incident Management
Capability: #2

Description: Healthcare and medical response coordination enables the healthcare delivery system and other organizations to share information, manage and share resources, and integrate their activities. During an emergency response, healthcare organizations and other HCC members contribute to the coordination of information-exchange and resource-sharing to ensure the best patient-care outcomes possible. HCCs and their members can best achieve enhanced coordination and improved situational awareness when there is active participation from hospitals, EMS, emergency management organizations, and public health agencies and by documenting roles, responsibilities, and authorities before, during, and immediately after an emergency. The Regional Healthcare Coordinator will make necessary edits to the existing HCC Response Plan and facilitate its adoption by the Regional HCC, in accordance with the requirements of the ***HCC Response Plan Guidance for FY2020***.

Successful Completion of the Deliverable(s) Includes:

- **Objective 4.1**: By May 1, 2020, the subrecipient will upload into GMIS an ODH-provided PDF confirming that the plan has been updated and adopted in accordance with the requirements detailed in the ***HCC Response Plan Guidance for FY2020***. _____**10.40%**

Deliverable – Objective 5– ODH 24/7 Drills
CDC Preparedness Domain: Information Sharing
Capability: #1 and #2

Description: The purpose of the 24/7 drill is to test the capacity and timeliness of the Regional Healthcare Coordinator's response in the event of a public health/medical emergency.

Successful Completion of the Deliverable(s) Includes:
The subrecipient must successfully pass **two** ODH 24/7 after-hours call drills to test the ability of the RHC, or designee, to receive and respond to an emergency within one hour.

- **Objective 5.1:** By December 19, 2019, the subrecipient must successfully complete the first ODH 24/7 drill and upload the pass/fail letter in GMIS. _____ **1.75%**

- **Objective 5.2:** By June 15, 2020, the subrecipient must successfully complete the second ODH 24/7 drill and upload the pass/fail letter in GMIS. _____**1.75%**

Deliverable – Objective 6– OH Trac Action Plan
CDC Preparedness Domain: Surge Management
Capability: #4

Description: Every hospital and response agency in Ohio now has access to OHTrac, a web-based patient tracking database, when responding to a mass casualty incident or disaster situation. Efficient use of OHTrac necessitates further implementation and usage of the system statewide.

Following a mass casualty incident or disaster situation, an incident is created on the OHTrac website. Then, a message is sent to agency users within the selected zip code radius of the incident. The emergency medical service team or fire department places a barcoded triage tag on all patients involved, allowing the patient tracking process to begin. As patients are assessed and triaged by first responders, the barcoded triage tag is used for documentation and tracking purposes. If capability exists on scene, the patients can be tracked to the incident during transport. Once the patients arrive at the hospital, the hospital uses each patient's triage tag number to update his / her arrival status in OHTrac.

Successful Completion of the Deliverable(s) Includes:

- **Objective 6.1:** By November 29, 2019, develop and submit an action plan according to the ODH-provided **** BP1/SFY20 OHTrac Action Plan template,*** engage no less than 20% use or acknowledgement of OHTrac in your region via GMIS. The EMS agencies' that comprise this 20% must differ from the agencies who comprised the 20% in the previous budget period_____**3.5%**
- **Objective 6.2:** By May 29, 2020, implement and submit, via GMIS, the completed action plan that engages no less than 20% of the identified EMS agencies' use or acknowledgment of OHTrac in your region. _____**3.5%**

Deliverable – Objective 7– Hospital Dispensing Documentation in OPOD
Domain: Countermeasures and Mitigation
Capability: #3

Description: All ASPR-funded hospitals must have plans to describe the hospitals' processes for requesting, receiving, and dispensing medical countermeasures to hospitals patients and staff (private POD). The following documents must be completed to ensure logistical and operational planning considerations have been met and documented for each facility, prior to a response.

Successful Completion of the Deliverable(s) Includes:

- **Objective 7.1:** By May 29, 2020, the subrecipient must ensure the following information is completed and uploaded in OPOD for each ASPR funded hospital in the region:

    - Floor Layout
    - Flow Chart Diagram
    - Location Map
    - Ohio Medical Countermeasures (MCM) Site Survey for Hospitals_____**12.60%**

Deliverable – Objective 8– Tactical Communications Strategy
Domain: Information Management
Capability: #2

Description: The establishment of a tactical communications strategy is essential to ensuring the availability of redundant communications in the event of a public health emergency. The communication flow between local, state, internal and external partners is paramount to ensure situational awareness. Based upon the successful completion of a quarterly MARCS radio check and alerting system drill, this will facilitate the testing of each agency's interoperability.

Successful Completion of the Deliverable(s) Includes:

The subrecipient must conduct one alerting drill via the agency's redundant communication system per quarter to prompt agency-designated critical infrastructure staff to respond to the activation of a dispensing campaign.

a) The subrecipient must report the completed action on the ****Communications Worksheet.***
b) The subrecipient must attach a report from the alerting system that reflects responder acknowledgment rate of 75% **or above.**
c) Alerting drills must be completed by the last business day of the first three quarters and no later than 25 June during the last quarter.

MARCS Radios: The subrecipient and all ASPR-funded hospitals must participate in scheduled quarterly MARCS radio checks conducted by ODH.

- **Objective 8.1:** Quarter 1: By October 11, 2019, the subrecipient must submit the ****Communications Worksheet*** and alerting system message summary report via GMIS.

_____**1.4%**

- **Objective 8.2:** Quarter 2: By January 10, 2020, the subrecipient must submit the ****Communications Worksheet*** and alerting system message summary report via GMIS. _____**1.4%**

- **Objective 8.3:** Quarter 3: By April 10, 2020, the subrecipient must submit the ****Communications Worksheet*** and alerting system message summary report via GMIS._____**1.4%**

- **Objective 8.4:** Quarter 4: By June 25, 2020, the subrecipient must submit the ****Communications Worksheet*** and alerting system message summary report via GMIS._____**1.4%**

Deliverable – HPP Objective 9– emPOWER Presentation
Domain: Community Resilience
Capability: #1

Description: Over 2.5 million Medicare beneficiaries in our communities rely upon electricity-dependent medical and assistive equipment, such as ventilators, wheel chairs, and cardiac devices. Severe weather and disasters that cause power outages can be life-threatening for these individuals.

Successful Completion of the Deliverable(s) Includes:
The Regional Healthcare Coordinator will communicate key information about emPOWER to the regional HCC every six (6) months, in accordance with the requirements of the ****emPOWER Presentation Guidance for FY2020***.

- **Objective 9.1**: By November 29, 2019, the subrecipient will upload into GMIS an ODH-provided PDF confirming that a presentation on emPOWER has been delivered in accordance with the requirements detailed in the ****emPOWER Presentation Guidance for FY2020***._____**2.0%**

- **Objective 9.2**: By May 29, 2020, the subrecipient will upload into GMIS an ODH-provided PDF confirming that a second presentation on emPOWER has been delivered in accordance with the requirements detailed in the **** emPOWER Presentation Guidance for FY2020***._____**2.0%**

Deliverable – Objective 10 – Attend Regional Training and Exercise Plan Workshop (TEPW)
CDC Preparedness Domain: Community Resilience
Capability: #1

Description: Subrecipients work together in a collaborative workshop environment to identify and set exercise program priorities based on PHEP and HPP capabilities. Based on these program priorities, subrecipients will develop a jurisdictional multi-year schedule of specific training and exercises. Workshop attendance is necessary to coordinate all training and exercise planning efforts among all the local jurisdiction subrecipients within the region and the regional healthcare coalition.

Successful Completion of the Deliverable(s) Includes:

Objective 10.1: By September 30, 2019 the Regional Healthcare Coordinator, or designee, must provide **in-person representation** to the Regional TEPW, and provide evidence of attendance by signing the sign-in sheet to be submitted by the RPHC via GMIS_____ **1.0%**

Deliverable – Objective 11 – Multi-Year Training and Exercise Plan (MYTEP)
CDC Preparedness Domain: Community Resilience
Capability: #1

Description: The Multi-Year Training and Exercise Plan (MYTEP) is the foundation document guiding a successful training and exercise program. The MYTEP articulates overall training and exercise program priorities. The HCC MYTEP Schedule (new Appendix in the MYTEP) outlines the schedule of training and exercise activities designed to meet those priorities. Deliverable compliance criteria and submission instructions for the MYTEP are located in the ***BP1/SFY20 Exercise Deliverable Technical Assistance*** document.

Successful Completion of the Deliverable(s) Includes:

Objective 11.1: By January 6, 2020, the subrecipient must submit the HCC (FY20-FY24) MYTEP on the **** ODH MYTEP Template*** that adheres to the deliverable compliance criteria and submission instructions. The HCC MYTEP must be submitted via GMIS_____**7.8%**

Deliverable – Objective 12 –After-Action Report/Improvement Plan (AAR/IP) for the Coalition Surge Test (CST) exercise
CDC Preparedness Domain: Community Resilience
Capability: #1

Description: The After-Action Report (AAR) summarizes key exercise-related evaluation information, including the exercise overview and analysis of objectives and HPP capabilities. The AAR is developed in conjunction with an Improvement Plan (IP). The IP identifies specific corrective actions, assigns them to responsible parties, and establishes target dates for completion. The ODH Exercise Event Review Form (EERF) is a tool (new Appendix in the AAR/IP) that captures the ratings assigned to (two minimum) HPP Capabilities and all associated activities tested through functional exercises, full-scale exercises, Coalition Surge Test (CST) and real-world responses. Deliverable compliance criteria and submission instructions for the AAR/IP are located in the ***BP1/SFY20 Exercise Deliverable Technical Assistance*** document.

Successful Completion of the Deliverable(s) Includes:

Objective 12.1: By March 30, 2020, the subrecipient must complete and submit the Coalition Surge Test (CST) AAR/IP on the ***ODH AAR/IP Template*** that adheres to the deliverable compliance criteria and submission instructions. The HCC AAR/IP must be submitted via GMIS. _____**20%**

Deliverable – Objective 13 – Attend Healthcare-Associated Infections (HAI) Advisory Group
CDC Preparedness Domain: Community Resilience and Information Sharing
Capability: #1, #2, #3

Description: Active participation in HAI Advisory Group calls/meetings is crucial to regional information exchange between ODH and regional partners. It is important to disseminate information to regional partners, including regional healthcare coalition (HCC) members to align efforts to prevent healthcare-associated infections. It is equally important for ODH to maintain a comprehensive operating picture of the HAI landscape. The Regional Healthcare Coordinator (RHC) is expected to act as a liaison between ODH and their HCC members for HAI Advisory Group calls/meetings.

The RHC will gather feedback from state stakeholders at the HCC and provide feedback to ODH E.g., recommendations for agenda items, speakers or topics; at the Joint RHC/Regional Public Health Coordinator (RPHC) Meetings.

Successful Completion of the Deliverable(s) Includes:

Objective 13.1: By June 1, 2020, the subrecipient, or his/her designee, will attend four HAI Advisory Group calls and/or in-person meetings. The subrecipient will submit, via GMIS, four summaries of these meetings, and proof of distribution of the information from the calls and/or in-person meetings to all local health departments within his/her region. _____**0.5%**

Appendix C2

GMIS Project #	SUBGRANTEE	Region	Total Amount	Deliverable 1 Coalition Membership Roster	Deliverable 2 HCC Meetings	Deliverable 3 Monthly ODH Meetings	Deliverable 4 HCC Response Plan	Deliverable 5 ODH 24/7 Drills
Percentage				3.000%	20.60%	4.00%	10.40%	3.50%
01860052RP1219	The Center for Health Affairs	Northeast	$750,068	$22,502	$154,514	$30,003	$78,007	$26,252
02560102RP1219	Research & Education Foundation of the Ohio Hospital Association	Southeast Central/SE	$480,921	$14,428	$99,070	$19,237	$50,016	$16,832
02560112RP1219	Central Ohio Trauma System	Central	$886,965	$26,609	$182,715	$35,479	$92,244	$31,044
03160182RP0919	The Health Collaborative	Southwest	$675,267	$20,258	$139,105	$27,011	$70,228	$23,634
04860042RP1219	Hospital Council of Northwest Ohio	Northwest	$706,188	$21,186	$145,475	$28,248	$73,444	$24,717
05760052RP1319	Greater Dayton Area Health Information Network	West Central	$450,047	$13,501	$92,710	$18,002	$46,805	$15,752
07760042RP1219	Akron Regional Hospital Association	Northeast Central	$867,735	$26,032	$178,753	$34,709	$90,244	$30,371

Deliverable 6 OH Trac Action Plan	Deliverable 7 Hospital Dispensing Documentation in OPOD)	Deliverable 8 Tactical Communications Strategy	Deliverable 9 emPOWER Presentation	Deliverable 10 Attend Regional Training and Exercise Plan Workshop (TEPW	Deliverable 11 Multi-Year Training and Exercise Plan (MYTEP)	Deliverable 12 After-Action Report/Improvement Plan (AAR/IP) for the Coalition Surge Test (CST) exercise	Deliverable 13 HAI Advisory Call	TOTAL
7.00%	12.60%	5.60%	4.00%	1.00%	7.80%	20.00%	0.50%	100.00%
$52,505	$94,509	$42,004	$30,003	$7,501	$58,505	$150,014	$3,750	$750,068
$33,664	$60,596	$26,932	$19,237	$4,809	$37,512	$96,184	$2,405	$480,921
$62,088	$111,758	$49,670	$35,479	$8,870	$69,183	$177,393	$4,435	$886,965
$47,269	$85,084	$37,815	$27,011	$6,753	$52,671	$135,053	$3,376	$675,267
$49,433	$88,980	$39,547	$28,248	$7,062	$55,083	$141,238	$3,531	$706,188
$31,503	$56,706	$25,203	$18,002	$4,500	$35,104	$90,009	$2,250	$450,047
$60,741	$109,335	$48,593	$34,709	$8,677	$67,683	$173,547	$4,339	$867,735
								$4,817,191

Appendix D

HOSPITAL PREPAREDNESS PROGRAM GRANT
APPLICATION SCORE SHEET
FY20- July 1, 2019 – June 30, 2024

Agency Name: Click or tap here to enter text.

Project Key:

1. Was this the only entry for this jurisdiction:
   ☐ **Yes** ☐ **No**
2. Does ODH have issues with this application?
   ☐ **Yes** ☐ **No**
3. The response to question number 1 was "No" please see the agency's score below:

Agency is being referred to CAR: ☐ **Yes** ☐ **No**

Additional Comments:

SECTION 1			
	PROGRAM ATTACHMENTS (46 POINTS) Date: _____ Scorer's Name: _____		
	GRANT APPLICATION COMPONENT	**SCORE**	**COMMENTS**
1.	☐ Application submitted on time (5 points)		
2.	☐ Attachment #1 was submitted and complete (5 points)		
3.	☐ Match Letter was submitted (2 points) ☐ Match Letter is on Agency letterhead (2 points) ☐ Correct funding and match amount used (2 points) ☐ Match letter was signed by Agency Head (2 points)		
4.	☐ Attachment C2 (Budget Allocations) was submitted (2 points) ☐ Signed by Agency Head (2 points)		
5.	☐ Public Health Impact Statement Summary was submitted (5 points)		
6.	☐ No less than 10 Letters of support from Regional Healthcare Coalition Members (10 points)		
7.	☐ Table of Organization was submitted (5 points)		
8.	☐ Regional Healthcare Coordination Subrecipient Expectations (Appendix E) was submitted (2 points) ☐ Signed by Agency Head (2 points) **Total 46 points**		
SECTION 1 TOTAL:			

SECTION 2				
PROJECT NARRATIVE				
(15 POINTS)		Date: _____ Scorer's Name:		
GRANT APPLICATION COMPONENT	**SME APPROVAL**	**PMP APPROVAL**	**FINAL SCORE**	**COMMENTS**
The agency summarizes their structure as it relates to this program and, as the lead agency, how it will manage the program. (5 points) A. The agency describes plans for hiring and training a Regional Healthcare Coordinator, if applicable. OR B. The agency does not need to hire a Regional Healthcare Coordinator, and identifies who will fill the role and how they meet the qualifications. (5 points – A or B) The agency provides a general overview of the agency staff who will be working on the HPP grant deliverables. (5 points)				

	HPP (Max 175 points)	
	SECTION MAXIMUM	**AGENCY SCORE**
SECTION 1	46	
SECTION 2	15	
TOTAL	**61**	
***Minimum score needed**	**43**	

*A score total of less than 70% of Maximum points will not be funded

Agency is being referred to CAR: ☐ Yes ☐ No

Additional Comments:

APPENDIX E

REGIONAL HEALTHCARE COORDINATION SUBRECIPIENT EXPECTATIONS

Successful applicant agencies for the Healthcare Preparedness Program (HPP) Grant agree to serve as the primary planning resource and liaison to the Assistant Secretary for Preparedness and Response (ASPR) hospitals and the healthcare coalitions in their planning region. These program requirements are for the project period of July 1, 2019 through June 30, 2024.

1. Provide data and information as requested by the Ohio Department of Health (ODH) to assist with the completion of local, state, and federal reports
2. As directed by ODH, the subrecipient must demonstrate a willingness to collaborate with any vendor under contract with the Ohio Department of Health's Office of Health Preparedness, for the conduct of any regional and statewide initiatives under the Assistant Secretary for Preparedness and Response (ASPR) Public Health Emergency Preparedness Grant.
3. Coordinate, plan and conduct public-health-related emergency preparedness and response training, periodic disaster drills and exercises with applicable hospitals, health departments, healthcare coalition agencies, other government agencies, and community agencies involved in public health emergency preparedness and response, as well as the general public.
4. Convene and facilitate regional meetings to assure coordination and collaboration. Compile meeting minutes and maintain documentation of strategies, activities and responsibilities.
5. Collaborate with the Regional Public Health Coordinator and EMA staff in regional planning.
6. Review and identify gaps in regional response plans as often as needed but at least annually. Provide documentation that collaboration takes place. Notify ODH of any barriers to collaboration and develop a plan to promote greater collaboration.
7. Participate in state-sponsored site visits, meetings and training activities when requested.
8. Provide representation, guidance and assistance as needed with local, regional and state planning partners for the purpose of developing and supporting local and regional partnerships and coalitions.
9. Identify technical assistance and guidance needed and support coordination of training to healthcare coalition members (e.g., Surgenet).
10. Promote communications between healthcare coalition members and provide situational awareness.
11. Assist healthcare coalition members, especially ASPR-funded with development, review and technical assistance of public health emergency plans, manuals and standard operating procedures, utilizing local, state and federal guidelines and requirements.
12. Facilitate regional healthcare coalition meetings.
13. Successfully complete two 24/7 response drills, conducted by the Ohio Department of Health, within the grant year.
14. Maintain a primary and back-up trained OPHCS Administrator.
15. Serve as regional contact and coordinator of use, including user access for hospitals within the region.
16. Coordinate efforts to expand communication and emergency response capabilities between members of the healthcare coalition and community agencies.
17. Coordinate efforts to enhance the healthcare system in the region for responding to a bioterrorism event or other emergency or disaster.

18. Plan, organize, conduct and evaluate regional response drills that test the use of equipment, communications, personnel and the emergency preparedness plan.
19. Maintains relationships with local public health, emergency management, homeland security and others in the region involved in healthcare preparedness planning.
20. Be an accessible source of preparedness and response best practices for newly engaged provider types as they adapt to the new requirements. Play a role in assisting members with closing planning gaps, as well as assuring integration with core coalition partners.
21. Ensure no funding provided by this grant can be allocated to fund entities in achieving the requirements stated in the Centers for Medicare and Medicaid Services (CMS) Emergency Preparedness Requirements Final Rule (i.e., writing plans and participating in exercises).
22. Subrecipient must submit an Exercise Request Form (ERF) for all planned exercises, on the current ***Exercise Request Form HEA 1100 posted on OPHCS*** no later than 10 business days after the Initial Planning Meeting (IPM).
23. Subrecipients must coordinate with their regions Health Care Coalition to aggregate and report the federal Capabilities Planning Guide (CPG) data requirements for their region upon request.
24. The subrecipient must coordinate with their regional healthcare coalitions to complete and submit the Coalition Assessment Tool.

Agency Name: _____

_____ **_____**

Agency Head Signature **Date**

APPENDIX F

Regional Healthcare Preparedness Program
ASPR-participating Hospital Roster (as of 10/1/2018)

	Hospital Name	Former Names	Address	City	County	Region	AHA Number
1	Berger Health System		600 N Pickaway St	Circleville	Pickaway	C	6410630
2	Bucyrus Community Hospital		629 North Sandusky Ave.	Bucyrus	Crawford	C	6410240
3	Diley Ridge Medical Center		7911 Diley Rd.	Canal Winchester	Fairfield	C	8967218
4	Fairfield Medical Center		401 N Ewing St	Lancaster	Fairfield	C	6411510
5	Fayette County Memorial Hospital		1430 Columbus Ave.	Washington Ct House	Fayette	C	6412305
6	Galion Community Hospital		269 Portland Way South	Galion	Crawford	C	6411350
7	Knox Community Hospital		1330 Coshocton Road	Mount Vernon	Knox	C	6411730
8	Licking Memorial Health Systems		1320 W Main St	Newark	Licking	C	6411800
9	Madison Health	Madison County Hospital, Madison Health Hospital	210 North Main St.	London	Madison	C	6411585
10	Mary Rutan Hospital		205 Palmer Ave.	Bellefontaine	Logan	C	6410165
11	Memorial Health	Memorial Hospital Of Union County	500 London Ave.	Marysville	Union	C	6411665
12	Morrow County Hospital		651 W Marion Rd	Mount Gilead	Morrow	C	6411725
13	Mt. Carmel East Hospital		6001 E. Broad Street	Columbus	Franklin	C	6418083
14	Mt. Carmel St Ann's Hospital		500 South Cleveland Ave.	Westerville	Franklin	C	6411060
15	Mt Carmel West Hospital		793 W State St	Columbus	Franklin	C	6411035
16	Nationwide Children's Hospital		700 Children's Drive	Columbus	Franklin	C	6410950
17	OhioHealth Doctors Hospital	Doctors Hospital	5100 W Broad Street	Columbus	Franklin	C	6410952
18	OhioHealth Dublin Methodist Hospital	Dublin Methodist Hospital	7500 Hospital Dr.	Dublin	Franklin	C	8967218
19	OhioHealth Grady Memorial Hospital	Grady Memorial Hospital	561 W Central Ave.	Delaware	Delaware	C	6411245
20	OhioHealth Grant Medical Center	Grant Medical Center	111 S Grant Ave.	Columbus	Franklin	C	6411010
21	OhioHealth Grove City Methodist Hospital		1375 Stringtown Road	Grove City	Franklin	C	

*Facilities do not receive ASPR funding for the 2018-19 fiscal year but are participating in ASPR programs.

	Hospital Name	Former Names	Address	City	County	Region	AHA Number
22	OhioHealth Hardin Memorial Hospital	Hardin Memorial Hospital	921 East Franklin St.	Kenton	Hardin	C	6411470
23	OhioHealth Marion General Hospital	Marion General Hospital	1000 McKinley Park Dr.	Marion	Marion	C	6411640
24	OhioHealth Riverside Methodist Hospital	Riverside Methodist Hospital	3535 Olentangy River Rd	Columbus	Franklin	C	6411110
25	Ohio State University Hospital East		1492 East Broad St.	Columbus	Franklin	C	6411070
26	Ohio State University Medical Center		410 W 10th Ave.	Columbus	Franklin	C	6411100
27	Wyandot Memorial Hospital		885 N Sandusky Ave.	Upper Sandusky	Wyandot	C	6412225
28	Ashtabula County Medical Center		2420 Lake Ave.	Ashtabula	Ashtabula	NE	6410120
29	Bedford Medical Center/A Campus of UH Regional Hospitals	UH Bedford Medical Center, Bedford Hospital	44 Blaine Street	Bedford	Cuyahoga	NE	6410170
30	The Cleveland Clinic	Cleveland Clinic Foundation	9500 Euclid Ave.	Cleveland	Cuyahoga	NE	6410670
31	Cleveland Clinic Avon Hospital		33300 Cleveland Clinic Blvd	Avon	Lorain	NE	6410566
32	Cleveland Clinic Euclid Hospital		18901 Lake Shore Boulevard	Euclid	Cuyahoga	NE	6410695
33	Cleveland Clinic Fairview Hospital		18101 Lorain Ave.	Cleveland	Cuyahoga	NE	6410710
34	Hillcrest Hospital		6780 Mayfield Rd	Mayfield Heights	Cuyahoga	NE	6410945
35	LakeHealth-TriPoint Medical Center	Tri Point Medical Center, Lake East Hospital	7590 Auburn Rd	Concord	Lake	NE	6411870
36	LakeHealth-West Medical Center	West Medical Center, Lake West Medical Center	36000 Euclid Ave.	Willoughby	Lake	NE	6411870
37	Cleveland Clinic Lutheran Hospital		1730 West 25th St.	Cleveland	Cuyahoga	NE	6410780
38	Marymount Hospital		12300 McCracken Road	Garfield Heights	Cuyahoga	NE	6411375

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	Hospital Name	Former Names	Address	City	County	Region	AHA Number
39	Mercy Allen Hospital	Allen Community Hospital	200 W Lorain St	Oberlin	Lorain	NE	6411840
40	Mercy Regional Medical Center	Community Regional Medical Center Community Health Partners	3700 Kolbe Road	Lorain	Lorain	NE	6410014
41	MetroHealth Medical Center		2500 Metrohealth Drive	Cleveland	Cuyahoga	NE	6410655
42	Richmond Medical Center/A Campus of UH Regional Hospitals	UH Richmond Medical Center, Richmond Heights Hospital	27100 Chardon Road	Richmond Heights	Cuyahoga	NE	6419080
43	Cleveland Clinic South Pointe Hospital		20000 Harvard Road	Warrensville Heights	Cuyahoga	NE	6410018
44	Southwest General Health Center		18697 Bagley Rd	Middleburg Heights	Cuyahoga	NE	6410200
45	St Vincent Charity Medical Center	St. Vincent Charity Hospital	2351 E 22nd St	Cleveland	Cuyahoga	NE	6410027
46	University Hospitals Ahuja Medical Center	UH Ahuja Medical Center	3999 Richmond Road	Beachwood	Cuyahoga	NE	6410199
47	University Hospitals Cleveland Medical Center	University Hospitals Case Medical Center	11100 Euclid Ave.	Cleveland	Cuyahoga	NE	6410920
48	University Hospitals Conneaut Medical Center	UHHS Brown Hospital, UH Conneaut Medical Center	158 W Main Rd	Conneaut	Ashtabula	NE	6411120
49	University Hospitals Elyria Medical Center	EMH Elyria Medical Center	630 East River St.	Elyria	Lorain	NE	6411290
50	University Hospitals Geauga Medical Center	UH Geauga Medical Center	13207 Ravenna Rd	Chardon	Geauga	NE	6410335
51	University Hospitals Geneva Medical Center	UH Geneva Medical Center	870 West Main St	Geneva	Ashtabula	NE	6411376

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Regional Healthcare Preparedness Program
ASPR-participating Hospital Roster (as of 10/1/2018)

	Hospital Name	Former Names	Address	City	County	Region	AHA Number
52	University Hospitals Parma Medical Center	Parma Community General Hospital	7007 Powers Boulevard	Parma	Cuyahoga	NE	6410805
53	University Hospitals Rainbow Babies and Children's Hospital		11100 Euclid Ave.	Cleveland	Cuyahoga	NE	6410920
54	University Hospitals St. John Medical Center	St John Medical Center, St. John West Shore	29000 Center Ridge	Westlake	Cuyahoga	NE	6419020
55	Akron Children's Hospital		1 Perkins Square	Akron	Summit	NEC	6410055
56	Akron Children's Hospital Mahoning Valley		6505 Market Street	Youngstown	Mahoning	NEC	8967370
57	Alliance Community Hospital		200 East State Street	Alliance	Stark	NEC	6410080
58	Aultman Health Foundation	Aultman Hospital	2600 Sixth St. SW	Canton	Stark	NEC	6410280
59	Aultman Orrville Hospital	Dunlap Community Hospital	832 South Main St.	Orrville	Wayne	NEC	6411855
60	Cleveland Clinic Akron General	Akron General Medical Center; Akron General Health System	1 Akron General Ave.	Akron	Summit	NEC	6410010
61	East Liverpool City Hospital		425 W 5th St.	East Liverpool	Columbiana	NEC	6411280
62	Cleveland Clinic, Akron General Lodi Hospital	Lodi Community Hospital	225 Elyria St	Lodi	Medina	NEC	6411570
63	Cleveland Clinic Medina Hospital	Medina Hospital	1000 E Washington St	Medina	Medina	NEC	6411700
64	Mercy Medical Center		1320 Mercy Drive NW	Canton	Stark	NEC	6410290
65	OhioHealth Mansfield Hospital *Listed in SurgeNet as: "Mansfield Hospital OhioHealth*	OhioHealth Medcentral Mansfield Hospital; MedCentral Mansfield Hospital	335 Glessner Ave.	Mansfield	Richland	NEC	6410016

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Regional Healthcare Preparedness Program
ASPR-participating Hospital Roster (as of 10/1/2018)

	Hospital Name	Former Names	Address	City	County	Region	AHA Number
66	OhioHealth Shelby Hospital *Listed in SurgeNet as:* *"Shelby Hospital OhioHealth*	OhioHealth Medcentral Shelby Hospital; MedCentral Shelby Hospital	199 W. Main St.	Shelby	Richland	NEC	6410016
67	Pomerene Hospital	Joel Pomerene Memorial Hospital	981 Wooster Road	Millersburg	Holmes	NEC	6411720
68	Salem Regional Medical Center	Salem Community Hospital	1995 East State St.	Salem	Columbiana	NEC	6411959
69	St. Elizabeth Boardman Hospital	St Joseph Health Center, Humility of Mary Health Partners - St. Elizabeth Boardman Health Center	8401 Market Street	Boardman	Mahoning	NEC	8967376
70	St. Elizabeth Youngstown Hospital	St Elizabeth Health Center, Humility of Mary Health Partners - St Elizabeth Health Center	1044 Belmont Ave.	Youngstown	Mahoning	NEC	6412440
71	St. Joseph Warren Hospital	St Joseph Health Center, Humility of Mary Health Partners - St Joseph Health Center	667 Eastland Ave. Se	Warren	Trumbull	NEC	6412270
72	Summa Akron City Hospital	Akron City Hospital	525 E. Market St	Akron	Summit	NEC	6410030

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Regional Healthcare Preparedness Program
ASPR-participating Hospital Roster (as of 10/1/2018)

	Hospital Name	Former Names	Address	City	County	Region	AHA Number
73	Summa Barberton Hospital	Barberton Citizens Hospital; Barberton Hospital	155 Fifth St. NE	Barberton	Summit	NEC	6410150
74	Trinity Twin City Hospital	Twin City Hospital	819 North First St.	Dennison	Tuscarawas	NEC	6411250
75	Trumbull Memorial Hospital		1350 East Market St.	Warren	Trumbull	NEC	6412290
76	Cleveland Clinic Union Hospital	Union Hospital	659 Boulevard	Dover	Tuscarawas	NEC	6411260
77	University Hospitals Portage Medical Center	Robinson Memorial Hospital	6847 N Chestnut St	Ravenna	Portage	NEC	6411930
78	University Hospitals Samaritan Medical Center	Samaritan Regional Health System	1025 Center St	Ashland	Ashland	NEC	6410110
79	Northside Medical Center		500 Gypsy Lane	Youngstown	Mahoning	NEC	6412455
80	Western Reserve Hospital	Cuyahoga Falls General Hospital	1900 23rd St	Cuyahoga Falls	Summit	NEC	6419115
81	Wooster Community Hospital		1761 Beall Ave.	Wooster	Wayne	NEC	6412370
82	Avita Ontario Hospital		715 Richland Mall	Ontario	Richland	NEC	6410578
83	Blanchard Valley Hospital		1900 South Main St	Findlay	Hancock	NW	6410017
84	Bluffton Hospital		139 Garau St.	Bluffton	Allen	NW	6410210
85	Community Hospitals and Wellness Centers- Bryan		433 West High St.	Bryan	Williams	NW	6410225
86	Community Hospitals and Wellness Centers - Montpelier		909 East Snyder Ave.	Montpelier	Williams	NW	6410049
87	Community Memorial Hospital		208 N Columbus St	Hicksville	Defiance	NW	6411435
88	Firelands Regional Medical Center		1111 Hayes Ave.	Sandusky	Erie	NW	6410015
89	Fisher-Titus Medical Center		272 Benedict Ave.	Norwalk	Huron	NW	6411830
90	Fulton County Health Center		725 S Shoop Ave.	Wauseon	Fulton	NW	6412310
91	Henry County Hospital		1600 East Riverview Avenue	Napoleon	Henry	NW	6411780
92	Joint Township District Memorial Hospital		200 Saint Clair St.	Saint Marys	Auglaize	NW	6411955

*Facilities do not receive ASPR funding for the 2018-19 fiscal year but are participating in ASPR programs.

	Hospital Name	Former Names	Address	City	County	Region	AHA Number
93	Lima Memorial Health System		1001 Bellefontaine Ave.	Lima	Allen	NW	6411540
94	Magruder Hospital	H B Magruder Memorial Hospital	615 Fulton St	Port Clinton	Ottawa	NW	6411900
95	Mercer Health	Mercer County Community Hospital, Mercer County Joint Township Community Hospital	800 West Main St.	Coldwater	Mercer	NW	6410947
96	Mercy Health Defiance Hospital	Mercy Defiance Hospital	1404 E Second St	Defiance	Defiance	NW	6410047
97	Mercy Health St. Anne Hospital	Mercy St. Anne Hospital	3404 W. Sylvania Ave.	Toledo	Lucas	NW	6412150
98	Mercy Health St. Charles Hospital	Mercy St. Charles Hospital	2600 Navarre Ave.	Oregon	Lucas	NW	6412155
99	Mercy Health St. Vincent Medical Center	Mercy St Vincent's Medical Center	2213 Cherry St	Toledo	Lucas	NW	6412170
100	Mercy Health Tiffin Hospital	Mercy Tiffin Hospital	45 St. Lawrence Street	Tiffin	Seneca	NW	6412080
101	Mercy Health Willard Hospital	Mercy Willard Hospital	1100 Neal Zick Road	Willard	Huron	NW	6412342
102	Paulding County Hospital		1035 W Wayne St.	Paulding	Paulding	NW	6411880
103	ProMedica Bay Park Hospital		2801 Bay Park Drive	Oregon	Lucas	NW	6410032
104	ProMedica Defiance Regional Hospital		1200 Ralston Ave.	Defiance	Defiance	NW	6411230
105	ProMedica Flower Hospital		5200 Harroun Rd	Toledo	Lucas	NW	6412110
106	ProMedica Fostoria Community Hospital		501 Van Buren St	Fostoria	Seneca	NW	6411325
107	ProMedica Memorial Hospital	Memorial Hospital	715 South Taft Ave.	Fremont	Sandusky	NW	6411340
108	ProMedica Toledo Hospital/Toledo Children's Hospital	Toledo Hospital and Toledo Children's	2142 North Cove Boulevard	Toledo	Lucas	NW	6412180

*Facilities do not receive ASPR funding for the 2018-19 fiscal year but are participating in ASPR programs.

Regional Healthcare Preparedness Program
ASPR-participating Hospital Roster (as of 10/1/2018)

	Hospital Name	Former Names	Address	City	County	Region	AHA Number
109	St. Luke's Hospital	ProMedica St. Luke's Hospital	5901 Monclova Rd	Maumee	Lucas	NW	6412160
110	Mercy Health St Rita's Medical Center	St. Rita's Medical Center	730 West Market St.	Lima	Allen	NW	6411560
111	The Bellevue Hospital		1400 W. Main St.	Bellevue	Sandusky	NW	6410190
112	University of Toledo Medical Center		3000 Arlington Ave.	Toledo	Lucas	NW	6412130
113	Van Wert Health	Van Wert County Hospital	1250 S Washington St.	Van Wert	Van Wert	NW	6412240
114	Wood County Hospital		950 W Wooster St	Bowling Green	Wood	NW	6410217
115	Adena Health System	Adena Regional Medical Center	272 Hospital Rd	Chillicothe	Ross	SC	6410340
116	Adena Pike Medical Center	Pike Community Hospital	100 Dawn Lane	Waverly	Pike	SC	6412313
117	Hocking Valley Community Hospital*		PO Box 966-601 ST RT 664 North	Logan	Hocking	SC	6411579
118	Holzer Medical Center		100 Jackson Pike	Gallipolis	Gallia	SC	6411370
119	Holzer Medical Center Jackson		500 Burlington Road	Jackson	Jackson	SC	6410042
120	O' Bleness Memorial Hospital		55 Hospital Drive	Athens	Athens	SC	6410140
121	Southern Ohio Medical Center		1805 27th St.	Portsmouth	Scioto	SC	6411905
122	Barnesville Hospital Association*		639 West Main St., Po Box 309	Barnesville	Belmont	SE	6410160
123	Belmont Community Hospital*		4697 Harrison St.	Bellaire	Belmont	SE	6410180
124	Coshocton County Memorial Hospital		1460 Orange St.	Coshocton	Coshocton	SE	6411130
125	East Ohio Regional Hospital		90 North Fourth St.	Martins Ferry	Belmont	SE	6411660
126	Genesis Healthcare System - Good Samaritan Hospital	Select Specialty Hospital	800 Forest Ave.	Zanesville	Muskingum	SE	6410020
127	Harrison Community Hospital*		951 East Market St.	Cadiz	Harrison	SE	6410243
128	Marietta Memorial Hospital		401 Matthew St.	Marietta	Washington	SE	6411630
129	Selby General Hospital		1106 Colegate Drive	Marietta	Washington	SE	6419165
130	Southeastern Ohio Regional Medical Center		1341 North Clark St.	Cambridge	Guernsey	SE	6410265
131	Trinity Medical Center-West*		4000 Johnson Rd	Steubenville	Jefferson	SE	6412075
132	Adams County Regional Medical Center		230 Medical Center Drive	Seaman	Adams	SW	6412315

*Facilities do not receive ASPR funding for the 2018-19 fiscal year but are participating in ASPR programs.

Regional Healthcare Preparedness Program
ASPR-participating Hospital Roster (as of 10/1/2018)

	Hospital Name	Former Names	Address	City	County	Region	AHA Number
133	Adena Greenfield Medical Center	Greenfield Area Medical Center	550 Mirabeau St.	Greenfield	Highland	SW	6411385
134	Atrium Medical Center	Middletown Hospital	One Medical Center Drive	Middletown	Warren	SW	6411710
135	Bethesda Butler Hospital		3125 Hamilton Mason Road	Hamilton	Butler	SW	6410077
136	Bethesda North Hospital		10500 Montgomery Rd	Cincinnati	Hamilton	SW	6410382
137	Cincinnati Children's Hospital Liberty Campus		7777 Yankee Road	Liberty Township	Butler	SW	6410391
138	Cincinnati Children's Hospital Medical Center		3333 Burnet Ave.	Cincinnati	Hamilton	SW	6410391
139	Clinton Memorial Hospital		610 West Main St.	Wilmington	Clinton	SW	6412345
140	Fort Hamilton Hospital*		630 Eaton Ave.	Hamilton	Butler	SW	6411405
141	Good Samaritan Hospital- Cincinnati		375 Dixmyth Ave.	Cincinnati	Hamilton	SW	6410490
142	Highland District Hospital		1275 North High St.	Hillsboro	Highland	SW	6411440
143	McCullough-Hyde Memorial Hospital		110 North Poplar St.	Oxford	Butler	SW	6411858
144	Mercy Health- Anderson Hospital		7500 State Road	Cincinnati	Hamilton	SW	6410580
145	Mercy Health- Clermont Hospital		3000 Hospital Drive	Batavia	Clermont	SW	6410155
146	Mercy Health-Fairfield Hospital		3000 Mack Road	Fairfield	Butler	SW	6410855
147	Mercy Health-West Hospital	Mercy Health Western Hills Hospital, Mercy Health Mt. Airy Hospital	3300 Mercy Health Blvd.	Cincinnati	Hamilton	SW	6410582
148	Shriners Hospital For Children-Cincinnati	Shriners Hospital for Children	3229 Burnet Ave.	Cincinnati	Hamilton	SW	6410622
149	The Christ Hospital Health Network	The Christ Hospital	2139 Auburn Ave.	Cincinnati	Hamilton	SW	6410430
150	The Christ Hospital Medical Center – Liberty Township*		7335 Yankee Road	Liberty Township	Butler	SW	TBD
151	The Jewish Hospital-Mercy Health		4777 East Galbraith Road	Cincinnati	Hamilton	SW	6419060
152	University of Cincinnati Medical Center	University Hospital	234 Goodman St.	Cincinnati	Hamilton	SW	6410435

*Facilities do not receive ASPR funding for the 2018-19 fiscal year but are participating in ASPR programs.

Regional Healthcare Preparedness Program
ASPR-participating Hospital Roster (as of 10/1/2018)

	Hospital Name	Former Names	Address	City	County	Region	AHA Number
153	West Chester Hospital	West Chester Medical Center	7700 University Drive	West Chester	Butler	SW	8967414
154	Dayton Children's	Children's Medical Center	One Children's Plaza	Dayton	Montgomery	WC	6411160
155	Grandview Medical Center*	Grandview Hospital & Medical Center	405 Grand Ave.	Dayton	Montgomery	WC	6411182
156	Greene Memorial Hospital*		1141 North Monroe Drive	Xenia	Greene	WC	6412395
157	Indu & Raj Soin Medical Center*		3535 Pentagon Boulevard	Beavercreek	Greene	WC	8967375
158	Kettering Medical Center*		3535 Southern Boulevard	Kettering	Montgomery	WC	6411466
159	Mercy Memorial Hospital		904 Scioto St.	Urbana	Champaign	WC	6412235
160	Miami Valley Hospital		One Wyoming St.	Dayton	Montgomery	WC	6411190
161	Miami Valley Hospital North		9000 North Main Street	Dayton	Montgomery	WC	6411190
162	Miami Valley Hospital South		2400 Miami Valley Drive	Centerville	Montgomery	WC	6411190
163	Southview Medical Center*	Southview Hospital	1997 Miamisburg Ctrville Rd	Dayton	Montgomery	WC	6411186
164	Springfield Regional Medical Center	Springfield Regional Medical Center – High Street Campus	100 medical center Drive	Springfield	Clark	WC	6412050
165	Sycamore Medical Center*		4000 Miamisburg-Centerville Road	Miamisburg	Montgomery	WC	6411173
166	Upper Valley Medical Center		3130 N. County Rd. 25-A	Troy	Miami	WC	6410022
167	Wayne Health Care	Wayne Hospital	835 Sweitzer St.	Greenville	Darke	WC	6411400
168	Wilson Health	Wilson Memorial Hospital	915 West Michigan St.	Sidney	Shelby	WC	6412020

*Facilities do not receive ASPR funding for the 2018-19 fiscal year but are participating in ASPR programs.

REGION **Appendix G**

Hospital Preparedness Program (HPP)

Regional Healthcare Coalition Membership Roster

Participating Members	Organization Type	If '*Other*' please elaborate	Organization Name	Address	County	Primary Point of Contact (POC) Name	Primary POC Telephone Number(s)	Primary POC email address	Secondary POC Name	Secondary POC Telephone Number(s)	Secondary POC email address

Ohio Department of Health

Change of Record Form

RHC Agency Name:

Change #	Change Date	Page # of Change	Description of change	Effective date
1				
2				
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APPENDIX I

Ohio Public Health Emergency Preparedness (PHEP) & Healthcare Preparedness Program (HPP) Regional Coordinators

Effective 07/01/2019

* Designates PHEP Regional Subrecipient

APPENDIX J

List of Documents that will be posted in the OPHCS Library

*The following documents, referenced in the solicitation will be uploaded to the OPHCS library July 1, 2019:

1. ***BP1/SFY20 Coalition Requirements***
2. ***BP1/SFY20 Coalition Membership Roster***
3. ***HCC Response Plan Guidance for FY2020***
4. ***OHTrac Action Plan Template***
5. ***Communications Worksheet***
6. ***emPOWER Presentation Guidance for FY2020***
7. ***BP1/SFY20 Exercise Deliverable Technical Assistance Document***
8. ***ODH AAR/IP Template***
9. ***ODH MYTEP Template***

APPENDIX K

Code of Federal Regulations (CFR), Title 45, §92.24, Matching or Cost Sharing

(a) Basic rule: Costs and contributions acceptable.

With the qualifications and exceptions listed in paragraph (b) of this section, a matching or cost sharing requirement may be satisfied by either or both of the following:
(1) Allowable costs incurred by the grantee, sub grantee or a cost-type contractor under the assistance agreement. This includes allowable costs borne by non- Federal grants or by other cash donations from non-Federal third parties.

(2) The value of third party in-kind contributions applicable to the period to which the cost sharing or matching requirement applies.

(b) Qualifications and exceptions—
(1) Costs borne by other Federal grant agreements.

Except as provided by Federal statute, a cost sharing or matching requirement may not be met by costs borne by another Federal grant. This prohibition does not apply to income earned by a grantee or sub grantee from a contract awarded under another Federal grant.
(2) General revenue sharing.

For the purpose of this section, general revenue sharing funds distributed under 31 U.S.C. 6702 are not considered Federal grant funds.
(3) Cost or contributions counted towards other Federal costs-sharing requirements.

Neither costs nor the values of third party in-kind contributions may count towards satisfying a cost sharing or matching requirement of a grant agreement if they have been or will be counted towards satisfying a cost sharing or matching requirement of another Federal grant agreement, a Federal procurement contract, or any other award of Federal funds.
(4) Costs financed by program income.

Costs financed by program income, as defined in Sec. 92.25, shall not count towards satisfying a cost sharing or matching requirement unless they are expressly permitted in the terms of the assistance agreement. (This use of general program income is described in Sec. 92.25(g).)
(5) Services or property financed by income earned by contractors.

Contractors under a grant may earn income from the activities carried out under the contract in addition to the amounts earned from the party awarding the contract. No costs of services or property supported by this income may count toward satisfying a cost sharing or matching requirement unless other provisions of the grant agreement expressly permit this kind of income to be used to meet the requirement.
(6) Records. Code of Federal Regulations (CFR), Title 45, §92.24, Matching or Cost Sharing Page 2 of 4

Costs and third party in-kind contributions counting towards satisfying a cost sharing or **matching** requirement must be verifiable from the records of grantees and sub grantee or cost-type contractors. These records must show how the value placed on third party in-kind contributions was derived. To the

extent feasible, volunteer services will be supported by the same methods that the organization uses to support the allowability of regular personnel costs.

(7) Special standards for third party in-kind contributions.

(i) Third party in-kind contributions count towards satisfying a cost sharing or matching requirement only where, if the party receiving the contributions were to pay for them, the payments would be allowable costs.

(ii) Some third party in-kind contributions are goods and services that, if the grantee, sub grantee, or contractor receiving the contribution had to pay for them, the payments would have been indirect costs. Costs sharing or matching credit for such contributions shall be given only if the grantee, sub grantee, or contractor has established, along with its regular indirect cost rate, a special rate for allocating to individual projects or programs the value of the contributions.

(iii) A third party in-kind contribution to a fixed-price contract may count towards satisfying a cost sharing or matching requirement only if it results in:

(A) An increase in the services or property provided under the contract (without additional cost to the grantee or sub grantee) or

(B) A cost savings to the grantee or sub grantee.

(iv) The values placed on third party in-kind contributions for cost sharing or matching purposes will conform to the rules in the succeeding sections of this part. If a third party in-kind contribution is a type not treated in those sections, the value placed upon it shall be fair and reasonable.

(c) Valuation of donated services—

(1) Volunteer services.

Unpaid services provided to a grantee or sub grantee by individuals will be valued at rates consistent with those ordinarily paid for similar work in the grantee's or sub grantee's organization. If the grantee or sub grantee does not have employees performing similar work, the rates will be consistent with those ordinarily paid by other employers for similar work in the same labor market. In either case, a reasonable amount for fringe benefits may be included in the valuation.

(2) Employees of other organizations.

When an employer other than a grantee, sub grantee, or cost-type contractor furnishes free of charge the services of an employee in the employee's normal line of work, the services will be valued at the employee's regular rate of pay exclusive of the employee's fringe benefits and overhead costs. If the services are in a different line of work, paragraph (c)(1) of this section applies.

(d) Valuation of third party donated supplies and loaned equipment or space.

(1) If a third party donates supplies, the contribution will be valued at the market value of the supplies at the time of donation.

(2) If a third party donates the use of equipment or space in a building but retains title, the contribution will be valued at the fair rental rate of the equipment or space.

(e) Valuation of third party donated equipment, buildings, and land.

If a third party donates equipment, buildings, or land, and title passes to a grantee or sub grantee, the treatment of the donated property will depend upon the purpose of the grant or sub grant, as follows:

(1) Awards for capital expenditures.

If the purpose of the grant or sub grant is to assist the grantee or sub grantee in the acquisition of property, the market value of that property at the time of donation may be counted as cost sharing or matching,

(2) Other awards

If assisting in the acquisition of property is not the purpose of the grant or sub grant, paragraphs (e)(2)(i) and (ii) of this section apply:
(i) If approval is obtained from the awarding agency, the market value at the time of donation of the donated equipment or buildings and the fair rental rate of the donated land may be counted as cost sharing or matching. In the case of a sub grant, the terms of the grant agreement may require that the approval be obtained from the Federal agency as well as the grantee. In all cases, the approval may be given only if a purchase of the equipment or rental of the land would be approved as an allowable direct cost. If any part of the donated property was acquired with Federal funds, only the

non-federal share of the property may be counted as cost-sharing or matching.
(ii) If approval is not obtained under paragraph (e)(2)(i) of this section, no amount may be counted for donated land, and only depreciation or use allowances may be counted for donated equipment and buildings. The depreciation or use allowances for this property are not treated as third party in-kind contributions. Instead, they are treated as costs incurred by the grantee or sub grantee. They are computed and allocated (usually as indirect costs) in accordance with the cost principles specified in Sec.

92.22, in the same way as depreciation or use allowances for purchased equipment and buildings. The amount of depreciation or use allowances for donated equipment and buildings is based on the property's market value at the time it was donated.
(f) Valuation of grantee or sub grantee donated real property for construction/acquisition.

If a grantee or sub grantee donates real property for a construction or facilities acquisition project, the current market value of that property may be counted as cost sharing or matching. If any part of the donated property was acquired with Federal funds, only the non-federal share of the property may be counted as cost sharing or matching.
(g) Appraisal of real property.

In some cases under paragraphs (d), (e) and (f) of this section, it will be necessary to establish the market value of land or a building or the fair rental rate of land or of space in a building. In these cases, the Federal agency may require the market value or fair rental value be set by an independent appraiser, and that the value or rate be certified by the grantee. This requirement will also be imposed by the grantee on sub grantees.

Appendix L

Hospital Preparedness Program

Regional Healthcare Coalition
Coalition Requirements
November 2018

Table of Contents

Introduction

In 2006, The Pandemic and All Hazards Preparedness Act initiated the transfer of the National Bioterrorism Hospital Preparedness Program (NBHPP) from the Health Resources and Services Administration (HRSA) to the Assistant Secretary for Preparedness and Response (ASPR). The focus of the program is now all-hazards preparedness from the original focus on bioterrorism. This governance document has been developed in accordance with the 2017-2022 Health Care Preparedness and Response Capabilities guidance developed by the U.S. Department of Health and Human Services' (HHS') Office of the Assistant Secretary for Preparedness and Response (ASPR).

The U.S. Department of Health and Human Services (HHS) Office of the Assistant Secretary for Preparedness and Response (ASPR) leads the country in preparing for, responding to, and recovering from the adverse health effects of emergencies and disasters. This is accomplished by supporting the nation's ability to withstand adversity, strengthening health and emergency response systems, and enhancing national health security. ASPR's Hospital Preparedness Program (HPP) enables the health care delivery system to save lives during emergencies and disaster events that exceed the day-to-day capacity and capability of existing health and emergency response systems. HPP is the only source of federal funding for health care delivery system readiness, intended to improve patient outcomes, minimize the need for federal and supplemental state resources during emergencies, and enable rapid recovery. HPP prepares the health care delivery system to save lives through the development of health care coalitions (HCCs) that incentivize diverse and often competitive health care organizations with differing priorities and objectives to work together.

The ASPR Hospital Preparedness Program (HPP) also enhances the ability of hospitals and health care systems to prepare for and respond to bioterrorism and other public health emergencies. Program priority areas include interoperable communication systems, National Incident Medical System compliance and training, bed tracking, personnel management, mass fatality management planning and hospital evacuation and shelter in place planning. During the past five years, HPP funds have also improved medical surge capacity and resources, decontamination capabilities, isolation capacity, pharmaceutical supplies, training, education, drills and exercises.

Hospitals, outpatient facilities, health centers, poison control centers, Emergency Medical Services (EMS) and other healthcare partners work with the appropriate state or local health department to acquire funding and improve healthcare system preparedness through this program. Funding is distributed directly to the Health Department of the State or political subdivision of a State (cities and counties are considered political subdivisions of States).

ASPR developed the 2017-2022 Health Care Preparedness and Response Capabilities guidance to describe what the health care delivery system, including HCCs, hospitals, and emergency medical services (EMS), have to do to effectively prepare for and respond to emergencies that impact the

public's health. Each jurisdiction, including emergency management organizations and public health agencies, provides key support to the health care delivery system.

Overview of Ohio's Regional Healthcare Coalitions

Ohio consists of eight Homeland Security Planning regions covering 88 counties, 44,828 square miles and over 11,660,000 people.

To assure collaborative planning and efficient response during a disaster, the coalitions have worked together for the past 15 years to plan, train, exercise and respond to events that affect healthcare providers and their patients. Partners have responded together to numerous floods and evacuations of long term care facilities, vaccine shortages, and the H1N1 pandemic.

Purpose

The purpose of the Regional Healthcare Coalition is to provide training and exercises, the coordination of plans, and operational support during emergency response, and to develop policies and procedures that identify responsibilities required for the successful interoperability of coalition partners: hospitals, public health, EMS, emergency management, and community partners during a major disaster.

Regional Healthcare Coalitions are formed by a network of healthcare organizations, government agencies, long term care, and other providers working together to strengthen emergency preparedness, response and recovery. The coalitions work to train all members in the local disaster response system procedures to ensure:

- All healthcare and long-term care agencies and facilities develop and exercise effective disaster plans
- Adequate and collaborative medical surge operations to care for victims of a mass casualty and/or large-scale events
- Ability to accurately determine the status of the region's healthcare system and the safety and location of patients and clients

Coalition Roles and Responsibilities during Disaster Response

In Ohio, the Regional Healthcare Coordinator serves as the Regional Healthcare Coalition lead and provides situational awareness, coordination, information sharing and communication for the healthcare systems within their region. Capability 2 of the *2017-2022 Health Care Preparedness and Response Capabilities* states:

Capability 2. Health Care and Medical Response Coordination

Health care and medical response coordination enables the health care delivery system and other organizations to share information, manage and share resources, and integrate their activities within their jurisdictions' Emergency Support Function-8 (ESF-8, Public Health and Medical Services) lead agency and ESF-6 (Mass Care, Emergency Assistance, Housing, and Human Services) lead agency at both the federal and state levels.

Private health care organizations and government agencies, including those serving as ESF-8 lead agencies, have shared authority and accountability for health care delivery system readiness, along with specific roles. In this context, Ohio health care coalitions (HCCs) serve a communication and coordination role within their respective jurisdiction(s). This coordination ensures the integration of health care delivery into the broader community's incident planning objectives and strategy development. It also ensures that resource needs that cannot be managed within the county can be rapidly communicated throughout the region and to the. HCC coordination may occur at its own coordination center, the local Emergency Operations Center (EOC), or by virtual means – all of which are intended to interface with the ESF-8 lead agency.

Regional Healthcare Coalition Governance

In Objective 1, Activity 3, Capability 1 of the Office of the Assistant Secretary for Preparedness and Response's (ASPR) 2017-2022 Health Care Preparedness and Response Capabilities, subrecipients are given instructions on how to establish health care coalition governance, as follows:
The HCC should define and implement a structure and processes to execute activities related to health care delivery system readiness and coordination. The elements of governance include organizational structures, roles and responsibilities, mechanisms to provide guidance and direction, and processes to

ensure integration with the ESF-8 lead agency. The HCC should specify how structure, processes, and policies may shift during a response, as opposed to a steady state. HCC members should adopt these elements and be part of regular reviews.

The HCC should document the following information related to its governance:

- *HCC membership*
- *An organizational structure to support HCC activities, including executive and general committees, election or appointment processes, and any necessary administrative rules and operational functions (e.g., bylaws)*
- *Member guidelines for participation and engagement that consider each member and region's geography, resources, and other factors*
- *Policies and procedures, including processes for making changes, orders of succession, and delegations of authority*
- *HCC integration within existing state, local, and member-specific incident management structures and specified roles—such as a primary point of contact who serves as the liaison to the ESF-8 lead agency and EOCs during an emergency*

Areas of Focus

Planning

The Coalition will focus on planning efforts to provide the best care for the public during a disaster, through collaboration between healthcare partners and community partners. Planning focus is determined on an annual basis and includes, but is not limited to, the following:

- Conduct specific workgroups or workshops to address how different types of providers (skilled nursing, dialysis, outpatient, home health, hospitals) can care for their patients during and after disasters/emergencies. Some possible examples of workgroups include:
    - Evacuation and shelter in place plans for long-term care facilities
    - Response to infectious disease including mass prophylaxis
    - Medical shelter planning with American Red Cross, public health, home health
- The Regional Healthcare Coordinator must develop and maintain Coalition response and preparedness plans to ensure health services are available during and after a disaster, and to increase the capacity of the healthcare system to respond to potential increased demand.

Training

The Coalition will focus on providing emergency preparedness training and educational opportunities for pre-hospital, hospital and outpatient healthcare personnel that will respond to a terrorist incident or other public health emergency. Possible training topics include:

- Long term care/home health/clinic disaster plan training
- Resource Request Training for Healthcare Providers
- National Incident Management System (NIMS)
- Evacuation planning for long term care and outpatient providers
- Hospital Incident Command System (HICS)
- Mass Casualty Incident—Active shooter
- Medical Shelter, Field Treatment Site, and Mass Prophylaxis
- Other training activities as identified/requested

Exercises

Participation in exercises tests disaster plans, communication and coordination of resources. Coalition members are encouraged to participate in exercises to test disaster plans and coordination of status and resources.

- Annual coalition surge test
- Communication drills for radios
- Other exercises as proposed by healthcare partner coalition
- Quarterly hospital request drills

Regional Healthcare Coalition Structure

Core Membership

Coalition membership must include:

A. Public Health

B. EMS

C. Local EMA

D. Hospitals

Executive Steering Committee Membership

- Executive Steering Committee and full Coalition meetings will be led by the **Regional Healthcare Coordinator (RHC)**.
- The **Regional Public Health Coordinator (RPHC)** must participate as a non-voting member of their Regional Healthcare Coalition's Executive Steering Committee, and fulfill all Executive

Steering Committee roles, responsibilities, and participation requirements as outlined in the Regional Healthcare Coalition Requirements.

Committee membership must include:

- At least one member from any of the 17 provider types subject to the **CMS Preparedness Rule.**
- **At least one representative from each county** within the region.
- Additionally, each core discipline (Public Health, EMA, EMS and Hospital) must be represented by the following breakdown:
    - 10 or fewer counties in your region: **at least one from each discipline.**
    - Greater than 10 counties in your region: **at least two from each discipline.**

Additional Coalition Partnership/Membership

A. American Red Cross

B. Outpatient Surgical Centers

C. Hospices

D. Law Enforcement Agencies

E. Department of Social Services

F. Mental Health Facilities

G. Maternal and Child Health Programs

H. Community Service Agencies

I. Amateur Radio Operators

J. Community non-profit organizations

K. Long-Term Care (LTC) Facilities

L. Critical Access Hospitals

M. Any of the 17 provider type agencies who are subject to the CMS Emergency Preparedness Rule

N. Additional partners as determined by the partnership/coalition

Additionally, coalitions may want to look to the Ohio Public Private Partnership (OP3) for members and future collaboration. In an effort to increasingly serve Ohioans before, during and after a disaster, the

Ohio Department of Public Safety (ODPS) created the OP3 program to strengthen partnerships between citizens, government, higher education, and private businesses. OP3 is an initiative designed to provide current information and situational awareness on disaster prevention, response, and recovery efforts to state agency and business executives, allowing decisions and resources to best support the needs of the impacted community.

Leadership

The Coalition governance structure was created by the Ohio Department of Health and carried out by an **Executive Steering Committee**.

Executive Steering Committee Roles and Responsibilities
Executive Steering Committee members must:

- Meet at least six times per year (50% of meetings may be conducted via conference call)
- Participate in scheduled meetings and activities
    - Take minutes for all Executive Steering Committee and full Coalition meetings and distribute to the full Coalition
- Obtain input on healthcare preparedness priorities from healthcare partners of similar disciplines within their region

The Regional Healthcare Coordinator, as the lead of the Executive Steering Committee, must:

- Decide the agenda for full Coalition meetings
- Provide situational awareness to local, county, and state partners
- Develop and engage in information sharing processes
- Integrate and coordinate disaster response operations across the healthcare system to meet the needs of the public
- Conduct a Hazard Vulnerability Analysis (HVA)
- Determine the training and exercise schedule for the Coalition
- Report out Executive Steering Committee activities to the full coalition
- Provide guidance over the development and evolution of the Coalition
- Determine the scope of services that the Coalition provides
- Maintain a record of regional resources and deployment plan
- Develop a HCC Spend Plan that includes the total HPP funding allocation and how it will be disbursed
- Must disseminate the HCC spend plan to all HCC members
- Consider the needs of the entire region in Committee deliberations

Executive Steering Committee

- If an individual representing an organization withdraws from participation or is terminated by the organization, the organization will appoint a new representative within 60 days.

- If RHCs are unable to find Executive Steering Committee representation from certain counties or disciplines as required above, they must provide ODH with evidence that an attempt was made to recruit these members *and* that the agency declined to participate (letters or emails are best).

- It is *recommended* that coalitions seek out members representing clinical and executive leadership of regional agencies, to promote buy-in across all facility and organization types, clinical departments, and non-clinical support services.

Executive Steering Committee Participation Requirements

By signing the ***Commitment to Participate***, Executive Steering Committee members will participate in the following activities to the best of their ability and as appropriate to their facility, agency or organization:

- Attend Executive Steering Committee meetings in their region.
- Participate in disaster/emergency trainings, drills, and exercises appropriate to their facility or agency.
- Participate in the annual healthcare partner disaster exercise and write after action reports with improvement plans for their agency/facility.
- Provide input and expertise when asked in order to develop or improve coalition plans, policies or procedures.
- Ensure that their facility or agency disaster plans and procedures have written procedures for how to contact and integrate with other providers and agencies during a disaster.

All members are requested to document their participation in the Executive Steering Committee and their coordination of disaster plans by signing the ***Commitment to Participate*.** This agreement does not supersede or replace any policies and/or procedures of each member's facility, agency, or organization, or any regulatory or licensing policies which may apply.

A copy of the ***Commitment to Participate*** signature page can be found in Appendix A.

Healthcare Coalition Participation

Coalition members that receive funding, equipment, or supplies to support their preparedness activities will enter into formal agreements. These agreements address the receivables and deliverables, including participation in Coalition activities. The agreements must also address mutual assistance during response to an event/emergency.

All coalition members benefit from the planning, trainings, exercises and expertise that are part of the overall collaboration of the healthcare partners with the goal of improving preparedness for disaster events in the region. The Coalition has various avenues and opportunities for healthcare organizations to participate in preparedness activities, test their capabilities and share best practices, including:

- Disaster communication drills
- Meeting, networking, and information sharing with members and other partner healthcare organizations
- Trainings
- Exercises

CMS Emergency Preparedness Rule

On September 8, 2016 the Federal Register posted the final rule *Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers.*

The regulation went into effect on November 16, 2016. Health care providers and suppliers affected by this rule were required to comply and implement all regulations one year after the effective date, on November 15, 2017. Each provider and supplier will have its own set of Emergency Preparedness regulations incorporated into its set of conditions or requirements for certification. There are 17 provider types to which this rule applies, and each agency included in these provider types must be in compliance with Emergency Preparedness regulations to participate in the Medicare or Medicaid program. These agencies' engagement a Healthcare Coalition may help fulfill your conditions of participation regarding the Emergency Preparedness Final Rule. However, these agencies *cannot* receive preparedness funding to meet Conditions of Participation (CoPs), as mandated by federal guidelines.

Access and Functional Needs Planning

Disaster events naturally increase the vulnerability of the entire affected population. Individuals who may not be "at risk" under normal conditions may be unable to protect and/or care for themselves as usual. The definition of persons with access and functional needs is fluid and evolving, but may include:

- Persons at extremes of age (young and elderly)
- Persons with cognitive or intellectual functional impairments
- Persons with special medical needs
- Persons who are homebound due to age, health, or mobility difficulties
- People needing bariatric equipment
- Individuals living in institutionalized settings, including hospital patients
- Persons requiring medications or specialized medical equipment for survival
- Persons who are culturally or physically isolated
- Women in late stages of pregnancy
- Persons with limited English proficiency
- Persons who are economically disadvantaged

The Regional Healthcare Coalition supports policies, activities and collaborations that encourage inclusion of individuals with access and functional needs in each phase of the emergency management cycle (preparedness, response, recovery, mitigation). The Coalition should promote activities to see that the following needs are addressed:

- Reasonable efforts should be made to reunite members of the functional needs community with necessary durable medical supplies and specialized equipment (wheelchairs, walkers, telephones) that are left behind in an evacuation or emergency transport.

- Personal and family preparedness education programs and promotion of local jurisdiction registries in accessible formats and languages which should reach most or all people in the jurisdiction.

- Emergency human services which are vital for the long-term recovery of a community and are as important as the repairs to its physical infrastructure.

- A sustained long-term commitment to providing human services to restore all residents to a state of mental, physical and social wellbeing.

NIMS Compliance

In compliance with Assistant Secretary for Preparedness and Response (ASPR) requirements, health care system partners use the Incident Command System (ICS) utilized by the National Incident Management System (NIMS) to manage incident response. The National Incident Management System (NIMS) provides a nationwide template to enable Federal, State and local governments, private sector and nongovernmental organizations to work together effectively and efficiently to prevent, prepare for, respond to, and recover from emergency and disaster incidents regardless of cause, size, or complexity. NIMS provides guidelines for common functions and terminology to support clear communications and effective collaboration in an emergency situation.

All facilities receiving federal ASPR funds are required to train assigned preparedness and response staff in incident command in order to meet federal requirements. There are many ways to meet the NIMS training requirements set forth by ASPR. The Federal Emergency Management Agency's Emergency Management Institute (EMI) has online courses in each of the NIMS training elements. Coalition members should ensure that their agencies' emergency management, preparedness and other related staff are trained to an appropriate level of NIMS compliance. This will ensure that the hospital's ICS is integrated into and consistent with its community's command structure.

The Regional Healthcare Coalition will provide support and facilitate training to comply with the baseline NIMS training guidance. Each member hospital and healthcare facility will keep their own records of compliance with guidelines and the Regional Healthcare Coordinator will follow-up to ensure compliance with audits.

Ohio Regional Healthcare Coalition Executive Steering Committee

Commitment to Participate

Signature Page

To assure collaborative planning and efficient response during a disaster, an Executive Steering Committee, including formal membership of partners, was implemented in the _____ region to oversee the Regional Healthcare Coalition.

_____

(organization's name)

will participate as an official member of the Regional Healthcare Coalition Executive Steering Committee.

By signing below, I acknowledge that I have read the *Ohio Regional Healthcare Coalition Requirements* and that our organization agrees to participate in the Executive Steering Committee for our Regional Healthcare Coalition according to the responsibilities established in the *Ohio Regional Healthcare Coalition Requirements.*

Organization's Executive Signature / Name and Title printed / Date

---

Organization's Disaster Coordinator Signature / Name and Title Printed / Date

To submit, please click the appropriate regional email button.

REGION 1 (submit)	REGION 2 (submit)	REGION 3 (submit)	REGION 4 (submit)
REGION 5 (submit)	REGION 6 (submit)	REGIONS 7 & 8 (submit)	

ATTACHMENT #1

Contact Information
REGIONAL HEALTHCARE SYSTEM COORDINATION FOR DISASTER PREPAREDNESS PROGRAM

Revised Date (mm/dd/yyyy): _____

(Any updates must be submitted to ODH throughout the year within 15 days of a change happening)

1. Identify the Regional Healthcare Coordinator (RHC) and the back-up to the RHC:

	RHC Primary	RHC Back-Up
Name		
Agency		
Phone		
E-mail		
Cell Phone		

2. Identify the subgrantee MARCS contact person: (Must also maintain/update Hospital MARCs & OPHCS contacts as requested by ODH)

	MARCS Primary	MARCS Back-Up
Name		
Agency		
Phone		
E-mail		
Cell Phone		

3. Identify the subgrantee OPHCS contact person: (Must also maintain/update Hospital MARCs & OPHCS contacts as requested by ODH)

	OPHCS Primary	OPHCS Back-Up
Name		
Agency		
Phone		
E-mail		
Cell Phone		

4. Identify 24/7 Contact:

	24/7 Primary	24/7 Back-Up
Name		
Agency		
Phone		
E-mail		
Cell Phone		

ATTACHMENT #2

Match Documentation Letter

Date:

Name of Health Commissioner/Agency Head Agency Name
Address

Dear ODH:

Our agency is required to contribute a total of___Matching funds to the Hospital Preparedness Program (HPP) grant, project #_____for the period of July 1, 2017 – June 30, 2018. Our total grant amount is_____. This match includes a minimum 7.7% match. The table below outlines the source and amount of the funds.

These funds are not used for other Match requirements nor are they federal funds. The funds come from our general revenue from our health department. These Matching funds reflect work and activities that enhance and support our public health preparedness efforts in our jurisdiction. If you have any questions about this, please contact your Public Health Consultant.

Sincerely,

_____

Agency Head (must be signed)

Match Category	Match Description	Match Amount
TOTAL MATCH AMOUNT		

ATTACHMENT #3

BUDGET JUSTIFICATION-HPP
SCENARIO 3

NOTES: Budget justification line items MUST be in the same order as in the GMIS budget.

A detailed breakout of the deliverable budget is not required and should not be included in the budget justification.

Provide the amount of funding for which the subgrantee will seek reimbursement based on the percentage ascribed to the Deliverable on C1. This document must be submitted with the signature of the Agency Head with the grant application.

OTHER DIRECT COSTS

Deliverable – Objective 1

Objective 1.1: By **September 6, 2019**, the subrecipient will submit a current Coalition Membership Roster using the ***BP1/SFY20 Coalition Membership Roster*** via GMIS. $_____

Deliverable – Objective 2

- **Objective 2.1**: By **July 30, 2019**, the subrecipient will submit a calendar schedule for six HCC meetings within the grant year via GMIS. $_____

- **Objective 2.2**: By **January 3, 2020**, the subrecipient will submit, via GMIS, three Regional Healthcare Coalition Meeting agenda, minutes, presentations, and sign-in sheets from each meeting within 21 days of the meeting occurrence. During the first scheduled HCC meeting, the HCC spend plan must be disseminated to all HCC members. Sign-in-sheets must identify name of the participating individuals and the agencies represented. The meeting materials must also be distributed to the meeting attendees, including the Regional Public Health Coordinator.

- **Objective 2.3**: By **May 29, 2020**, the subrecipient will submit, via GMIS, three Regional Healthcare Coalition Meeting agenda, minutes, presentations, and sign-in sheets from each meeting within 21 days of the meeting occurrence. The subrecipient must conduct, complete, and submit a Hazard Vulnerability Analysis (HVA) during one of these meetings. Sign-in-sheets must identify name of the participating individuals and the agencies represented. The meeting materials must also be distributed to the meeting attendees, including the Regional Public Health Coordinator.

$_____

Deliverable – Objective 3

Objective 3.1: By **June 3, 2020** the Regional Healthcare Coordinator or his/her designee will attend ALL monthly ODH-sponsored meetings. 50% of these meetings must be attended in person, in Columbus, Ohio, as evidenced by the ODH Sign-in Sheet. $_____

Deliverable – Objective 4

- **Objective 4.1**: By **May 1, 2020,** the subrecipient will upload into GMIS an ODH-provided PDF confirming that the plan has been updated and adopted in accordance with the requirements detailed in the ***HCC Response Plan Guidance for FY2020.*** $_____

Deliverable – Objective 5

Objective 5.1: By **December 16, 2019**, the subrecipient must successfully complete the first ODH 24/7 drill and upload the pass/fail letter in GMIS. $_____

Objective 5.2: By **June 15, 2020**, the subrecipient must successfully complete the second ODH 24/7 drill and upload the pass/fail letter in GMIS. $_____

Deliverable – Objective 6

Objective 6.1: By **November 29, 2019**, develop and submit an action plan according to the ODH-provided ***OHTrac Action Plan template,*** engage no less than 20% use or acknowledgement of OHTrac in your region via GMIS. The EMS agencies' that comprise this 20% must differ from the agencies who comprised the 20% in the previous budget period. $_____

Objective 6.2: By **May 29, 2020**, implement and submit, via GMIS, the completed action plan that engages no less than 20% of the identified EMS agencies' use or acknowledgment of OHTrac in your region. $_____

Deliverable – Objective 7

Objective 7.1: By **May 29, 2020,** the subrecipient must ensure the following information is completed and uploaded in OPOD for each ASPR funded hospital in the region. $_____

Deliverable – Objective 8

- **Objective 8.1**: Quarter 1: By **October 11, 2019**, the subrecipient must submit the ***Communications Worksheet*** and alerting system message summary report via GMIS. $_____

- **Objective 8.2**: Quarter 2: By **January 10, 2020**, the subrecipient must submit the ***Communications Worksheet*** and alerting system message summary report via GMIS. $_____

- **Objective 8.3**: Quarter 3: By **April 10, 2020**, the subrecipient must submit the ***Communications Worksheet*** and alerting system message summary report via GMIS. $_____

- **Objective 8.4:** Quarter 4: By **June 25, 2020**, the subrecipient must submit the ***Communications Worksheet*** and alerting system message summary report via GMIS. $_____

Deliverable – Objective 9

- **Objective 9.1**: By **November 29, 2019**, the subrecipient will upload into GMIS an ODH-provided PDF confirming that a presentation on emPOWER has been delivered in accordance with the requirements detailed in the ***emPOWER Presentation Guidance for FY2020***. $_____

- **Objective 9.2**: By **May 29, 2020**, the subrecipient will upload into GMIS an ODH-provided PDF confirming that a second presentation on emPOWER has been delivered in accordance with the requirements detailed in the ***emPOWER Presentation Guidance for FY2020***.

$_____

Deliverable – Objective 10

Objective 10.1: By **September 30, 2019**, the Regional Healthcare Coordinator, or designee, must provide **in-person representation** to the Regional TEPW, and provide evidence of attendance by signing the sign-in sheet to be submitted by the RPHC via GMIS. $_____

Deliverable – Objective 11

Objective 11.1: By **January 6, 2020**, the subrecipient must submit the HCC (FY20-FY24) MYTEP on the ***ODH MYTEP Template*** that adheres to the deliverable compliance criteria and submission instructions. The HCC MYTEP must be submitted via GMIS. $_____

Deliverable – Objective 12

Objective 12.1: By **March 30, 2020**, the subrecipient must complete and submit the Coalition Surge Test (CST) AAR/IP on the ***ODH AAR/IP Template*** that adheres to the deliverable compliance criteria and submission instructions. The HCC AAR/IP must be submitted via GMIS. $_____

Deliverable – Objective 13

Objective 13.1: By **June 1, 2020**, the subrecipient, or his/her designee, will attend four HAI Advisory Group calls and/or in-person meetings. The subrecipient will submit, via GMIS, four summaries of these meetings, and proof of distribution of the information from the calls and/or in-person meetings to all local health departments within his/her region. $_____

Total Other Direct Costs **$_____**

Notes:

1. **The budget justification must be signed by the agency head listed in GMIS.**
2. **Budget revisions that do not include a signed budget justification by the agency head listed in GMIS will be disapproved.**
3. **Authorized representative certification language must also be included with agency head signature.**

Subrecipient's authorized representative certifies the foregoing:

- 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).
- Sub-recipient'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 agency policy in 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.

_____

Signature

_____

Print Name & Title

_____

Date