Iowa Department of Public Health

Division of Health Promotion and Chronic Disease Prevention

Community-Based Programs of
Maternal Health, Child Health (including ***hawk-i*** Outreach and Oral Health) and Family Planning

Federal Fiscal Year (FFY) 2014 Request for Application (RFA)

Project Period: October 1, 2010 through September 30, 2015
Contract Period: October 1, 2013 through September 30, 2014

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Attachments are posted in a separate file on the IDPH Web page under *Funding Opportunities:* www.idph.state.ia.us.

SECTION 1 – GENERAL AND ADMINISTRATIVE ISSUES

1.01 Purpose

The purpose of this Request for Application (RFA) is to provide guidance for current contractors to submit a continuation application for Federal Fiscal Year (FFY) 2014, the fourth year of the project period established by Request for Proposal (RFP) #58810019, RFP #58810037, and RFP #58811002. In this RFA, references to the RFP shall include RFP #58810019, RFP #58810037, and RFP #58811002.

Services covered by this application include public health services at the community level for Maternal Health (MH), Child Health (CH), and Family Planning (FP). CH includes ***hawk-i*** Outreach, Early ACCESS, Healthy Child Care Iowa (HCCI), and Oral Health (OH). OH components include the I-Smile™ project and CH-Dental. CHIPRA II Teen Outreach will not be funded for FFY2014.

This RFA serves to:

1. Maintain and advance integration of public health activities,
2. Maintain and advance delivery of essential services and core public health functions, and
3. Build stronger relationships with community partners.

1.02 Project and contract period

FFY 2014 is the fourth year of a five year project period. Continued funding during the defined project period is dependent upon approval of the continuation application, applicant performance during FFY 2013, applicant compliance with general and special conditions of the contract, and availability of project funds. The Iowa Department of Public Health (IDPH) expects the contract period to be a one-year term from October 1, 2013 through September 30, 2014.

1.03 Eligible applicants

Applicants must meet each of the following eligibility requirements.

Eligible Applicants

Only current contractors funded from the RFP for Community-Based Programs of MH, CH (including ***hawk-i*** Outreach, and OH) and FP are eligible to submit a continuation application for FFY 2014. Refer to **Appendix I** which lists current contractors by program.

Electronic Communication Requirements

Applicant is required to maintain and provide to IDPH, upon application, a current and valid email account for electronic communications with IDPH.

1.04 Client confidentiality compliance

Agencies and their subcontractors shall comply with IDPH policies and procedures to protect client confidentiality and assure security of client information, including electronic files. Contractors are required to comply with all applicable regulations of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

1.05 Service delivery area

Refer to the RFP for service delivery area parameters. Any changes in the current service delivery area must adhere to these instructions. Any service delivery area changes for this RFA must be agreed upon by existing contractors and applicable Boards of Health, and must be approved by IDPH. Submit requests to Stacey Hewitt at stacey.hewitt@idph.iowa.gov.

Written approval must be obtained prior to submitting a continuation application.

1.06 Funding

The source of funding is Federal and State funds as identified in the RFP.

Applicants may apply for up to the amounts listed for each program in **Appendix I** for the entire FFY 2014 contract period. Funding for CHRPRA II Teen outreach is not available for the FFY 2014 contract. Actual total awards and individual contract funding levels may vary from that listed, or funding may be withdrawn completely, depending on availability of funding.

Match requirements:
MH and CH funds, including CH-Dental, must be matched at a rate of 1:4 (one dollar of local funds for every four dollars of MH and CH grant funds).

The ***hawk-i*** Outreach and I-Smile™ funds do not require a match. These funds are not eligible to be claimed as match for other governmental programs. However, CH applicants are expected to secure other funds to support the I-Smile™ program.

There is no match requirement for the FP program. However, FP applicants are expected to secure other funds to support the FP program. A minimum of ten percent (10%) of project costs must be paid by non-Title X funds.

1.07 Schedule of important dates

The table below lists critical dates in the application and contract award process. Contractors are encouraged to review the entire RFA for detailed information about events, dates, times and sites.

EVENT	DATE
RFA Issued	**March 1, 2013**
Written Questions and Responses	
Round 1 Questions Due Interim Responses Posted by	March 11, 2013 March 18, 2013
Final Questions Due Final Cumulative Responses Posted by	April 10, 2013 April 17, 2013
Applications Due	**April 30, 2013**
Post Notice of Intent to Award	**August 1, 2013**

1.08 Application and forms availability

The RFA will be available on the IDPH Web site under *Funding Opportunities* link: www.idph.state.ia.us. IDPH will send a copy of the RFA to any person or entity which requests the RFA. Blank forms (Attachments) will be available separately in a Zip format compatible with Microsoft (MS) Word 7.0. The provided forms must be used to submit the application.

1.09 Application packet

Contractors are strongly encouraged to review all materials in the application packet and must follow the instructions regarding application forms and format.

Contractors should refer to the RFP and this RFA for information on specific administrative or program issues.

1.10 Administrative inquiries

Written questions related to the RFA must be submitted via email to Stacey Hewitt at stacey.hewitt@idph.iowa.gov no later than **the dates specified in the table above.**

Questions must be submitted by electronic mail. If the question or comment pertains to a specific section of the RFA, the section and page must be referenced. Verbal questions will not be accepted.

IDPH will prepare written responses to all pertinent and properly submitted questions and post the written questions and responses on the IDPH Web page. IDPH's written responses will be considered part of the RFA. Written responses will be prepared and posted according the schedule of events table above.

It is the responsibility of the applicant to check the IDPH Web site periodically for written questions and responses to this RFA.

1.11 Technical assistance

Technical assistance is available for developing program-specific components of the application. Contractors are encouraged to contact their assigned regional consultant (by phone) with questions about program, technical, or budgeting issues.

In no case shall verbal communications override written communications. Only written communications are binding on the IDPH. IDPH assumes no responsibility for representations made by its officers or employees prior to the execution of a legal contract, unless representations are specifically incorporated into the RFA.

1.12 Application submission

Applications must be received by 4:00 p.m. (local Iowa time) on **April 30, 2013** by the IDPH SharePoint Service Contract Application Center in compliance with the following requirements:

- Email application documents as a single zipped file (containing Word and Excel documents) OR a

single PDF, no larger than 20MB, to applications@idph.iowa.gov. **The preferred submission is a single zipped file.** Instructions on zipping documents are in **Appendix II**. (Note: Following the application process, IDPH will require receipt of budgets in Microsoft Excel and Activity Worksheets in Microsoft Word, if not submitted in that format.)

- The subject line of the email must read "RFA FFY 2014 MCHFP". Do not include anything else in the subject line of the email.
- The single zipped file or single PDF must be named "RFA FFY 2014 MCHFP (insert your agency name)".
- Do not include additional information or text in the body of the email as it will not be available to IDPH staff.

Applications submitted to IDPH in any manner other than through the IDPH SharePoint Service Contract Application Center (e.g. electronic mail to any other address, faxed, hand-delivered, mailed or shipped or courier-service delivered versions) will be rejected, not reviewed by IDPH and a notice will be sent to the applicant. Any information submitted separately from the application will not be considered in the review process.

Applications will be rejected and not reviewed by IDPH for the following reasons:

- If the application is received by the IDPH SharePoint Service Contract Application Center after the stated due date and time.
- If the application is submitted in any manner other than by email to applications@idph.iowa.gov.
- If the application is not submitted as a single zipped file or a single PDF file.

The due date and time requirements for receipt of the proposal by the IDPH SharePoint Service Contract Application Center are mandatory requirements and will not be subject to waiver as a minor deficiency.

The application that is attached to the applicant's email is automatically removed from the email upon receipt by the server and is filed in the IDPH SharePoint Service Contract Application Center. The application is date and time stamped upon filing in the IDPH SharePoint Service Contract Application Center. The time that is automatically documented on the submitted and filed application within the IDPH SharePoint Service Contract Application Center is slightly delayed from the time the email is received by the server, and is not the time that the applicant sent the email. Although the delay is minimal, it may be increased when server traffic is high or other uncontrollable internet traffic circumstances, encryption issues, firewall issues, or server issues, etc.

The date and time stamp by the IDPH SharePoint Service Contract Application Center shall serve as the official time of receipt of the application.

It is the applicant's sole responsibility to submit emailed applications in sufficient time so the application is received by the IDPH Service Contract Application Center prior to the stated due date and time. Applicants are strongly encouraged to submit emailed applications as early as possible to allow sufficient time for any unforeseen issues to be resolved prior to the deadline, if they occur. Applications received

by the IDPH SharePoint Service Contract Application Center after the stated due date and time will be rejected, not reviewed by IDPH and a notice sent to the applicant.

An electronic notification of receipt of the applicant's application within the IDPH SharePoint Service Contract Application Center will be generated automatically and emailed to the sender of the emailed application. If the electronic notification is not received within ten (10) minutes of the applicant's email, please contact the SharePoint Helpdesk at 1-866-520-8987 to confirm delivery (available prior to 4 PM on weekdays, excluding state holidays).

If an applicant emails the application multiple times, only the last submission received by the IDPH SharePoint Service Contract Application Center prior to the stated due date and time will be accepted for review.

1.13 Right to reject applications/Cancellation of RFA

IDPH reserves the right to reject, in whole or in part, any or all applications, to advertise for new applications, to arrange to receive or itself perform the services herein, to abandon the need for such services, and to cancel this RFA if it is in the best interests of IDPH.

Any application will be rejected outright and not evaluated for the following reasons:

1. The applicant fails to submit the application in sufficient time for receipt by IDPH SharePoint Service Contract Center prior to the stated due date and time or in the manner stated in section 1.12.
2. The applicant is not an eligible applicant as defined in section 1.03.

Any application may be rejected outright and not evaluated for any of the following reasons:

1. The applicant fails to include required information, or fails to include sufficient information to determine whether an RFA requirement has been satisfied.
2. The applicant fails to follow the application format instructions or presents information requested by this RFA in a format inconsistent with the instructions of the RFA.
3. The applicant provides misleading or inaccurate answers.
4. The applicant states that a mandatory requirement cannot be satisfied.
5. The applicant's response materially changes a mandatory requirement.
6. The applicant's response limits the rights of IDPH.
7. The applicant fails to respond to IDPH's request for information, documents, or references.
8. The applicant fails to include any signature, certification, authorization, or stipulation requested in this RFA

1.14 Appeal of rejection decision

The applicant's receipt of a rejection letter constitutes receipt of notification of the adverse decision per 641Iowa Administrative Code Chapter 176.8(1). Applicants may appeal the adverse decision only for a timely submitted application. The appeal shall be submitted in writing within ten business days of receipt of notification of the adverse decision. Appeals shall be submitted in writing, return receipt requested, to Stacey Hewitt, Contract Administrator, Division of Administration and Professional Licensure, Iowa Department of Public Health, Lucas State Office Building, Des Moines, Iowa 50319-0075. Appeals must clearly and fully identify all issues being contested and demonstrate what procedures in the proposal were not followed. In the event of an appeal, the Department will continue working with the successful applicant pending the outcome of the appeal.

1.15 Appeal of award decision

The posting of the Notice of Intent to Award on the IDPH Web page constitutes receipt of notification of the adverse decision per *641Iowa Administrative Code Chapter 176.8(1).* Applicants may appeal the adverse award decision by filing a written appeal to IDPH within 10 working days of posting of the Notice of Intent to Award in accordance with *641 Iowa Administrative Code Chapters 76.17 and 74.12.* Appeals shall be submitted in writing, return receipt requested, to Stacey Hewitt, Contract Administrator, Division of Administration and Professional Licensure, Iowa Department of Public Health, Lucas State Office Building, Des Moines, Iowa 50319-0075. Appeals must clearly and fully identify all issues being contested and demonstrate what procedures in the applications were not followed. In the event of an appeal, the Department will continue working with the successful applicant pending the outcome of the appeal.

SECTION 2 – APPLICATION COMPONENTS

2.01 Scope and description of services

The scope and description of services are defined and outlined in the RFP. Applicants are responsible for referencing the RFP document under which they were funded.

Changes in state or federal law or policy that occur after the published date of the RFP may require applicants to assume modifications to the work and services described.

Goals of the MH and CH programs:
MH and CH programs promote the development of community-based systems of preventive health care for Iowa's pregnant women, children ages zero through 21 years, and their families.

Goals of the MH and CH programs are to:

- Promote the health of mothers and children by ensuring access to quality MH and CH preventive health services, especially for low-income families or families with limited availability of health services
- Reduce infant mortality and the incidence of preventable diseases and disabling conditions
- Increase the number of children appropriately immunized against disease

MH and CH programs also promote and improve oral health of women and children served.

Goals of the FP program:

- Promote the health of persons of reproductive age and families
- Provide access to family planning and reproductive health services for persons of reproductive age by offering a broad range of acceptable and effective contraceptive methods; health and cancer screening; and STI/HIV prevention, education, testing and treatment.

Fundamentals of MH, CH, and FP services

Fundamental to MH, CH, and FP programs are services that are family-centered, community-based, collaborative, comprehensive, accessible, flexible, coordinated, culturally competent, and developmentally appropriate. Services must be available for persons who cannot access services during traditional business or school hours.

No exemption based on source of funding

MH, CH, and FP services provided by the applicant are subject to terms of the RFP and the resulting FFY 2014 contract *regardless of the source of funds*. The applicant and/or its subcontractors **may not** claim exemption to IDPH policy and procedure requirements based upon the payment source for services provided.

Direct care and FQHCs / RHCs

Applicants that are Federally Qualified Health Centers (FQHCs) or Rural Health Centers (RHCs) must emphasize infrastructure building and enabling activities that involve collaboration with medical and

dental practices within the service area. Efforts must be made to encourage and recruit private practices within the service area to provide services for low-income women and children, both uninsured and those enrolled in Medicaid.

For applicants that are FQHCs or RHCs, MH, CH (including OH), and FP grant funds and/or associated program income **may not** be used to support *direct health care services* provided by the FQHC or RHC. MH and CH programs are encouraged to refer clients to the clinical operations (direct care arm) of FQHC or RHC clinics, as well as to private medical and dental providers, for direct care services. Revenue generated by MH, CH, OH, and FP programs **must** be used to enhance the respective programs, e.g., informing, care coordination, oral screenings, and local transportation services.

Quality assurance

The MH, CH, and FP programs require on-going quality assurance/quality improvement activities as described in the RFP.

For more information on MCH Quality Assurance, see *MCH Administrative Manual 4th Edition,* Section 501, here.

For more information on FP Quality Assurance, refer to the RFP.

2.02 Application requirements

Note that the prepared application should reflect overall consistency between the various forms (e.g. Activity Worksheet, Service Delivery Form, and Budget Summaries and Narratives).

A. Cover Page: Identifies the applicant's legal name, federal identification number, and key contact information for the project. Complete required form **Attachment A** following these instructions:

Field	Description
Federal Tax ID Number and Agency Legal Name	Provide the applicant federal identification number and the legal name of the applicant entity. This must be the entity associated with the Federal Identification (ID) number per the Internal Revenue Service (IRS). If the entity operates under another name as a "d/b/a" (doing business as), please include that in the legal name. Provide the applicant address, telephone, and FAX number as requested in the first section of **Attachment A**.
County and Program	Provide the county name(s) and applicable program abbreviations for which the agency is applying (MH, CH, FP).
Total Dollar Amount Requested	Indicate the total amount of funds requested by program, not to exceed the amounts outlined in **Appendix I.** For the purposes of this RFA, funds may be included for MH, CH, ***hawk-i*** Outreach, CH-Dental, I-Smile™, and/or FP.
Conditions/Signature	The person authorized to execute legal documents on behalf of the entity must date and insert an electronic signature to certify that the applicant is in agreement with the conditions listed. • According to the definition outlined in Iowa Code 554D.103 and U.S. Code (http://www.gpo.gov/fdsys/pkg/PLAW-106publ229/pdf/PLAW-

	106publ229.pdf) defines an electronic signature as "an electronic sound, symbol, or process, attached to or logically associated with a contract or other record and executed or adopted by a person with the intent to sign the record." An applicant may insert an electronically scanned signature, a digital signature, or a typed name, symbol, etc. in compliance with this definition for the electronic signature.
Key Personnel for this Application	Provide information for agency personnel associated with this application. Include the information in the table provided on page 2 of the Cover Page (**Attachment A**). Describe the executive, management, technical, and professional staff who would perform duties related to this project. Provide evidence for any necessary applicable professional licenses required by law by listing the license number associated with the professional personnel. • Executive Director: Name, email address, credentials/license number, as applicable, phone number, and contingency plan – Complete the table by providing the requested information for the individual who has overall responsibility and authority for administering the program in which the entity is applying for the funds. • Project Director: Name, email address, credentials/license number as applicable, phone number, and contingency plan – Complete the table by providing the requested information for the individual with overall responsibility and authority for project. • MH Program Coordinator: Name, email address, credentials/license number as applicable, phone number, and contingency plan – Complete the table by providing the requested information for the individual with direct day-to-day responsibility for this program and the person that the department can contact concerning the application. • CH Program Coordinator: Name, email address, credentials/license number as applicable, phone number, and contingency plan – Complete the table by providing the requested information for the individual with direct day-to-day responsibility for this program and the person that the department can contact concerning the application. • EPSDT Coordinator: Name, email address, credentials/license number as applicable, phone number, and contingency plan – Complete the table by providing the requested information for the individual with direct day-to-day responsibility for this program and the person that the department can contact concerning the application. • ***hawk-i*** Outreach Coordinator: Name, email address, credentials/ license number as applicable, phone number, and contingency plan – Complete the table by providing the requested information for the individual with direct day-to-day responsibility for this program and the person that the department can contact concerning the application. • I-Smile™ Coordinator: Name, email address, credentials/license number,

	phone number, and contingency plan – Complete the table by providing the requested information for the individual with direct day-to-day responsibility for this program and the person that the department can contact concerning the application. • FP Program Coordinator: Name, email address, credentials/license number as applicable, phone number, and contingency plan – Complete the table by providing the requested information for the individual with direct day-to-day responsibility for this program and the person that the department can contact concerning the application. • Fiscal Director: Name, email address, credentials/license number as applicable, phone number, and contingency plan – Complete the table by providing the requested information for the individual with overall responsibility and authority for financial management for this program.

Contingency Plan: Identify the specific staff (by name and title) who are qualified to assume the duties of the position in the event that the position is vacated (e.g. due to resignation or leave of absence).

B. Minority Impact Statement: Identifies the applicant's potential impact of the project's proposed programs or policies on minority groups. Complete required form **Attachment B** following these instructions:

- Applicants must independently complete the "Minority Impact Statement" form by checking the box that most accurately reflects the proposed project programs or policies impact on minority persons.
- Describe the rationale or evidence for your choice in a brief narrative, as well as identifying the specific minority groups in which there is a positive or negative impact (if applicable) on the checklist.
- Document must be electronically signed and dated by a person authorized by the applicant agency and return it with the application.

C. Activity Worksheets FFY 2014. Using the forms provided (**Attachments C-1 through C-5**), applicants must complete an Activity Worksheet for each program for which they are applying (MH, CH, and/or FP). CH applicants must also complete activity worksheets for ***hawk-i*** Outreach, and CH-OH (I-Smile™ and CH-Dental).

General Activity Worksheet Instructions:

The Activity Worksheet demonstrates the FFY 2014 implementation plan for each program. It must illustrate how an applicant proposes to use grant funds and resulting program income to carry out program services that advance performance measures (found in the logic models in **Appendix III**). Activities developed for the worksheet are part of the **Outputs** of the logic model.

Activities must:

- Be **written for the fourth year** of the project period (October 1, 2013 through September 30, 2014).
- **Describe specific steps** (methodology) the contractor will take to accomplish intended results.
- **Include sufficient detail** about how services listed on the logic model will be implemented, including the **counties to be served,** and **community partners** involved.
- When applicable, be developed on **evidence-based, promising practices**.

Development of brochures will only be accepted as an activity as part of an overall marketing campaign and must be approved by IDPH, regardless of funding source.

Applicants may continue activities developed for FFY 2013 when appropriate. New and innovative activities are also encouraged. All activities for an optional performance measure listed in your FFY 2013 RFA do not need to be continued in FFY 2014. Activities can be added or modified to address your FFY 2014 plan. Additional optional performance measures can also be added as they pertain to your service area needs. See **Attachments C-1** through **C-5.**

Follow these instructions to complete the activity worksheet for each program for which the applicant is applying:

Field	**Instruction for the Field**
Applicant	Provide the name of the contract agency.
Baseline Measure (does not apply to CH-OH)	Report the Baseline Measure following instructions on the program-specific Activity Worksheets where indicated.
Target FFY14 (does not apply to CH-OH)	Establish a Target that projects performance measure improvement for FFY2014 where indicated.
Staff	Identify all agency personnel responsible for completing the activity (or staff position if currently vacant). For CH-OH Activity Worksheet, provide the name(s) of all agency personnel *who will complete* the activity (or staff position if currently vacant).
Activities	Describe the applicant's methodology to provide services to advance performance measures. Describe activities in sufficient detail to demonstrate **how** the activity will be accomplished for your agency. A single activity may address more than one performance measure. Add additional rows as needed.
County(s) served (does not apply to FP)	Identify the county(s) to be served by the activity listed.
Pyramid level (does not apply to FP)	Identify the MCH pyramid level(s) the proposed activity falls within by placing an "x" in the appropriate column (I=infrastructure building; P=population-based; E=enabling; D=direct care).

Year-End Report	Do not complete this column. At the end of the contract period, applicants will be required to report on completion of activities as a part of the Year-End Report. Applicants will also report their 'current measure' as part of the Year-End Report.

1. **MH Activity Worksheet requirements:**

   Applicants must follow the "General Activity Worksheet Instructions" outlined above and follow these program specific requirements.

   Examine the MH Logic Model (**Appendix III**). Review the list of **Inputs** (resources), **Outputs** (services), and **Intended Results** (performance measures and outcomes). The overall impact for the maternal health program is to ***improve childbirth outcomes***.

   Applicants **must** develop activities that advance the following **required performance measures and outcomes**:
   - NPM #18 The percent of infants born to pregnant women receiving prenatal care beginning in the first trimester
   - The percent of women served (maternal health program) who report a medical home.

   Services must be available to all pregnant women regardless of ability to pay.

   The following provides instructions for completing the MH Activity Worksheet (**Attachment C-1**). At a minimum, applicants are **required** to develop activities that address the following:

Linking with LBOH

- Describe plans to provide input to and elicit feedback from each LBOH in the service area. Describe activities for monitoring MH progress and providing MH updates in on-going CHNA & HIP meetings conducted by the LBOH for each county served.

  Note: Consider the following:
  - the agency's plan for attendance at LBOH meetings
  - the content of program updates
  - opportunities for the LBOH to monitor the program's progress
  - how the agency will elicit feedback from the LBOH
  - how the agency will address the feedback and incorporate it into the program
  - how the agency will collaborate with local partners to address the specific CHNA & HIP priorities related to the MH program in your service area. Include partners and intended collaboration.

  See examples in **Section 4** – Contract of this RFA.

Addressing health disparities

- Describe activities that address health disparities relevant to the service area. At a minimum, describe how cultural isolation, geographic barriers, or racial/ethnic barriers to maternal health services will be minimized for pregnant women in the service area. Consider the following:
  - the specific populations the agency will address
  - the inequities they experience
  - activities that the agency will implement to impact health outcomes and minimize inequities
  - how the agency will know the activities are successful

  For definitions and examples refer to **Appendix IV**.

Promoting access and early entry into prenatal health care

- Initiate activities to ensure access to care by assisting clients with presumptive Medicaid eligibility determination if uninsured.
- Develop public education campaigns that promote importance of prenatal care.
- Describe activities that link with providers who do pregnancy testing and or provide other services to pregnant women.

Promoting access to preventive health care services for pregnant women and promoting medical homes.

- Include activities that advance public-private partnerships with local medical and dental practitioners.
- Describe activities that strive to assure that pregnant women receive a regular source of prenatal care.
- Describe activities that promote development of effective care coordination services. These may include but are not limited to data analysis, developing/revising/strengthening protocols, training of staff, and coordinating the provision of care coordination services with other programs.
- Describe activities to promote effective referral and follow-up services.

Activities may also be included that address the following optional activities:

- Tobacco Cessation for women of childbearing age
- Screening and referral for depression
- Reducing teen pregnancy
- Provide counseling about developing a reproductive life plan
- Increasing access to dental care
- Outreach and advocacy for pregnant women

MH Year End Report (YER): The YER fields are not to be completed as part of this application. Applicants will be required to submit a MH YER. Items included on the YER are found on the MH Activity Worksheet. They include a report on:

- Completion of proposed MH activities and
- Performance measures listed on the MH Logic Model. A current measure related to the baseline measure and target will be reported. Applicants may also choose to report on additional performance measures, including NPMs and SPMs, related to MH.

2. CH Activity Worksheet requirements:

Applicants must follow the "General Activity Worksheet Instructions" outlined above and follow these program specific requirements.

Review the CH Logic Model (**Appendix III**), noting the list of **Inputs** (resources invested), **Outputs** (planned services), and **Intended Results** (performance measures and outcomes). The intended impact for the child health program is to **improve health outcomes for children.**

The CH Activity Worksheet (**Attachment C-2**) establishes the FFY 2014 plan for the Child Health program. Activities **must** advance linking with the local Boards of Health and **seven required CH performance measures:**

- Percent of inform completions
- CMS 416 Participation Rates
- Percent of children with a medical home
- Percent of children fully immunized by 24 months of age
- Percent of children ages 9-35 months receiving a blood lead test
- Early ACCESS – Developmental testing and monitoring
    - The number of infants and toddlers ages 0 to three years for which the agency completes a developmental test (Ages and Stages Questionnaire (ASQ) and Ages and Stages Questionnaire - Social Emotional (ASQ-SE) that results in a referral to the AEA
    - The number of infants and toddlers ages 0 to three years found not eligible for Early ACCESS by the AEA and were referred to the child health agency for developmental monitoring
- The number of child care businesses receiving on-site CCNC services

Applicants may choose to develop activities to advance any of four optional measures:

- Reducing childhood unintentional injuries (SPM #8)
- Reducing childhood death/injury due to motor vehicle crashes (NPM #10)
- Reducing childhood obesity (NPM #14)
- Reducing suicides among adolescents (NPM #16)

The following provides instructions for completing the CH Activity Worksheet. The CH Activity Worksheet consists of two components:

- Part A: CH Activities and
- Part B: CH-CCNC Staffing Table

Part A: CH Activities

At a minimum, applicants **are required to** develop activities that address the following:

- **Linking with local BOH –** Describe plans to provide input to and elicit feedback from each LBOH in the service area. Describe activities for monitoring CH progress and providing CH updates in on-going CHNA & HIP meetings conducted by the LBOH for each county served.

  Note**:** Consider the following:
  - the agency's plan for attendance at LBOH meetings
  - the content of program updates
  - opportunities for the LBOH to monitor the program's progress
  - how the agency will elicit feedback from the LBOH
  - how the agency will address the feedback and incorporate it into the program
  - how the agency will collaborate with local partners to address the specific CHNA & HIP priorities related to the CH program in your service area. Include partners and intended collaboration.

  See examples in **Section 4** – Contract of this RFA.

- **Addressing health disparities** – Describe activities that address health disparities relevant to the service area. At a minimum, describe how cultural isolation, geographic barriers, or racial/ethnic barriers to child health services will be minimized for children in the service area. Consider the following:
  - the specific populations the agency will address
  - the inequities they experience
  - activities that the agency will implement to impact health outcomes and minimize inequities
  - how the agency will know the activities are successful

  For definitions and examples, refer to **Appendix IV**.

- **Developing quality informing/re-informing services** - Describe activities that enhance reaching families of newly Medicaid eligible children to explain the benefits of the EPSDT program (achieving inform/re-inform completions).

- **Promoting access to preventive health care services for children and promoting medical homes** - Develop activities that strive to assure that children receive regular well child (EPSDT) exams, ideally through medical homes. Include activities that promote development of effective care coordination services. Describe activities that advance public –private partnerships with local medical practitioners.

- **Promoting childhood immunizations** - Develop activities that advance children receiving the full schedule of age appropriate immunizations per the Advisory Committee for Immunization Practices (ACIP) Childhood Immunization Schedule. Activities may address coordination of immunizations with local practitioners, promoting the use of Immunization Registry Information

System (IRIS), strengthening referral relationships with providers, and/or developing public education campaigns that promote children's immunizations. Activities may involve administering immunizations and/or providing related assessment, education, anticipatory guidance, and follow-up.

- **Promoting access to blood lead testing** - Develop activities that advance children ages 9-35 months receiving blood lead tests according to program guidelines. Activities may address coordination of blood lead testing with local practitioners, strengthening referral relationships with providers, and/or public education campaigns that promote blood lead testing for young children. Activities shall include coordination with local Healthy Homes and Lead Poisoning Prevention Programs (HHLPPP), if established in your service area. (See the current HHLPPP map in **Appendix V**). Activities may also involve providing blood lead tests, blood lead analysis (Lead Care II), and/or related assessment, education, anticipatory guidance, and follow-up on elevated lead levels.

- **Promoting Early ACCESS** developmental testing and monitoring - Develop activities that:
  - promote the Early ACCESS system (Examples: distribute Early ACCESS materials; promote the Early ACCESS website; educate community partners; display at community events).
  - advance public–private partnerships with local medical practitioners.
  - offer developmental testing (ASQ and ASQ-SE) to infants and toddlers ages 0 to three years.
  - assure that infants and toddlers ages 0 to three years with ASQ and ASQ-SE scores that indicate further evaluation is needed are referred to the AEA.
  - develop a referral process with the AEAs to assure that infants and toddlers ages 0 to three years found not eligible for Early ACCESS services receive developmental monitoring by the child health agency.
  - develop a protocol for providing developmental monitoring for infants and toddlers ages 0 to three years who were determined not eligible for Early ACCESS services.

- **Capacity building for Child Care Nurse Consultant (CCNC) (required for all applicants even if not employing or contracting a CCNC)** - Develop infrastructure building activities that promote leadership for development of health and safety in child care in all counties of the service area. (See MCH Administrative Manual Section 610.) Describe activities that address the following:
  - Securing funding for CCNC services
  - Promoting development of partnership(s) leading to an agreement with Child Care Resource & Referral (CCR&R)[s] for all counties served
  - Developing professional relationships with early care and education businesses
  - Assessing the provision of CCNC services throughout the service area
  - Developing local agency capacity by integrating activities that promote health and safety in early care and education businesses and continuation of HCCI activities in the child health

contract agency's business plan; incorporating public health principles and practices into child care policy and procedure; attending HCCI informational meetings; providing Medicaid or ***hawk-i*** information to early care and education businesses; providing or ensuring access to health care services for children attending early care and education who need well-child health care through a medical or dental home and provide care coordination services to families; and developing a contingency plan for future vacancies to ensure continuity and access to child care nurse consultation services.

- Providing structure for services of the CCNC, including a plan for supervision and monitoring progress on child health activities and service priorities; a plan for prioritization of services based on community needs assessment; a plan for full integration of the CCNC as a member of the child health team; and defining goals and outcomes for the health and safety of children in early care and education settings in the service area.

Report the anticipated number of hours per month to be spent on the capacity building activities described in the CCNC Activities table.

CH Year End Report (YER): The YER fields are not to be completed as part of this application. Applicants will be required to submit a CH YER. Items included on the YER are found on the CH Activity Worksheet. They include a report on:

- Completion of proposed CH activities and
- Performance measures listed on the CH Logic Model. A current measure related to the baseline measure and target will be reported. Applicants may also choose to report on additional performance measures, including NPMs and SPMs, related to CH.

Part B: CH – Child Care Nurse Consultant (CCNC) Staffing Table

Field	Instruction for the field
Check one	Check the first box if a CCNC will be employed or contracted as part of your CH program. If this box is checked, complete the CCNC Staffing Table below. Check the second box if a CCNC position will not be a part of your CH program. No further entries are required on this form.
Name of CCNC	Report the first and last name of the CCNC(s) who will be employed or contracted by your agency. Report 'vacant' if this position is not currently filled but is planned to be filled.
Nursing Education	Check the appropriate box(s) for each CCNC listed. ADN = Associate Degree in Nursing; Diploma = Diploma in Nursing; BSN = Bachelor of Science in Nursing; MSN = Masters of Science in Nursing; NP = Nurse Practitioner
FTE	Report the amount of FTE dedicated to CCNC work (e.g., .8 FTE)
Location of Office or Primary Worksite	Report the street address, city, state, and zip code for the primary worksite (office location) for the CCNC.
Phone & Email	Report the CCNC's business phone and email address.

Counties Served	Report the counties of the child care businesses that will be served by the CCNC.
Extended Hours	If services will be made available evenings and/or Saturdays (with advanced scheduling), check the appropriate box(s).

For agencies employing/contracting a CCNC: See **Appendix IX** - Draft Contract Template 'Child Health Reports' table. A CCNC ECI Statewide Performance Measures Report is due August 15, 2014. All Child Health Agencies employing/contracting a CCNC are required to report on the following statewide performance measures: number of technical assistance contacts; number of visits to early learning environments by a consultant; number of registered child development homes/licensed centers involved in quality improvement activities (unduplicated); number of public relations contacts; percent implementing an evidence based curriculum (unduplicated); percent of programs participating in a quality initiative (unduplicated); cost per service; percent of participants receiving onsite assessment and consultation that improve health and safety conditions in their learning environment; percent of children with special health care needs with a special needs care plan in place at the child care center.

3. *hawk-i* Outreach Activity Worksheet requirements:

Applicants must follow the "General Activity Worksheet Instructions" outlined above and follow these program specific requirements.

Review the ***hawk-i*** Outreach Logic Model (**Appendix III**), noting the list of **Inputs** (resources invested), **Outputs** (planned services), and **Intended Results** (performance measures and outcomes). The intended **impact** for ***hawk-i*** Outreach is to **increase the number of children with health insurance coverage.**

The ***hawk-i*** Outreach Activity Worksheet (**Attachment C-3**) is required for CH applicants. It establishes the FFY 2014 plan by describing the applicant's methodology to provide ***hawk-i*** Outreach in the proposed service area.

Identify a FFY 2014 target for the number of uninsured children who will become enrolled in ***hawk-i*** or Medicaid. Use the Iowa State Children's Health Insurance Program (SCHIP) Enrollment by County Report to assist in establishing your target. See http://hawk-i.org/statedir/. **No baseline measure is required**.

Identify agency personnel who will complete the activities (or staff position if currently vacant). It is intended that the ***hawk-i*** Outreach Coordinator will complete most activities.

At a minimum, applicants must develop activities that promote:

- Presumptive eligibility determinations for children
- ***hawk-i*** outreach within *each county of the service* area to
  - Schools,
  - Faith-based organizations,
  - Health care providers, *and*
  - Special populations, including racial and ethnic minority groups

Do not complete the 'Year-End Report' column as part of this application.

4. **CHIPRA II TEEN Outreach** program will end August 2013. No activity worksheets will be required for FFY 2014.

5. **CH - OH Activity Worksheet requirements:**
   CH applicants must follow the "General Activity Worksheet Instructions" outlined previously and also follow these program-specific requirements.

   Review the CH-OH Logic Model (**Appendix III**), noting the list of **Inputs** (resources invested), **Outputs** (planned services), and **Intended Results** (performance measures and outcomes). The intended **impact** for OH services is **children with good oral health.**

   The CH-OH Activity Worksheet (**Attachment C-4**) must describe how the applicant will use I-Smile™ funds for infrastructure-building, population-based, and non-billable enabling activities, use CH-Dental funds for infrastructure-building activities, as well as use resulting program income. It is the intent of IDPH that the I-Smile™ Coordinator will complete most of the infrastructure-building and enabling activities.

   Dental care coordination and direct dental services are documented on the CH-OH Service Delivery Form (**Attachment D-4)** and should not be described on the Activity Worksheet.

   The CH-OH Activity Worksheet does not include "Target FFY2014". As appropriate to meet requirements, applicants are expected to develop new activities and may also build upon activities approved during the RFA FFY2013 process. Activities must be based on the following services and include the specific requirements as listed:

   - **Linkage with local board of health** – At a minimum, I-Smile™ Coordinator must provide a written and/or verbal I-Smile™ report and program updates to each LBOH in the service area at least once per contract year. Describe activities that demonstrate how the I-Smile™ Coordinator will provide input to and elicit feedback from LBOH and monitor OH progress and provide OH updates in any ongoing CHNA&HIP meetings conducted by LBOH for each county served.

     Note: Consider the following:
     - the agency's plan for attendance at LBOH meetings
     - the content of program updates
     - opportunities for the LBOH to monitor the program's progress;
     - how the agency will elicit feedback from the LBOH
     - how the agency will address the feedback and incorporate it into the program
     - how the agency will collaborate with local partners to address the specific CHNA & HIP priorities related to the CH-OH program in your service area. Include partners and intended collaboration.

     See examples in **Section 4** – Contract of this RFA.

- **Addressing health disparities** – Describe activities that address health disparities relevant to the service area. Consider the following:
  - the specific populations the agency will address
  - the inequities they experience
  - activities that the agency will implement to impact health outcomes and minimize inequities
  - how your agency will know the activities are successful

  At a minimum, describe how cultural isolation, geographic barriers, or racial/ethnic barriers to oral health services will be minimized for children in the service area. For definitions and examples, refer to **Appendix IV.**

- **Oral health planning and needs assessment** – Describe activities that show how quantitative data (e.g., EPSDT rates, school screening data, FFY2012 Needs Assessment) and qualitative information (e.g., personal stories, observations) will be used in assessing agency oral health programs. At a minimum, describe how the I-Smile™ Coordinator will review, monitor, and use local data and oral health information to plan I-Smile™ activities within the service area.

- **Development of partnerships** – Describe activities that will strengthen local oral health infrastructure through partnerships. At a minimum, I-Smile™ Coordinator must develop **new** partnerships with no less than three businesses, business organizations, civic organizations, and/or faith-based organizations. The **name** of the planned partner and the **intent** of each partnership must be specifically identified. **All counties within the service area** must benefit from one or more of the partnerships. Do not include agency partnerships with WIC and Head Start.

  (Examples: Contact the Human Resources director at Blue Meatpacking to explain the ***hawk-i*** dental option and consider other ways we can work with the company; offer to provide a presentation about children's oral health and I-Smile™ to the Orange County Kiwanis to generate interest in possible fundraising for back-to-school event; coordinate efforts with the Red City Economic Development group to begin recruiting a new dentist to replace Dr. Yellow when he retires in 2015.)

- **Establishment of referral networks** – Describe activities that will enable the I-Smile™ Coordinator and agency staff to refer children for dental care. At a minimum, the I-Smile™ Coordinator must conduct written and/or verbal contact with all general practice and pediatric dental offices within the service delivery area to promote I-Smile™, encourage participation in Medicaid and ***hawk-i***, and to promote age 1 dental visits.

- **Outreach to health care providers** – Describe activities that will assure medical practitioners are informed about the I-Smile™ dental home and referral system. At a minimum, I-Smile™ Coordinator must conduct written and/or verbal contact with all pediatric and family practice medical offices in the service area to offer I-Smile™ referral and care coordination services and promote the age 1 dental visit. Other activities may include offering training for screening, fluoride varnish application, and billing; follow-up on prior training; and/or oral health education and promotion materials.

- **Coordination of school screening and audit process** – Describe activities that demonstrate a local system to meet the school screening requirement. At a minimum, I-Smile™ Coordinator

must ensure completion of school screening audit requirement with applicable local BOH(s) and provide outreach and communication with school personnel and dental office staff about the school screening requirement (e.g., provide trainings, share updates, distribute forms).

- **Oral health promotion** – Describe activities that promote children's oral health and I-Smile™ locally. At a minimum, the I-Smile™ Coordinator must conduct two health promotion initiatives within the service area that include use of the I-Smile™ name and logo. One promotion must specifically target dentists and/or physicians. (Examples: media advertisements; mass mailings of informational flyers; promotional distributions at exhibits or events; use of online social media sites; circulation of materials supporting benefits of water fluoridation.)

Applicants are encouraged to also include activities that address any other services listed on the logic model, as well as pertinent issues specific to the service area. All services are based on the I-Smile™ strategies as described in Section 2 of the RFP.

The YER fields are not to be completed as part of this application. Applicants will be required to complete a year-end report (YER) that includes:

- Completion of CH-OH activities

6. FP Activity Worksheet requirements: Applicants must follow the "General Activity Worksheet Instructions" outlined above and follow these program specific requirements.

Carefully review the FP Logic Model (**Appendix III**). Consider the agency **Inputs** (resources invested), **Outputs** (services), and **Intended Results** (performance measures and outcomes). The overall impact of the family planning program is to **increase the percentage of pregnancies in Iowa that are intended.** Applicants may continue activities from FFY2012 when appropriate. *If an applicant chooses to continue previously approved activities, please identify any changes proposed. Identification of new and innovative activities is also encouraged.* The FP Activity Worksheet (**Attachment C-5**) must describe how the applicant will advance the eight family planning performance measures found in the 2011-2015 RFPs under which the applicant was initially funded. An applicant may choose to develop activities to address optional services.

A single activity may address more than one required service and advance more than one required performance measure. The required services are listed on the activity worksheet in bold font. Each required service must be addressed in the activity worksheet. Applicants should identify which measure(s) are being advanced.

Activities must address health disparities in the contracted service area. For Title X applicants, this includes adolescents, males and minority or hard to reach populations.

At a minimum, applicants must address the following services in the activity worksheet:

- Develop linkages with LBOH - Describe plans to provide input to and elicit feedback from each LBOH in the service area. Describe activities for monitoring FP progress and providing FP updates in any on-going CHNA&HIP meetings conducted by LBOH for each county served.

Note: Consider the following:

- the agency's plan for attendance at LBOH meetings
- the content of program updates
- opportunities for the LBOH to monitor the program's progress
- how the agency will elicit feedback from the LBOH
- how the agency will address the feedback and incorporate it into the program
- how the agency will collaborate with local partners to address the specific CHNA & HIP priorities related to the FP program in your service area. Include partners and intended collaboration.

See examples in **Section 4** - Contract of this RFA.

- Supporting national priorities, key issues and legislative mandates of the federal Department of Health and Human Services (DHHS) by promoting the health of persons of reproductive age and families; and providing access to family planning and reproductive health services (FP Counseling – FPC) http://www.hhs.gov/opa/title-x-family-planning. For 2014, the priorities include the encouragement of vaccinations of patients and health care personnel to protect against influenza.
- Direct service delivery providing of a broad range of contraceptive methods; health and cancer screening; STI/HIV prevention education, testing and treatment (FP Full service -FPF)
- Counseling on Reproductive Life Plan (RLP) – continues to be a 2014 OPA national priority and State Performance Measure Number 4
- Outreach and community education, including:
  a. Advocacy
  b. Social networking and/or marketing plans
  c. Develop community partnerships (see Logic Model for examples)

Activities may also be developed to address the following:

- Immunizations
- Health promotion and disease prevention activities
- STI screening and testing, including HIV
- Gynecologic services
- Counseling and referral around substance use and abuse, sexual abuse, domestic violence, nutrition, sexual function
- Genetic information and referral
- Postpartum care
- Other (specify)

FP Year End Report (YER): The YER fields are not to be completed as part of this application. Applicants will be required to submit a FP YER. Items included on the YER are found on the FP Activity Worksheet. They include a report on:

- Completion of proposed FP activities and
- Required services listed on the FP Logic Model. A current measure related to the baseline measure and target will be reported. Applicants may also choose to report on additional performance measures, including NPMs and SPMs related to FP.

FP applicants will be required to provide a narrative description of the outreach activities conducted during each contract year. In 2014 FP contractors will be required to provide a list of formal community education programs provided.

D. Service Delivery Forms. The Service Delivery Forms (**Attachment D-1** through **D-5**) are required for each program for which the applicant is applying. There are two forms for MH (MH and MH-OH), two forms for CH (CH and CH-OH), and one form for FP.

Instructions for each form are provided in this section.

1. MH Service Delivery Form

The MH Service Delivery Form (**Attachment D-1**) is required. Complete one form for all maternal health services to be provided within the MH program. Direct dental services provided to pregnant women should be included on the separate MH Oral Health Service Delivery Form.

Rows may be deleted or added to this form as needed.

Follow these instructions to complete:

Field	**Instruction for the field**
Applicant	Provide the name of the applicant agency.
County where services will be provided. Include a brief description if multiple counties are provided service through this location.	List each county ***within which*** MH services will physically be provided. Provide a brief description if clients in multiple counties are provided services through this location. (For example, Orange County provides the nursing home visits for our entire service area).
Service setting and Location	For each location where MH services will be provided, identify the service setting (e.g., WIC, MH) and the address/city.
Services to be provided	Use the list of MH services at the bottom of the form. For each location, record the services to be provided. **Required** services as a part of the MH program are in bold font on the form.
Service Provider	Record the name of the person(s) who will provide the services at each location. If person has not been hired, record the staff position as vacant.
Number of hours per month	Record the number of hours per month that the identified services will be provided at the location listed.
Extended hours scheduled?	Check the "yes" box if services will be scheduled outside of the hours of 8:00 AM to 5:00 PM. Check the "no" box if services will only be offered between 8:00 AM and 5:00 PM. If you check "no", in the comment box at the end of the form • describe special accommodations that can be made for families outside of business hours. • explain how families are made aware of this option

Co-located health service programs	Record the names of other programs (CH, FP, WIC, school health clinic) that will be offered at the same location and time as the MH services identified. If none of these specific programs will be offered in conjunction with the MH service, enter 'none'.
Narrative justification for capacity to provide home visits	In the text box provided, describe your agency's capacity to provide home visits including post partum home visits, social worker home visits, and care coordination home visits.

2. MH-OH Service Delivery Form

The MH-OH Service Delivery Form (**Attachment D-2**) is required. Complete one form for all direct dental services to be provided within the MH program or to document that direct dental services are not planned for FFY2014. Dental care coordination services are to be included on the separate *Maternal Health Service Delivery Form*.

Rows may be deleted or added to this form as needed.

Follow these instructions to complete:

Field	Instruction for the field
Applicant	Provide the name of the contract agency.
No MH-OH services planned	If applicant does not plan to provide any MH-OH direct dental services during FFY2014, check this box. No additional information on this form is needed.
County where services will be provided	If applicant will provide MH-OH direct dental services, list the county ***within which*** direct dental services will ***physically*** be provided.
Service Setting and Town	Identify the service setting (e.g., WIC, migrant camp) and the town (when applicable) where direct dental services will be provided.
Services to be provided	For ***each*** service setting/town, record the services to be provided at that location. Use the list of MH-OH services at the bottom of the form.
Name(s) of staff providing service and how many hours a month or year they provide services	**Name**: For ***each*** service setting/town, record the name of ***each*** person who will provide the services listed at the service setting/town. If person has not been hired, record "vacant". **Hrs/Mon or Hrs/Yr for Each Name**: For ***each*** person (name) listed, specify the number of hours per month the services will be provided at this location. For settings where direct dental services are provided 1-3 times per year, specify the hours per year (rather than per month). Example: Jane Doe, 4 hours/mon

3. CH Service Delivery Form

For the CH Service Delivery Form (**Attachment D-3**) complete one form (Parts A and B) for services to be provided within your CH program, except for those that pertain to oral health. Dental care coordination and oral health direct care services will be reported on a separate form.

- Part A addresses informing/re-informing and care coordination services, including home visits for care coordination.
- Part B addresses CH direct care services.

Rows may be deleted or added to this form as needed. Follow these instructions to complete:

Part A: Informing and Care Coordination Services

Field	Instruction for the field
Applicant	Provide the name of the applicant agency.
County where informing/re-informing and care coordination services will be provided	List each county in which CH informing/re-informing and care coordination services will physically be provided.
Location	Record the street address and city for each location where CH informing/re-informing and care coordination services will be provided.
County(ies) of residence *of clients* served	Record the county(ies) ***where clients reside*** that are served through the location identified.
Number of hours per month	Record the number of hours per month that the informing/re-informing and care coordination services will be provided at the location listed.
Extended hours	Identify extended hours offered outside of an 8:00 AM to 5:00 PM timeframe for these services. Extended hours ***are required*** for informing and care coordination services. (For example, 5:00 – 7:00 p.m. Mondays, Tuesdays, and Thursdays.)
Narrative for CH program capacity for home visits for care coordination	In the text box provided, describe your agency's capacity to provide home visits for care coordination. The capacity to provide home visits is **required**.

Part B: Direct Care Services

County where services will be provided	List each county in which CH direct care services will physically be provided.
Location	Record the street address and city for each location where CH direct care services will be provided.
County(ies) of residence *of clients* served	Record the county(ies) ***where clients reside*** that are served through the location identified.
Services to be provided	Use the list of CH direct care services found at the bottom of the form. **Required** services are in bold font. For each location, record the direct care services to be provided.
Ages of children to be served	For each location, record the age ranges of children (in years) who will receive services.

Number of hours per month	Record the number of hours per month that the identified services will be provided at the location listed.
Extended hours scheduled?	Check the "yes" box if services will be scheduled outside of the hours of 8:00 AM to 5:00 PM. Check the "no" box if services will only be offered between 8:00 AM and 5:00 PM. If you check "no", in the comment box at the end of the form • describe special accommodations that can be made for families outside of business hours. • explain how families are made aware of this option.
Co-located health service programs	Record the names of other programs (MH, WIC, school health clinic, FP) that will be offered at the same location and time as the CH services identified. If none of these specific programs will be offered in conjunction with the CH service, enter 'none'.
Narrative justification for full well child exams	Applicants proposing to provide *full well child exams* must complete narrative justification in the comment box at the end of the form. Provide rationale that demonstrates that provider availability or other barriers to accessing care exist. Data must demonstrate the need for the applicant agency to provide full well child exams. Examples may include but are not limited to: • Documentation of MUA, MUP, or HPSA status for the county of service (If the applicant is an FQHC, no narrative is required.) • Data that support the identification of medically underserved populations • Data that support a lack of medical practitioners willing to provide well child exams for Medicaid or uninsured/underinsured children

4. CH-OH Service Delivery Form Instructions

The CH-OH Service Delivery Form (**Attachment D-4**) is required. Complete one form (Parts A and B) for dental care coordination and direct dental services to be provided within your CH program.

- Part A: Dental Care Coordination Services – Use this section to document dental care coordination (e.g. care coordination entered into CAReS as a dental service). Include dental care coordination provided in conjunction with other care coordination on the CH Service Delivery Form.
- Part B: Direct Dental Services – Use this section to document direct dental services that will be provided by agency staff or contracted personnel.

  At a minimum, all applicants must work with local WIC programs to provide oral screenings and fluoride varnish applications to children ages 0-2 years in all counties within the service area. Applicants are encouraged to provide services for children ages 0-5 years at additional sites such as Head Start/Early Head Start centers. Gap-filling services for children older than 5 years may also be provided. (Do not include school-based sealant services funded by a separate contract with IDPH on this form.)

Rows may be deleted or added to this form as needed.

Follow these instructions to complete**:**

Part A: Dental Care Coordination Services

Field	**Instruction for the field**
Applicant	Provide the name of the contract agency.
Office Location	Provide the street address and city of the location where dental care coordination services will be provided.
County(s) of residence of clients served	List the county(s) of residence for clients that will receive dental care coordination services from this location.
Name(s) of staff providing dental care coordination	Record the name(s) of the person(s) who will provide the dental care coordination from each location listed. If person has not been hired, write "vacant".

Part B: Direct Dental Services

Field	**Instruction for the field**
County where services will be provided	List each county ***within which*** direct services will ***physically*** be provided.
Service Setting and Town	Identify the service setting (e.g., WIC, migrant camp, preschool) and the town (when applicable) where direct dental services will be provided.
Services to be provided	For each service setting/town, record the services to be provided at that location. Use the list of CH-OH services at the bottom of the form.
Name(s) of staff providing service and how many hours a month or year they provide services	**Name**: For ***each*** service setting/town, record the name of ***each*** person who will provide the services listed at the service setting/town. If person has not been hired, record "vacant". **Hrs/Mon or Hrs/Yr for Each Name**: For ***each*** person (name) listed, specify the number of hours per month the services will be provided at this location. For settings where direct dental services are provided 1-3 times per year, specify the hours per year (rather than per month). Example: Jane Doe, 4 hours/month

Note: I-Smile™ Coordinators must spend at least 20 hours a week providing infrastructure-building, population-based and/or enabling services. Information on this form must be consistent with Activity Worksheets and Budgets.

5. FP Service Delivery Form Instructions:

For the FP Service Delivery Form (**Attachment D-5**) complete one form for services to be provided under the Family Planning program.

Rows may be deleted or added to this form as needed.

Follow these instructions to complete:

Field	Instruction for the field
Applicant	Provide the name of the applicant agency.
County of residence of clients served	List county of residence of clients that this location will serve.
Location	Report the street address, city and county where FP Services will be physically located.
Services to be provided	Use the list of FP services at the bottom of the form. Record the names of the services to be provided at each location. Required services of the FP program are identified in **bold font** on the form.
Number of hours per month	Record the number of hours per month that the identified services will be provided at the location listed.
Extended hours offered?	Check the "yes" box if services will be scheduled outside of the hours of 8:00 AM to 5:00 PM. Check the "no" box if services will only be offered between 8:00 AM and 5:00 PM, and describe accommodations available outside of business hours in the comment box provided, and how clients are notified of accommodations. • describe special accommodations that can be made for families outside of business hours. • explain how families are made aware of this option.
Co-located health service programs	Record the names of other programs that will be offered at the same location and time as the FP services identified. Select from the following: MH, WIC, school health clinics, CH and/or STI/HIV. If none of these specific programs will be offered in conjunction with the FP service, enter 'none'.
Narrative	Describe your agency plan for community input into development, implementation, and evaluation of the Title X program in your service area.

E. Subcontracts Form (Required) **(Attachment E**):

Applicants must clearly identify their use of subcontracted services with a value of $2,000 or greater. Use of subcontracts must be appropriate for implementation of the project. If the applicant intends to use subcontractors in completing work and services of this RFA, complete the Subcontracts Form (**Attachment E**). This information must include:

1. The name of the subcontractor if known
2. The address of the subcontractor if known
3. The scope of work to be performed by each subcontractor
4. The programs for which the subcontract will be issued (MH, CH, and/or FP)
5. Subcontractor qualifications

If applicant has no subcontracts, the box at the top of the Subcontract Form (**Attachment E)** must be checked indicating the applicant has no planned subcontracts.

Note: In the event of a funded application for MH, CH, and/or FP, proposed subcontracted services with a value of $2,000 or greater must be defined in a legal agreement, submitted to and approved by IDPH **prior to** signature by either party. (Per Section 5 of the IDPH General Conditions)

F. Reporting for the MH, CH, and FP Programs

The reporting requirements for the MH, CH, and FP programs are outlined in the DRAFT Contract Template (**Appendix IX**). This is for informational purposes only, there are no application submission requirements related to reports.

G. Meetings for the MH, CH, and FP Programs

The meeting requirements for the MH, CH, and FP programs are outlined in the DRAFT Contract Template (**Appendix IX**). This is for planning purposes (budgeting, etc.).

2.03 Budget

General Budget Instructions:
Application budgets demonstrate the proposed use of grant funds and associated program income for administering the MH, CH, and FP programs. The CH Program has four separate budgets: CH, ***hawk-i*** Outreach, CH-Dental, and I-Smile™. Preliminary Funding Allocations are found in **Appendix I**. The line item budgets are for the period of October 1, 2013 through September 30, 2014.

MH, CH, CH-Dental, I-Smile™, and FP budgets incorporate anticipated funds from other sources to support program activities.

The budget(s) must reflect the program Service Delivery Form(s) and Activity Worksheet(s) and be consistent with the funds requested.

The following budget forms are found in **Attachment F**. Specific instructions for each program budget summary and narrative are outlined below. Follow the instructions for each program.

- MH Budget Summary and Narrative
- CH Budget Summary and Narrative
- ***hawk-i*** Outreach Budget Summary and Narrative
- CH-Dental Budget Summary and Narrative
- I-Smile™ Budget Summary and Narrative
- Family Planning Budget Summary and Narrative

The required budget forms are provided in a single Microsoft Excel 2007 document. Each tab in the document represents a separate program and includes both the Budget Summary and Budget Narrative for that program. The budget must be submitted in the Excel format. Do not submit the budget as a PDF.

Formulas for computing the totals have been inserted on the Budget Summaries and Narratives. **Do not insert additional columns in the worksheets or change spreadsheet formulas.**

The budget(s) shall include the line item categories listed below:

- **Salaries/Fringe:** This line item category includes all staff directly funded, wholly or partially, with grant funds and program income. This includes positions that are currently vacant.
- **Contracted Providers:** This line item category includes contracted providers or organizations directly funded, wholly or partially, with grant funds and program income. All subcontracts as listed on the subcontract form must be included within this line item.
- **Equipment:** This line item category includes any equipment funded, wholly or partially, with grant funds and program income. Equipment is defined as those items with a cost or value of $5,000 or more and with an anticipated useful life of one year or more. If the item does not meet this definition, it should be included in "other" costs.
- **Other:** This line item category includes other anticipated expenses funded, wholly or partially, with grant funds and program income. Other items may include office supplies, educational supplies, project supplies, incentives, communication, rent and utilities, training, information technology-related expense, travel, etc. This will include any equipment costs not meeting the above definition for equipment. Expenditures for the development, purchase, and printing of brochures may only be budgeted if part of an overall marketing plan.

  IDPH will not reimburse travel amounts in excess of limits established by the Iowa Department of Administrative Services, State Accounting Enterprise. Current in-state maximum allowable amounts are:
  - Food - $8.00/breakfast, $12.00/lunch, $23.00/dinner
  - Lodging - Maximum $83.00 plus taxes per night
  - Mileage - Maximum of $0.39 per mile

  Out-of-state maximum allowable amounts for meals can be found at the Department of Administrative Services (DAS) Web site here.
- **Administrative Costs or Federally Approved Indirect Rate:** This line item category includes either indirect or administrative costs, but not both. Budgeting indirect or administrative costs is optional. If an applicant plans to include cost in this line item and has a Federally Approved Indirect Cost Rate Agreement, this rate must be used instead of charging administrative costs. **If an applicant charges indirect or administrative costs, those costs must be charged to all programs.** Indirect or administrative costs must not duplicate costs included in the line items listed above.
  - **Indirect Costs**: Applicants with a Federally Approved Indirect Cost Rate Agreement must use this rate if choosing to bill indirect costs (and no additional administrative costs may be charged). If applicants charge indirect costs, a copy of the current, signed federally approved Indirect Cost Rate Agreement must be submitted with the proposal as proposal appendices. IDPH reserves the right to negotiate the indirect rate per individual contract. If indirect costs are being charged, the same percent **must** be charged to all programs.

    Indirect costs must be proportionally allocated across both grant funds and program income according to the Federally Approved Indirect Cost Rate Agreement. Program Income sources

may not be included in the cost basis for indirect costs charged to *grant funds*. No indirect costs may be charged to the ***hawk-i*** Outreach program.

- **Administrative Costs: Administrative costs may not be claimed if an applicant has a Federally Approved Indirect Cost Agreement.** In the absence of a federally approved Indirect Cost Rate Agreement, the applicant may charge an Administrative Cost not to exceed a maximum rate of 15% of the total amount applied for.

  Administrative costs are those that are incurred for common or joint objectives, and therefore cannot be identified readily and specifically with a sponsored program, but are nevertheless necessary to the operations of the organization. For example, the costs of operating and maintaining facilities, depreciation and administrative salaries are generally treated as indirect/administrative costs.

  The applicant shall maintain documentation to support the administrative cost allocation. IDPH reserves the right to request the documentation at any time.

  For more information on budgets, refer to RFP.

MH and CH Budget Summary and Narrative Instructions

For applicants applying for MH and CH funds, incorporate the "General Budget Instructions" above, and follow the guidelines below to complete the MH and CH Budget summary and narrative.

Overview

MH and CH applicants must complete a Budget Summary and Narrative for the program(s) for which they are applying. MH and CH Preliminary Funding Allocations are found in **Appendix I**. Develop budgets for FFY2014 (October 1, 2013 – September 30, 2014). Both Title V (MH, CH) grant funds and program income are included on the budget summary and narrative.

The MH and CH Budget Summary and Narrative forms consist of three sections:

- Budget Summary
- Presumptive Eligibility and Care Coordination Estimates (MH), Informing and Care Coordination Estimates (CH)
- Budget Narrative

One dollar of local matching funds is required for every four dollars of Title V (MH and/or CH) grant funds budgeted.

OH employed and contracted staff that provides billable care coordination services must be included on the MH and/or CH budget summary and narrative.

Budget Summary instructions

Complete the Budget Summary portion of the MH and/or CH budget forms according to the following instructions.

Field	Instruction for the field
Applicant	Provide the name of the applicant agency.
A. Salaries/ Fringe	In this row: • Enter the estimated amount of employee salaries and fringe from MH and/or CH Title V grant funds according to the MCH pyramid levels. • Enter the estimated amounts of employee salaries and fringe from Program Income within the appropriate column(s).*
B. Contracted Providers	In this row: • Enter the estimated amount of MH and/or CH Title V grant funds to be used for contracted providers according to the MCH pyramid levels. • Enter the estimated amounts of Program Income anticipated to be used for contracted providers, within the appropriate column(s).*
C. Equipment	In this row: • Enter the estimated amount of MH and/or CH Title V grant funds to be used to purchase equipment according to the MCH pyramid levels. • Enter the estimated amounts of Program Income to be used to purchase equipment, within the appropriate column(s).*
D. Other	In this row: • Enter the estimated amount of MH and/or CH Title V grant funds to be used for "Other" expenses according to the MCH pyramid levels. • Enter the estimated amount of Program Income to be used for "Other" expenses within the appropriate column(s).*
E. Indirect or Administrative Costs	In this row: • If applicable, enter the amount of indirect or administrative costs to be charged against MH and/or CH Title V grant funds according to the MCH pyramid levels. • If applicable, enter the estimated amount of indirect or administrative costs to be charged against Program Income within the appropriate column(s).* • If neither indirect nor administrative costs are charged, enter $0. Note: **Either** indirect costs or administrative costs may be charged, but not both.
TOTAL	Information in this row will be automatically computed, totaling the amounts listed in each column per line item category.

*See instructions below for completing the Presumptive Eligibility/Informing and Care Coordination Funds (blue column entitled CH-Informing and Care Coordination funds or MH-Presumptive Eligibility and Care Coordination funds).

Presumptive Eligibility and Care Coordination Estimates (MH only)
Complete the Presumptive Eligibility and Care Coordination Estimates within the MH Budget form according to the following instructions.

Field	Instruction for the field
Anticipated number of services/units	In this column: • Report the anticipated number of presumptive eligibility determination for pregnant women to be provided during FFY 2014. • Report the anticipated number of care coordination **units of service** (per 15 minute unit) to be provided to **Medicaid clients** in the MH program during FFY 2014. This includes medical and dental care coordination. • Report the anticipated number of care coordination **units of service** (per 15 minute unit) to be provided to **non-Medicaid clients** in the MH program during FFY 2014. This includes medical and dental care coordination. **Allocations are required in this field.** • Report the anticipated number of home visit for care coordination **units of service** (per 15 minute unit) to be provided to **Medicaid clients** in the MH program during FFY 2014. • Report the anticipated number of home visit for care coordination **units of service** (per 15 minute unit) to be provided to **non-Medicaid clients** in the MH program during FFY 2014.
2013 Agency Cost per Service or Unit of Service	In this column: • Report the agency's FFY 2013 cost for service for: a. Presumptive eligibility determinations for pregnant women b. Care coordination services (per 15 minute unit) c. Home visit for care coordination (per 15 minute unit)
Maximum Reimbursement	In this column: No entries are required. Maximum reimbursement rates are established by IDPH and are provided for the benefit of the applicant.
Anticipated Reimbursement (Title XIX and Title V)	In this column: • No entries are required. The amounts are automatically calculated based on amounts entered for 2013 Agency Costs compared to the maximum reimbursements anticipated for FFY 2014. The 2013 Agency costs are used if the amounts are less than or equal to the maximum reimbursements anticipated for FFY 2014. Note: All applicants *are* ***required*** *to complete a MCH Cost Analysis prior to billing services. MH applicants are requ*ired to bill their agency cost.
SUBTOTALS and TOTAL	Information in these rows will be automatically *computed, subtotaling and totaling the amounts listed under* ***Anticipated Title XIX and V Reimbursements:*** • Presumptive eligibility • Care coordination (Medicaid and non-Medicaid clients), and • Home visit for care coordination (Medicaid and non-Medicaid clients)

	The **TOTAL Anticipated FFS Reimbursement for FFY2014** amount must be used to distribute FFS funds per budget category in the **Presumptive Eligibility and Care Coordination Funds** column on the MH Budget Summary. These two totals must be the same.

Informing and Care Coordination Estimates (CH only)
Complete the Informing and Care Coordination Estimates within the CH Budget form according to the following instructions.

Field	Instruction for the field
Anticipated number of services/units	In this column: • Report the anticipated number of informing and re-informing services to be provided during FFY 2014. • Report the anticipated number of care coordination **units of service** (per 15 minute unit) to be provided to **Medicaid clients** in the CH program during FFY 2014. This includes medical and dental care coordination. • Report the anticipated number of care coordination **units of service** (per 15 minute unit) to be provided to **non-Medicaid clients** in the CH program during FFY 2014. This includes medical and dental care coordination. **Allocations are required in this field.** • Report the anticipated number of home visit for care coordination **units of service** (per 15 minute unit) to be provided to **Medicaid clients** in the CH program during FFY 2014. • Report the anticipated number of home visit for care coordination **units of service** (per 15 minute unit) to be provided to **non-Medicaid clients** in the CH program during FFY 2014.
2013 Agency Cost per Service or Unit of Service	In this column: • Report the agency's FFY2013 cost of services for: a. Informing/re-informing services b. Care coordination services (per 15 minute unit) c. Home visit for care coordination (per 15 minute unit)
Maximum Reimbursement	In this column: No entries are required. Maximum reimbursement rates are established by IDPH and are provided for the benefit of the applicant.
Anticipated Reimbursement (Title XIX and Title V)	In this column: • No entries are required. The amounts are automatically calculated based on amounts entered for 2013 Agency Costs compared to the maximum reimbursements anticipated for FFY 2014. The 2013 Agency costs are used if the amounts are less than or equal to the maximum reimbursements anticipated for FFY 2014. Note: All applicants are required to complete a MCH Cost Analysis prior to billing services. CH applicants are required to bill their agency cost.
SUBTOTALS and TOTAL	Information in these rows will be automatically *computed, subtotaling and totaling the amounts listed under* ***Anticipated Title XIX and V Reimbursements:***

	• Informing/re-informing • Care coordination (Medicaid and non-Medicaid clients), and • Home visit for care coordination (Medicaid and non-Medicaid clients) The **TOTAL Anticipated FFS Reimbursement for FFY2014** amount must be used to distribute FFS funds per budget category in the **Informing and Care Coordination Funds** column on the MH Budget Summary. These two totals must be the same.

Budget Narrative instructions

This section of the MH and CH Budgets provides breakdowns of the line item amounts listed in the Budget Summary. Complete according to the following instructions.

Field	Instruction for the field
Applicant	This field will be automatically filled in from the Budget Summary.
A. Salaries/ Fringe	• List the names of all agency employees or positions (if vacant) whose salaries/fringe are charged to the MH and/or CH program (included in this category on the Budget Summary). • For each employee/position, enter the total FTE charged to the MH and/or CH program. • For each employee/position, enter the dollar amount charged to the MH and/or CH Title V grant. • For each employee/position, enter the dollar amount charged to Program Income.
B. Contracted Providers	• List all contracted providers charged to the MH and/or CH program (included in this category on the Budget Summary). • For each contracted provider, enter the dollar amount charged to the MH and/or CH Title V grant. • For each contracted provider, enter the dollar amount charged to Program Income.
C. Equipment	• Provide a description of any equipment $5,000 or greater charged to the MH and/or CH program (included in this category on the Budget Summary). • For each piece of equipment, enter the dollar amount charged to the MH and/or CH Title V grant. • For each piece of equipment, enter the dollar amount charged to Program Income.
D. Other	• Provide a brief description of all other expenses charged to the MH and/or CH program (included in this category on the Budget Summary). Entries may be grouped (e.g., travel, professional development, supplies). • For each, enter the dollar amount charged to the MH and/or CH Title V grant. • For each, enter the dollar amount charged to Program Income.
E. Indirect or	If entering Indirect costs:

Administrative Costs	• Enter the applicant's Federally Approved Indirect Rate. • Specify what line item(s) are being charged per the applicant's federally-approved Cost Rate Agreement (e.g., Salaries, Salaries and Fringe, or Total Grant Funds) • Enter the percent of indirect costs charged to MH and/or CH program. (The same percent must be charged to all programs.) If no indirect costs are charged, enter a zero. • Enter the dollar amount of indirect costs charged to MH and/or CH Title V grant funds. If no indirect costs are charged, enter a zero. • Enter the dollar amount of indirect costs charged to Program Income. If no indirect costs are charged, enter a zero. If entering Administrative costs: • Enter the percent of administrative costs charged to the MH and/or CH program, not to exceed 15 percent. (The same percent must be charged to all programs.) If no administrative costs are charged, enter a zero. • Enter the dollar amount of administrative costs charged to MH and CH Title V grant funds. If no administrative costs are charged, enter a zero. • Enter the dollar amount of administrative costs charged to Program Income. If no administrative costs are charged, enter a zero.
TOTAL	Information in this row will automatically be computed, totaling the amounts listed in each column per line item category.

The amounts subtotaled for each category in the **Amount Charged to Grant** column of the ***Budget Narrative*** must equal the respective line item budget category totals in the **Grant Funds Total** column of the ***Budget Summary***.

The amounts subtotaled for each category in the **Amount Charged to Program Income** column of the ***Budget Narrative*** must equal the respective line item budget category totals in the **Program Income Total** column of the ***Budget Summary***. Totaled, these amounts represent the sum of Presumptive Eligibility/Informing and Care Coordination Funds and Matching Funds.

***hawk-i* Outreach Budget Summary and Narrative Instructions**
For applicants applying for ***hawk-i*** funds, incorporate the "General Budget Instructions" above, and follow the guidelines below to complete the ***hawk-i*** budget summary and narrative.

Overview
Applicants are required to submit two budgets for ***hawk-i*** Outreach.

- The first budget must show anticipated expenditures from October 1, 2013 through June 30, 2014, using 75 percent of the agency total from ***hawk-i*** Outreach Preliminary Funding Allocation in **Appendix I**.

- The second budget must show anticipated expenditures from July 1, 2014 through September 30, 2014, using 25 percent of the agency total from ***hawk-i*** Outreach Preliminary Funding Allocation in **Appendix I**.
- Applicants must set aside at least 20 percent of the total amounts of the ***hawk-i*** Outreach budgets (Oct-June and July-Sept) for presumptive eligibility determinations for children. The applicants will receive reimbursement for their cost per presumptive eligibility determination per family per year up to a maximum allowable rate established by the Department.

The sum of the two budgets must correspond to the agency total on the application Cover Page. No matching funds are required for ***hawk-i*** Outreach.

Complete the following steps to budget for October 1, 2013 through June 30, 2014 budget. Repeat all steps to budget for July 1, 2014 through September 30, 2014.

Budget Summary Instructions

Field	Instruction for the field
Applicant	Provide the name of the applicant agency.
A. Salaries/ Fringe	In this row: • Enter the estimated amount of salaries and fringe from ***hawk-i*** Outreach funds, according to the allowable MCH pyramid levels.
B. Contracted Providers	In this row: • Enter the estimated amount of expenditures for contracted providers from ***hawk-i*** Outreach funds, according to the allowable MCH pyramid levels.
C. Equipment	In this row: • Enter the estimated amount of expenditures for equipment from ***hawk-i*** Outreach funds, according to the allowable MCH pyramid levels.
D. Other	In this row: • Enter the estimated amount of Other expenditures from ***hawk-i*** Outreach funds, according to the allowable MCH pyramid levels.
E. Indirect or Administrative Costs	Indirect or Administrative costs **may not** be charged to ***hawk-i*** Outreach funds.
TOTAL	Information in this row will automatically be computed, totaling the amounts listed in each column per line item category.

Presumptive Eligibility for Children Estimates

Complete the Presumptive Eligibility for Children Estimates within the ***hawk-i*** Outreach Budget form according to the following instructions.

Field	Instruction for the field
Anticipated number of services/units	In this column: • Report the anticipated number of presumptive eligibility determinations for

	children to be provided during FFY 2014.
2013 Agency Cost per Service or Unit of Service	In this column: • Report the agency's cost for service for presumptive eligibility determinations for children
Maximum Reimbursement	In this column: • No entries are required. The maximum reimbursement rate is established by IDPH and is provided for the benefit of the applicant.
Total Anticipated Reimbursement	In this column: • No entry is required. The amount is automatically calculated based on amount entered for 2013 Agency Cost compared to the maximum reimbursement anticipated for FFY 2014. The 2013 Agency cost are used if the amount is less than or equal to the maximum reimbursement anticipated for FFY 2014. This figure must equal the TOTAL of the **ENABLING Presumptive Eligibility for children** column in the Budget Summary. This figure must be at least 20 percent of the total amount of each budget.

Budget Narrative instructions

Field	Instruction for the field
Applicant	This field is automatically filled in from the Budget Summary.
A. Salaries/ Fringe	• List the names of all agency employees or positions (if vacant) whose salaries/fringe are charged to the ***hawk-i*** Outreach grant (included in this category on the Budget Summary). • For each employee/position, enter the total FTE charged to the ***hawk-i*** Outreach grant. • For each employee/position, enter the dollar amount being charged to the ***hawk-i*** Outreach grant.
B. Contracted Providers	• List all contracted providers being charged to the ***hawk-i*** Outreach grant (included in this category on the Budget Summary). • For each contracted provider, enter the dollar amount being charged to the ***hawk-i*** Outreach grant.
C. Equipment	• Provide a description of any equipment $5,000 or greater charged to the ***hawk-i*** Outreach grant (included in this category on the Budget Summary). • For each piece of equipment, enter the dollar amount charged to the ***hawk-i*** Outreach grant.
D. Other	• Provide a brief description of all other expenses charged to the ***hawk-i*** Outreach grant (included in this category on the Budget Summary). Entries may be grouped (e.g., travel, professional development, supplies). • For each, enter the dollar amount charged to the ***hawk-i*** Outreach grant.
E. Indirect or Administrative Costs	Indirect or Administrative costs **may not** be charged to ***hawk-i*** Outreach funds.
TOTAL	Information in this row will automatically be computed, totaling the amounts listed in each column per line item category.

CH-Dental Budget Summary and Narrative Instructions

CH applicants must incorporate the "General Budget Instructions" above and follow the guidelines below to complete the CH-Dental Budget Summary and Narrative.

Overview

CH applicants must complete the CH-Dental Budget Summary and Narrative.

Using the CH-Dental Preliminary Funding Allocations found in **Appendix I,** develop a budget for FFY2014 (October 1, 2013 – September 30, 2014). CH-Dental funds are budgeted by the Infrastructure-building and/or Direct Services levels of the MCH Pyramid.

Line item costs associated with direct dental services for Title V child health clients who are not eligible for Medicaid or ***hawk-i*** are to be shown on this budget. This would include services provided by agency staff and/or costs to use dental vouchers for services by dentists. CH-Dental funds that are not used for direct dental services may be used for infrastructure-building.

The CH-Dental budget includes limited Program Income categories of Early Childhood Iowa (ECI), In-Kind, and Other Funds. Title XIX is not included as Program Income on this budget. Include anticipated Title XIX revenue for direct dental services as Program Income on the I-Smile™ and/or CH budgets. CH-Dental funds and program income (for direct services provided to children who are not eligible for Medicaid or ***hawk-i***) must reflect the CH-OH Service Delivery Form.

CH-Dental funds are a set-aside from CH funds. CH applicants must include CH-Dental funds with the total of CH funds when determining the amount of match funds required. These may be reported on the CH Budget Summary, CH-Dental Budget Summary, and/or the I-Smile™ Budget Summary.

CH-Dental Budget Summary Instructions

Complete the CH-Dental Budget Summary according to the following instructions.

Field	Instruction for the field
Applicant	Provide the name of the agency.
A. Salaries/ Fringe	In this row: • Enter the estimated amount of employee salaries and fringe to be used from CH-Dental grant funds according to the allowable MCH pyramid levels. • Enter the estimated amount of employee salaries and fringe to be used from Program Income, within the appropriate column(s).
B. Contracted Providers	In this row: • Enter the estimated amount of CH-Dental grant funds to be used for contracted providers according to the allowable MCH pyramid levels. (*Note: Include the amount anticipated to be used for dentists paid through MOUs for dental services provided to Title V-eligible clients.*) • Enter the estimated amount of Program Income anticipated to be used for contracted providers, within the appropriate column(s).
C. Equipment	In this row: • Enter the estimated amount of CH-Dental grant funds to be used to purchase

	equipment according to the allowable MCH pyramid levels. • Enter the estimated amount of Program Income to be used to purchase of equipment, within the appropriate column(s).
D. Other	In this row: • Enter the estimated amount of CH-Dental grant funds to be used for "Other" expenses according to the allowable MCH pyramid levels. • Enter the estimated amount of Program Income to be used for "Other" expenses within the appropriate column(s).
E. Indirect or Administrative Costs	In this row: • If neither indirect nor administrative costs are charged, enter zero in both MCH pyramid level columns. No additional information needed. • If including either indirect or administrative costs, enter the amount to be charged against CH-Dental grant funds according to the allowable MCH pyramid levels. • If including either indirect or administrative costs, also enter the estimated amount to be charged against Program Income in the appropriate column(s).
TOTAL	Information in this row will automatically be computed, totaling the amounts listed in each column per line item category.

CH-Dental Budget Narrative Instructions

This section of the budget provides breakdowns of the line item amounts listed in the CH-Dental Budget Summary. Applicants with two non-contiguous service areas must indicate which area (or both) for which each listed expense is anticipated (e.g., "N" for north, "S" for south).

Complete according to the following instructions.

Field	Instruction for the field
Applicant	This field is automatically filled in from the Budget Summary.
A. Salaries/ Fringe	• List the name of each agency employee (or position title, if vacant) whose salary/fringe is included in this category from the Budget Summary. • For each listed employee/position, enter the total FTE (annual) for that employee to be paid using the CH-Dental grant funds and program income. • For each employee/position listed, enter the amount to be paid by grant funds (CH-Dental). • For each employee/position listed, enter the amount to be paid by Program Income.
B. Contracted Providers	• List the name of all contracted providers whose funding is included in this category from the Budget Summary. • If the contracted provider listed will be providing services for the agency, include the total hours per year that contracted provider will be working for the agency. • For each contracted provider listed, enter the amount to be charged to the grant (CH-Dental funds). • For each contracted provider listed, enter the amount to be charged to Program Income. • NOTE: If CH-Dental funds will be used as vouchers to pay dentists for direct care services using MOUs, identify that here. Do not list all individual dentists by name. Identify them as "dentists" with one total estimated expenditure amount and do not

	include "hours per year".
C. Equipment	• Provide a description of any equipment for which costs are included in this category from the Budget Summary. • For each item listed, enter the amount to be charged to the grant (CH-Dental funds). • For each item listed, enter the amount to be charged to Program Income.
D. Other	• Provide a brief description of all other expenses for which costs are included in this category from the Budget Summary. Entries may be grouped (e.g., travel, professional development, dental supplies). • For each, enter the amount to be charged to the grant (CH-Dental funds). • For each, enter the amount to be charged to Program Income.
E. Indirect or Administrative Costs	If no indirect or administrative costs are being charged: • Enter zero in the columns for amount charged to grant and amount charged to program income. If including Indirect costs: • Enter the applicant's Federally Approved Indirect Rate. • Specify what line item(s) is charged per the applicant's federally-approved Cost Rate Agreement. (e.g., Salaries, Salaries and Fringe, or Total Grant Funds) • Enter the percent of indirect costs charged to grant funds. (The same percent must be charged to all programs.) • Enter the dollar amount of indirect costs charged to grant funds (CH-Dental). • Enter the dollar amount of indirect costs charged to Program Income. • Indirect costs must be proportionally allocated across both grant funds and program income. If including Administrative costs: • Enter the percent of administrative costs charged to grant funds, not to exceed 15 percent. (The same percent must be charged to all programs.) • Enter the dollar amount of administrative costs charged to grant funds (CH-Dental). • Enter the dollar amount of administrative costs charged to Program Income. • Administrative costs must be proportionally allocated across both grant funds and program income.

The amounts subtotaled for each category in the **Amount Charged to Grant** column of the ***Budget Narrative*** must equal the respective line item budget category totals in the **Grant Funds Total** column of the ***Budget Summary***.

The amounts subtotaled for each category in the **Amount Charged to Program Income** column of the ***Budget Narrative*** must equal the respective line item budget category totals in the **Program Income Total** column of the ***Budget Summary***.

I-Smile™ Budget Summary and Narrative Instructions

CH applicants must incorporate the "General Budget Instructions" above and follow the guidelines below to complete the I-Smile™ Budget Summary and Narrative.

Overview
CH applicants must complete I-Smile™ Budget Summary and Narrative (1) and (2).

Develop two budgets using the Preliminary I-Smile™ Funding Allocation found on **Appendix I.**

1. Show anticipated expenditures from October 1, 2013 through June 30, 2014, using the allocation table column "Budget 1" (75 percent of the applicant's total I-Smile™ allocation).
2. Show anticipated expenditures from July 1, 2014 through September 30, 2014, using the allocation table column "Budget 2" (25 percent of the applicant's total I-Smile™ allocation).

Include I-Smile™ Grant Funds and Program Income (if applicable) on the Budget Summary and Narrative. I-Smile™ Grant Funds are to be budgeted by the Infrastructure-building, Population-based, and/or Enabling levels of the MCH Pyramid. I-Smile™ Grant Funds **cannot** be used for costs associated with direct care provided by agency staff or non-agency staff, including costs to purchase clinical supplies (e.g., fluoride varnish, vinyl gloves). Direct care costs must be captured within Program Income (e.g., Title XIX, Early Childhood Iowa) on this budget or on the CH-Dental or CH Budgets.

Applicants must bill Medicaid for billable direct dental services provided to Medicaid-enrolled children. The anticipated Medicaid revenue from direct dental services should be included on this budget and must reflect the CH-OH Service Delivery Form. Applicants must include billable dental care coordination on the CH Budget Summary and Narrative.

No matching funds are required. However, CH applicants are expected to secure other funds to support I-Smile™. Program income on the I-Smile™ budget may be used as matching funds for the CH and CH-Dental funds.

I-Smile™ funds and resulting program income must reflect the CH-OH Activity Worksheet and CH-OH Service Delivery Form. The total grant funds for the two I-Smile™ budgets must be consistent with the I-Smile™ funds requested on the Cover Page. OH contracted and employed staff that provides billable care coordination must be included on the MH and/or CH budget summary and narrative.

Complete the following steps to budget for (1) October 1, 2013 through June 30, 2014 and then repeat all steps to budget for (2) July 1, 2014 through September 30, 2014.

I-Smile™ Budget Summary Instructions
Complete the I-Smile™ Budget Summary according to the following instructions.

Field	Instruction for the field
Applicant	Provide the name of the contract agency.
A. Salaries/ Fringe	In this row: • Enter the estimated amount of employee salaries and fringe to be used from I-Smile™ grant funds according to the allowable MCH pyramid levels. • Enter the estimated amount of employee salaries and fringe to be used from Program Income, within the appropriate column(s).
B. Contracted Providers	In this row: • Enter the estimated amount of I-Smile™ grant funds to be used for contracted

	providers according to the allowable MCH pyramid levels. • Enter the estimated amount of Program Income anticipated to be used for contracted providers, within the appropriate column(s).
C. Equipment	In this row: • Enter the estimated amount of I-Smile™ grant funds to be used to purchase equipment according to the allowable MCH pyramid levels. • Enter the estimated amount of Program Income to be used to purchase of equipment, within the appropriate column(s).
D. Other	In this row: • Enter the estimated amount of I-Smile™ grant funds to be used for "Other" expenses according to the allowable MCH pyramid levels. • Enter the estimated amount of Program Income to be used for "Other" expenses within the appropriate column(s).
E. Indirect or Administrative Costs	In this row: • If neither indirect nor administrative costs will be charged, enter zero in each of the pyramid level columns. • If including either indirect or administrative costs, enter the amount to be charged against I-Smile™ grant funds according to the allowable MCH pyramid levels. • If including either indirect or administrative costs, enter the amount to be charged against Program Income within the appropriate column(s).
TOTAL	Information in this row will automatically be computed, totaling the amounts listed in each column per line item category.

I-Smile™ Budget Narrative Instructions

This section of the budget provides breakdowns of the line item amounts listed in the I-Smile™ Budget Summary. Applicants with two non-contiguous service areas must indicate which area (or both) for which each listed expense is anticipated (e.g., "N" for north, "S" for south). Complete according to the following instructions.

Field	Instruction for the field
Applicant	This field is automatically filled in from the Budget Summary.
A. Salaries/ Fringe	• List the name of all agency employees (or positions if vacant) whose salaries/fringe is included in this category from the Budget Summary. • For each listed employee/position, enter the total FTE (annual) to be charged to the I-Smile™ grant funds and program income. • For each employee/position listed, enter the amount to be charged to the grant (I-Smile™ funds). • For each employee/position listed, enter the amount to be charged to Program Income.
B. Contracted Providers	• List the name of all contracted providers (or position if vacant) whose funding is included in this category from the Budget Summary. • If the contracted provider listed will be providing services for the agency, include the total hours per year that the contracted provider will be working for the agency. • For each contracted provider listed, enter the amount to be charged to the grant

	(I-Smile™ funds). • For each contracted provider listed, enter the amount to be charged to Program Income.
C. Equipment	• Provide a description of any equipment for which costs are included in this category from the Budget Summary. • For each item listed, enter the amount to be charged to the grant (I-Smile™ funds). • For each item listed, enter the amount to be charged to Program Income.
D. Other	• Provide a brief description of all other expenses for which costs are included in this category from the Budget Summary. Entries may be grouped (e.g. travel, professional development, dental supplies). • For each, enter the amount to be charged to the grant (I-Smile™ funds). • For each, enter the amount to be charged to Program Income.
E. Indirect or Administrative	If no indirect or administrative costs are being charged: • Enter zero in the columns for amount charged to grant and amount charged to program income. If including Indirect costs: • Enter the applicant's Federally Approved Indirect Rate. • Specify what line item(s) is being charged per the applicant's federally-approved Cost Rate Agreement. (e.g., Salaries, Salaries and Fringe, or Total Grant Funds) • Enter the percent of indirect costs being charged to grant funds. (The same percent must be charged to all programs). • Enter the dollar amount of indirect costs being charged to grant funds (I-Smile™). • Enter the dollar amount of indirect costs being charged to Program Income. • Indirect costs must be proportionally allocated across both grant funds and program income. If including Administrative costs: • Enter the percent of administrative costs being charged to grant funds, not to exceed 15 percent. (The same percent must be charged to all programs.) • Enter the dollar amount of administrative costs being charged to grant funds (I-Smile™). • Enter the dollar amount of administrative costs being charged to Program Income. • Administrative costs must be proportionally allocated across both grant funds and program income.
TOTAL	Information in this row will automatically be computed, totaling the amounts listed in each column per line item category.

The amounts subtotaled for each category in the **Amount Charged to Grant** column of the ***Budget Narrative*** must equal the respective line item budget category totals in the **Grant Funds Total** column of the ***Budget Summary***.

The amounts subtotaled for each category in the **Amount Charged to Program Income** column of the ***Budget Narrative*** must equal the respective line item budget category totals in the **Program Income Total** column of the ***Budget Summary***.

FP Budget Summary and Narrative Instructions
For applicants applying for FP funds, incorporate the "General Budget Instructions" above, and follow the guidelines below to complete the FP budget summary and narrative.

Overview
FP applicants must complete a Budget Summary and Narrative. FP Preliminary Funding Allocations are found in **Appendix I.** Develop a budget for FFY2014 (October 1, 2013 through September 30, 2014). Both Title X (FP) grant funds and program income are included on the budget summary and narrative.

No matching funds are required. However, a minimum of 10 percent alternative funds must be identified.

FP Budget Summary instructions
Complete the Budget Summary portion of the FP Budget form according to the following instructions.

Field	Instruction for the field
Applicant	Provide the name of the applicant agency.
A. Salaries/ Fringe	In this row: • Enter the estimated amount of salaries and fringe from Title X grant funds. • Enter the estimated amount of salaries and fringe from Program Income.
B. Contracted Providers	In this row: • Enter the estimated amount of Title X grant funds to be used for contracted providers. Enter the estimated amount of Program Income to be used for contracted providers.
C. Equipment	In this row: • Enter the estimated amount of Title X grant funds to be used to purchase equipment. • Enter the estimated amount of Program Income to be used for purchase of equipment.
D. Other	In this row: • Enter the estimated amount of Title X grant funds to be used for "other" expenses. • Enter the estimated amount of Program Income to be used for "other" expenses.
E. Indirect or Administrative Costs	In Line E: • If applicable, enter the amount of indirect or administrative costs charged against Title X grant funds. • If applicable, enter the estimated amount of indirect or administrative costs charged against Program Income. • If neither indirect nor administrative costs are charged, enter zero.
TOTAL	Information in this row will automatically be computed, totaling the amounts listed in each column per line item category.

FP Budget Narrative Instructions

This section of the budget provides breakdowns of the line item amounts listed in the Budget Summary. Complete the Budget Narrative portion of the FP Budget form according to the following instructions.

Field	Instruction for the field
Applicant	This field is automatically carried filled upon entry on the Budget Summary.
A. Salaries/ Fringe	• List the names of all agency employees or positions (if vacant) whose salaries/fringe are charged to Title X funds (included in this category from the Budget Summary). • For each employee/position, enter the FTE. • For each employee/position, enter the dollar amount being charged to the grant. • For each employee/position, enter the dollar amount being charged to Program Income.
B. Contracted Providers	• List all contracted providers charged to the grant (included in this category from the Budget Summary). • For each contracted provider, enter the dollar amount charged to the grant. • For each contracted provider, enter the dollar amount charged to Program Income.
C. Equipment	• List all equipment charged to the grant (included in this category from the Budget Summary). • For each piece of equipment, enter the dollar amount charged to the grant. • For each piece of equipment, enter the dollar amount charged to Program Income.
D. Other	• List all other expenses charged to the grant (included in this category from the Budget Summary). Entries may be grouped. • For each, enter the dollar amount charged to the grant. • For each, enter the dollar amount charged to Program Income.
E. Indirect or Administrative Costs	If entering Indirect costs: • Enter the applicant's Federally Approved Indirect Rate. • Specify what line items are charged per the applicant's federally-approved Cost Rate Agreement. (e.g., Salaries, Salaries and Fringe, or Total Grant Funds) • Enter the percent of indirect costs charged to grant funds. (The same percent must be charged to all programs.) If no indirect costs are being charged, enter a zero. • Enter the dollar amount of indirect costs charged to grant funds. If no indirect costs are being charged, enter a zero. • Enter the dollar amount of indirect costs charged to Program Income funds. If no indirect costs are being charged, enter a zero.

	If entering Administrative costs: • Enter the percent of administrative costs *being charged* to grant funds, *not to exceed 15 percent*. (The same percent must be charged to all programs.) If no administrative costs are charged, enter a zero. • Enter the dollar amount of administrative costs charged to grant funds. If no administrative costs are being charged, enter a zero. • Enter the dollar amount of administrative costs charged to Program Income. If no administrative costs are being charged, enter a zero.
TOTAL	Information in this row will automatically be computed, totaling the amounts listed in each column per line item category.

SECTION 3 – EVALUATION PROCESS AND CRITERIA

3.01 Review process

Review Committee: All applications that meet the technical requirements outlined in Section 3.03 of this RFA will be assigned to review teams of IDPH staff (to include program-specific staff) for review of content and completeness. In this continuing year of the project period, applications will be reviewed without awarding point scores.

Final Review and Award: The appropriate Bureau Chief(s) and the Division Director will review the evaluation and recommendation.

On **August 1, 2013**, a Notice of Intent to Award the contract(s) will be posted on the IDPH Web page www.idph.state.ia.us under *Funding Opportunities link* by 4:30 pm. Applicants are solely responsible for reviewing the Notice of Intent to Award to determine their award status.

Following the posting of the Notice of Intent to Award, the successful applicant(s) will retrieve a contract document through the IDPH SharePoint Service Contract system. The successful applicant has ten working days from date of receipt in which to negotiate and sign a contract with IDPH. If a contract is not executed within ten working days, IDPH reserves the right to request competitive applications, or offer the contract to a contractor in a contiguous county/region, or other entity deemed appropriate by IDPH. IDPH may, at its sole discretion, extend the time period for negotiations of the contract.

3.02 Review tool

Each application will be reviewed using the review tools, **Appendix VI** and **Appendix VII** to this RFA.

3.03 Technical requirements

A. Application documents must be submitted in a single zipped file (**preferred**) or single PDF file format, no larger than 20 MB, and emailed per the instructions outlined in section 1.06 E. Shortcuts or links to application documents will not be accepted and shall result in document rejection, which may result in rejection of the application.
B. Applications must be typewritten and follow the format delineated herein.

Aspect	Requirement
Format	Application documents must be submitted in a single zipped file (**preferred**) or single PDF file.
Length	There is no page limit for the narrative sections.
Font size	Applications must be in a minimum of 12 point font. A smaller font may be used for tables, figures or maps.
Document Organization	All components, found listed on **Appendix VIII**, Application Checklist, must be submitted.
Spacing	No more than double-spaced.

Pagination	All pages are to be sequentially numbered (1, 2, 3…) at the bottom or top of each page, including the cover page, maps, charts, tables, and appendices or attachments; and beginning with the cover page as number one. Page numbers are not required on budget forms.
Cover Page	The cover page (page 1 of **Attachment A**) must be complete and contain: • Agency Federal tax ID, name, d/b/a, and agency address, phone, and Fax. • Counties served and programs included in the application • Total requested funds per applicable program that match the preliminary funding allocation tables. • Electronic signatures by an individual authorized to obligate the applicant agency. • Completed key personnel table for applicable programs.
Minority Impact Statement	The minority impact statement must be complete and contain an electronic signature by an individual authorized by the applicant agency.
Application content	Failure to adhere to prescribed instructions, technical requirements, format, or application content may result in disqualification (rejection) of the application.

C. Do not submit promotional materials. Promotional materials or items other than required by this RFA will not be considered during the review process.

D. Any information or materials submitted separately from the application will not be considered in the review process.

3.04 Misleading or inaccurate information

All materials submitted are subject to verification. Providing misleading or inaccurate information shall be grounds for rejection of the application.

3.05 Application Checklist

The Application Checklist is provided to guide the applicant in assembling the application. The applicant shall submit all required components listed on the Application Checklist (**Appendix VIII**).

Do not submit the Application Checklist with the proposal.

SECTION 4 – CONTRACT

4.01 Conditions

Any contract awarded by the IDPH shall include specific contract provisions and the IDPH General Conditions effective January 1, 2013 and revised January 10, 2013, as posted on the IDPH Web page under *Funding Opportunities:* www.idph.state.ia.us. Refer to **Appendix IX** for the Draft Contract Template. The Draft Contract Template included is for reference only and is subject to change at the sole discretion of IDPH.

The contract terms contained in the general conditions are not intended to be a complete listing of all contract terms, but are provided only to enable applicants to better evaluate the costs associated with the RFA and the potential resulting contract. Applicants should plan to include such terms in any contract awarded as a result of the RFA. All costs associated with complying with these requirements should be included in the application. If the contract exceeds $500,000, or if the contract together with other contracts awarded to the Contractor by IDPH exceeds $ 500,000 in the aggregate, the Contractor shall be required to comply with the provisions of Iowa Code Chapter 8F.

IDPH requires contractors to link with the local board of health when providing services supported by IDPH funding. In particular, contractors are expected to assist the local board of health in carrying out the three core functions of public health as defined in 641 IAC 77.3 (137): assessment, policy development and assurance. Examples of linking with the board of health include, but are not limited to:

- Provide environmental and/or health data to the local board of health for the purposes of, and provide assistance in, assessing and analyzing the health status of the community.
- Submit reports to the local board of health on the effectiveness, accessibility, and quality of services provided.
- Include the local board of health in establishing policies and plans associated with the services provided. This can be accomplished by establishing a liaison between the contractor and the board of health or by attending regular meetings of the board of health.
- Educate the local board of health about the services provided and work with the board to identify target populations in need of the services provided.
- Be active in the Community Health Needs Assessment and Health Improvement Plan process.
- Provide the board of health expert input on the services provided and how those services relate to; the health priorities of the community and health improvement plans to address those priorities.

The contractor is expected to provide documentation of linkage efforts if requested by IDPH.

Results of the review process or changes in federal or state law may require additions or changes in final contract conditions requirements.

4.02 Incorporation of documents

The RFP, any amendments, and written responses to applicant questions, and the application submitted in response to the RFA form a part of the contract. The parties are obligated to perform all services described in the RFP, RFA, and applications unless the contract specifically directs otherwise.

4.03 Contractual payments

The IDPH provides contractual payments on the basis of reimbursement of expenses in accordance with Iowa Code 8A.514. In the event the contractor lacks sufficient working capital to provide the services of the contract, an advance not to exceed one-twelfth (1/12) of the contractual amount may be provided by the IDPH. One -third (1/3) of this advance will be deducted from eligible reimbursement of expenses for the 7th, 8th and 9th months of service.

SECTION 5 – APPENDICES

Appendices are posted in a separate file on the IDPH Web page under *Funding Opportunities:* www.idph.state.ia.us.

- Appendix I Preliminary Funding Allocations
- Appendix II Zipping Instructions
- Appendix III Logic Models
- Appendix IV Disparities- Definition and Examples of Activities
- Appendix V HHLPPP Map
- Appendix VI Technical Review Tool
- Appendix VII Individual Review Tool
- Appendix VIII Application Checklist
- Appendix IX DRAFT Contract Template

SECTION 6 – ATTACHMENTS

Attachments are posted in a separate file on the IDPH Web page under *Funding Opportunities:* www.idph.state.ia.us. Applicants must download these forms and include them in the applications as outlined in Section 2 of this RFA.

- Attachment A — Cover Page and Key Personnel
- Attachment B — Minority Impact Statement
- Attachment C — FFY2013 Activity Worksheet
  - C-1 MH
  - C-2 CH
  - C-3 ***hawk-i*** Outreach
  - C-4 CH-OH
  - C-5 FP
- Attachment D — Service Delivery Table
  - D-1 MH
  - D-2 MH-OH
  - D-3 CH
  - D-4 CH-OH
  - D-5 FP
- Attachment E — Subcontracts Form
- Attachment F — Budget-Excel Worksheets (MH, CH, ***hawk-i*** Outreach, CH-Dental, I-Smile™, FP)