**Appendix B**

**Application Form**

## The forms in this attachment are for reference only.

**The complete application form can be downloaded on January 4, 2023 from the Women, Infant, and Community Wellness Section website at:** [**https://wicws.dph.ncdhhs.gov/**](https://wicws.dph.ncdhhs.gov/)**.**

## Application Face Sheet

**Reducing Infant Mortality in Communities**

**RFA #A378R**

This form provides basic information about the applicant and the proposed program with Reducing Infant Mortality in Communities, including the signature of the individual authorized to sign “official documents” for the agency. This form is the application’s cover page. Signature affirms that the facts contained in the applicant’s response to RFA #A378R are truthful and that the applicant is in compliance with the assurances and certifications that follow this form and acknowledges that continued compliance is a condition for the award of a contract. Please follow the instructions below.

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| 1. Legal Name of Agency: 2. Name of individual with Signature Authority: | | | | | | |
| 1. Mailing Address (include zip code+4): 2. Address to which checks will be mailed: | | | | | | |
| 1. Street Address: | | | | | | |
| 1. Contract Administrator:   Name:  Title: | | | | | Telephone Number:  Fax Number:  Email Address | |
| 1. Agency Status (check all that apply): | | | | | | |
| 🞏 Public |  | 🞏 Private Non-Profit |  | 🞏 Local Health Department | | |
| 1. Agency Federal Tax ID Number: | | | | | | 1. Agency UEI Number: |
| 1. Agency’s URL (website): | | | | | | |
| 1. Agency’s Financial Reporting Year: | | | | | | |
| 1. Current Service Delivery Areas (county(ies) and communities): | | | | | | |
| 1. Proposed Area(s) To Be Served with Funding (county(ies) and communities): | | | | | | |
| 1. Amount of Funding Requested | | | | | | |
| 1. Projected Expenditures: Does applicant’s state and/or federal expenditures exceed $500,000 for applicant’s current fiscal year (excluding amount requested in #14) Yes 🞏 No 🞏 | | | | | | |
| The facts affirmed by me in this application are truthful and I warrant that the applicant is in compliance with the assurances and certifications contained in NC DHHS/DPH Assurances Certifications. I understand that the truthfulness of the facts affirmed herein and the continuing compliance with these requirements are conditions precedent to the award of a contract. The governing body of the applicant has duly authorized this document and I am authorized to represent the applicant. | | | | | | |
| 1. Signature of Authorized Representative: | | | | | | 1. Date |

**Section 1**

**Needs Assessment**

**Do not delete the question headers.**

Please provide your response to each question under the heading.

**Total Point Value:**

**20**

**Page Limit:**

**6 single-spaced**

**(excluding citation page)**

* 1. Provide a written description that includes which evidence-based strategies (EBSs) were selected for the Reducing Infant Mortality in Communities (RIMC) program, and how the community was involved in the EBS selection process. **At least two (2)** of the five (5) available EBSs must be selected. The five (5) EBSs are: Breastfeeding Support Services (BF), Centering Pregnancy (CP), Doula Services (Doula), Infant Safe Sleep Services (ISSS), and Preconception and Interconception Health Services (PIHS). (5 points)
  2. Provide a written description for the need of each selected EBS. Provide appropriate and **recent data** to support the need for each selected EBS. Please include qualitative data if available. Please refer to **Appendix D** for a list of recommended data resources. Provide the following required data for each selected EBS as listed in the table below. (8 points)

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Required Data** | **Evidence-Based Strategies** | | | | |
| **Provide recent county and state data, by race and ethnicity (when available), if marked by an “X” under the EBS for the following:** | **BF** | **CP** | **Doula** | **ISSS** | **PIHS** |
| Infant mortality rates | X | X | X | X | X |
| Percentages for low-birth-weight births | X | X | X | X | X |
| Preterm birth rates | X | X | X | X | X |
| Percentages for trimester prenatal care initiation |  | X | X |  |  |
| Percentages for mother smoked during pregnancy |  |  |  | X | X |
| Percentages for breastfeeding at discharge | X |  | X | X |  |
| Percentages for method of delivery |  | X | X |  |  |
| Percentages for maternal pre-pregnancy body mass index (BMI) |  |  |  |  | X |
| Percentages for adult obesity |  |  |  |  | X |
| Percentages for gestational diabetes |  |  |  |  | X |

1-3. Describe the specific population to be served within the county for each selected EBS. This description should include factors that have an impact on birth outcomes, such as: race/ethnicity, age, educational level, income level, and housing. Please note that it is not sufficient to state that potential program participants are at “high risk.” Describe how the community will be engaged in reaching the specific population to be served. (6 points)

1-4. Appropriate data sources must be cited in the needs assessment. One way this can be done is by using endnotes. If you use endnotes, the citation list can be included on a separate page at the end of the needs assessment section. The citation page will not count against the page limit for this section. (1 point)

**Section 2**

**Program Plan**

**Do not delete the question headers.**

Please provide your response to each question under the heading.

**Total Point Value:**

**30**

**Page Limit:**

**18 single-spaced**

2-1.Describe how your agency will implement each selected evidence-based strategy (EBS). Describe, in detail, how your agency will meet each program requirement and the specific activities involved to meet these program requirements (who is responsible, when, where and how will activities occur). Describe the community engagement component chosen for each EBS and the specific guidance, support and/or services the non-profit/501(c)(3) organization will provide under each EBS. Please refer to the Scope of Work in section III of the RFA, pages 7-20.   
NOTE: For Breastfeeding Support Services, include the Letter of Commitment from the WIC program in Attachment A. (14 points)

2-2. Describe how the training requirements will be met for program staff under each selected EBS. (4 points)

2-3. Describe how your agency will meet each performance outcome measure under each selected EBS. (8 points)

2-4 Describe how your agency will address issues that affect meeting program requirements and performance outcome measures (loss of contact with program participants, no shows for home visits or counseling sessions, recruitment and retention issues, and low attendance at education or program sessions). (4 points)

**Section 3**

**Data Collection, Evaluation and Reporting**

**Do not delete the question headers.**

Please provide your response to each question under the heading.

**Total Point Value:**

**12**

**Page Limit:**

**5 single-spaced**

3-1.Describe who will be responsible for collecting program data for each EBS. (2 points)

3-2. Describe who will be responsible for submitting biannual program reports that include program data and detailed information on program deliverables and annual performance outcome measures. (2 points)

3-3. Describe how you will evaluate the guidance, support and/or services provided by the non-profit/501(c)(3) organization(s) under the unfunded and/or funded partnerships. (3 points)

3-4. For each selected EBS, describe who will be responsible for administering the program participant satisfaction surveys. (4 points)

1. For agencies that chose the Doula Services strategy, describe who will be responsible for administering the birth satisfaction survey and entering survey responses online.
2. For agencies that chose the Infant Safe Sleep Services strategy, describe who will be responsible for administering the infant safe sleep education three (3) month follow-up survey.
3. How will you use participant feedback to improve each selected EBS?
4. Who will be responsible for collecting and reviewing feedback from the surveys?
5. Who will be responsible for submitting the annual survey summary?

3-5. Describe how participant information will be kept confidential. (1 point)

**Section 4**

**Agency Ability**

**Do not delete the question headers.**

Please provide your response to each question under the heading.

**Total Point Value:**

**14**

**Page Limit:**

**4 single-spaced**

4-1.Describe your agency’s mission, background and services and how these relate to the Reducing Infant Mortality in Communities program. Describe your agency’s experience working with minority communities and implementing programs serving men, women, and families in the community. Describe your agency’s experience collaborating with non-profit/501(c)(3) organizations. Include the agency’s organizational chart Attachment B. (4 points)

4-2. Describe who will be responsible for managing grant funds, budgeting, purchasing, tracking program expenses, and submitting monthly expenditure reports. (2 points)

4-3 Describe the process for recruiting and hiring program staff if they are not currently in place. Describe the plan for training program staff for selected EBSs with required trainings. (2 points)

4-4 Using the chart below, list each staff position title that is necessary to implement and support each selected EBS. Include the employee’s name if already hired, or if not hired list as vacant. Please insert additional rows if needed. Include copies of **job descriptions and resumes** for staff positions already hired, and copies of job descriptions for staff positions that are not hired in Attachment B. (4 points)

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Position Title** | **Employee Name** | **Full-Time Equivalency (FTE) %** | **Evidence-Based Strategy** | **Check the items attached for each position** |
|  |  |  |  | ☐ Job Description  ☐ Resume |
|  |  |  |  | ☐ Job Description  ☐ Resume |
|  |  |  |  | ☐ Job Description  ☐ Resume |
|  |  |  |  | ☐ Job Description  ☐ Resume |

4-5.Describe your agency’s history of staff turnover over the past four (4) years. Describe how you will minimize staff turnover during the grant period. (2 points)

**Section 5**

**Community Engagement**

**Do not delete the question headers**.

Please provide your response to each question under the heading.

**Total Point Value:**

**14**

**Page Limit:**

**5 single-spaced**

5-1.Describe how the community was engaged in the process for selecting each evidence-based strategy (EBS). (2 points)

5-2. Describe the community engagement component you chose (unfunded or funded partnership) for each selected EBS. Describe the non-profit/501(c)(3) organization that was selected for each selected EBS. Provide a justification/rationale for why the non-profit/501(c)(3) organization was selected for an unfunded or funded partnership for each selected EBS. For a funded partnership, a subcontractor budget must be included in the year one (1) budget submitted with the application. (4 points)

5-3. Describe how the guidance, support and/or services provided by the non-profit/501(c)(3) organization will impact the population to be served for each selected EBS. (2 points)

5-4.Using the table below, briefly describe the guidance, support and/or services that will be provided by the non-profit/501(c)(3) organization under an unfunded or funded partnership. Include a copy of the signed Letter of Commitment (LOC) and/or Memorandum of Agreement (MOA) that outlines the roles and responsibilities for both parties in Attachment A. (2 points)

|  |  |  |
| --- | --- | --- |
| **Brief Description of Support/Services** | **Name of the Organization** | **LOC/MOA Attached?** |
|  |  | ☐ **Yes** ☐ **No** |
| ☐ **Unfunded Partnership** ☐ **Funded Partnership** |
|  |  | ☐ **Yes** ☐ **No** |
| ☐ **Unfunded Partnership** ☐ **Funded Partnership** |
|  |  | ☐ **Yes** ☐ **No** |
| ☐ **Unfunded Partnership** ☐ **Funded Partnership** |

5-5. Describe how your agency will continue to engage the community to meet the needs of individuals being served, and how the non-profit/501(c)(3) organization will ensure that people with lived experience are engaged in all aspects of the program for each selected EBS. (2 points)

5-6. Describe how and when the Health Equity Impact Assessment (HEIA) will be conducted for each selected EBS. (2 points)

**Section 6**

**Budget**

**Total Point Value:**

**8**

**Page Limit:**

**Not Applicable**

**Insert Open Windows Budget Form**

Applicants must complete the Open Window Budget Form for Year 1 (6/1/2023 – 5/31/2024). Applicants must ensure that all worksheet cells are expanded to expose the full narrative justification for each line item before printing. The Open Window Budget Form can be downloaded from the Women, Infant, and Community Wellness Section website at <https://wicws.dph.ncdhhs.gov/> on January 4, 2023.

A narrative justification must be included for every expense listed in the Year 1 budget. Each justification should show how the amount on the line-item budget was calculated, and it should be clear how every expense relates to the program. The instructions for completing the Open Window Budget Form can be downloaded from the Women, Infant, and Community Wellness Section website at <https://wicws.dph.ncdhhs.gov/> on January 4, 2023.

## ATTACHMENT A: Memoranda of Agreement/Letter of Commitment

This attachment includes:

* A Memoranda of Agreement (MOA) is required from a non-profit/501(c)(3) organization that the applicant will subcontract with (funded partnership) to implement services for a selected evidence-based strategy. The MOA must outline the specific roles and responsibilities for each party.
* A Letter of Commitment (LOC) is required from a non-profit/501(c)(3) organization that the applicant will be in partnership with (unfunded partnership) to provide guidance, support and/or services for a selected evidence-based strategy. The LOC must outline the specific roles and responsibilities for each party.
* A Letter of Commitment (LOC) is required from the WIC Program for the Breastfeeding Support Services evidence-based strategy. The LOC must outline the responsibilities of each program and assure that duplication of services will not occur.

**ATTACHMENT B: Agency Information**

This attachment includes:

* Organizational chart of the applying agency.
* Job descriptions and/or resumes for all staff positions that are necessary to implement and support the selected evidence-based strategies.