

Appendix A

Forms A through K

Minnesota Department of Health
Community HIV Health Education and Risk Reduction Projects
Notice of Intent- Year 2008
(please type or print)

1. Agency Name and Contact Information

Applicant Agency Name: _____
Address: _____ Contact Person: _____
Telephone: _____
Fax: _____
E-mail: _____

2. Proposed Target Population(s)

Instructions:
Check the target population(s) the agency proposes to reach.
Keep in mind **EACH** of the eligibility criteria checked below pertains to **EACH** target population the agency proposes to reach.

1. HIV Positive Persons <input type="checkbox"/> HIV + Persons All Races, All Ages, and All Gender	3. High Risk Heterosexual (HRH) Men and Women <input type="checkbox"/> Young HRH All Races (ages 13-24) <input type="checkbox"/> African HRH (ages 25+) <input type="checkbox"/> African American HRH (ages 25+) <input type="checkbox"/> Latino/a HRH (ages 25+) <input type="checkbox"/> Native American HRH (ages 25+) <input type="checkbox"/> Asian and Pacific Islander HRH (ages 25+)
2. Men Who Have Sex with Men (MSM) <input type="checkbox"/> MSM of All Races (ages 25+) <input type="checkbox"/> Young High Risk MSM of All Races (ages 13-24)	4. Injection Drug Users (IDU) <input type="checkbox"/> MSM/IDU All Races and All Ages <input type="checkbox"/> IDUs All Races, Ages, Genders; except MSM/IDU

3. Agency Eligibility

Agencies must be able to check "yes" to all of the following to be eligible to write a project proposal: **EACH** of these eligibility criteria pertains to **EACH** target population proposed to be reached. Agencies must submit a separate proposal for each target population it proposes to serve.

1. Does (or will) the agency's project receive ongoing input from the target population for its development, implementation, and evaluation?
 Yes If yes, how? _____
 No

2. Are at least 50% of current or expected clients of the agency's project from the target population?
 Yes No

3. Does the agency currently provide or has it provided in the past five (5) years: 1) HIV health education and risk reduction programming, or, 2) services for people living with HIV/AIDS, or 3) health programming to one or more of the target populations? (NOTE: This includes all programming regardless of the funding source.)
 Yes No

If you answered "No" to any one of the questions above, the agency is NOT eligible to write a project proposal for THAT population.

If you answered "Yes" to all of the questions above for EACH selected population, the agency may submit a proposal or proposals.

REMINDER:
This form must be submitted by 4:00 p.m., Monday, May 5, 2008

**Minnesota Department of Health
Community HIV Health Education and Risk Reduction Projects
Notice of Intent Instructions**

Notices should follow the format presented on the Notice of Intent form (Form A). Only one completed Notice of Intent is required regardless of the number of proposals you intend to submit.

Proposals will NOT be accepted from applicants who fail to submit a Notice of Intent.

Notice of Intent Purpose:

Notices of Intent are used by the MDH to assist staff in communicating with submitting agencies, plan the technical assistance workshops, and to plan for the proposal review process. In addition, agencies submitting a Notice of Intent will receive a summary of the questions and answers from the pre-proposal workshops. Notices of Intent are not used as a screening tool.

Notices of Intent submitted after Friday, May 5, 2008 will not be accepted.

All applicants should begin work on their proposal as soon as possible. Agencies submitting a Notice of Intent will receive confirmation from MDH that the notice of intent was received.

Agencies intending to submit a proposal MUST submit a Notice of Intent by:

4:00 p.m., Monday, May 5, 2008

Options for Submission:

1. Mail Notice of Intent to:

**Jessica Barry
STD and HIV Section
Minnesota Department of Health
625 Robert Street North
P.O. Box 64975
St. Paul, Minnesota 55164-0975**

If submitting by U.S. Post Service, you are encouraged to use registered mail and secure a receipt.

The Notice of Intent must have a legible postmark from the United States Postal Service, or a legible pick-up or drop-off time from a private carrier with a date and time that precedes 4:00 p.m., Friday, May 5, 2008. Postmarks from private, in-office metering machines are not acceptable.

OR

2. Electronic Mail (e-mail):
Complete the Notice of Intent form (Form A) and e-mail it as an attachment to Jessica Barry at: jessica.barry@health.state.mn.us

OR

3. Hand Deliver During Pre-proposal Workshop:
Complete the Notice of Intent form (Form A) and hand deliver it to Gary Novotny at a pre-proposal workshop on either May 2 or May 5, 2008.

WARNING: MDH will not be responsible for Notices of Intent lost in transit by any carrier or electronic means.

Minnesota Department of Health
Community HIV Health Education and Risk Reduction Project
Forms Checklist and Certification

Note: This form is NOT scored.

Please check each form as it is completed and include it with the application packet.

- FORM A: Notice of Intent (to be submitted by May 5, 2008) – Year 2008
- FORM B: Forms Checklist and Certification
- FORM C: Applicant Information Sheet
- FORM D: Project Information Sheet
- FORM E: Agency Overview Narrative
- FORM F: Project Description Narrative
- FORM G: Project Budget
- FORM H: Project Budget Narrative
- FORM I: Partners Chart
- FORM J: Accounting System and Financial Capability Questionnaire
- FORM K: Evidence of Compliance of Workers' Compensation Insurance

Remember to also attach if applicable:

- Evidence of 501 (c) 3 status
- Evidence of compliance with worker's compensation insurance coverage
- Copy of most recent audit report

Reminder:

1. Submit one (1) signed unbound original and ten (10) copies of the complete application.
2. Use 12-point font, 1-inch margins, and single spaced lines on 8½ X 11-inch paper.
3. Do not exceed the section page limits.
4. Include a proposal Table of Contents.
5. Number all pages including any attachments.
6. Staple or clip proposal. Do not bind in any other way.

If ALL forms are not completed and submitted by the deadline, proposals may be disqualified from this process.

Certification:

I hereby certify that all required forms have been completed as instructed. I also certify that all information describing my agency's eligibility is correct. I understand that if any of the required information is missing, this application may be disqualified from this process. I further certify that I have reviewed Appendix G – Sample Grant Agreement and understand the contractual obligations described. I understand that all awards are final and that a grievance can only be filed with regard to a faulty process and not with regard to an unfavorable decision.

Signature of Director of Applicant Agency

Title

Date

Minnesota Department of Health
Community HIV Health Education and Risk Reduction Projects
Applicant Information Sheet

Applicant Agency with which grant agreement would be executed:

Agency Legal Name: _____

Agency Address: _____

Website Address: _____

Minnesota Tax I.D. Number: _____

Dun and Bradstreet (DUNS) Number: _____

Federal Tax I.D. (EIN) Number: _____

Non-profit Status – 501(c) 3

Yes Not Applicable

If “Yes” attach the agency’s documentation of 501 (c) 3 status.

Agency Type:

- | | |
|---|---|
| <input type="checkbox"/> Local Health Department | <input type="checkbox"/> Academic Institution |
| <input type="checkbox"/> Other Public Agency | <input type="checkbox"/> Other (specify): _____ |
| <input type="checkbox"/> Community Based Organization (CBO) | |

Evidence of Workers’ Compensation Insurance

(see Form K: Evidence of Compliance of Workers’ Compensation Insurance)

No Yes Not Applicable

Director of Applicant Agency

Name: _____	E-mail Address: _____
Title: _____	Telephone Number: _____
Address: _____	Fax Number: _____

Contact Person for Further Information on Application *(if different from above)*

Name: _____	E-mail Address: _____
Title: _____	Telephone Number: _____
Address: _____	Fax Number: _____

Certification

I certify that the information contained herein is true and accurate to the best of my knowledge and that I have authority to submit this application on behalf of the applicant agency.

_____ Signature of Director of Applicant Agency	_____ Title	_____ Date
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Minnesota Department of Health
Community HIV Health Education and Risk Reduction Projects
Applicant Information Sheet
Instructions

Please type or print all items on the Applicant Information Sheet.

If there are questions, or assistance is needed in completing this form, please contact Gary Novotny by e-mail at gary.novotny@health.state.mn.us or if you do not have e-mail access telephone him at 651-201-4029.

Applicant Agency/Address/Website

Legal name of the agency authorized to enter into a grant agreement with the Minnesota Department of Health (e.g., Northwoods County Community Health Service, I.M. Healthy Community Clinic, or OutReachers Community-based Organization.) Mailing address for the applicant agency. If the agency has a website, list the website address.

Tax ID numbers and DUNS number

Minnesota Tax ID number is issued by the Minnesota Department of Revenue, the EIN (Employer Identification Number) is the federal tax identification number, and the Data Universal Numbering System (DUNS) number is a unique nine-digit identification number provided by the Dun and Bradstreet Company. If an agency does not have a DUNS number one can be obtained at no cost by calling 1-888-814-1435 Monday-Friday, 8:00 a.m. - 6:00 p.m. or go to www.dnb.com/us. Under "D&B Resources" click on "Get a D&B DUNS Number" and follow instructions for "Get a DUNS number only."

Non-profit Status – 501 (c) 3 Copy Attachment

Check appropriate answer. Agencies other than governmental units are required to attach their 501 (c) 3 documentation with the application as evidence the agency is a non-profit institution, corporation, or organization.

Agency Type

Check appropriate answer.

Local Health Department - county or city health department

Other Public Agency - correctional institutions, mental health facilities, etc.

Community Based Organization (CBO) - 501 (c) 3 tax exempt non-profit organization

Academic/Research Institution - university, research center, etc.

If none of the options fit, then fill in "other" and specify.

Workers' Compensation

Minnesota Statutes, Chapter 176.181 subdivision 2 states that every employer in Minnesota must have Workers' Compensation insurance unless given an exemption by the Commissioner of the Department of Commerce. Complete the Form K entitled "*Evidence of Compliance of Workers' Compensation Insurance*" and if applicable attach the evidence to your application.

Director of the Applicant Agency

Person responsible for directing the applicant agency.

Contact Person for Further Information

Person who may be contacted for detailed information concerning the application, or proposed project(s), if different from number 6 above.

Certification and Signature of Director of Applicant Agency

By signing the Director of the applicant agency certifies that they are in agreement with the statement. Provide original signature and date.

Minnesota Department of Health
Community HIV Health Education and Risk Reduction Projects
Project Information Sheet

Agency Name:	Project Name (if appropriate):
Target Population:	
Selected Intervention(s): <input type="checkbox"/> Counseling Testing and Referral (CTR) (Note: Please read and understand Appendix E) <input type="checkbox"/> Community Level Intervention <input type="checkbox"/> Health Communication/Public Information <input type="checkbox"/> Outreach Intervention <input type="checkbox"/> Group Level Intervention <input type="checkbox"/> Individual Level Intervention <input type="checkbox"/> Comprehensive Risk Counseling and Services (CRCS) (Note: Contact Gary Novotny at (651) 201- 4029 if this intervention is chosen)	Selected Co-factors: (Refer to Appendix C then list your selected co-factors)
Total Requested Funding (4 year): \$	12-month Project Budget Estimate: \$
Service Area (city or cities, county, or counties):	

Instructions:

Please type or print all items on the Project Information Sheet.

If there are questions, or assistance is needed in completing this form, please contact Gary Novotny by e-mail at gary.novotny@health.state.mn.us or if you do not have e-mail access telephone him at 651-201-4029.

Agency Name

Legal name of the agency authorized to enter into a grant agreement with the Minnesota Department of Health, (e.g., Northwoods County Community Health Service, I.M. Healthy Community Clinic, or OutReachers Community-based Organization).

Project Name

List if appropriate (or if you have one) the name of the proposed HIV HERR Project (e.g., Healthy Hotties Project).

Target Population

List the selected target population (one of the eleven) that this proposed project intends to serve (see page 9 of the Application and Proposal Packet).

Selected Intervention(s)

Check the box corresponding to the intervention(s) being proposed for this project. See “HIV Prevention Intervention Comparison Guide” within Appendix D for definitions of all interventions and required core elements for each of these interventions. See Appendix E for details regarding Counseling Testing and Referral (CTR) and requirements for this intervention. If a DEBI project is going to be replicated or adapted, then check off the box(es) for the interventions that make up the DEBI project (example: Many Men, Many Voices is a group level intervention). Due to restricted available funds, it is the intent of this RFP to fund only HC/PI activities for the Native American High Risks Heterosexual and Asian Pacific Islander High Risk Heterosexual target populations.

Selected Co-factors

After reviewing Appendix C and selecting the co-factors that best fit the capacity of the agency and the proposed project; list these co-factors in the space provided.

Total Requested Funding (4 year)

The total requested funding amount for the project proposed for the four (4) year grant period (1/1/09 – 12/31/12). Consider planning for competitive salaries, cost of living increases, fringe rate increases, and inflation. Agencies may need to complete Forms G and H prior to providing this information.

12-month Project Budget Estimate

The total 12-month project budget estimate as described in Forms G and H. Proposed projects must be within the range of \$39,000-\$156,000 per project (except the Native American High Risk Heterosexual and Asian Pacific Islander High Risk Heterosexual target populations). No project over \$156,000 will be considered. See Principle #4 of Allocation and Funding Principles (Appendix F). Agencies may need to complete Forms G and H prior to providing this information.

Service Area (city or cities, county, or counties)

List the geographic area where the proposed project will be delivered. If the project will have multiple delivery sites list all sites. If the proposed project is state wide state so.

Minnesota Department of Health
Community HIV Health Education and Risk Reduction Projects

Agency Overview Narrative

(20 point value)

Instructions:

LIMIT: **Four (4) pages or less**

REMEMBER: Applicants must write their proposal in a **12-point font** with one-inch margins and **single-spaced** lines on 8½ X 11-inch paper.

Criteria in *italics* are indicators of cultural competency.

Please provide a description of your agency, including:

Agency Name: _____

1. A brief description your agency history and its mission.
2. A description of your current or history within the past five (5) years of providing HIV HERR programming that reaches the target population you are proposing to serve. If you do not currently provide HIV HERR programming to the target population, then describe the current or historical health programming or services for people living with HIV/AIDS that you do provide. Please include the following information: a description of who you reach (i.e., within the broader target population, who is your intervention(s) targeted to), a brief description of the intervention(s) and the setting in which it is provided, and how long you have been providing the intervention(s).
3. A brief description of sexual health education and health promotion provided in current programming.
4. *What makes your agency well suited to provide HIV HERR programming for the target population you are proposing to serve?*

Criteria for Scoring Proposals: The Agency Overview Narrative section of the application will be reviewed and scored according to the following criteria (20 Points):

- **The applicant agency history and mission are compatible with providing HIV HERR programming.**
- **The applicant agency has current or historical (within the past five (5) years) experience providing HIV HERR programming (or health programming or services for people living with HIV/AIDS) to the intended target population.**
- **The applicant agency currently provides sexual health education and health promotion programming.**
- *The applicant agency is well suited to provide HIV HERR for the intended target population.*

Minnesota Department of Health
Community HIV Health Education and Risk Reduction Projects

Project Description Narrative

(75 point value)

Instructions:

LIMIT: **Ten (10) pages**, may be less depending on the number of proposed interventions.

REMEMBER: Applicants must write their proposal in a **12-point font** with one-inch margins and **single-spaced** lines on 8½ X 11-inch paper.

Criteria in *italics* are indicators of cultural competency.

Agency name: _____

Project name: _____

Target population: _____

Intervention(s):

Check the box corresponding to the intervention(s) you are proposing for this project.

Note: Interventions are NOT listed in any ranked order.

Note: Due to restricted available funds, it is the intent of this RFP to fund only HC/PI activities for the Native American High Risks Heterosexual and Asian Pacific Islander High Risk Heterosexual target populations. See Principle #4 of Allocation and Funding Principles (Appendix F) and Appendix B for the definition of HC/PI and all other interventions.

- A. Counseling Testing and Referral (CTR)
(Note: Please read and understand Appendix E)
(Also: If you propose CTR you MUST also propose ILI and describe how CTR will be conducted in the context of ILI.)
- B. Community Level Intervention (CLI)
- C. Health Communication/Public Information (HC/PI)
- D. Outreach Intervention
- E. Group Level Intervention (GLI)
- F. Individual Level Intervention (ILI)
- G. Comprehensive Risk Counseling and Services (CRCS)
(Note: Contact Gary Novotny by e-mail at gary.novotny@health.state.mn.us or if you do not have e-mail access telephone him at 651-201-4029 if this intervention is chosen)

1. Check the box(es) indicating the rationale(s) that serves as the foundation in the development for each of the checked intervention(s) that make up your proposed project and provide the information requested. Note: These are NOT listed in any ranked order.

- A. Scientific, theoretical, or operational basis (e.g. social learning theory, evaluation of agency project, journal article).

For interventions based on a scientific theory or published journal article, describe how the theory or findings from the journal article will be reflected in intervention activities:

- B. Replication¹ of evidence-based project from Appendix D with documented evidence of effectiveness. If the intention is to replicate a DEBI project, then the interventions that make up the DEBI project must be defined. (Example: Many Men, Many Voices is a group level intervention)

Name of project/intervention to be replicated:

- C. Adaptation² of evidence-based project from Appendix D with documented evidence of effectiveness. If you intend to adapt a DEBI project, then you must define the interventions that make up the DEBI project. (Example: Many Men, Many Voices is a group level intervention)

Name of project/intervention to be adapted:

Describe the adaptations that will be made for use with your target population:

- D. CDC Guidelines (e.g. CTR, CRCS)

Describe how CDC Guidelines have or will be put into place:

- E. Program Outcome Monitoring

If your agency has conducted Outcome Monitoring in the past, describe the project, its findings, and how the findings support the proposed continuance of the project. Add if applicable, how findings informed any project improvements:

- F. Other rationale or experience

If none of the above apply, then describe why you believe the proposed interventions will be effective in reducing HIV risk behaviors in your target population:

¹ Replication means that you will implement the intervention EXACTLY as it was designed.

² Adaptation means that you will tailor the intervention for your target population but you will meet ALL core elements of the intervention. If you are adapting a DEBI but are not meeting ALL of its core elements, then it is not considered an adaptation and you must select another evidence basis option.

2. *Describe how ongoing input from the target population will be gathered, documented, and used for the development, implementation, and evaluation of this project.*

3. **Describe how high-risk individuals will be recruited and reached to participate in the project.**

4. *Describe how you will ensure that the project is culturally and developmentally appropriate to the target population. Explain why the activities proposed will work for that target population.*

5. **a. For EACH intervention, use a table like the one below to describe where it will take place (the location/setting), the activities that will be conducted, and the estimated number of people from the target population who will be served by the intervention(s).**

(Note: If you propose CTR you MUST also propose ILI and describe how CTR will be conducted in the context of ILI.)

Intervention	Location/setting (be specific)	Intervention activities	Estimated number of people reached for a 12-month period

- b. If two or more interventions are proposed, describe how the interventions knit together to create a whole.**

6. **Describe the specific and measurable changes that are expected in the target population as a result of the intervention activities and explain how these changes would be measured (e.g. changes in participant knowledge, attitudes, behavioral intentions, beliefs, and skills). Be S.M.A.R.T. – specific, measurable, achievable, relevant/realistic, and time-bound.**

7. **Describe the types and methods of referrals that will be made during the intervention(s) (both internally and externally).**

8. *Describe the cultural factors that create barriers to delivering prevention messages to and implementing prevention interventions with the target population.*

9. *Given the barriers described in your answer to #9 above, describe your plan to deliver your programming in light of the described barriers.*

10. Describe how this project will address the core HIV risk factors and the co-factor(s) you selected for this target population (selected from listings in Appendix C). Note: you must refer to Appendix C prior to completing 10. b. and c. below.

- a. How will the core HIV risk factors (see Appendix B) be addressed through the delivery of the intervention(s)?
- b. *How will the risk co-factor(s) selected for this target population be addressed (see Appendix C) through the delivery of the intervention(s)?*
- c. Briefly describe other resources that address the co-factor(s) selected for this target population and how partnerships will be established with these resources to prevent the duplication of services.

11. Describe how the proposed project will integrate health education and risk reduction regarding STDs and hepatitis A, B, and C into intervention delivery.

12. Describe staffing needs and staff recruitment.

- a. *Describe the types of staff needed, the number of staff needed, and the duties of each staff person involved in project administration and delivery (e.g. who will be responsible for delivering intervention services, who will attend required training, who will collect and report project data, etc.).*
- b. *Be sure to include the desired qualifications/requirements of staff hired to deliver these interventions. If you currently have an HIV prevention project that is the same or similar to the proposed project, describe the qualifications and skills of current staff. (Do not attach resumes or CVs.)*
- c. *If not currently in place, how will staff be recruited?*

13. Describe how the agency will monitor the planning, implementation and evaluation of the proposed project.

Criteria for Scoring Proposals: The Project Description Narrative section of the application will be reviewed and scored according to the following criteria (75 Points):

- Strong rationale(s) and support for the intervention(s) that make up the project are provided.
- *Methods to gather, document, and use input from the target population for the development, implementation, and evaluation of the project are fully described.*
- Strategies to recruit high-risk individuals are fully described.
- *Methods to ensure cultural and developmental appropriateness for the target population are fully described and are workable for the target population.*
- Settings and activities for each intervention are appropriate and feasible.
- If two or more interventions are proposed, how the interventions work together to create the proposed project is fully described.
- Expected outcomes (i.e., changes in knowledge, attitudes, behavioral intentions, beliefs, and skills) relate to the proposed activities and are measurable indicators of success.
- Types and methods of client referrals within or between agencies are fully described and are feasible.
- *Cultural factors that create barriers to delivering prevention messages to and implementing prevention interventions with the target population are fully described.*
- *Strategies to deliver programming in light of described cultural factors and barriers are fully described and are feasible.*
- Strategies to address core HIV risk factors are fully described and are feasible.
- *Between one (1) and four (4) co-factors are selected, the selections are realistic and consistent with the resources available, and the identified co-factors are fully described and non-duplicative with other service providers. (Note: Projects will not be evaluated based on the number of co-factors selected; rather, they will be evaluated based on how well the proposed intervention(s) will address the co-factor(s).*
- Integration of STD and hepatitis (A, B, and C) prevention into programming is fully described.
- *The type and number of staff needed and the duties of each staff member are stated and appropriate.*
- *Staff qualifications/requirements (and recruitment strategies, if needed) are stated and appropriate.*
- The description of monitoring the planning, implementation and evaluation of the proposed project is fully described and feasible.

**Minnesota Department of Health
Community HIV Health Education and Risk Reduction Project
Project Budget**

(10 point value combined Project Budget and Project Budget Narrative)

Name of Applicant Agency:	
Project Name and Target Population:	
Name of Contact Person for Budget:	
Phone:	E-mail:
Line Item	Total Proposed 12-month Amount
1. Salaries	\$
2. Fringe Benefits	\$
3. Travel and Subsistence	\$
4. Supplies	\$
5. Contractual	\$
6. Equipment	\$
7. Other Expenses	\$
8. Subtotal	\$
9. Administrative Costs (Not to exceed 17%)	\$
10. Total	\$

11. Proposed Amount for 4 Year Grant Period (1/1/2009 – 12/31/2012)	
Total:	\$

Criteria for Scoring Proposals: The Project Budget and Project Budget Narrative section of the application will be reviewed and scored according to the following criteria (10 Points):

- The project budget and project budget narrative are complete.
- The project budget and project budget narrative are correct.
- The information in the budget narrative is consistent with the proposed activities.
- The costs projected for the proposed activities and staffing level are reasonable.

**Minnesota Department of Health
Community HIV Health Education and Risk Reduction Project
Project Budget Instructions for Completion**

- Line 1: **Salaries:** Enter the proposed 12-month budget for salaries. This includes all full and part time paid employees with project responsibility.
- Line 2: **Fringe Benefits:** Enter the proposed budget for all fringe costs (if applicable) for employees listed in line 1. A definition of fringe is outlined in Form H.
- Line 3: **Travel and Subsistence:** Enter the 12-month budget for travel and subsistence if applicable. A definition of travel and subsistence is outlined in Form H.
- Line 4: **Supplies:** Enter the 12-month budget for supplies if applicable. A definition of supplies is outlined in Form H.
- Line 5: **Contractual:** Enter the proposed 12-month budget for all contractual services if applicable. These include only services that can be supported by written agreements. A definition of contractual services is outlined in Form H.
- Line 6: **Equipment:** Enter the proposed 12-month budget for equipment. A definition of equipment is outlined in Form H.
- Line 7: **Other Expenses:** Enter the proposed 12-month budget for other expenses. A definition of other expenses is outlined in Form H.
- Line 8: **Subtotal:** Subtotal the project budget column (add lines 1–7)
- Line 9: **Administrative Costs:** Enter the 12-month budget for the calculated administrative costs. This line is not to exceed 17% of the total of your other proposed expenses. A definition of allowable administrative costs is outlined in Form H.
- Line 10: **Total:** Total lines 8–9. Proposed projects MUST be within the range of \$39,000-\$156,000 per project (unless within the Native American High Risks Heterosexual and Asian Pacific Islander High Risk Heterosexual target populations). No project over \$156,000 will be considered.
- Line 11: **Proposed Amount for 4 Year Grant Period (1/1/09-12/31/12):** Enter the amount estimated for this project for the total 4 year time period. Consider planning for competitive salaries, cost of living increases, fringe rate increases, and inflation.
- Note:** **Please ensure that mathematical calculations are accurate.**

Minnesota Department of Health
Community HIV Health Education and Risk Reduction Project
Project Budget Narrative

(10 point value combined Project Budget and Project Budget Narrative)

- A. Please present a brief justification for the budget items requested. Include an explanation of how costs were determined. If more space is required, attach another sheet. Keep in mind that this is a 12-month budget.

List Project Name and Target Population:

1. **Salaries:** Indicate for each position the name and title, the full time equivalent on this project, the expected rate of pay, and the total amount for a 12-month period. State each staff person's salary per year. Funds can be used for salary of staff members directly involved in the proposed project (planning, developing, delivering, or evaluating). Salaries should be based on qualifications and experience.

“Full time equivalent” (or FTE) is defined as the percentage of time a person will work on the proposed project. To calculate the FTE, divide the hours the person will work by the standard number of work hours, which is 40 hours per week, 174 hours per month, or 2,088 hours per year. For example, a person who works 20 hours per week on this project is a 0.5 FTE ($20/40 = 0.5$).

Example: .75 FTE Health Educator, \$35,000 per year x 12-months = \$ 26,250

2. **Fringe:** All other costs, except for compensation, for full- or part-time employees of the applicant agency with project responsibilities, except those funded from administrative costs. These may, but do not have to, include: employer portion of FICA and Medicare, medical and dental insurance, long-term disability insurance, life and accidental death and dismemberment insurance, workers compensation insurance, and unemployment insurance. State each staff person's fringe per year.
3. **Travel and Subsistence:** All costs related to the transportation of project employees for approved project activities. Client travel is reported under “Other” expenses. Mileage should be calculated at a maximum of the current IRS allowable amount. Only instate travel should be calculated here.
4. **Supplies:** All project costs related to the purchase of items with a cost of less than \$5,000. Examples: office supplies (paper products, clips, pencils), condoms & lube, copying costs, brochures and educational material, computer, software, client incentives, etc.
5. **Contractual Services:** If you plan to hire independent contractors for specific services on a fee basis, please indicate: (1) the name(s) of the contractor(s) or consultant(s); (2) the dollar amount(s); (3) the specific expense line items; and, (4) the service(s) being provided. Please use additional pages if necessary. Note: Sub-contracts require prior written approval by the MDH.
6. **Equipment:** Itemize all costs of equipment that has purchase a price above \$5,000, is tangible, and has a useful life of more than one year. Note: Please contact Gary Novotny by e-mail at gary.novotny@health.state.mn.us or if you do not have e-mail access telephone him at 651-201-4029 if equipment costs are proposed.

7. **Other:** All project cost items, not included in the previous definitions must be specified here. Examples: office phone, cell phone, internet access, postage, refreshments, advertising, translation/interpretation costs, costs associated with staff training. It is highly recommended to plan for approximately \$1,800 per 1.0 FTE for staff training and out of state travel expenses. Out of state travel will require prior approval by the State’s Authorized Representative on a case by case basis during the grant agreement period and pending availability of grant agreement funds. Note: Do not include HIV testing kits nor laboratory processing costs (see Appendix E).

8. **Subtotal:** (no narrative required for this line)

9. **Administrative Costs:**

This line is not to exceed 17% of the total of the proposed expenses.

Administrative Costs are defined as costs that represent the expenses of doing business that are not easily identified with a particular grant, contract, project, function, or activity but are necessary for the general operation of the organization and the conduct of activities it performs. Examples: accounting, human resources, general agency administration, and costs to operate and maintain facilities (including occupancy).

Describe what kinds of administrative costs are expected.

Administrative expenses will not be provided to other government agencies or universities.

10. **Total:** (no narrative required for this line)

Proposed projects MUST be within the range of \$39,000-\$156,000 per project (unless within the Native American High Risks Heterosexual and Asian Pacific Islander High Risk Heterosexual target populations). No project over \$156,000 will be considered.

Note: If awarded funding, an “Administrative/Indirect Cost Allocation for HIV HERR projects” Form will be completed.

B. If funding from other sources has been secured, or will be requested to support this project, please indicate: (1) the dollar amount; (2) the source of these funds; and, (3) when a final decision regarding the funding requests is expected.

Amount Requested	Source	Status	Date of Expected Response

C. Please estimate the total project budget necessary to maintain this project from January 1, 2009 through December 31, 2012 (4 year budget).

D. Describe if applicable, any “in-kind” contribution your agency will provide to support this project.

**Minnesota Department of Health
 Community HIV Health Education and Risk Reduction Project
Partners Chart**

(10 point value)

Applicant Agency: _____ Project Name: _____

Target Population: _____

The MDH emphasizes the importance of people working together in communities. The MDH wants to know what partnerships are proposed, what experience exists in working together, what role those partners have in the project, and who was contacted about this proposed project. Use the grid below to provide information on the partnerships proposed in this project. (Hint: Partners may appear on each other's Partners Charts.) Complete this chart only if partnerships make sense in the planning, development, and/or implementation of the proposed project. Examples of partnerships may include collaborations, mentoring, and clinic referral. This chart is not limited to one page, **you may add rows as needed, however please do not exceed two pages.**

Name of Partner Agency, Organization, Group, or Individual	Describe existing partnership experiences	Describe the partner's role in the proposed project	Key Partner Contact Person

Note: Please DO NOT submit letters of support as they will not be forwarded to the Review Committee.
Note: If there is a COLLABORATIVE that is more elaborate than this form captures, please attach a 1-2 page description.

<p>Criteria for Scoring Proposals: The Partners Chart section of the application will be reviewed and scored according to the following criteria (10 Points):</p>
<ul style="list-style-type: none"> • Cooperative relationships with other community organizations appear to be in place and are appropriate.



ACCOUNTING SYSTEM AND FINANCIAL CAPABILITY QUESTIONNAIRE

This standard form is used to determine the financial capacity of grant applicants. This form should be used for applicant agencies that: are requesting, or will receive, more than \$50,000; are new to state granting; are recently incorporated (five years or less); had previous unfavorable financial performance with federal and/or state funds; had significant audit findings; or for any applicant whose financial capacity is unknown or questionable. All applicants for this RFP are required to complete this form.

No applicants will be excluded from receiving funding based solely on the answers to these questions.

SECTION A: APPLICANT INFORMATION		
1. Organization Name and Address	2. Employer Identification Number	3. Number of Employees Full Time: Part Time:
	4. When did the applicant receive its 501(c)3 status? (MM/DD/YYYY)?	
5. Is the applicant affiliated with or managed by any other organizations (Ex. regional or national offices)? <input type="checkbox"/> YES <input type="checkbox"/> NO If "Yes," provide details:	6a. Total revenue in most recent accounting period (12 months).	
5b. Does the applicant receive management or financial assistance from any other organizations? <input type="checkbox"/> YES <input type="checkbox"/> NO If "Yes," provide details:	6b. How many different funding sources does the total revenue come from?	
7. Does the applicant have written policies and procedures for the following business processes?		
a. Accounting	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure	If yes please attach a copy of the table of contents
b. Purchasing	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure	If yes please attach a copy of the table of contents
c. Payroll	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure	If yes please attach a copy of the table of contents
SECTION B: ACCOUNTING SYSTEM		
1. Has a Federal or State Agency issued an official opinion regarding the adequacy of the applicants accounting system for the collection, identification and allocation of costs for grants <input type="checkbox"/> Yes <input type="checkbox"/> No <i>Note: If a financial review occurred within the past three years, omit Questions 2 – 6 of this Section and 1-3 of Section C.</i>		
a. If yes, provide the name and address of the reviewing agency:	b. Attach a copy of the latest review and any subsequent documents.	
2. Which of the following best describes the accounting system? <input type="checkbox"/> Manual <input type="checkbox"/> Automated <input type="checkbox"/> Combination		
3. Does the accounting system identify the deposits and expenditures of program funds for each and every grant separately?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure	
4. If the applicant has multiple programs within a grant, does the accounting system record the expenditures for each and every program separately by budget line items?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure <input type="checkbox"/> Not Applicable	
5. Are time studies conducted for an employee(s) who receives funding from multiple sources?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure <input type="checkbox"/> No Multiple Sources	
6. Does the accounting system have a way to identify over spending of grant funds?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure	

SECTION C: FUND CONTROL

- | | | | |
|---|------------------------------|-----------------------------|-----------------------------------|
| 1. Is a separate bank account maintained for grant funds? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Not Sure |
| 2. If grant funds are mixed with other funds, can the grants expenses be easily identified? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Not Sure |
| 3. Are the officials of the organization bonded? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Not Sure |

SECTION D: FINANCIAL STATEMENTS

- | | | | |
|---|------------------------------|-----------------------------|-----------------------------------|
| 1. Did an independent certified public accountant (CPA) ever examine the organization's financial statements? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Not Sure |
|---|------------------------------|-----------------------------|-----------------------------------|

SECTION E: CERTIFICATION

I certify that the above information is complete and correct to the best of my knowledge.

1. Signature

2. Date / /

3. Title

Minnesota Department of Health
Community HIV Health Education and Risk Reduction Projects
Evidence of Compliance of Workers' Compensation Insurance

Minnesota Statutes, Chapter 176.181 subdivision 2 states that every employer in Minnesota must have workers' compensation insurance unless given an exemption by the Commissioner of the Department of Commerce. The exception to this requirement is a self-employed grantee who has no employees. An employee, as defined by M.S. 176.011, subd. 9, is any person who performs services for another for hire, including minors and family members.

The statement above is: (check appropriate box)

Applicable to My Agency Not Applicable to My Agency

If the agency does not fall within the exception and wishes to enter into a grant agreement with the Commissioner of Health, it must furnish acceptable evidence of compliance with worker's compensation coverage in any one of the following four ways:

1. Attach a certificate of insurance (supplied by your workers' compensation carrier) to this Evidence of Compliance form; or,
2. If self-insured, attach to this Evidence of Compliance form, a written order from the Minnesota Commissioner of Commerce allowing for self-insurance; or,
3. If self-insured and a state agency or a municipal subdivision of the state, pursuant to M.S. 176.181, subd. 2, and therefore not required to obtain a written order from the Commissioner of Commerce, **circle this entire statement and sign and date in the space provided below**; or,
4. Fill in the information for each item below and sign and date the form in the space provided.

Name and Address of applicant's Insurance Carrier:	Applicant's Insurance Policy Number:
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*I affirm that all of the employees of _____
(Applicant Agency Name)
are covered by the workers' compensation insurance policy listed above.*

Signed By:	Title:	Date:
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Note: By signing a grant agreement with the Minnesota Department of Health, an agency certifies that it is in compliance with workers' compensation requirements.