



Request for Applications

RFA #A345

Perinatal/Neonatal Outreach Coordinator

FUNDING AGENCY: North Carolina Department of Health and Human Services
Division of Public Health
Women's and Children's Health Section
Women's Health Branch

ISSUE DATE: August 16, 2017

DEADLINE DATE: September 29, 2017

Applications will be received until 5:00 p.m. on September 29, 2017

Applications may be submitted by mailing to either the mailing address or the delivery address.

MAILING ADDRESS:

Tara Owens Shuler, M.Ed., LCCE, FACCE
Perinatal Health Unit Manager
NCDHHS - Division of Public Health
WCHS - Women's Health Branch
1929 Mail Service Center
Raleigh, NC 27699-1929

DELIVERY ADDRESS (i.e. Fed Ex, UPS):

Tara Owens Shuler, M.Ed., LCCE, FACCE
Perinatal Health Unit Manager
NCDHHS - Division of Public Health
WCHS - Women's Health Branch
5601 Six Forks Road, 2nd Floor
Raleigh, NC 27609-3811

INQUIRIES:

Direct all inquiries concerning this RFA to:

Tara Owens Shuler, M.Ed., LCCE, FACCE
Perinatal Health Unit Manager
Phone: (919) 707-5708 Fax: (919) 870-4827
E-mail: tara.shuler@dhhs.nc.gov

IMPORTANT NOTE: Indicate agency/organization name and RFA number on the front of each application envelope or package, along with the RFA deadline date.

RFA Table of Contents

I. INTRODUCTION ----- 4
 ELIGIBILITY ----- 5
 FUNDING ----- 5

II. BACKGROUND ----- 5

III. SCOPE OF SERVICES ----- 7

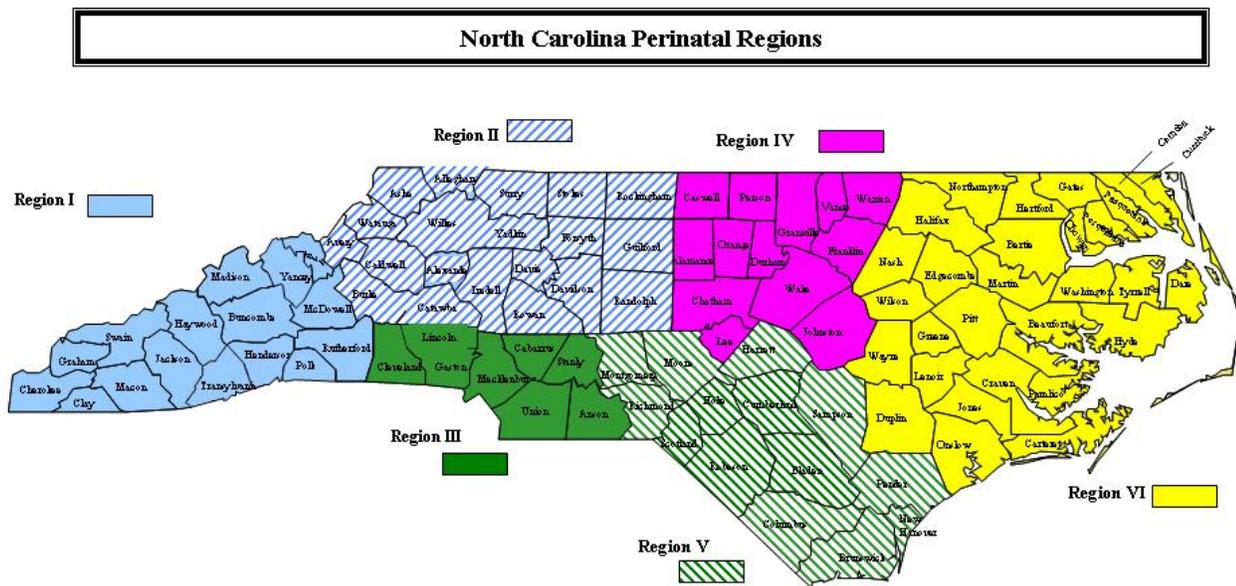
IV. GENERAL INFORMATION ON SUBMITTING APPLICATIONS ----- 9
 1. Award or Rejection ----- 9
 2. Decline to Offer ----- 9
 3. Cost of Application Preparation ----- 9
 4. Elaborate Applications ----- 9
 5. Oral Explanations ----- 9
 6. Reference to Other Data ----- 10
 7. Titles ----- 10
 8. Form of Application ----- 10
 9. Exceptions ----- 10
 10. Advertising ----- 10
 11. Right to Submitted Material ----- 10
 12. Competitive Offer ----- 10
 13. Agency and Organization’s Representative ----- 10
 14. Subcontracting ----- 10
 15. Proprietary Information ----- 10
 16. Participation Encouraged ----- 11
 17. Contract ----- 11

V. APPLICATION PROCUREMENT PROCESS AND APPLICATION REVIEW --- 11
 1. Announcement of the Request for Applications (RFA) ----- 11
 2. Distribution of the RFA ----- 11
 3. Bidder’s Webinar / Question & Answer Period ----- 11
 4. Applications ----- 11
 5. Original Application ----- 12
 6. Copies of Application ----- 12
 7. Format ----- 12
 8. Space Allowance ----- 12
 9. Application Deadline ----- 12
 10. Receipt of Applications ----- 12
 11. Review of Applications ----- 12
 12. Request for Additional Information ----- 12
 13. Audit ----- 13
 14. Assurances ----- 13
 15. Additional Documentation to Include with Application ----- 13
 16. Federal Certifications ----- 13
 17. System for Award Management Database (SAM) ----- 13
 18. Additional Documentation Prior to Contract Execution ----- 14
 19. Registration with Secretary of State ----- 14
 20. Federal Funding Accountability and Transparency Act (FFATA) ----- 14
 21. Iran Divestment Act Certification of Eligibility ----- 15

| | | |
|-------|--|----|
| | 22. Application Process Summary Dates ----- | 15 |
| VI. | PROJECT BUDGET ----- | 15 |
| VII. | EVALUATION CRITERIA ----- | 18 |
| VIII. | APPLICATION ----- | 19 |
| | Completing the Application ----- | 19 |
| | Application Checklist ----- | 23 |
| | Cover Letter ----- | 24 |
| | Application Face Sheet ----- | 26 |
| | Applicant's Response ----- | 27 |
| | Project Budgets ----- | 45 |
| | Indirect Cost Rate Approval Letter (if applicable) ----- | 46 |
| | Letters of Commitment and Memorandums of Agreement ----- | 47 |
| | Agency Information ----- | 48 |
| | IRS Letter ----- | 49 |
| | Verification of 501 (c)(3) Status Form ----- | 50 |
| | Appendix A Forms for Reference ----- | 51 |
| | FEDERAL CERTIFICATIONS ----- | 52 |
| | LETTER TO IDENTIFY INDIVIDUALS TO SIGN CONTRACTS ----- | 61 |
| | LETTER TO IDENTIFY INDIVIDUALS TO SIGN EXPENDITURE REPORTS ----- | 62 |
| | NOTARIZED STATEMENT AND CONFLICT OF INTEREST POLICY ----- | 63 |
| | NO OVERDUE TAX DEBTS CERTIFICATION ----- | 66 |
| | CONTRACTOR CERTIFICATIONS ----- | 67 |
| | FFATA Form ----- | 69 |
| | IRAN DIVESTMENT ACT CERTIFICATION OF ELIGIBILITY ----- | 70 |
| | Appendix B: North Carolina Perinatal Care Regions County Listing ----- | 71 |
| | Appendix C: Citation Guidance for Determination of Need ----- | 73 |
| | Appendix D: CDC Maternal & Neonatal Levels of Care Assessment Tool ----- | 75 |

I. INTRODUCTION

This Request for Applications will provide funding for two to three Perinatal/Neonatal Outreach Coordinator projects in two to three perinatal regions in North Carolina. Each funded project must be located within one of the designated perinatal care regions in the state (see map below). A listing of counties in each perinatal care region can be found in Appendix B. Each program will be expected to focus on perinatal and neonatal initiatives. Funding is expected to be available for three years. The first year of funding begins February 1, 2018 and ends May 31, 2018. Funding will be administered by the North Carolina Department of Health and Human Services, Division of Public Health, Women's and Children's Health Section, Women's Health Branch, Perinatal Health Unit.



Public or non-profit private institutions will receive funding to implement Perinatal/Neonatal Outreach Coordinator projects. Each project will support a Perinatal/Neonatal Outreach Coordinator position who will conduct regional assessments, and develop and implement initiatives, to improve maternal and neonatal systems of care and increase the availability of immediate postpartum insertion of highly effective, long-acting contraceptive methods.

The goals of the Perinatal/Neonatal Outreach Coordinator project are:

1. To improve (reduce) North Carolina's maternal and neonatal morbidity and mortality rates by:
 - a. Establishing a system to determine risk appropriate levels of maternal and neonatal care.
 - b. Promoting the development of collaborative systems that promote proactive integration of risk-appropriate antepartum, intrapartum, and postpartum care.
2. To improve birth outcomes through the reduction in unintended pregnancies by:
 - a. Increasing the availability of immediate postpartum insertion of highly effective, long-acting contraceptive methods.

ELIGIBILITY

Each applicant must be a North Carolina public or non-profit private institution that is physically located within the perinatal region it proposes to serve, and must have the capacity to serve the entire perinatal region. Non-profit private institutions must document their 501(c)(3) status in Attachment B and must be registered to do business in the State of North Carolina before contract execution. Public agencies must provide a legal document or letter verifying both legal name and federal tax identification number as Attachment B. For-profit agencies need not apply.

Applicants must have expertise in providing multidisciplinary and subspecialty perinatal care, and assist the Perinatal/Neonatal Outreach Coordinator in identifying specific perinatal issues and support programmatic interventions. The Perinatal/Neonatal Outreach Coordinator is not expected to provide direct clinical care, but must have an ongoing relationship with perinatal staff to enhance program efforts and address program issues. The institution's staff will need to be actively involved in assisting the Perinatal/Neonatal Outreach Coordinator in identifying specific perinatal issues and support programmatic interventions.

FUNDING

Two to three Perinatal/Neonatal Outreach Coordinator projects will be funded at an award level of \$150,000 to \$200,000 annually. Funding is expected to be available for three years. The first year of funding will begin on February 1, 2018, and end on May 31, 2018:

Year 1: 2/1/2018 – 5/31/2018

Year 2: 6/1/2018 – 5/31/2019

Year 3: 6/1/2019 – 5/31/2020

Continuation of funding will be dependent upon project performance and future funding availability. The final number and award amount will depend upon the number of quality applications received, the appropriateness of the applicants' proposed goals, objectives, strategies and activities, and the likelihood of the success of the proposed project. This program is 100% federally funded from the Maternal and Child Health Block Grant.

Applicants should consider whether their agency has the capacity to administer state grant funds if awarded. Recipients of state funds are expected to have established written general agency policies including personnel and financial accounting policies. Funds to grantees will be dispersed on a cost reimbursement basis only and agencies should carefully consider if they have the capacity to implement the program under this system.

II. BACKGROUND

Pursuant to Senate Bill 257, the North Carolina Department of Health and Human Services, Division of Public Health, Women's Health Branch is administering the Perinatal/Neonatal Outreach Coordinator project to improve maternal and neonatal outcomes in the state. The previously funded Perinatal/Neonatal Outreach Coordinator program provided training across the state to improve clinical practices and patient outcomes in the state's birthing hospitals, community health centers, health departments and physician office practices. Funding for the program ended in 2009. With this new legislation, the project will work to improve the state's maternal and neonatal morbidity and mortality rates and improve birth outcomes through the reduction in unintended pregnancies.

For the years 2011-2014, North Carolina’s pregnancy-related mortality rates were 14.2 per 100,000 live births for non-Hispanic White women and 27.9 per 100,000 live births for non-Hispanic Black women.¹ Non-Hispanic Black women are twice as likely to experience a pregnancy-related death than non-Hispanic White women. For the years 2011-2015, North Carolina’s infant mortality rate was 7.2 per 1,000 live births, 5.5 per 1,000 live births for non-Hispanic White infants and 8.0 per 1,000 live births for minority infants (includes population categories of non-Hispanic Black, non-Hispanic American Indian, non-Hispanic other, and Hispanic).¹ The table below shows the number of infant deaths and infant mortality rates for 2011-2015 for each perinatal care region in North Carolina.¹

| Perinatal Care Region (PCR) | 2011-2015 Number of Infant Deaths | 2011-2015 Infant Mortality Rates |
|------------------------------------|--|---|
| PCR I | 248 | 6.5 |
| PCR II | 953 | 7.5 |
| PCR III | 755 | 6.3 |
| PCR IV | 878 | 6.7 |
| PCR V | 730 | 7.9 |
| PCR VI | 761 | 8.2 |
| NC TOTAL | 4,325 | 7.2 |

In 2015, the percentage of unintended pregnancies was 50.6% in North Carolina.¹ There were 34.9% unintended pregnancies for non-Hispanic White women, and 57.4% of pregnancies were unintended for minority women (includes population categories of non-Hispanic Black, non-Hispanic other, and Hispanic).¹ The table below shows the percentage of unintended pregnancies for each perinatal care region.¹

| Perinatal Care Region (PCR) | 2015 Percent Unintended Pregnancies* |
|------------------------------------|---|
| PCR I | 46.5 |
| PCR II | 52.7 |
| PCR III | 50.5 |
| PCR IV | 47.0 |
| PCR V | 52.5 |
| PCR VI | 51.6 |
| NC TOTAL | 50.1 |

**Number of unintended pregnancies as estimated by the sum of abortions, births to teens 18 years old or younger, and out-of-wedlock births to women over 18 years of age*

¹ North Carolina State Center for Health Statistics. North Carolina Department of Health and Human Services, Division of Public Health. www.schs.state.nc.us/data. Accessed July 14, 2017.

In March 2016, the North Carolina Department of Health and Human Services released the collaborative North Carolina Perinatal Health Strategic (NCPHS) Plan. The NCPHS Plan is designed to address infant mortality, maternal health, maternal morbidity, and the health of men and women of childbearing age. The NCPHS Plan has three over-arching goals:

- 1) Improve health care for women and men;
- 2) Strengthen families and communities; and
- 3) Address social and economic inequities.

The following are selected goals and strategies from the NCPHS Plan, among others, to improve health care for women and men that specifically relate to the work of the Perinatal/Neonatal Outreach Coordinator:

- Provide interconception care to women with prior adverse pregnancy outcomes
 - Strategy: Support healthy pregnancy intervals through access to effective methods of contraception, including increased access to long acting reversible contraception.
- Improve the quality of maternal care
 - Strategy: Ensure that all pregnant women and high-risk infants have access to the appropriate level of care through a well-established regional perinatal system.
 - Action step: Assess the levels of neonatal and maternity care services for hospitals using the consensus recommendations of the American Academy of Pediatrics (AAP), the American College of Obstetricians and Gynecologists (ACOG), and the Society for Maternal-Fetal Medicine (SMFM).

With this new legislation, the Perinatal/Neonatal Outreach Coordinator project will work to implement initiatives that fit under the NCPHS Plan's strategies to support healthy pregnancies through access to effective methods of contraception, and to ensure all pregnant women and high-risk infants have access to the appropriate level of care.

III. SCOPE OF SERVICES

Year One (February 1, 2018 – May 31, 2018)

Applicants shall:

- A. Hire a full-time Perinatal/Neonatal Outreach Coordinator with the following minimum qualifications:
 1. Registered Nurse licensed in the State of North Carolina.
 2. MSN or MPH, or other related degree, with a curriculum vitae submitted in Attachment B (if applicable).
 3. Experience providing technical assistance, working on collaborative teams, and working on quality improvement projects.
 4. A minimum of two year's clinical experience in obstetrical and/or neonatal care (inpatient, outpatient, or both).
- B. Ensure the Perinatal/Neonatal Outreach Coordinator is trained on the Centers for Disease Control and Prevention's (CDC) Maternal and Neonatal Levels of Care Assessment Tool (LOCATe). CDC LOCATe will be used to assess the neonatal and maternal levels of care at birthing facilities in each project's designated perinatal care region. A copy of the CDC LOCATe is in Appendix D. Each Perinatal/Neonatal Outreach Coordinator project is required to use the most up-to-date version of the LOCATe tool.

The CDC LOCATe encourages important dialogue among stakeholders around neonatal and maternal levels of care. This tool will: provide a description of how birthing facilities are functioning in relation to the guidelines and policy statements issued by the American Academy of Pediatrics (AAP) and American Congress of Obstetricians and Gynecologists (ACOG) and the Society of Maternal-Fetal Medicine; analyze differences in services within the perinatal care region; and analyze how neonatal and maternal levels of care impact infant or maternal mortality and morbidity. The CDC LOCATe is geared to assist facilities in strengthening guidelines as well as produce standardized assessments for maternal and neonatal levels of care.

- C. Establish relationships with at least 90% of birthing facilities in their perinatal care region to develop an implementation plan for conducting the CDC LOCATe.
 - 1. Develop a project description to build trust and buy-in for internal stakeholders at the various facilities.
 - 2. Send letters of introduction and encouragement to the birthing facilities to help secure their participation.
- D. Evaluate the existing CDC LOCATe and determine the best strategy for increasing the response rate by reducing barriers to completing the tool.
- E. Conduct an assessment of birthing facilities in their perinatal care region to determine which have implemented policies and initiatives for immediate postpartum insertion of highly effective, long-acting contraceptive methods.
- F. Determine the challenges and barriers for birthing facilities in their perinatal care region that have impeded implementation of immediate postpartum insertion of highly effective, long-acting contraceptive methods.

Year 2 (June 1, 2018 – May 31, 2019)

Applicants shall:

- A. Work with the birthing facilities within the perinatal care region to support them in administering the CDC LOCATe.
 - 1. Support administration of the CDC LOCATe within at least 75% of the birthing facilities in the perinatal care region.
 - 2. Evaluate whether the implementation and data collection process should start with maternal levels of care or neonatal levels of care.
 - 3. Use established relationships to survey and interview representatives at the birthing facilities to improve the data collection process.
- B. Convene a group of stakeholders from birthing facilities to facilitate data informed discussions related to improving the system of risk-appropriate care.
- C. Provide education, technical assistance, and support for quality improvement initiatives based on needs or gaps identified by CDC LOCATe.
- D. Collaborate with at least five (5) birthing facilities within the perinatal care region to develop and implement policies and initiatives on immediate postpartum insertion of highly effective, long-acting contraceptive methods

Year 3 (June 1, 2019 – May 31, 2020)

Applicants shall:

- A. Administer CDC LOCATe to the remaining 25% of birthing facilities within the perinatal care region.

- B. Collaborate with representatives from the birthing facilities to propose a set of uniform criteria for maternal and neonatal levels of care for the facilities in the perinatal care region.
- C. Present proposed set of criteria for maternal and neonatal levels of care to the North Carolina Division of Public Health (DPH), Women’s Health Branch (WHB) using collected data, and the guidelines and policy statements issued by the American Academy of Pediatrics (AAP) and American Congress of Obstetricians and Gynecologists (ACOG), and the Society of Maternal-Fetal Medicine.
- D. Submit a summary report on the data collected using the CDC LOCATe, including identified barriers and lessons learned while administering this tool.
- E. Provide education and technical assistance to the birthing facilities to support the policies and initiatives developed, in year two, for immediate postpartum insertion of highly effective, long-acting contraceptive methods.
- F. Collaborate with at least five additional birthing facilities within the perinatal care region to develop and implement policies and initiatives on immediate postpartum insertion of highly effective, long-acting contraceptive methods.
- G. Submit a report on the initiatives conducted and policies implemented within birthing facilities on immediate postpartum insertion of highly effective, long-acting contraceptive methods.

IV. GENERAL INFORMATION ON SUBMITTING APPLICATIONS

1. Award or Rejection

All qualified applications will be evaluated and award made to that agency or organization whose combination of budget and service capabilities are deemed to be in the best interest of the funding agency. The funding agency reserves the unqualified right to reject any or all offers if determined to be in its best interest. Successful applicants will be notified by **October 20, 2017**.

2. Decline to Offer

Any agency or organization that receives a copy of the RFA but declines to make an offer is requested to send a written “Decline to Offer” to the funding agency. Failure to respond as requested may subject the agency or organization to removal from consideration of future RFAs.

3. Cost of Application Preparation

Any cost incurred by an agency or organization in preparing or submitting an application is the agency's or organization's sole responsibility; the funding agency will not reimburse any agency or organization for any pre-award costs incurred.

4. Elaborate Applications

Elaborate applications in the form of brochures or other presentations beyond that necessary to present a complete and effective application are not desired.

5. Oral Explanations

The funding agency will not be bound by oral explanations or instructions given at any time during the competitive process or after awarding the grant.

6. **Reference to Other Data**

Only information that is received in response to this RFA will be evaluated; reference to information previously submitted will not suffice.

7. **Titles**

Titles and headings in this RFA and any subsequent RFA are for convenience only and shall have no binding force or effect.

8. **Form of Application**

Each application must be submitted on the form provided by the funding agency, and will be incorporated into the funding agency's Performance Agreement (contract).

9. **Exceptions**

All applications are subject to the terms and conditions outlined herein. All responses will be controlled by such terms and conditions. The attachment of other terms and conditions by any agency or organization may be grounds for rejection of that agency or organization's application. Funded agencies and organizations specifically agree to the conditions set forth in the Performance Agreement (contract).

10. **Advertising**

In submitting its application, agencies and organizations agree not to use the results therefrom or as part of any news release or commercial advertising without prior written approval of the funding agency.

11. **Right to Submitted Material**

All responses, inquiries, or correspondence relating to or in reference to the RFA, and all other reports, charts, displays, schedules, exhibits, and other documentation submitted by the agency or organization will become the property of the funding agency when received.

12. **Competitive Offer**

Pursuant to the provision of G.S. 143-54, and under penalty of perjury, the signer of any application submitted in response to this RFA thereby certifies that this application has not been arrived at collusively or otherwise in violation of either Federal or North Carolina antitrust laws.

13. **Agency and Organization's Representative**

Each agency or organization shall submit with its application the name, address, and telephone number of the person(s) with authority to bind the agency or organization and answer questions or provide clarification concerning the application.

14. **Subcontracting**

Agencies and organizations may propose to subcontract portions of work provided that their applications clearly indicate the scope of the work to be subcontracted, and to whom. All information required about the prime grantee is also required for each proposed subcontractor.

15. **Proprietary Information**

Trade secrets or similar proprietary data which the agency or organization does not wish disclosed to other than personnel involved in the evaluation will be kept confidential to the

extent permitted by NCAC TO1: 05B.1501 and G.S. 132-1.3 if identified as follows: Each page shall be identified in boldface at the top and bottom as "CONFIDENTIAL." Any section of the application that is to remain confidential shall also be so marked in boldface on the title page of that section.

16. Participation Encouraged

Pursuant to Article 3 and 3C, Chapter 143 of the North Carolina General Statutes and Executive Order No. 77, the funding agency invites and encourages participation in this RFA by businesses owned by minorities, women and the disabled, including utilization as subcontractor(s) to perform functions under this Request for Applications.

17. Contract

The Division will issue a contract to the recipient of the RFA funding. Expenditures can begin immediately upon receipt of a completely signed contract.

V. APPLICATION PROCUREMENT PROCESS AND APPLICATION REVIEW

The following is a general description of the process by which applicants will be selected for funding for this project.

1. Announcement of the Request for Applications (RFA)

The announcement of the RFA and instructions for receiving the RFA will be posted at the following DHHS website on **August 16, 2017**:

<http://www.ncdhhs.gov/about/grant-opportunities/public-health-grant-opportunities> and may be sent to prospective agencies and organizations via direct mail, email, and/or the Program's website.

2. Distribution of the RFA

RFAs will be posted on the Program's website <http://whb.ncpublichealth.com/> and may be sent via email to interested agencies and organizations beginning **August 16, 2017**.

3. Bidder's Webinar / Question & Answer Period

All prospective applicants are **required to attend** a Bidder's Webinar on **August 28, 2017 from 11:00 am – 12:00 pm**. The webinar may be accessed through the following link:

<http://whb.adobeconnect.com/pocrfa/>.

Written questions concerning the specifications in this Request for Applications will be received by Tara Owens Shuler at tara.shuler@dhhs.nc.gov until **September 1, 2017**. As an addendum to this RFA, a summary of all questions and answers will be posted at:

<http://whb.ncpublichealth.com/> by **September 8, 2017**.

4. Applications

Applicants shall submit an original and four copies of the application. All copies shall include the required attachments. Electronic submission will not be accepted in lieu of an original. Faxed applications will not be accepted.

5. **Original Application**

The original application must contain original documents, and all signatures in the original application must be original. Mechanical, copied, or stamped signatures are not acceptable. The original application should be clearly marked “original” on the application face sheet.

6. **Copies of Application**

Along with the **original application**, submit **four** photocopies of the application in its entirety. Copies of the application should be clearly marked “copy” on the application face sheet.

7. **Format**

The application must be typed, single-side on 8.5” x 11” paper with margins of 1”. Line spacing should be single-spaced. The font should be easy to read and no smaller than an 11-point font.

8. **Space Allowance**

Page limits are clearly marked in each section of the application. Refer to Applicant’s Response in section VIII for specifics.

9. **Application Deadline**

All applications must be received by the date and time on the cover sheet of this RFA. Faxed or emailed applications **will not** be accepted in lieu of the original and required number of hard copies. Original signatures are required. Note: If the US Postal Service is used, allow sufficient time for delivery to the funding agency by 5:00 PM, close of business, on **September 29, 2017**.

10. **Receipt of Applications**

Applications from each responding agency and organization will be logged into the system and stamped with the date received on the cover sheet.

11. **Review of Applications**

Applications are reviewed by a multi-disciplinary committee of public and private health and human services providers who are familiar with the subject matter. Staff from applicant agencies may not participate as reviewers.

Applications will be evaluated by a committee according to completeness, content, experience with similar projects, ability of the agency's or organization's staff, cost, etc. The award of a grant to one agency and organization does not mean that the other applications lacked merit, but that, all facts considered, the selected application was deemed to provide the best service to the State. Agencies and organizations are cautioned that this is a request for applications, and the funding agency reserves the unqualified right to reject any and all applications when such rejections are deemed to be in the best interest of the funding agency.

12. **Request for Additional Information**

At their option, the application reviewers may request additional information from any or all applicants for the purpose of clarification or to amplify the materials presented in any part of the application. However, agencies and organizations are cautioned that the reviewers are not required to request clarification. Therefore, all applications should be complete and reflect the most favorable terms available from the agency or organization.

13. Audit

Please be advised that successful applicants may be required to have an audit in accordance with G.S. 143C-6-22 and G.S. 143C-6-23 as applicable to the agency's status.

G.S. 143C-6-23 requires every nongovernmental entity that receives State or Federal pass-through grant funds directly from a State agency to file annual reports on how those grant funds were used.

There are 3 reporting levels which are determined by the total direct grant receipts from all State agencies in the entity's fiscal year:

Level 1: Less than \$25,000

Level 2: At least \$25,000 but less than \$500,000

Level 3: \$500,000 or more

Level 3 grantees are required to submit a "Yellow Book" Audit done by a CPA. Only Level 3 grantees may include audit expenses in the budget. Audit expenses should be prorated based on the ratio of the grant to the total pass-through funds received by the entity.

14. Assurances

The contract may include assurances that the successful applicant would be required to execute prior to receiving a contract as well as when signing the contract.

15. Additional Documentation to Include with Application

All applicants are required to include documentation of their tax identification number.

Those applicants which are private non-profit agencies are to include a copy of an IRS determination letter regarding the agency's 501(c)(3) tax-exempt status. (This letter normally includes the agency's tax identification number, so it would also satisfy that documentation requirement.)

In addition, those private non-profit agencies are to provide a completed, signed, and notarized page verifying continued existence of the agency's 501(c)(3) status. An example of this page is provided in section VIII Verification of 501(c)(3) Status.

16. Federal Certifications

Agencies or organizations receiving Federal funds would be required to execute Federal Certifications regarding Non-discrimination, Drug-Free Workplace, Environmental Tobacco Smoke, Debarment, Lobbying, and Lobbying Activities. A copy of the Federal Certifications is included in this RFA for your reference (see Appendix A). Federal Certifications should NOT be signed or returned with application.

17. System for Award Management Database (SAM)

All grantees receiving federal funds must be actively registered in the federal government's System for Award Management (SAM) database, or be willing to complete the registration process in conjunction with the award (see www.sam.gov). To maintain an active SAM record, the record must be updated no less than annually.

18. **Additional Documentation Prior to Contract Execution**

Contracts require more documentation prior to contract execution. After the award announcement, agencies will be contacted about providing the following documentation:

- a. A completed and signed letter from the agency's Board President/Chairperson identifying individuals as authorized to sign contracts. (A reference version appears in Appendix A.)
- b. A completed and signed letter from the agency's Board President/Chairperson identifying individuals as authorized to sign expenditure reports. (A reference version appears in Appendix A.)
- c. Documentation of the agency's DUNS number. Documentation consists of a copy of communication (such as a letter or email correspondence) from Dun & Bradstreet (D&B) which indicates the agency or organization's legal name, address, and DUNS number. In lieu of a document from D&B, a copy of the agency or organization's SAM record is acceptable.

If your agency does not have a DUNS number, please use the D&B online registration (<http://fedgov.dnb.com/webform>) to receive one free of charge. (DUNS is the acronym for the Data Universal Numbering System developed and regulated by D&B.)

Contracts with private non-profit agencies require additional documentation prior to contract execution. After the award announcement, private non-profit agencies will be contacted about providing the following documentation:

- a. A completed, signed, and notarized statement which includes the agency's Conflict of Interest Policy. (A reference version appears in Appendix A.)
- b. A completed, signed, and notarized page certifying that the agency has no overdue tax debts. (A reference version appears in Appendix A)

All grantees receiving funds through the State of North Carolina are required to execute Contractor Certifications Required by North Carolina Law. A copy of the certifications is included in this RFA for your reference (see Appendix A). Contractor Certifications should NOT be signed or returned with application.

Note: At the start of each calendar year, all agencies with current DPH contracts are required to update their contract documentation. These agencies will be contacted a few weeks prior to the due date and will be provided the necessary forms and instructions.

19. **Registration with Secretary of State**

Private non-profit applicants must also be registered with the North Carolina Secretary of State to do business in North Carolina, or be willing to complete the registration process in conjunction with the execution of the contract documents. (See www.secretary.state.nc.us/corporations.)

20. **Federal Funding Accountability and Transparency Act (FFATA) Data Reporting Requirement**

The Contractor shall complete and submit to the Division, the Federal Funding Accountability and Transparency Act (FFATA) Data Reporting Requirement form within 10 State Business

Days upon request by the Division when awarded \$25,000 or more in federal funds. A reference version appears in Appendix A.

21. Iran Divestment Act Certification of Eligibility

Pursuant to G.S. 147-86.59, any person identified as engaging in investment activities in Iran, determined by appearing on the Final Divestment List created by the State Treasurer pursuant to G.S. 147-86.58, is ineligible to contract with the State of North Carolina or any political subdivision of the State. The Iran Divestment Act of 2015, G.S. 147-86.55 et seq.* requires that each vendor, prior to contracting with the State certify that the vendor is not identified on the Final Divestment List of entities that the State Treasurer has determined engages in investment activities in Iran and that the vendor shall not utilize on any contract with the State agency any subcontractor that is identified on the Final Divestment List. The vendor must complete, sign, and return the under the Act for every contract and contract amendment. A reference version appears in Appendix A.

22. Application Process Summary Dates

08/16/2017: Request for Applications released to eligible applicants.

08/28/2017: Required Bidder’s Webinar at 11:00 am – 12:00 pm
Webinar link: <http://whb.adobeconnect.com/pocrfa/>

09/01/2017: End of Q&A period. All questions due in writing by 5:00 pm.

09/08/2017: Answers to Questions released to all applicants, as an addendum to the RFA.
Posted at: <http://whb.ncpublichealth.com/>

09/29/2017: Applications due by 5:00 pm.

10/20/2017: Successful applicants will be notified.

02/01/2018: Proposed contract start date.

VI. PROJECT BUDGET

Budget and Justification

Applicants must complete and submit the **Open Windows Budget Form** for **each year** of the three-year grant period: Year 1 (2/1/18 – 5/31/18), Year 2 (6/1/18 – 5/31/19), and Year 3 (6/1/19 – 5/31/20). The Open Windows Budget Form requires a line item budget and a narrative justification for each line item. The Open Windows Budget Form can be downloaded from the Women’s Health Branch website at: <http://whb.ncpublichealth.com/>. A copy of each Open Windows Budget Form for Years 1, 2, and 3 **must be included** in the application. Instructions on How to Fill Out the Open Windows Budget Form are posted on the Women’s Health Branch website at <http://whb.ncpublichealth.com/>.

Narrative Justification for Expenses

A narrative justification must be included for every expense listed in the budget. Each justification should show how the amount on the line item budget was calculated, and it should be clear how the expense relates to the project.

Travel Reimbursement Rates

Mileage reimbursement rates must be based on rates determined by the North Carolina Office of State Budget and Management (OSBM). Because mileage rates fluctuate with the price of fuel, the OSBM will release the "Change in IRS Mileage Rate" memorandum to be found on OSBM's website when there is a change in this rate. The current state mileage reimbursement rate is \$0.535 cents per mile.

For other travel related expenses, please refer to the current rates for travel and lodging reimbursement, presented in the chart below. However, please be advised that reimbursement rates periodically change. The Division of Public Health will only reimburse for rates authorized in OSBM's North Carolina Budget Manual or adopted by means of an OSBM Budget Memo. These documents are located here: <https://www.osbm.nc.gov/library>

Current Rates for Travel and Lodging (as of July 1, 2017)

| Meals | In State | Out of State |
|---|------------------------|---------------------|
| Breakfast | \$8.40 | \$8.40 |
| Lunch | \$11.00 | \$11.00 |
| Dinner | \$18.90 | \$21.60 |
| <i>Total Meals Per Diem Per Day</i> | <i>\$38.30</i> | <i>\$41.00</i> |
| Lodging (Maximum rate per person, excludes taxes and fees) | \$71.20 | \$84.10 |
| Total Travel Allowance Per Day | \$109.50 | \$125.10 |
| Mileage | \$0.535 cents per mile | |

Audits

G.S. 143C-6-23 requires every nongovernmental entity that receives State or Federal pass-through grant funds directly from a State agency to file annual reports on how those grant funds were used.

There are 3 reporting levels that are determined by the total direct grant receipts from all State agencies in the entity's fiscal year:

Level 1: Less than \$25,000

Level 2: At least \$25,000 but less than \$500,000

Level 3: \$500,000 or more

Level 3 grantees are required to submit an audit. Only Level 3 grantees may include audit expenses in the budget. Audit expenses should be prorated based on the ratio of the grant to the total pass-through funds received by the entity.

Indirect Cost

Indirect cost is the cost incurred for common or joint objectives which cannot be readily identified but are necessary to the operations of the organization (e.g. the cost of operating and maintaining facilities, depreciation, administrative salaries, accounting, audits, payroll and personnel management).

Regulations restricting the allocation of indirect cost vary based on the funding source. This program is funded through the federal Maternal Child Health Block Grant (MCHBG).

MCHBG

The MCHBG award limits administrative cost to 10 percent.

Where the applicant has a Federal Negotiated Indirect Cost Rate (FNICR), the indirect cost rate requested may not exceed the award's limits of 10%, regardless of the applicant's recognized rate. The total modified direct cost identified in the applicant's FNICR shall be applied. A copy of the FNICR must be included with the applicant's budget.

If the applicant does not have an FNICR, a 10% indirect cost rate (known as the *de minimis* rate) may be used on the total, modified direct cost as defined in 2 CFR 200.68, *Modified Total Direct Cost (MTDC)*, with no additional documentation required, per the U.S. Office of Management and Budget (OMB) Omni-Circular. Applicants must indicate in the budget narrative that they wish to use the *de minimis* rate, or some part thereof. Applicants who do not wish to claim any indirect cost should enter "No indirect cost requested" in the indirect cost line item of the budget narrative.

VII. EVALUATION CRITERIA

The application is worth a total of 100 points. The page limit for the narrative section of the application, including the cover letter and application face sheet, is **27 pages**. Budget pages, endnote pages, and attachments are not counted in the narrative section page limit. Point values are clearly marked within each section of the applicant's response. The total point value for each section of the applicant's response is listed below. A multi-disciplinary committee will review the application for both content and quality of responses to each section of the application.

1. Cover Letter

Total point value = 2

2. Determination of Need

Total point value = 12

3. Project Plan

Total point value = 34

4. Data Collection and Evaluation

Total point value = 12

5. Resources and Capabilities

Total point value = 12

6. Collaboration and Coordination

Total point value = 16

7. Project Budgets

Total point value = 12

VIII. APPLICATION

Completing the Application

The information below provides a detailed description of the documents (cover letter, application face sheet, attachments) that must be included with the application, and a detailed description of the information that must be included in each section of the Applicant's Response.

Cover Letter

A cover letter must be on agency letterhead and signed by the lead administrator of the agency submitting the application. A list of the required information to include in the cover letter is provided on page 25, and a cover letter template is provided on page 26.

Application Face Sheet

This form serves as the cover page for the application. It provides important information about the applicant and proposed project, and requires the signature of the individual authorized to sign official documents for the agency. Complete the application face sheet with all the information requested. The name and contact information of the person best suited to answer questions about the proposed project should be included on the face sheet.

Applicants must enter their Data Universal Numbering System (DUNS) number, which is developed and regulated by Dun & Bradstreet. If your agency does not have a DUNS number, please use the Dun & Bradstreet (D&B) online registration (<http://fedgov.dnb.com/webform>) to receive one free of charge.

Section 1: Determination of Need

All applicants must provide a clear description of the need for the proposed Perinatal/Neonatal Outreach Coordinator project in their perinatal care region. In order to improve maternal and neonatal morbidity and mortality rates and birth outcomes within perinatal care regions in North Carolina, applicants must describe: 1) the factors that contribute to poor birth outcomes; 2) the factors that contribute to poor maternal and neonatal morbidity and mortality rates; 3) the birthing facilities in their perinatal care region; 4) the need for assigning risk-appropriate levels of care to birthing facilities in their perinatal region; 5) capacity of existing birthing facilities within the region to care for mothers and newborns with high-risk conditions; and 6) the need for increasing access to immediate postpartum insertion of highly effective, long-acting contraceptive methods in their perinatal care region.

Provide recent data as evidence to support the determination of need as related to the goals of the Perinatal/Neonatal Outreach Coordinator project. County-level data can be provided to support the need where birthing facilities are located within a perinatal care region. State data must be provided for comparison to support the need of the project.

The following data must be included:

- State, perinatal care region and/or county-level infant mortality rates, include data by race and ethnicity;
- State, perinatal care region and/or county-level low birth weight rates, include data by race and ethnicity;

- State, perinatal care region and/or county-level preterm birth rates, include data by race and ethnicity;
- State, perinatal care region and/or county-level pregnancy-related mortality rates, include data by race and ethnicity;
- State, perinatal care region and/or county-level unintended pregnancy rates, include data by race and ethnicity;
- Number and geographic distribution of birthing facilities in the perinatal care region; and
- Current neonatal level of care of birthing facilities within your perinatal care region.

Citations

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 and will not count against the page limit for this section. For further information on citing references using endnotes, please refer to the Citation Guidance for Determination of Need in Appendix C.

Section 2: Project Plan

Applicants must describe their plan to implement the Perinatal/Neonatal Outreach Coordinator project in their perinatal care region. Please refer to the Scope of Services in section III of this RFA for details. Applicants must describe how their project will meet or exceed the Perinatal/Neonatal Outreach Coordinator project's service deliverables, and describe the activities involved to meet the deliverables. The applicant's response includes a detailed workplan for year one, year two, and year three which must be completed and submitted with the application. Applicants must include the activities, timeline for each activity, measures of accomplishment, and person(s) responsible for each objective listed in the workplans.

Section 3: Data Collection and Evaluation

Applicants must describe their plan for the use of the Centers for Disease Control and Prevention (CDC) Maternal and Neonatal Levels of Care Assessment Tool (LOCATe) with birthing facilities in their perinatal care region. Applicants must describe who will be responsible for data collection, how the data will be collected, and who will be responsible for the data evaluation and reporting. Applicants must describe their plan for the data collection, evaluation and reporting for the initiatives with birthing facilities on immediate postpartum insertion for highly effective, long-acting contraceptive methods.

Section 4: Resources and Capabilities

Applicants should describe their agency's mission, background and services, and current capacity for implementing the Perinatal/Neonatal Outreach Coordinator project. Describe how the agency's services and capacity relates to the Perinatal/Neonatal Outreach Coordinator project's goals. The agency's organizational chart and list of current Board of Directors must be included in Attachment B.

Applicants must describe their plan to hire a Perinatal/Neonatal Outreach Coordinator. The minimum qualifications for the Perinatal/Neonatal Outreach Coordinator position are:

- Registered Nurse licensed in the State of North Carolina.
- MSN, MPH, or other related degree.

- Experience providing technical assistance, working on collaborative teams, and working on quality improvement projects.
- A minimum of two year's clinical experience in obstetrical and/or neonatal care (inpatient, outpatient, or both).

Applicants must include a job description and curriculum vitae (if applicable) for the Perinatal/Neonatal Outreach Coordinator position in Attachment B.

Section 5: Collaboration & Coordination

Applicants must describe the current and planned linkages with birthing facilities in their perinatal care region. Applicants must describe the plan for collaboration and coordination with birthing facilities and other institutions necessary to complete the Perinatal/Neonatal Outreach Coordinator project's activities. A letter of commitment or Memorandum of Agreement (MOA) must be included from each birthing facility or other institution that has committed to collaborate on the Perinatal/Neonatal Outreach Coordinator project. The letters of commitment and MOAs must outline the proposed activities or contributions to the Perinatal/Neonatal Outreach Coordinator project. All letters of commitment and MOAs must be included in Attachment A.

Section 6: Project Budgets

Applicants must complete and submit the **Open Windows Budget Form** for **each year** of the three-year grant period: Year 1 (2/1/18 – 5/31/18), Year 2 (6/1/18 – 5/31/19), and Year 3 (6/1/19 – 5/31/20). The Open Windows Budget Form requires a line item budget and a narrative justification for each line item. The Open Windows Budget Form can be downloaded from the Women's Health Branch website at: <http://whb.ncpublichealth.com/>. A copy of each Open Windows Budget Form for years one, two, and three **must be included** in this section of the application. Instructions on How to Fill Out the Open Windows Budget Form are posted on the Women's Health Branch website at <http://whb.ncpublichealth.com/>.

Attachment A: Letters of Commitment & Memorandums of Agreement

This attachment must include letters of commitment and Memorandums of Agreement (MOAs) from each of the following agencies or individuals:

- A letter of commitment or MOA from any agency that the applicant will be relying on to successfully implement the proposed project's activities. The letter of commitment or MOA must include the specific contribution from the agency to the project.

Attachment B: Agency Information

This attachment must include each of the following:

- Organizational chart of the applying agency.
- List of current Board of Directors of the applying agency.
- Job descriptions and curriculum vitae (if applicable) for all staff positions, including but not limited to the Perinatal/Neonatal Outreach Coordinator, that are necessary to implement and support the project.
- Documentation of agency tax identification number from IRS.
 - 501 (c) (3) Letter (*Private Non-Profit Agencies Only*) – Not required if previously submitted to the Division of Public Health in response to the general request for documentation made to current grantees by the Contracts Office in November of 2016.

- Verification of 501(c)(3) Status (*Private Non-Profit Agencies Only*) – Not required if previously submitted to the Division of Public Health in response to the general request for documentation made to current grantees by the Contracts Office in November of 2016. (A blank form is provided)

Application Checklist

The following items must be included in the application. Please use a binder clip at the top left corner on each of the **five copies** of the application (original and four copies). The original application should be clearly marked “original” on the Application Face Sheet and the four copies should be marked “Copy” on the Application Face sheet. Do not include the Application Checklist with your application. Please assemble each copy of the application in the following order:

1. ___ **Cover Letter**
2. ___ **Application Face Sheet**
3. ___ **Applicant’s Response**
4. ___ **Project Budgets – Year 1, 2, and 3**
5. ___ **Indirect Cost Rate Approval Letter** (if applicable)
6. ___ **Attachment A - Letters of Commitment or Memorandums of Agreement**
7. ___ **Attachment B – Agency Information – includes:**

IRS Documentation

___ **IRS Letter Documenting Your Organization’s Tax Identification Number** (public agencies)

or

___ **IRS Determination Letter Regarding Your Organization’s 501(c)(3) Tax-exempt Status** (private non-profits)

and

___ **Verification of 501(c)(3) Status Form** (private non-profits)

Cover Letter

Total Point Value:

2

Page Limit:

3 single-spaced

The cover letter template (below) is for reference only.

The application must include a cover letter, on agency letterhead, signed and dated by an individual authorized to legally bind the Applicant.

The cover letter must include:

- A cover letter on agency letterhead.
- The legal name of the Applicant agency.
- The RFA number.
- The Applicant agency's federal tax identification number.
- The Applicant agency's DUNS number.
- The closing date for applications.
- Signed and dated by an individual authorized to legally bind the Applicant.
- The contact information listed on the template.
- The cover letter must also indicate a clear understanding of and strong commitment to the program requirements of the Perinatal/Neonatal Outreach Coordinator project.

Cover Letter Template
(This Must be Printed on Agency Letterhead)

Date

Dear Tara Owens Shuler,

Describe your agency's mission, background and current services. How does implementing the Perinatal/Neonatal Outreach Coordinator project fit within your agency?

Provide description of your commitment to the program and the evaluation plan, and your agency's capacity to implement the Perinatal/Neonatal Outreach Coordinator project.

Executive Director:

Phone #:

Email:

Board President:

Phone #:

Email:

Provide the person who knows and understands the program and program plan written in the RFA. This person may be contacted any time during the RFA process by the Perinatal Health Unit Manager.

Name:

Phone #:

Email:

Address of the facility where the program will be conducted.

Application Face Sheet
RFA #A345
Perinatal/Neonatal Outreach Coordinator

This form provides basic information about the applicant and the proposed project with the Perinatal/Neonatal Outreach Coordinator project, 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 #A345 are truthful and that the applicant complies 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: | |
| 3. Mailing Address (include zip code+4): | |
| 4. Address to which checks will be mailed: | |
| 5. Street Address: | |
| 6. Contract Administrator: Name: | Telephone Number: |
| Title: | Fax Number: |
| | Email Address |
| 7. Agency Status (check all that apply): | |
| <input type="checkbox"/> Public <input type="checkbox"/> Private Non-Profit <input type="checkbox"/> Local Health Department | |
| 8. Agency Federal Tax ID Number: | 9. Agency DUNS Number: |
| 10. Agency’s URL (website): | |
| 11. Agency’s Financial Reporting Year: | |
| 12. Current Service Delivery Areas (county(ies) and communities): | |
| 13. Proposed Area(s) To Be Served with Funding (county(ies) and communities): | |
| 14. Amount of Funding Requested | |
| 15. 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 <input type="checkbox"/> No <input type="checkbox"/> | |
| 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. | |
| 16. Signature of Authorized Representative: | 17. Date |

Applicant's Response

The application is worth a total of 100 points.

Point values and page limits are clearly marked for each section of the application form.

Do not delete the question headers within the application form.

Please provide your response to each question under the heading.

Section 1

Determination of Need

Do not delete the question headers.
Please provide your response to each question under the heading.

Total Point Value:

12

Page Limit:

3 single-spaced (excluding citation page)

- 1-1. Provide recent data, for data listed below, as evidence to support the determination of need as related to the goals of the Perinatal/Neonatal Outreach Coordinator project. Perinatal care regional data and/or county-level data should be provided to support the need where birthing facilities are located within a perinatal care region. State data must be provided for comparison to support the need of the Perinatal/Neonatal Outreach Coordinator project. Data should also be included by race and ethnicity (4 points)
 - a. Infant mortality rates
 - b. Low birth weight rates
 - c. Preterm birth rates
 - d. Pregnancy-related mortality rates
 - e. Unintended pregnancy rates

- 1-2. Describe the factors that contribute to poor birth outcomes and poor maternal and neonatal morbidity and mortality rates within the perinatal care region. (2 points)

- 1-3. Describe the perinatal care region where the Perinatal/Neonatal Outreach Coordinator project will be located. Describe the birthing facilities in the perinatal care region, including the number and their geographic distribution. (2 points)

- 1-4. Describe the need for assigning risk-appropriate levels of care to birthing facilities and the need for increasing access to immediate postpartum insertion of highly effective, long-acting contraceptive methods in the perinatal care region. (2 points)

- 1-5. 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 and will not count against the page limit for this section. (2 points)

Section 2

Program Plan

Do not delete the question headers.
Please provide your response to each question under the heading.

Total Point Value:
34

Page Limit:
10 single-spaced

- 2-1. Describe how your Perinatal/Neonatal Outreach Coordinator project will meet or exceed the Perinatal/Neonatal Outreach Coordinator project's service deliverables. Describe the activities involved to meet the deliverables. Complete the detailed workplan for year one, year two, and year three and include the activities, timeline for each activity, measures of accomplishment, and person(s) responsible for each objective listed. (25 points)

- 2-2. Describe how the activities will be effective in addressing the Perinatal/Neonatal Outreach Coordinator project's objectives and goals. (9 points)

YEAR ONE WORK PLAN

(02/01/2018 – 05/31/2018)

| Goal 1: To improve (reduce) maternal and neonatal morbidity and mortality rates. | | | | | | | | | | | | | | | | |
|--|------------|----------|---|---|---|---|---|---|---|---|---|---|---|----------------------------|-----------------------|--|
| Objectives | Activities | Timeline | | | | | | | | | | | | Measures of Accomplishment | Person(s) Responsible | |
| | | J | J | A | S | O | N | D | J | F | M | A | M | | | |
| Year 1 – Objective 1 Hire a full-time Perinatal/Neonatal Outreach Coordinator. | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | |
| Year 1 – Objective 2 By May 31 st , the Perinatal/Neonatal Outreach Coordinator will complete training on the CDC LOCATe. | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | |
| Year 1 – Objective 3 By May 31 st , establish relationships with 90% of the birthing facilities in the perinatal care region to develop an implementation plan for conducting the CDC LOCATe. | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | |
| Year 1- Objective 4 By May 31 st , evaluate the existing CDC LOCATe and determine the best strategy for increasing response rate. | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | |

YEAR ONE WORKPLAN (continued)
(02/01/2018 – 05/31/2018)

| Goal 2: To improve birth outcomes through the reduction in unintended pregnancies. | | | | | | | | | | | | | | | | |
|---|-------------------|-----------------|----------|----------|----------|----------|----------|----------|----------|----------|----------|----------|----------|-----------------------------------|------------------------------|--|
| Objectives | Activities | Timeline | | | | | | | | | | | | Measures of Accomplishment | Person(s) Responsible | |
| | | J | J | A | S | O | N | D | J | F | M | A | M | | | |
| Year 1 – Objective 1 By May 31st, conduct an assessment of birthing facilities in the perinatal care region to determine which have implemented policies and initiatives for immediate postpartum insertion of highly effective, long-acting contraceptive methods. | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | |
| Year 1 – Objective 2 By May 31 st , determine the challenges and barriers that impeded implementation of immediate postpartum insertion of highly effective, long-acting contraceptive methods. | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | |

YEAR TWO WORKPLAN

(06/01/2018 – 05/31/2019)

| Goal 1: To improve (reduce) maternal and neonatal morbidity and mortality rates. | | | | | | | | | | | | | | | | |
|--|------------|----------|---|---|---|---|---|---|---|---|---|---|---|----------------------------|-----------------------|--|
| Objectives | Activities | Timeline | | | | | | | | | | | | Measures of Accomplishment | Person(s) Responsible | |
| | | J | J | A | S | O | N | D | J | F | M | A | M | | | |
| Year 2 – Objective 1 By May 31st, administer CDC LOCATe with at least 75% of the birthing facilities in the perinatal care region. | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | |
| Year 2 – Objective 2 By May 31st, convene a group of stakeholders from birthing facilities to facilitate data informed discussions related to improving the system of risk-appropriate care. | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | |
| Year 2 – Objective 3 By May 31st, provide education, technical assistance, and support for quality improvement initiatives based on needs or gaps identified by CDC LOCATe. | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | |

YEAR TWO WORKPLAN (continued)
(06/01/2018 – 05/31/2019)

| Goal 2: To improve birth outcomes through the reduction in unintended pregnancies. | | | | | | | | | | | | | | | |
|--|------------|----------|---|---|---|---|---|---|---|---|---|---|----------------------------|-----------------------|---|
| Objectives | Activities | Timeline | | | | | | | | | | | Measures of Accomplishment | Person(s) Responsible | |
| | | J | J | A | S | O | N | D | J | F | M | A | | | M |
| Year 2 – Objective 1 By May 31st, collaborate with at least five birthing facilities to develop and implement policies and initiatives on immediate postpartum insertion of highly effective, long-acting contraceptive methods. | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | |

YEAR THREE WORKPLAN
(06/01/2019 – 05/31/2020)

| Goal 1: To improve (reduce) maternal and neonatal morbidity and mortality rates. | | | | | | | | | | | | | | | |
|---|------------|----------|---|---|---|---|---|---|---|---|---|---|----------------------------|-----------------------|---|
| Objectives | Activities | Timeline | | | | | | | | | | | Measures of Accomplishment | Person(s) Responsible | |
| | | J | J | A | S | O | N | D | J | F | M | A | | | M |
| Year 3 – Objective 1 By May 31, administer CDC LOCATe to the remaining 25% of birthing facilities in the perinatal care region. | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | |

YEAR THREE WORKPLAN (continued)
(06/01/2019 – 05/31/2020)

| Objectives | Activities | Timeline | | | | | | | | | | | | Measures of Accomplishment | Person(s) Responsible | |
|---|------------|----------|---|---|---|---|---|---|---|---|---|---|---|----------------------------|-----------------------|--|
| | | J | J | A | S | O | N | D | J | F | M | A | M | | | |
| Year 3 – Objective 2 By May 31 st , collaborate with representatives from birthing facilities to propose a set of uniform criteria for maternal and neonatal levels of care for the facilities in the perinatal care region. | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | |
| Year 3 – Objective 3 By May 31 st , present proposed set of criteria for maternal and neonatal levels of care to the DPH, WHB using collected data and the guidelines and policy statements issued by the AAP, ACOG, and SMFM. | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | |
| Year 3 – Objective 4 By May 31 st , submit a summary report on the data collected using CDC LOCATe, including lessons learned while administering this tool. | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | |

YEAR THREE WORKPLAN (continued)
(06/01/2019 – 05/31/2020)

| Goal 2: To improve birth outcomes through the reduction in unintended pregnancies. | | | | | | | | | | | | | | | | |
|---|-------------------|-----------------|----------|----------|----------|----------|----------|----------|----------|----------|----------|----------|----------|-----------------------------------|------------------------------|--|
| Objectives | Activities | Timeline | | | | | | | | | | | | Measures of Accomplishment | Person(s) Responsible | |
| | | J | J | A | S | O | N | D | J | F | M | A | M | | | |
| Year 3 – Objective 1 By May 31st, provide education and technical assistance to birthing facilities to support the policies and initiatives developed in Year 2, for immediate postpartum insertion of highly effective, long-acting contraceptive methods. | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | |
| Year 3 – Objective 2 By May 31 st , collaborate with at least five additional birthing facilities to develop and implement policies and initiatives on immediate postpartum insertion of highly effective, long-acting contraceptive methods. | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | |

YEAR THREE WORKPLAN (continued)
(06/01/2019 – 05/31/2020)

| Objectives | Activities | Timeline | | | | | | | | | | | | Measures of Accomplishment | Person(s) Responsible | |
|---|------------|----------|---|---|---|---|---|---|---|---|---|---|---|----------------------------|-----------------------|--|
| | | J | J | A | S | O | N | D | J | F | M | A | M | | | |
| Year 3 – Objective 3 By May 31 st , submit a report on the initiatives conducted and policies implemented within birthing facilities on immediate postpartum insertion of highly effective, long-acting contraceptive methods. | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | |

Section 3

Data Collection and Evaluation

Do not delete the question headers.
Please provide your response to each question under the heading.

Total Point Value:
12

Page Limit:
4 single-spaced

- 3-1. Describe the plan for the use of the Centers for Disease Control and Prevention (CDC) Maternal and Neonatal Levels of Care Assessment Tool (LOCATe) with the birthing facilities in your perinatal care region. (4 points)
- 3-2. Describe who will be responsible for data collection using the CDC LOCATe, how the data will be collected, and who will be responsible for the data evaluation and reporting. (4 points)
- 3-3. Describe your plan for the data collection, evaluation, and reporting for the initiatives with birthing facilities on immediate postpartum insertion of highly effective, long-acting contraceptive methods. (4 points)

Section 4

Resources and Capabilities

Do not delete the question headers.
Please provide your response to each question under the heading.

Total Point Value:
12

Page Limit:
3 single-spaced

- 4-1. Describe your agency's mission, background and services and current capacity for implementing the Perinatal/Neonatal Outreach Coordinator project. Include the agency's organizational chart and list of current Board of Directors in Attachment B. (6 points)
- 4-2. Describe how your agency's services and capacity relates to the Perinatal/Neonatal Outreach Coordinator project's goals. (2 points)
- 4-3. Describe your agency's plan to hire a Perinatal/Neonatal Outreach Coordinator. Include a job description for the Perinatal/Neonatal Outreach Coordinator position and curriculum vitae (if available) in Attachment B. (2 points)
- 4-4. Describe your agency's capacity to administer the grant funds if awarded. (2 points)

Section 5

Collaboration and Coordination

Do not delete the question headers.
Please provide your response to each question under the heading.

Total Point Value:
16

Page Limit:
3 single-spaced

- 5-1. Describe your agency’s current and planned linkages with birthing facilities in your perinatal care region. (8 points)
- 5-2. Describe the plan for collaboration and coordination with birthing facilities and other institutions necessary to complete the Perinatal/Neonatal Outreach Coordinator project’s activities. Letters of commitment and Memorandum of Agreements (MOAs) must be included from each birthing facility or other institution that has committed to collaborate on the Perinatal/Neonatal Outreach Coordinator project. Letters of commitment and MOAs must outline the proposed activities or contributions to the Perinatal/Neonatal Outreach Coordinator project. Complete the table below and include all letters of commitment and MOAs in Attachment A. (8 points)

| Name of Agency | Proposed Activities or Contributions to the Perinatal/Neonatal Outreach Coordinator Project | LOC/MOA Attached? |
|----------------|---|--|
| | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | | <input type="checkbox"/> Yes <input type="checkbox"/> No |

Section 6

Project Budgets

Total Point Value:
12

Page Limit:
Not Applicable

Applicants must complete and submit the **Open Windows Budget Form for Year 1 (2/1/18 - 5/31/18), Year 2 (6/1/18 - 5/31/19), and Year 3 (6/1/19 - 5/31/20)**. Applicant must ensure that all worksheet cells are expanded to expose the full narrative justifications before printing the application. The Open Window Budget Form can be downloaded from the Women's Health Branch website at <http://whb.ncpublichealth.com/>. A copy of each Open Windows Budget Form for years one, two, and three **must be included** in this section of the application.

A narrative justification must be included for every line-item expense listed in Year 1, Year 2, and Year 3 budgets. Each justification should show how the total amount for each line item budget was calculated, and it should be clear how the expense relates to the Perinatal/Neonatal Outreach Coordinator project's activities. Instructions on **How to Fill Out the Open Windows Budget Form** are posted on the Women's Health Branch website at <http://whb.ncpublichealth.com/>.

Indirect Cost Rate Approval Letter (if applicable)

If the applicant has a Federally Negotiated Indirect Cost Rate (FNICR), please include a copy of the agency's most recent federal indirect cost rate approval letter.

If the applicant does not have an FNICR but still wishes to claim the de minimis rate, or a portion thereof, no documentation is required.

Attachment A

Letters of Specific Commitment & Memorandums of Agreement

This attachment must include letters of commitment and Memorandums of Agreement (MOAs) from each of the following agencies or individuals:

- A letter of commitment or MOA from any agency that the applicant will be relying on to successfully implement the proposed project's activities. The letter of commitment or MOA must include the specific contribution from the agency to the project.

Attachment B

Agency Information

This attachment must include each of the following:

- Organizational chart of the applying agency.
- List of current Board of Directors of the applying agency.
- Job descriptions or resumes for all staff positions that are necessary to implement and support the project.
- Documentation of agency tax identification number from IRS.
- 501 (c) (3) Letter (*Private Non-Profit Agencies Only*) – Not required if previously submitted to the Division of Public Health in response to the general request for documentation made to current grantees by the Contracts Office in November of 2016.
- Verification of 501(c)(3) Status (*Private Non-Profit Agencies Only*) – Not required if previously submitted to the Division of Public Health in response to the general request for documentation made to current grantees by the Contracts Office in November of 2016. (A blank form is provided on page 52)

IRS Letter

Public Agencies:

Provide a copy of a letter from the IRS which documents your organization's tax identification number. The organization's name and address on the letter must match your current organization's name and address.

Private Non-profits:

Provide a copy of an IRS determination letter which states that your organization has been granted exemption from federal income tax under section 501(c)(3) of the Internal Revenue Code. The organization's name and address on the letter must match your current organization's name and address.

This IRS determination letter can also satisfy the documentation requirement of your organization's tax identification number.

Verification of 501(c)(3) Status Form

Verification of 501 (C) (3) Status

We, the undersigned entity, hereby testify that the undersigned entity's 501 (c)(3) status, on file with the North Carolina Department of Health and Human Services is still in effect.

Name of Agency

Signature of Chairman, Executive Director, or other authorized official

Title of above signed authorized official

Sworn to and subscribed before me this _____ day of _____, 20__.

Notary Signature and Seal

Notary's commission expires _____, 20 ____.

Appendix A Forms for Reference

Do **NOT** complete these documents at this time **nor return them** with the RFA response.
They are for reference only.

FEDERAL CERTIFICATIONS

The undersigned states that:

- (a) He or she is the duly authorized representative of the Contractor named below;
- (b) He or she is authorized to make, and does hereby make, the following certifications on behalf of the Contractor, as set out herein:
 - a. The Certification Regarding Nondiscrimination;
 - b. The Certification Regarding Drug-Free Workplace Requirements;
 - c. The Certification Regarding Environmental Tobacco Smoke;
 - d. The Certification Regarding Debarment, Suspension, Ineligibility and Voluntary Exclusion Lower Tier Covered Transactions; and
 - e. The Certification Regarding Lobbying;
- (c) He or she has completed the Certification Regarding Drug-Free Workplace Requirements by providing the addresses at which the contract work will be performed;
- (d) [Check the applicable statement]
 - He or she **has completed** the attached **Disclosure of Lobbying Activities** because the Contractor **has made, or has an agreement to make**, a payment to a lobbying entity for influencing or attempting to influence an officer or employee of an agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with a covered Federal action;
 - OR**
 - He or she **has not completed** the attached **Disclosure of Lobbying Activities** because the Contractor **has not made, and has no agreement to make**, any payment to any lobbying entity for influencing or attempting to influence any officer or employee of any agency, any Member of Congress, any officer or employee of Congress, or any employee of a Member of Congress in connection with a covered Federal action.
- (e) The Contractor shall require its subcontractors, if any, to make the same certifications and disclosure.

| | |
|------------------|--------------|
| Signature | Title |
|------------------|--------------|

| | |
|---|-------------|
| Contractor [Organization's] Legal Name | Date |
|---|-------------|

[This Certification must be signed by a representative of the Contractor who is authorized to sign contracts.]

I. Certification Regarding Nondiscrimination

The Contractor certifies that it will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685-1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to nondiscrimination in the sale, rental or financing of housing; (h) the Food Stamp Act and USDA policy, which prohibit discrimination on the basis of religion and political beliefs; and (i) the requirements of any other nondiscrimination statutes which may apply to this Agreement.

II. Certification Regarding Drug-Free Workplace Requirements

1. **The Contractor certifies** that it will provide a drug-free workplace by:
 - a. Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the Contractor's workplace and specifying the actions that will be taken against employees for violation of such prohibition;
 - b. Establishing a drug-free awareness program to inform employees about:
 - (1) The dangers of drug abuse in the workplace;
 - (2) The Contractor's policy of maintaining a drug-free workplace;
 - (3) Any available drug counseling, rehabilitation, and employee assistance programs; and
 - (4) The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;
 - c. Making it a requirement that each employee be engaged in the performance of the agreement be given a copy of the statement required by paragraph (a);
 - d. Notifying the employee in the statement required by paragraph (a) that, as a condition of employment under the agreement, the employee will:
 - (1) Abide by the terms of the statement; and
 - (2) Notify the employer of any criminal drug statute conviction for a violation occurring in the workplace no later than five days after such conviction;
 - e. **Notifying the Department within ten days after receiving notice under subparagraph (d)(2) from an employee or otherwise receiving actual notice of such conviction;**
 - f. Taking one of the following actions, within 30 days of receiving notice under subparagraph (d)(2), with respect to any employee who is so convicted:

- (1) taking appropriate personnel action against such an employee, up to and including termination; or
 - (2) Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency; and
- g. Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f).
2. The sites for the performance of work done in connection with the specific agreement are listed below (list all sites; add additional pages if necessary):
- Street Address No.1:
-
- City, State, Zip Code:
-
- Street Address No.2:
-
- City, State, Zip Code:
-
3. Contractor will inform the Department of any additional sites for performance of work under this agreement.
4. False certification or violation of the certification may be grounds for suspension of payment, suspension or termination of grants, or government-wide Federal suspension or debarment. 45 C.F.R. 82.510.

III. Certification Regarding Environmental Tobacco Smoke

Public Law 103-227, Part C-Environmental Tobacco Smoke, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, day care, education, or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee. The law does not apply to children's services provided in private residences, facilities funded solely by Medicare or Medicaid funds, and portions of facilities used for inpatient drug or alcohol treatment. Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to \$1,000.00 per day and/or the imposition of an administrative compliance order on the responsible entity.

The Contractor certifies that it will comply with the requirements of the Act. The Contractor further agrees that it will require the language of this certification be included in any subawards that contain provisions for children's services and that all subgrantees shall certify accordingly.

IV. Certification Regarding Debarment, Suspension, Ineligibility and Voluntary Exclusion Lower Tier Covered Transactions

Instructions

[The phrase "prospective lower tier participant" means the Contractor.]

1. By signing and submitting this document, the prospective lower tier participant is providing the certification set out below.
2. The certification in this clause is a material representation of the fact upon which reliance was placed when this transaction was entered into. If it is later determined that the prospective lower tier participant knowingly rendered an erroneous certification, in addition to other remedies available to the Federal Government, the department or agency with which this transaction originate may pursue available remedies, including suspension and/or debarment.
3. The prospective lower tier participant will provide immediate written notice to the person to whom this proposal is submitted if at any time the prospective lower tier participant learns that its certification was erroneous when submitted or has become erroneous by reason of changed circumstances.
4. The terms "covered transaction," "debarred," "suspended," "ineligible," "lower tier covered transaction," "participant," "person," "primary covered transaction," "principal," "proposal," and "voluntarily excluded," as used in this clause, have the meanings set out in the Definitions and Coverage sections of rules implementing Executive Order 12549, 45 CFR Part 76. You may contact the person to whom this proposal is submitted for assistance in obtaining a copy of those regulations.
5. The prospective lower tier participant agrees by submitting this proposal that, should the proposed covered transaction be entered into, it shall not knowingly enter any lower tier covered transaction with a person who is debarred, suspended, determined ineligible or voluntarily excluded from participation in this covered transaction unless authorized by the department or agency with which this transaction originated.
6. The prospective lower tier participant further agrees by submitting this document that it will include the clause titled "Certification Regarding Debarment, Suspension, Ineligibility and Voluntary Exclusion--Lower Tier Covered Transaction," without modification, in all lower tier covered transactions and in all solicitations for lower tier covered transactions.
7. A participant in a covered transaction may rely upon a certification of a prospective participant in a lower tier covered transaction that it is not debarred, suspended, ineligible, or voluntarily excluded from covered transaction, unless it knows that the certification is erroneous. A participant may decide the method and frequency by which it determines the eligibility of its principals. Each participant may, but is not required to, check the Nonprocurement List.
8. Nothing contained in the foregoing shall be construed to require establishment of a system of records in order to render in good faith the certification required by this clause. The knowledge and information of a participant is not required to exceed that which is normally possessed by a prudent person in the ordinary course of business dealings.
9. Except for transactions authorized in paragraph 5 of these instructions, if a participant in a covered transaction knowingly enters into a lower tier covered transaction with a person who is suspended, debarred, ineligible, or voluntarily excluded from participation in this transaction, in addition to other remedies available to the Federal Government, the department or agency with

which this transaction originated may pursue available remedies, including suspension, and/or debarment.

Certification

- a. **The prospective lower tier participant certifies**, by submission of this document, that neither it nor its principals is presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participation in this transaction by any Federal department or agency.
- b. Where the prospective lower tier participant is unable to certify to any of the statements in this certification, such prospective participant shall attach an explanation to this proposal.

V. Certification Regarding Lobbying

The Contractor certifies, to the best of his or her knowledge and belief, that:

1. No Federal appropriated funds have been paid or will be paid by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.
2. If any funds other than Federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federally funded contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form SF-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions.
3. The undersigned shall require that the language of this certification be included in the award document for subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans, and cooperative agreements) who receive federal funds of \$100,000.00 or more and that all subrecipients shall certify and disclose accordingly.
4. This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, Title 31, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than \$10,000.00 and not more than \$100,000.00 for each such failure.

VI. Disclosure of Lobbying Activities

Instructions

This disclosure form shall be completed by the reporting entity, whether subawardee or prime Federal recipient, at the initiation or receipt of a covered Federal action, or a material change to a previous filing, pursuant to title 31 U.S.C. section 1352. The filing of a form is required for each payment or agreement to make payment to any lobbying entity for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with a covered Federal action. Use the SF-LLL-A Continuation Sheet for additional information if the space on the form is inadequate. Complete all items that apply for both the initial filing and material change report. Refer to the implementing guidance published by the Office of Management and Budget for additional information.

1. Identify the type of covered Federal action for which lobbying activity is and/or has been secured to influence the outcome of a covered Federal action.
2. Identify the status of the covered Federal action.
3. Identify the appropriate classification of this report. If this is a follow-up report caused by a material change to the information previously reported, enter the year and quarter in which the change occurred. Enter the date of the last previously submitted report by this reporting entity for this covered Federal action.
4. Enter the full name, address, city, state and zip code of the reporting entity. Include Congressional District, if known. Check the appropriate classification of the reporting entity that designates if it is, or expects to be, a prime or sub-award recipient. Identify the tier of the subawardee, e.g., the first subawardee of the prime is the 1st tier. Subawards include but are not limited to subcontracts, subgrants and contract awards under grants.
5. If the organization filing the report in Item 4 checks "Subawardee", then enter the full name, address, city, state and zip code of the prime Federal recipient. Include Congressional District, if known.
6. Enter the name of the Federal agency making the award or loan commitment. Include at least one organizational level below agency name, if known. For example, Department of Transportation, United States Coast Guard.
7. Enter the Federal program name or description for the covered Federal action (Item 1). If known, enter the full Catalog of Federal Domestic Assistance (CFDA) number for grants, cooperative agreements, loans, and loan commitments.
8. Enter the most appropriate Federal Identifying number available for the Federal action identified in Item 1 (e.g., Request for Proposal (RFP) number, Invitation for Bid (IFB) number, grant announcement number, the contract grant, or loan award number, the application/proposal control number assigned by the Federal agency). Include prefixes, e.g., "RFP-DE-90-001."
9. For a covered Federal action where there has been an award or loan commitment by the Federal agency, enter the Federal amount of the award/loan commitment for the prime entity identified in Item 4 or 5.
10. (a) Enter the full name, address, city, state and zip code of the lobbying entity engaged by the reporting entity identified in Item 4 to influence the covered Federal action.

(b) Enter the full names of the individual(s) performing services, and include full address if different from 10(a). Enter Last Name, First Name and Middle Initial (MI).
11. Enter the amount of compensation paid or reasonably expected to be paid by the reporting entity (Item 4) to the lobbying entity (Item 10). Indicate whether the payment has been made (actual) or will be made (planned). Check all boxes that apply. If this is a material change report, enter the cumulative amount of payment made or planned to be made.
12. Check the appropriate boxes. Check all boxes that apply. If payment is made through an in-kind contribution, specify the nature and value of the in-kind payment.
13. Check the appropriate boxes. Check all boxes that apply. If other, specify nature.
14. Provide a specific and detailed description of the services that the lobbyist has performed, or will be expected to perform, and the date(s) of any services rendered. Include all preparatory and related

activity, not just time spent in actual contact with Federal officials. Identify the Federal official(s) or employee(s) contacted or the officer(s), employee(s), or Member(s) of Congress that were contacted.

15. Check whether or not a SF-LLL-A Continuation Sheet(s) is attached.

16. The certifying official shall sign and date the form, print his/her name, title, and telephone number.

16. Information requested through this form is authorized by title 31 U. S. C. section 1352. This disclosure of lobbying activities is a material representation of fact upon which reliance was placed by the tier above when this transaction was made or entered into. This disclosure is required pursuant to 31 U. S. C. 1352. This information will be reported to the Congress semi-annually and will be available for public inspection. Any person who fails to file the required disclosure shall be subject to a civil penalty of not less than \$10,000 and not more than \$100,000 for each such failure.

Signature: _____

Print Name: _____

Title: _____

Telephone No: _____ Date: _____

Federal Use Only

Authorized for Local Reproduction
Standard Form - LLL

Public reporting burden for this collection of information is estimated to average 30 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the Office of Management and Budget, Paperwork Reduction Project (0348-0046), Washington, D. C. 20503

LETTER TO IDENTIFY INDIVIDUALS TO SIGN CONTRACTS

**Letter from Board President/Chairperson Identifying
Individuals as Authorized to Sign Contracts**

I, _____, Board President/Chairperson of
_____ [Agency/Organization's legal name]

hereby identify the following individual(s) who is (are) authorized to sign **Contracts** for the
organization named above:

| Printed Name | Title |
|--------------|-------|
| 1. _____ | _____ |
| 2. _____ | _____ |
| 3. _____ | _____ |
| 4. _____ | _____ |

Reference only — Not for signature

| | | |
|-----------|---|------|
| Signature | * Title | Date |
| | <i>* Indicate if you are the Board President or Chairperson</i> | |

LETTER TO IDENTIFY INDIVIDUALS TO SIGN EXPENDITURE REPORTS

**Letter from Board President/Chairperson
Identifying Individuals as Authorized to Sign
Contract Expenditure Reports**

I, _____, Board President/Chairperson of
_____ [Organization's legal name] hereby
identify the following individual(s) who is (are) authorized to sign **Contract Expenditure
Reports** for the organization/agency named above:

| Printed Name | Title | Signature |
|--------------|-------|-----------|
| 1. _____ | _____ | _____ |
| 2. _____ | _____ | _____ |
| 3. _____ | _____ | _____ |
| 4. _____ | _____ | _____ |

Reference only — Not for signature

| Signature | * Title | Date |
|-----------|---------|------|
|-----------|---------|------|

** Indicate if you are the Board President or Chairperson*

NOTARIZED STATEMENT AND CONFLICT OF INTEREST POLICY

Notarization of Conflict of Interest Policy

State of North Carolina, County of _____
I, _____, Notary Public for said County and State, certify that
_____ personally appeared before me this day and
acknowledged that he/she is _____
[title]
of _____
[name of organization]
and by that authority duly given and as the act of the Organization, affirmed that the foregoing
Conflict of Interest Policy was adopted by the Board of Directors/Trustees or other governing
body in a meeting held on the ____ day of _____, _____.
Sworn to and subscribed before me this _____ day of _____, 20____.

Notary Signature and Seal
Notary's commission expires _____, 20 ____.

Instruction for the Organization:
Sign below and **attach the organization's Conflict of Interest Policy** which is referenced
above.

Reference only — Not for signature

Signature of above named Organization Official

Conflict of Interest Policy

The Board of Directors/Trustees or other governing persons, officers, employees or agents are to avoid any conflict of interest, even the appearance of a conflict of interest. The Organization's Board of Directors/Trustees or other governing body, officers, staff and agents are obligated to always act in the best interest of the organization. This obligation requires that any Board member or other governing person, officer, employee or agent, in the performance of Organization duties, seek only the furtherance of the Organization mission. At all times, Board members or other governing persons, officers, employees or agents, are prohibited from using their job title, the Organization's name or property, for private profit or benefit.

A. The Board members or other governing persons, officers, employees, or agents of the Organization should neither solicit nor accept gratuities, favors, or anything of monetary value from current or potential contractors/vendors, persons receiving benefits from the Organization or persons who may benefit from the actions of any Board member or other governing person, officer, employee or agent. This is not intended to preclude bona-fide Organization fund raising-activities.

B. A Board or other governing body member may, with the approval of Board or other governing body, receive honoraria for lectures and other such activities while not acting in any official capacity for the Organization. Officers may, with the approval of the Board or other governing body, receive honoraria for lectures and other such activities while on personal days, compensatory time, annual leave, or leave without pay. Employees may, with the prior written approval of their supervisor, receive honoraria for lectures and other such activities while on personal days, compensatory time, annual leave, or leave without pay. If a Board or other governing body member, officer, employee or agent is acting in any official capacity, honoraria received in connection with activities relating to the Organization are to be paid to the Organization.

C. No Board member or other governing person, officer, employee, or agent of the Organization shall participate in the selection, award, or administration of a purchase or contract with a vendor where, to his knowledge, any of the following has a financial interest in that purchase or contract:

1. The Board member or other governing person, officer, employee, or agent;
2. Any member of their family by whole or half blood, step or personal relationship or relative-in-law;
3. An organization in which any of the above is an officer, director, or employee;
4. A person or organization with whom any of the above individuals is negotiating or has any arrangement concerning prospective employment or contracts.

D. **Duty to Disclosure** — Any conflict of interest, potential conflict of interest, or the appearance of a conflict of interest is to be reported to the Board or other governing body or one's supervisor immediately.

E. **Board Action** — When a conflict of interest is relevant to a matter requiring action by the Board of Directors/Trustees or other governing body, the Board member or other governing person, officer, employee, or agent (person(s)) must disclose the existence of the conflict of

interest and be given the opportunity to disclose all material facts to the Board and members of committees with governing board delegated powers considering the possible conflict of interest. After disclosure of all material facts, and after any discussion with the person, he/she shall leave the governing board or committee meeting while the determination of a conflict of interest is discussed and voted upon. The remaining board or committee members shall decide if a conflict of interest exists.

In addition, the person(s) shall not participate in the final deliberation or decision regarding the matter under consideration and shall leave the meeting during the discussion of and vote of the Board of Directors/Trustees or other governing body.

F. Violations of the Conflicts of Interest Policy — If the Board of Directors/Trustees or other governing body has reasonable cause to believe a member, officer, employee or agent has failed to disclose actual or possible conflicts of interest, it shall inform the person of the basis for such belief and afford the person an opportunity to explain the alleged failure to disclose. If, after hearing the person's response and after making further investigation as warranted by the circumstances, the Board of Directors/Trustees or other governing body determines the member, officer, employee or agent has failed to disclose an actual or possible conflict of interest, it shall take appropriate disciplinary and corrective action.

G. Record of Conflict — The minutes of the governing board and all committees with board delegated powers shall contain:

1. The names of the persons who disclosed or otherwise were found to have an actual or possible conflict of interest, the nature of the conflict of interest, any action taken to determine whether a conflict of interest was present, and the governing board's or committee's decision as to whether a conflict of interest in fact existed.
2. The names of the persons who were present for discussions and votes relating to the transaction or arrangement that presents a possible conflict of interest, the content of the discussion, including any alternatives to the transaction or arrangement, and a record of any votes taken in connection with the proceedings.

Approved by:

Reference only — Not for signature

Legal Name of Organization

Signature of Organization Official

Title of Organization Official

Date

NO OVERDUE TAX DEBTS CERTIFICATION

State Grant Certification – No Overdue Tax Debts¹

To: State Agency Head and Chief Fiscal Officer

Certification:

We certify that the _____
[Organization’s full legal name] does not have any overdue tax debts, as defined by **N.C.G.S. 105-243.1**, at the federal, State, or local level. We further understand that any person who makes a false statement in violation of **N.C.G.S. 143C-6-23(c)** is guilty of a criminal offense punishable as provided by **N.C.G.S. 143C-101(b)**.

Sworn Statement:

_____ [Name of Board Chair] and
_____ [Name of Second Authorizing Official] being
duly sworn, say that we are the Board Chair and

_____ [Title of Second Authorizing Official],
respectively, of _____

[Agency/Organization’s full legal name] of _____ [City] in the State of
_____ [State]; and that the foregoing certification is true, accurate and
complete to the best of our knowledge and was made and subscribed by us. We also
acknowledge and understand that any misuse of State funds will be reported to the appropriate
authorities for further action.

Reference only — Not for
signature

Board Chair

Reference only — Not for
signature

Title

Date

Signature

Title of Second Authorizing Official

Date

Sworn to and subscribed before me this _____ day of _____, 20__.

Reference only — Not for signature

Notary Signature and Seal

Notary’s commission expires _____, 20__.

¹ G.S. 105-243.1 defines: Overdue tax debt – Any part of a tax debt that remains unpaid 90 days or more after the notice of final assessment was mailed to the taxpayer. The term does not include a tax debt, however, if the taxpayer entered into an installment agreement for the tax debt under G.S. 105-237 within 90 days after the notice of final assessment was mailed and has not failed to make any payments due under the installment agreement.”

CONTRACTOR CERTIFICATIONS

Contractor Certifications Required by North Carolina Law

Instructions

The person who signs this document should read the text of the statutes listed below and consult with counsel and other knowledgeable persons before signing.

- The text of Article 2 of Chapter 64 of the North Carolina General Statutes can be found online at:
http://www.ncqa.state.nc.us/EnactedLegislation/Statutes/PDF/ByArticle/Chapter_64/Article_2.pdf
- The text of G.S. 105-164.8(b) can be found online at:
http://www.ncqa.state.nc.us/EnactedLegislation/Statutes/PDF/BySection/Chapter_105/GS_105-164.8.pdf
- The text of G.S. 143-48.5 (S.L. 2013-418, s. 2.(d)) can be found online at:
<http://www.ncqa.state.nc.us/Sessions/2013/Bills/House/PDF/H786v6.pdf>
- The text of G.S. 143-59.1 can be found online at:
http://www.ncqa.state.nc.us/EnactedLegislation/Statutes/PDF/BySection/Chapter_143/GS_143-59.1.pdf
- The text of G.S. 143-59.2 can be found online at:
http://www.ncqa.state.nc.us/EnactedLegislation/Statutes/PDF/BySection/Chapter_143/GS_143-59.2.pdf
- The text of G.S. 147-33.95(g) (S.L. 2013-418, s. 2.(e)) can be found online at:
<http://www.ncqa.state.nc.us/Sessions/2013/Bills/House/PDF/H786v6.pdf>

Certifications

- (1) **Pursuant to G.S. 143-48.5 and G.S. 147-33.95(g)**, the undersigned hereby certifies that the Contractor named below, and the Contractor's subcontractors, complies with the requirements of Article 2 of Chapter 64 of the NC General Statutes, including the requirement for each employer with more than 25 employees in North Carolina to verify the work authorization of its employees through the federal E-Verify system." E-Verify System Link: www.uscis.gov
- (2) **Pursuant to G.S. 143-59.1(b)**, the undersigned hereby certifies that the Contractor named below is not an "ineligible Contractor" as set forth in G.S. 143-59.1(a) because:
 - (a) Neither the Contractor nor any of its affiliates has refused to collect the use tax levied under Article 5 of Chapter 105 of the General Statutes on its sales delivered to North Carolina when the sales met one or more of the conditions of G.S. 105-164.8(b); **and**
 - (b) [check **one** of the following boxes]
 - Neither the Contractor nor any of its affiliates has incorporated or reincorporated in a "tax haven country" as set forth in G.S. 143-59.1(c)(2) after December 31, 2001; **or**
 - The Contractor or one of its affiliates **has** incorporated or reincorporated in a "tax haven country" as set forth in G.S. 143-59.1(c)(2) after December 31, 2001 **but** the United States is not the principal market for the public trading of the stock of the corporation incorporated in the tax haven country.
- (3) **Pursuant to G.S. 143-59.2(b)**, the undersigned hereby certifies that none of the Contractor's officers, directors, or owners (if the Contractor is an unincorporated business entity) has been convicted of any

violation of Chapter 78A of the General Statutes or the Securities Act of 1933 or the Securities Exchange Act of 1934 within 10 years immediately prior to the date of the bid solicitation.

(4) *The undersigned hereby certifies further that:*

(f) *He or she is a duly authorized representative of the Contractor named below;*

(g) *He or she is authorized to make, and does hereby make, the foregoing certifications on behalf of the Contractor; and*

(h) *He or she understands that any person who knowingly submits a false certification in response to the requirements of G.S. 143-59.1 and -59.2 shall be guilty of a Class I felony.*

Contractor's Name

Signature of Contractor's Authorized Agent

Date

Printed Name of Contractor's Authorized Agent

Title

Signature of Witness

Title

Printed Name of Witness

Date

The witness should be present when the Contractor's Authorized Agent signs this certification and should sign and date this document immediately thereafter.

FFATA Form

Federal Funding Accountability and Transparency Act (FFATA) Data Reporting Requirement
NC DHHS, Division of Public Health Subaward Information

A. Exemptions from Reporting

1. Entities are **exempted** from the entire FFATA reporting requirement if **any** of the following are true:
 - The entity has a gross income, from all sources, of less than \$300,000 in the previous tax year
 - The entity is an individual
 - If the required reporting would disclose classified information
2. Entities who are not exempted for the FFATA reporting requirement may be exempted from the requirement to provide executive compensation data. This executive compensation data is **required only if both** are true:
 - More than 80% of the entity's gross revenues are from the federal government **and** those revenues are more than \$25 million in the preceding fiscal year
 - Compensation information is *not* already available through reporting to the U.S. Securities and Exchange Commission.

By signing below, I state that the entity listed below is exempt from:

The entire FFATA reporting requirement:

- as the entity's gross income is less than \$300,000 in the previous tax year.
- as the entity is an individual.
- as the reporting would disclose classified information.

Only executive compensation data reporting:

- as at least one of the bulleted items in item number 2 above is not true.

Reference only — Not for signature

Signature _____ Name _____ Title _____

Entity _____ Date _____

B. Reporting

1. **FFATA Data** required by all entities which receive federal funding (except those exempted above) per the reporting requirements of the *Federal Funding Accountability and Transparency Act (FFATA)*.

Entity's Legal Name _____ Contract Number _____

Active SAM registration record is attached

An active registration with SAM is required

Entity's DUNS Number _____

Entity's Parent's DUNS Nbr (if applicable) _____

Entity's Location

street address _____
city/st/zip+4 _____
county _____

Primary Place of Performance for specified contract

Check here if address is the **same** as Entity's Location

street address _____
city/st/zip+4 _____
county _____

2. **Executive Compensation Data** for the entity's five most highly compensated officers (unless exempted above):

| Title | Name | Total Compensation |
|----------|-------|--------------------|
| 1. _____ | _____ | _____ |
| 2. _____ | _____ | _____ |
| 3. _____ | _____ | _____ |
| 4. _____ | _____ | _____ |
| 5. _____ | _____ | _____ |

IRAN DIVESTMENT ACT CERTIFICATION OF ELIGIBILITY

**Certification of Eligibility
Under the Iran Divestment Act**

Pursuant to G.S. 147-86.59, any person identified as engaging in investment activities in Iran, determined by appearing on the Final Divestment List created by the State Treasurer pursuant to G.S. 147-86.58, is ineligible to contract with the State of North Carolina or any political subdivision of the State. The Iran Divestment Act of 2015, G.S. 147-86.55 *et seq.** requires that each vendor, prior to contracting with the State certify, and the undersigned on behalf of the Vendor does hereby certify, to the following:

1. that the vendor is not identified on the Final Divestment List of entities that the State Treasurer has determined engages in investment activities in Iran;
2. that the vendor shall not utilize on any contract with the State agency any subcontractor that is identified on the Final Divestment List; and
3. that the undersigned is authorized by the Vendor to make this Certification.

Vendor:

By: _____
Signature Date

Printed Name Title

The State Treasurer’s Final Divestment List can be found on the State Treasurer’s website at the address: <https://www.nctreasurer.com/inside-the-department/OpenGovernment/Pages/Iran-Divestment-Act-Resources.aspx> and will be updated every 180 days. For questions about the Department of State Treasurer’s Iran Divestment Policy, please contact Meryl Murtagh at *Meryl.Murtagh@nctreasurer.com* or (919) 814-3852.

* Note: Enacted by Session Law 2015-118 as G.S. 143C-55 *et seq.*, but has been renumbered for codification at the direction of the Revisor of Statutes.

Appendix B
Perinatal Care Regions
County Listing

**North Carolina
Perinatal Care Regions County Listing**

| Region I | Region II | Region III | |
|------------------|------------------|-------------------|-------------|
| Buncombe | Alexander | Anson | |
| Cherokee | Alleghany | Cabarrus | |
| Clay | Ashe | Cleveland | |
| Graham | Avery | Gaston | |
| Haywood | Burke | Lincoln | |
| Henderson | Caldwell | Mecklenburg | |
| Jackson | Catawba | Stanly | |
| Macon | Davidson | Union | |
| Madison | Davie | | |
| McDowell | Forsyth | | |
| Mitchell | Guilford | | |
| Polk | Iredell | | |
| Rutherford | Randolph | | |
| Swain | Rockingham | | |
| Transylvania | Rowan | | |
| Yancey | Stokes | | |
| | Surry | | |
| | Watauga | | |
| | Wilkes | | |
| | Yadkin | | |
| | | | |
| Region IV | Region V | Region VI | |
| Alamance | Bladen | Beaufort | Jones |
| Caswell | Brunswick | Bertie | Lenoir |
| Chatham | Columbus | Camden | Martin |
| Durham | Cumberland | Carteret | Nash |
| Franklin | Harnett | Chowan | Northampton |
| Granville | Hoke | Craven | Onslow |
| Johnston | Montgomery | Currituck | Pamlico |
| Lee | Moore | Dare | Pasquotank |
| Orange | New Hanover | Duplin | Perquimans |
| Person | Pender | Edgecombe | Pitt |
| Stokes | Richmond | Gates | Tyrrell |
| Vance | Robeson | Greene | Washington |
| Wake | Sampson | Halifax | Wayne |
| Warren | Scotland | Hertford | Wilson |
| | | Hyde | |
| | | | |

Appendix C

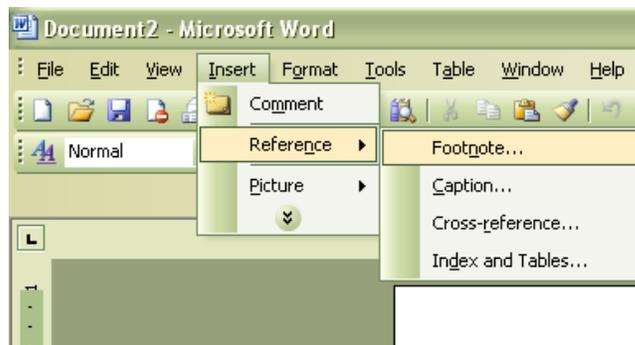
Citation Guidance for Determination of Need

Citation Guidance for Determination of Need

In the RFA #A345, the Determination of Need (section 1) asks you to use endnotes to cite sources for any data and/or statistics that you use to establish the need for the project. In Microsoft Word 2016, you can insert endnotes by going to the References tab and click on the small arrow in the bottom right corner near Footnotes. The “Endnote and Footnote” dialog box will open. Under location, click on “Endnotes”, and select “End of document.” Under Format, select 1, 2, 3...” and then click Insert.



For earlier versions of Microsoft Word, you can insert endnotes by going to the Insert tab → References → Footnote. The “Footnote and Endnote” display box will appear as shown above. Follow the same instructions as outlined above.



Appendix D

CDC Maternal & Neonatal Levels of Care Assessment Tool (LOCATe)



CDC Maternal & Neonatal Levels of Care Assessment Tool (CDC LOCATe V 0.7.0)

DEMOGRAPHICS

Facility name: _____ City: _____

Date survey was completed: _____ State: _____ ZIP code: _____

Please list the **job titles** of all persons who contributed the information that was needed to complete this survey.
(Example: NICU Director, DON, Quality Director, etc.)

| Neonatal Care | | Maternal Care | |
|---------------|--|---------------|--|
| | | | |
| | | | |

SURVEY CONTACT: _____
Name
Email
Phone

PATIENT CARE

| NEONATAL CARE | |
|--|--|
| <i>The next 11 questions relate to services and staff available at your facility that involve the care of newborns.</i> | |
| N1. Does your facility provide congenital cardiac surgery for neonates onsite ? | <input type="radio"/> Yes <input type="radio"/> No <i>(If "No" skip to N2.)</i> |
| N1.1. In the last 12 months, did your facility provide 10 or more congenital cardiac surgeries for neonates ? | <input type="radio"/> Yes <input type="radio"/> No |
| N2. Does your facility provide complex pediatric subspecialty surgery for neonates other than cardiac surgery onsite ? <i>(Capable of surgical repair of complex congenital or acquired conditions)</i> | <input type="radio"/> Yes <input type="radio"/> No <i>(If "No" skip to N3.)</i> |
| N2.1. In the last 12 months, did your facility provide 10 or more complex pediatric sub-specialty surgeries for neonates other than cardiac surgery? | <input type="radio"/> Yes <input type="radio"/> No |



CDC Maternal & Neonatal Levels of Care Assessment Tool (CDC LOCATe V 0.7.0)

| | |
|--|--|
| <p>N3.1-5 What types of neonatal providers does your facility have available? <i>(Mark all that apply)</i></p> <p>Specify other: _____</p> | <p><input type="checkbox"/> Neonatologist(s) <input type="checkbox"/> Pediatric hospitalist(s) <input type="checkbox"/> Neonatal nurse practitioner(s) <input type="checkbox"/> Other</p> <p><input type="checkbox"/> None <i>(If "None" skip to N4.)</i></p> |
| <p><i>Answer if N3.1 Neonatologist(s) is checked</i></p> <p>N3.1.1 Is a neonatologist available... <i>(Choose one)</i></p> | <p><input type="radio"/> Onsite 24/7, <u>or</u> <input type="radio"/> Within 30 minute, <u>or</u> <input type="radio"/> Between 30-60 minute, <u>or</u> <input type="radio"/> More than 60 minutes away, <u>or</u> <input type="radio"/> By telemedicine only, <u>or</u> <input type="radio"/> By phone consultation only</p> |
| <p><i>Answer if N3.2 Pediatric hospitalist(s) is checked</i></p> <p>N3.2.1 Is a pediatric hospitalist available... <i>(Choose one)</i></p> | <p><input type="radio"/> Onsite 24/7, <u>or</u> <input type="radio"/> Within 30 minute, <u>or</u> <input type="radio"/> Between 30-60 minute, <u>or</u> <input type="radio"/> More than 60 minutes away, <u>or</u> <input type="radio"/> By telemedicine only, <u>or</u> <input type="radio"/> By phone consultation only</p> |
| <p><i>Answer if N3.3 Neonatal nurse practitioner(s) is checked</i></p> <p>N3.3.1 Is a neonatal nurse practitioner available... <i>(Choose one)</i></p> | <p><input type="radio"/> Onsite 24/7, <u>or</u> <input type="radio"/> Within 30 minute, <u>or</u> <input type="radio"/> Between 30-60 minute, <u>or</u> <input type="radio"/> More than 60 minutes away, <u>or</u> <input type="radio"/> By telemedicine only, <u>or</u> <input type="radio"/> By phone consultation only</p> |
| <p>N4. Does your facility have a range of pediatric medical subspecialists and pediatric surgical specialists available?</p> | <p><input type="radio"/> Yes <input type="radio"/> No <i>(If "No" skip to N5.)</i></p> |



CDC Maternal & Neonatal Levels of Care Assessment Tool (CDC LOCATe V 0.7.0)

| | |
|---|--|
| <p>N4.1-4. Do these pediatric medical subspecialists and pediatric surgical specialists include... <i>(Mark all that apply)</i></p> <p>Specify other: _____</p> | <p><input type="checkbox"/> Pediatric surgeon(s) <input type="checkbox"/> Pediatric anesthesiologist(s) <input type="checkbox"/> Pediatric ophthalmologist(s) <input type="checkbox"/> Pediatric radiologist(s) <input type="checkbox"/> Other pediatric subspecialists(s)</p> |
| <p>Answer if N4.1 Pediatric surgeon(s) is checked</p> <p>N4.1.1. Is a pediatric surgeon always available... <i>(Choose one)</i></p> | <p><input type="radio"/> Onsite 24/7, <u>or</u> <input type="radio"/> Within 30 minute, <u>or</u> <input type="radio"/> Between 30-60 minute, <u>or</u> <input type="radio"/> More than 60 minutes away, <u>or</u> <input type="radio"/> By telemedicine only, <u>or</u> <input type="radio"/> By phone consultation only</p> |
| <p>Answer if N4.1 Pediatric anesthesiologist(s) is checked</p> <p>N4.2.1 Is a pediatric anesthesiologist always available... <i>(Choose one)</i></p> | <p><input type="radio"/> Onsite 24/7, <u>or</u> <input type="radio"/> Within 30 minute, <u>or</u> <input type="radio"/> Between 30-60 minute, <u>or</u> <input type="radio"/> More than 60 minutes away, <u>or</u> <input type="radio"/> By telemedicine only, <u>or</u> <input type="radio"/> By phone consultation only</p> |
| <p>Answer if N4.1 Pediatric ophthalmologist(s) is checked</p> <p>N4.3.1 Is a pediatric ophthalmologist always available... <i>(Choose one)</i></p> | <p><input type="radio"/> Onsite 24/7, <u>or</u> <input type="radio"/> Within 30 minute, <u>or</u> <input type="radio"/> Between 30-60 minute, <u>or</u> <input type="radio"/> More than 60 minutes away, <u>or</u> <input type="radio"/> By telemedicine only, <u>or</u> <input type="radio"/> By phone consultation only</p> |



CDC Maternal & Neonatal Levels of Care Assessment Tool (CDC LOCATE V 0.7.0)

| | |
|--|--|
| <p>Answer if N4.1 Pediatric radiologist(s) is checked</p> <p>N4.4.1 Is a pediatric radiologist always available... (Choose one)</p> | <p><input type="radio"/> Onsite 24/7, <u>or</u></p> <p><input type="radio"/> Within 30 minute, <u>or</u></p> <p><input type="radio"/> Between 30-60 minute, <u>or</u></p> <p><input type="radio"/> More than 60 minutes away, <u>or</u></p> <p><input type="radio"/> By telemedicine only, <u>or</u></p> <p><input type="radio"/> By phone consultation only</p> |
| <p>N5. Does your facility provide advanced (complex) imaging for neonates onsite 24/7 with interpretation available onsite or remotely 24/7? (Example: CT, MRI, echocardiography)</p> | <p><input type="radio"/> Yes</p> <p><input type="radio"/> No (If "No" skip to N6.)</p> |
| <p>N5.1 In the last 12 months, did your facility provide 10 or more advanced imaging procedures for neonates?</p> | <p><input type="radio"/> Yes</p> <p><input type="radio"/> No</p> |
| <p>N6. Does your facility provide complex ventilation for neonates onsite? (High frequency ventilation, iNO)</p> | <p><input type="radio"/> Yes</p> <p><input type="radio"/> No (If "No" skip to N7.)</p> |
| <p>N6.1 In the last 12 months, did your facility provide 10 or more complex ventilation procedures for neonates?</p> | <p><input type="radio"/> Yes</p> <p><input type="radio"/> No (If either, skip to N8.)</p> |
| <p>N7. Does your facility provide conventional mechanical and/or continuous positive airway pressure (CPAP) ventilation support for neonates until the infant can be transferred to a higher level facility? (Ventilation for less than 24 hours)</p> | <p><input type="radio"/> Yes</p> <p><input type="radio"/> No (If "No" skip to N8.)</p> |
| <p>N7.1 In the last 12 months, did your facility provide 10 or more conventional mechanical and/or continuous positive airway pressure (CPAP) ventilation support for neonates?</p> | <p><input type="radio"/> Yes</p> <p><input type="radio"/> No</p> |
| <p>N8. Does your facility receive neonatal transports?</p> | <p><input type="radio"/> Yes</p> <p><input type="radio"/> No (If "No" skip to N10.)</p> |



CDC Maternal & Neonatal Levels of Care Assessment Tool (CDC LOCATE V 0.7.0)

| | |
|---|--|
| <p>N8.1 What type of neonatal transports do you receive? <i>(Mark all that apply)</i></p> | <p><input type="checkbox"/> Complicated, high-risk <input type="checkbox"/> Convalescent neonates</p> |
| <p>N9. Does your facility coordinate emergency transport for neonates?</p> | <p><input type="radio"/> Yes <input type="radio"/> No <i>(If "No" skip to N9.)</i></p> |
| <p>N10. Does your facility currently have a neonatal level of care designation?</p> | <p><input type="radio"/> Yes <input type="radio"/> No <i>(If "No" skip to N11.)</i></p> |
| <p>N10.1 What is your neonatal level of care designation? <i>(Choose one)</i> Specify other: _____</p> | <p><input type="radio"/> I <input type="radio"/> II <input type="radio"/> III <input type="radio"/> IV <input type="radio"/> Other</p> |
| <p>N10.2.1-6 How is this neonatal level of care designated? <i>(Mark all that apply)</i> Specify other: _____</p> | <p><input type="checkbox"/> State regulatory based <input type="checkbox"/> State voluntary based <input type="checkbox"/> AAP based <input type="checkbox"/> Self-designated <input type="checkbox"/> Unknown (not sure) <input type="checkbox"/> Other</p> |
| <p>N11. Based on the 2012 AAP guidelines for neonatal levels of care, what do you consider your neonatal level of care to be? <i>(Choose one)</i></p> | <p><input type="radio"/> I <input type="radio"/> II <input type="radio"/> III <input type="radio"/> IV <input type="radio"/> Unknown (not sure)</p> |



CDC Maternal & Neonatal Levels of Care Assessment Tool (CDC LOCATe V 0.7.0)

MATERNAL CARE

The next 14 questions relate to services and staff available at your facility that involve the care of obstetric (maternal) patients.

| | |
|--|--|
| <p>W1. Does your facility staff an OB Unit (Labor and Delivery, LDR, LDRP)?</p> <p>NOTE: If "No" is selected for this option, the survey assumes that you do not provide obstetric services other than emergency care; and you should skip to the NEONATAL STATISTICS section on the last page of this survey.</p> <p><i>This answer is appropriate for most children's hospitals, many small rural hospitals, and other hospitals that do not specifically staff an obstetric unit.</i></p> | <p><input type="radio"/> Yes <input type="radio"/> No <i>(If "No" skip to STATISTICS section on the last page.)</i></p> |
| <p>W2.1-2 What type of obstetric/maternal care patients does your facility accept? <i>(High risk, complicated examples include...placenta previa and severe preeclampsia)</i> <i>(Mark all that apply)</i></p> | <p><input type="checkbox"/> Uncomplicated <input type="checkbox"/> High risk, complicated</p> |
| <p>W3. Does your facility have a formal written plan for transport of complicated obstetric/maternal patients?</p> | <p><input type="radio"/> Yes <input type="radio"/> No <i>(If "No" skip to W4.)</i></p> |
| <p>W3.1 Does this formal written plan include... <i>(Mark all that apply)</i></p> | <p><input type="checkbox"/> Transport out to a higher level of care facility <input type="checkbox"/> Receipt from a lower level of care facility</p> |
| <p>W4. Does your facility have an intensive care unit onsite that is available to accept obstetric/maternal care patients?</p> | <p><input type="radio"/> Yes <input type="radio"/> No</p> |



CDC Maternal & Neonatal Levels of Care Assessment Tool (CDC LOCATe V 0.7.0)

| | |
|---|--|
| <p>W5.1-11 What other onsite hospital services does your facility provide 24/7?</p> <p>* Equipment must be onsite and staffed 24/7. Interpretation can be available either onsite or remote, but must be available 24/7</p> <p><i>(Mark all that apply)</i></p> | <ul style="list-style-type: none"> <input type="checkbox"/> Laboratory <input type="checkbox"/> Blood bank <input type="checkbox"/> * Obstetric ultrasound, w/ interpretation <input type="checkbox"/> * General radiology, w/ interpretation <input type="checkbox"/> * CT Scan, w/ interpretation <input type="checkbox"/> * MRI, w/ interpretation <input type="checkbox"/> Interventional radiology <input type="checkbox"/> Nuclear Medicine <input type="checkbox"/> Organ transplantation <input type="checkbox"/> Interventional cardiovascular procedures <input type="checkbox"/> None of the above |
| <p>W6. Does your facility have written policies & procedures in place for...</p> <p><i>(Mark all that apply)</i></p> | <ul style="list-style-type: none"> <input type="checkbox"/> Obstetric hemorrhage <input type="checkbox"/> Hypertensive emergency <input type="checkbox"/> Thromboembolism prophylaxis <input type="checkbox"/> None of the above <i>(If "None" skip to W7.)</i> |
| <p>W6.1 Do these policies and procedures have a unit-standard approach using a stage-based management plan with checklists that have been reviewed & updated in the last 3 years?</p> <p><i>(Mark all that apply)</i></p> | <ul style="list-style-type: none"> <input type="checkbox"/> Yes, Obstetric hemorrhage <input type="checkbox"/> Yes, Hypertensive emergency <input type="checkbox"/> Yes, Thromboembolism prophylaxis <input type="checkbox"/> No, none of them |
| <p>W6.2 Has your staff practiced drills in preparation for these events within the last 12-months?</p> <p><i>(Mark all that apply)</i></p> | <ul style="list-style-type: none"> <input type="checkbox"/> Yes, Obstetric hemorrhage <input type="checkbox"/> Yes, Hypertensive emergency <input type="checkbox"/> Yes, Thromboembolism prophylaxis <input type="checkbox"/> No, none of them |



CDC Maternal & Neonatal Levels of Care Assessment Tool (CDC LOCATe V 0.7.0)

| | |
|---|--|
| <p>W7. What types of obstetric providers does your facility have available? <i>(Mark all that apply)</i></p> <p>Specify other: _____</p> | <p><input type="checkbox"/> Certified Nurse Midwife (CNM) <input type="checkbox"/> Certified Midwife (CM) <input type="checkbox"/> Certified Professional Midwife (CPM) <input type="checkbox"/> Licensed Midwife (LM)</p> <p><input type="checkbox"/> Advanced Practice Nurse (APN) <input type="checkbox"/> Physician Assistant (PA)</p> <p><input type="checkbox"/> Family Medicine Physician <input type="checkbox"/> Obstetrician <input type="checkbox"/> Maternal Fetal Medicine Specialist</p> <p><input type="checkbox"/> Other</p> <p><input type="checkbox"/> None of the above <i>(If 1-3, 6 or "None" skip to W8.)</i></p> |
| <p>W7.8.1 Is an Obstetrician always... <i>(If Obstetrician is checked in W7)</i></p> <p><i>(Choose one)</i></p> | <p><input type="radio"/> Onsite 24/7, <u>or</u> <input type="radio"/> Available to be onsite 24/7, <u>or</u> <input type="radio"/> Available to be onsite, but not 24/7, <u>or</u> <input type="radio"/> Available by telemedicine only, <u>or</u> <input type="radio"/> Available by phone only</p> |
| <p>W7.9.1 Is a Maternal Fetal Medicine Specialist always... <i>(If Maternal-Fetal Medicine specialist is checked in W7)</i></p> <p><i>(Choose one)</i></p> | <p><input type="radio"/> Onsite 24/7, <u>or</u> <input type="radio"/> Available for consultation 24/7, with inpatient privileges, <u>or</u> <input type="radio"/> Available for consultation as needed, but not 24/7, <u>or</u> <input type="radio"/> Available by telemedicine only, <u>or</u> <input type="radio"/> Available by phone only</p> |
| <p>W8. Does your facility have an Obstetric provider with privileges to perform an emergency C-section on staff?</p> | <p><input type="radio"/> Yes <input type="radio"/> No <i>(If "No" skip to W9.)</i></p> |
| <p>W8.1 What type of Obstetric provider?</p> <p>Specify other: _____</p> | <p><input type="checkbox"/> Obstetrician <input type="checkbox"/> Family Medicine Physician</p> <p><input type="checkbox"/> Other</p> |



CDC Maternal & Neonatal Levels of Care Assessment Tool (CDC LOCATe V 0.7.0)

| | |
|---|--|
| <p>W9. Does your facility have a Certified Registered Nurse Anesthetist (CRNA) available for Labor and Delivery?</p> | <p><input type="radio"/> Yes <input type="radio"/> No <i>(If "No" skip to W10.)</i></p> |
| <p>W9.1 Is a Certified Registered Nurse Anesthetist (CRNA) always... <i>(Choose one)</i></p> | <p><input type="radio"/> Onsite 24/7, <u>or</u> <input type="radio"/> Available to be onsite 24/7, <u>or</u> <input type="radio"/> Available to be onsite, but not 24/7, <u>or</u> <input type="radio"/> Available by telemedicine only, <u>or</u> <input type="radio"/> Available by phone only</p> |
| <p>W10. Does your facility have an Anesthesiologist Physician available for Labor and Delivery?</p> | <p><input type="radio"/> Yes <input type="radio"/> No <i>(If "No" skip to W11.)</i></p> |
| <p>W10.1 Is an Anesthesiologist Physician always... <i>(Choose one)</i></p> | <p><input type="radio"/> Onsite 24/7, <u>or</u> <input type="radio"/> Available to be onsite 24/7, <u>or</u> <input type="radio"/> Available to be onsite, but not 24/7, <u>or</u> <input type="radio"/> Available by telemedicine only, <u>or</u> <input type="radio"/> Available by phone only</p> |
| <p>W10.2 Does your facility have an Anesthesiologist Physician who is an Obstetric Specialist that is in charge of obstetric anesthesia?</p> | <p><input type="radio"/> Yes <input type="radio"/> No</p> |
| <p>W11. Does your facility have a general surgeon available for obstetric patients?</p> | <p><input type="radio"/> Yes <input type="radio"/> No</p> |
| <p>W11.1 Is a General Surgeon... <i>(If General surgeon is checked in W11)</i> <i>(Choose one)</i></p> | <p><input type="radio"/> Onsite 24/7, <u>or</u> <input type="radio"/> Available to be onsite 24/7, <u>or</u> <input type="radio"/> Available to be onsite, but not 24/7, <u>or</u> <input type="radio"/> Available by telemedicine only, <u>or</u> <input type="radio"/> Available by phone only</p> |



CDC Maternal & Neonatal Levels of Care Assessment Tool (CDC LOCATe V 0.7.0)

| | |
|--|---|
| <p>W12. Does your facility have other types of physician specialists/subspecialists that are available for obstetric patients? <i>(Mark all that apply)</i></p> <p>Specify other: _____</p> | <p><input type="checkbox"/> Cardiologist <input type="checkbox"/> Hematologist <input type="checkbox"/> Infectious Disease Specialist <input type="checkbox"/> Nephrologist <input type="checkbox"/> Neurologist <input type="checkbox"/> Critical Care Medicine <i>(Anesth, IM, OBGYN, Peds, and/or Surg)</i></p> <p><input type="checkbox"/> Other specialists</p> <p><input type="checkbox"/> None of the above <i>(If "None of the above", skip to W13.)</i></p> |
| | |
| <p>W12.1.1 Is a Cardiologist... <i>(If Cardiologist is checked in W12)</i> <i>(Choose one)</i></p> | <p><input type="radio"/> Onsite 24/7, <u>or</u> <input type="radio"/> Available to be onsite 24/7, <u>or</u> <input type="radio"/> Available to be onsite, but not 24/7, <u>or</u> <input type="radio"/> Available by telemedicine only, <u>or</u> <input type="radio"/> Available by phone only</p> |
| <p>W12.2.1 Is a Hematologist... <i>(If Hematologist is checked in W12)</i> <i>(Choose one)</i></p> | <p><input type="radio"/> Onsite 24/7, <u>or</u> <input type="radio"/> Available to be onsite 24/7, <u>or</u> <input type="radio"/> Available to be onsite, but not 24/7, <u>or</u> <input type="radio"/> Available by telemedicine only, <u>or</u> <input type="radio"/> Available by phone only</p> |
| <p>W12.3.1 Is an Infectious Disease specialist... <i>(If Infectious Disease specialist is checked in W12)</i> <i>(Choose one)</i></p> | <p><input type="radio"/> Onsite 24/7, <u>or</u> <input type="radio"/> Available to be onsite 24/7, <u>or</u> <input type="radio"/> Available to be onsite, but not 24/7, <u>or</u> <input type="radio"/> Available by telemedicine only, <u>or</u> <input type="radio"/> Available by phone only</p> |



CDC Maternal & Neonatal Levels of Care Assessment Tool (CDC LOCATE V 0.7.0)

| | |
|--|--|
| <p>W12.4.1 Is a Nephrologist... <i>(If Nephrologist is checked in W12)</i> <i>(Choose one)</i></p> | <p><input type="radio"/> Onsite 24/7, <u>or</u> <input type="radio"/> Available to be onsite 24/7, <u>or</u> <input type="radio"/> Available to be onsite, but not 24/7, <u>or</u> <input type="radio"/> Available by telemedicine only, <u>or</u> <input type="radio"/> Available by phone only</p> |
| <p>W12.5.1 Is a Neurologist... <i>(If Neurologist is checked in W12)</i> <i>(Choose one)</i></p> | <p><input type="radio"/> Onsite 24/7, <u>or</u> <input type="radio"/> Available to be onsite 24/7, <u>or</u> <input type="radio"/> Available to be onsite, but not 24/7, <u>or</u> <input type="radio"/> Available by telemedicine only, <u>or</u> <input type="radio"/> Available by phone only</p> |
| <p>W12.6.1 Is a Critical Care specialist(s)... <i>(If Critical Care specialist is checked in W12)</i> <i>(Choose one)</i></p> | <p><input type="radio"/> Onsite 24/7, <u>or</u> <input type="radio"/> Available to be onsite 24/7, <u>or</u> <input type="radio"/> Available to be onsite, but not 24/7, <u>or</u> <input type="radio"/> Available by telemedicine only, <u>or</u> <input type="radio"/> Available by phone only</p> |
| <p>W13. Does your facility currently have a maternal level of care designation?</p> | <p><input type="radio"/> Yes <input type="radio"/> No <i>(If "No" skip to 14.)</i></p> |
| <p>W13.1 What is your maternal level of care designation? <i>(Choose one)</i></p> <p>Specify other: _____</p> | <p><input type="radio"/> Birth Center <input type="radio"/> I <input type="radio"/> II <input type="radio"/> III <input type="radio"/> IV <input type="radio"/> Other</p> |
| <p>W13.2 How is this maternal level of care designated? <i>(Mark all that apply)</i></p> <p>Specify other: _____</p> | <p><input type="checkbox"/> State regulatory based <input type="checkbox"/> State voluntary based <input type="checkbox"/> ACOG based <input type="checkbox"/> Self-designated <input type="checkbox"/> Other <input type="checkbox"/> Unknown (not sure)</p> |



CDC Maternal & Neonatal Levels of Care Assessment Tool (CDC LOCATe V 0.7.0)

W14. Based on the **2015 ACOG/SMFM guidelines** for maternal levels of care, what do you consider your **maternal level of care** to be?

(Choose one)

- Birthing Center
- I
- II
- III
- IV
- Unknown (not sure)



CDC Maternal & Neonatal Levels of Care Assessment Tool (CDC LOCATe V 0.7.0)

STATISTICS

S1. Time frame for the facility statistics. *(Please use the latest complete year of data available)*

From: _____
(mm/dd/yyyy)

To: _____
(mm/dd/yyyy)

| NEONATAL STATISTICS | Born (Total) | Newborn deaths | High risk neonates transferred out | Convalescent neonates received back |
|--|--------------|----------------|------------------------------------|-------------------------------------|
| S2.1 All live births at your facility | | | | |
| S2.2 Live births less than 1,500 grams (VLBW) | | | | |
| S2.3 Live births less than 32 weeks gestation (VPTD) | | | | |

| MATERNAL STATISTICS (#s) | Delivered (Total) | Transported OUT to a higher level of care facility AFTER delivery | Maternal deaths prior to discharge | Received 4 or more units of whole blood or packed cells | Were admitted to an Intensive Care Unit (ICU) |
|--|-------------------|---|------------------------------------|---|---|
| S3. Women who delivered at your facility | | | | | |

| FETAL DEATH STATISTICS | Fetal deaths (Total) | Fetal deaths 20-24 weeks gestation | Fetal deaths 25-28 weeks gestation | Fetal deaths more than 28 weeks gestation |
|---|----------------------|------------------------------------|------------------------------------|---|
| S4. Number of fetal deaths delivered at your facility | | | | |