## Application Face Sheet

**Healthy Beginnings**

**RFA #A390**

This form provides basic information about the applicant and the proposed program with Healthy Beginnings, 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 #A390 are truthful, and that the applicant is in compliance with the assurances and certifications that follow this form and acknowledges that continued compliance is a condition for the award of a contract. Please follow the instructions below.

|  |
| --- |
| 1. Legal Name of Agency:
2. Name of individual with Signature Authority:
 |
| 1. Mailing Address (include zip code+4):
2. Address to which checks will be mailed:
 |
| 1. Street Address:
 |
| 1. Contract Administrator:

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

**Section 1**

**Needs Assessment**

**Do not delete the question headers.**

Please provide your response to each question under the heading.

**Total Point Value:**

**20**

**Page Limit:**

**4 single-spaced (excluding citation page)**

* 1. Provide recent data to demonstrate the need for the Healthy Beginnings (HB) program in the community you propose to serve. Provide **state and county level data for** **minority populations** for the following: (6 points)
1. Infant mortality rates
2. Low and very low birth weight rates
3. Preterm birth rates
4. Prenatal care initiation rates
5. Percent of women who received adequate prenatal care
6. Smoking during pregnancy rates
7. Data on women who gave birth in your county (i.e. age, health status, education level, pre-pregnancy body mass index)
	1. Define the specific community that will be served by the HB program. A community may be a county, zip code, or town/city. (2 points)
	2. Describe the specific population to be served within the community. This description should include factors (also known as social determinants of health) that have an impact on birth outcomes, such as: age, race/ethnicity, educational level, income level, housing, nutrition, stress, substance use, and intimate partner violence. Describe how this population was identified. (6 points)
	3. Describe the availability and accessibility of health and social services and other support services in the community. Describe strengths, barriers and gaps in services. (4 points)
	4. Appropriate data sources must be cited in the needs assessment. One way this can be done is by using endnotes. If you use endnotes, the citation list can be included on a separate page 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:**

**30**

**Page Limit:**

 **12 single-spaced**

2-1.Describe how your agency will meet or exceed the Healthy Beginnings (HB) program deliverables. Describe, in detail, the activities your agency will conduct to meet or exceed HB program deliverables (who is responsible, and when, where and how will activities occur). (12 points)

1. Maintain a minimum caseload of 40 unduplicated minority women and serve all enrolled women and their children prenatally and up to two years interconceptionally. Describe in detail your recruitment and retention plan, including incentives.
2. Provide a minimum of 12 care coordination contacts annually with each enrolled program participant, a minimum of one contact must be provided each month. These 12 care coordination contacts must include a minimum of six (6) home visits and a minimum of six (6) contacts conducted by phone or in-person (office, clinic or other location).
3. Provide one additional home visit (or visit in hospital) within one week of the baby’s birth, or as soon as possible thereafter, to all program participants enrolled prenatally.
4. Provide a minimum of seven (7) group educational sessions per year, which includes one (1) group educational session for fathers/partners or other family members and pregnant and breastfeeding program participants on breastfeeding. Describe how you will address potential barriers to attendance, such as transportation and childcare. Describe how you will ensure that program participants attend, and how will fathers/partners and family members be encouraged to attend. Describe how incentives will be used, logged, and maintained (if applicable).
5. Maintain a Community Advisory Board that convenes quarterly.
6. Conduct and/or participate in four (4) community outreach and education activities per year.

2-2. Describe how your agency will provide care coordination services under each program component for program participants during the prenatal period and interconception period as described in this RFA (pages 5-8). (12 points)

2-3. Describe how your agency will meet each program performance outcome measure. (6 points)

1. At least 80% of pregnant program participants shall begin receiving prenatal care in the first trimester.
2. At least 90% of program participants enrolled prenatally shall receive a home visit (or visit in hospital) ideally within one week of baby’s birth but no later than three weeks after baby’s birth.
3. At least 35% of interconception program participants shall initiate breastfeeding and maintain for at least six months.
4. At least 90% of interconception program participants shall receive their postpartum checkup.
5. At least 95% of program participants shall receive depression screening within 30 days of enrollment.
6. At least 80% of interconception program participants shall always lay their babies down to sleep on their backs until their child reaches 12 months of age.
7. At least 90% of interconception program participants shall experience an interpregnancy interval greater than 18 months.
8. At least 40% of all currently enrolled program participants will attend each group educational session.
9. At least 80% of all program participants attending group educational sessions shall report increased knowledge of maternal and child health topics.

**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:**

**3 single-spaced**

3-1.Describe who will be responsible for entering program participant data into the Healthy Beginnings (HB) Database and submitting quarterly HB Database reports. Describe who will be responsible for monitoring and the frequency of monitoring the HB Database to ensure that complete and accurate data is being entered. (3 points)

3-2. Describe who will be responsible for completing and submitting the HB biannual program reports online through Survey Monkey. (2 points)

3-3. How will you ensure the confidentiality of program participant records? (2 points)

3-4. Describe how you will administer the HB Participant Satisfaction Survey (online and/or in written form) and use program participant feedback. (3 points)

1. How often will you administer the survey?
2. Who will be responsible for collecting and reviewing feedback?
3. Who will be responsible for entering all written survey responses online through Survey Monkey?
4. How will the participant feedback be used to improve your program?

3-5. Describe who will be responsible for developing and administering the pre-tests and post-tests for each group educational session. Describe who will be responsible for calculating the percent increase in knowledge for each group educational session and ensuring the confidentiality and anonymity of the pre-tests and post-tests. (2 points)

**Section 4**

**Agency Ability**

**Do not delete the question headers.**

Please provide your response to each question under the heading.

**Total Point Value:**

**14**

**Page Limit:**

**4 single-spaced**

4-1.Describe your agency’s mission, background and services and how these relate to the Healthy Beginnings (HB) program’s goals. Describe your agency’s experience working with minority communities and implementing maternal and infant health programs in the community. Applicants who are or have been funded to implement the HB program should describe their experience implementing the program, including successes and challenges experienced. Include the agency’s organizational chart and list of current Board of Directors in Attachment B. (3 points)

4-2. Using the chart below, list each staff position that is necessary to implement and support the HB program, include the percentage of time (full-time equivalency percentage) to be spent on the program. Please insert additional rows if needed. Include copies of job descriptions and resumes for staff positions already hired, and job descriptions for staff positions that are not hired in Attachment B. (3 points)

1. If staff are not currently in place, explain the process for recruiting and hiring new staff to implement the program.

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

4-3.Describe the plan for training newly hired staff and provide the proposed dates for each required training or provide the dates current staff received each required training under these topics: breastfeeding, home visiting, infant safe sleep practices, and tobacco/smoking cessation. Please refer to Appendix C for the required trainings under the specific topics listed above. (3 points)

4-4. Describe staff turnover and staff development within your agency. (3 points)

1. Describe your agency’s history of staff turnover over the past four years.
2. How will you minimize staff turnover during the grant period?
3. Describe how program services will continue if staff turnover is experienced.
4. How will you ensure that staff receive opportunities for staff development?

4-5. Describe your agency’s capacity to implement the program under a cost reimbursement system. (2 points)

**Section 5**

**Community Involvement**

**Do not delete the question headers**.

Please provide your response to each question under the heading.

**Total Point Value:**

**14**

**Page Limit:**

**5 single-spaced**

5-1.Describe how you will establish a Healthy Beginnings (HB) Community Advisory Board (CAB) that consists of a minimum of 10 members (not including HB staff), including at least two (2) HB program participants (current or past enrollees), and how CAB members will be involved in program improvement. If you have an existing CAB, then describe how CAB members (including program participants) are engaged and involved in program improvement, what agencies are currently represented on the CAB and what agencies are missing, and what your plans are for recruiting new members.

(4 points)

5-2. Using the table below, list each member that will serve on your HB CAB. Please insert additional rows if needed. A letter of specific commitment (LOC) from each member must be included in Attachment A. (3 points)

|  |  |  |
| --- | --- | --- |
| **Member Name** | **Name of Agency or Program Participant** | **LOC Attached?** |
|  |  | ☐ **Yes** ☐ **No** |
|  |  | ☐ **Yes** ☐ **No** |
|  |  | ☐ **Yes** ☐ **No** |
|  |  | ☐ **Yes** ☐ **No** |
|  |  | ☐ **Yes** ☐ **No** |
|  |  | ☐ **Yes** ☐ **No** |
|  |  | ☐ **Yes** ☐ **No** |
|  |  | ☐ **Yes** ☐ **No** |

5-3.Using the table below, list the collaborating agencies that will assist with program implementation (i.e. meeting space, transportation, childcare). Please insert additional rows if needed. Include a Memorandum of Agreement (MOA) for each agency detailing their contribution to the program in Attachment A. (3 points)

|  |  |  |
| --- | --- | --- |
| **Name of Agency** | **Description of Contribution** | **MOA Attached?** |
|  |  | ☐ **Yes** ☐ **No** |
|  |  | ☐ **Yes** ☐ **No** |
|  |  | ☐ **Yes** ☐ **No** |
|  |  | ☐ **Yes** ☐ **No** |

* 1. Using the table below, list where you will refer program participants for services that are beyond the scope of your agency (contraception, intimate partner violence, mental health, substance use). Please insert additional rows if needed. Include a Memorandum of Agreement (MOA) for each agency in Attachment A. (4 points)
1. Describe how you will determine that referrals were completed.

|  |  |  |
| --- | --- | --- |
| **Name of Referral Agency** | **Description of Service** | **MOA Attached?** |
|  |  | ☐ **Yes** ☐ **No** |
|  |  | ☐ **Yes** ☐ **No** |
|  |  | ☐ **Yes** ☐ **No** |

**Section 6**

**Budget**

**Total Point Value:**

**8**

**Page Limit:**

**Not Applicable**

**Insert Open Windows Budget Form**

Applicants must complete the Open Windows Budget Form for Year 1 (6/1/22 through 5/31/23). Applicant must ensure that all worksheet rows are expanded to expose the full narrative justification for each line item before printing. The Open Window Budget Form can be downloaded from the Women’s Health Branch website at [http://whb.ncpublichealth.com](http://whb.ncpublichealth.com/) on October 25, 2021.

A narrative justification must be included for every expense listed in the Year 1 budget. Each justification should show how the amount on the line-item budget was calculated, and it should be clear how each expense relates to the program. The instructions for completing the Open Windows Budget Form can be downloaded from the Women’s Health Branch website at [http://whb.ncpublichealth.com](http://whb.ncpublichealth.com/) on October 25, 2021.

**Attachment A**

**Letters of Specific Commitment & Memoranda of Agreement**

This attachment must include a table of contents that lists each letter of specific commitment and each Memoranda of Agreement (MOA) from the following agencies or individuals:

* Letters from current or prospective Community Advisory Board (CAB) members that indicate both their commitment to serve and the responsibilities they will assume as a member of the CAB.
* A MOA from any agency that the applicant will be relying on to successfully implement the proposed program activities. Examples of such agencies include those that will provide meeting space, childcare, transportation, referrals to the program, or resources for program participants. Each MOA must include the specific contribution from the agency to the program and specific commitment to provide a representative to serve on the CAB (if applicable).
* A MOA from any agency that the applicant will refer program participants to for services beyond the scope of the applicant. Referrals must include, but are not limited to: contraception, intimate partner violence, mental health, and substance abuse. Each MOA must include the specific contribution from the agency to the program and specific commitment to provide a representative to serve on the CAB (if applicable).

**Attachment B**

**Agency Information**

This attachment must include a table of contents that lists each of the following items:

* Organizational chart of the applying agency.
* List of current Board of Directors of the applying agency.
* List of current and/or prospective Community Advisory Board members.
* Job descriptions and/or resumes for all staff positions that are necessary to implement and support the program.
* All applicants must include IRS documentation of their tax identification number.

*(Public and Private Non-Profit Agencies)*

* A copy of the IRS determination letter regarding the agency’s 501(c)(3) tax-exempt status *(Private Non-Profit Agencies Only)*
* A completed, signed, and notarized page verifying continued existence of the agency’s 501(c)(3) status. Please use the Verification of 501(c)(3) form in Appendix B.

*(Private Non-Profit Agencies Only)*