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| **VI. APPLICATION FORMS** |

**COVER SHEET**

**REQUEST FOR PROPOSAL**

**RFP DPH Log# 2019-0903**

**CONNECTICUT DEPARTMENT OF PUBLIC HEALTH**

**Applicant Information**

Applicant Agency: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Legal Name

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Address

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 City/Town State Zip Code

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Telephone No. FAX No. Email Address

Contact Person: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Title: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Telephone No: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**TOTAL PROGRAM COST:** $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I certify that to the best of my knowledge and belief, the information contained in this application is true and correct. The application has been duly authorized by the governing body of the applicant, the applicant has the legal authority to apply for this funding, the applicant will comply with applicable state and federal laws and regulations, and that I am a duly authorized signatory for the applicant.

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Signature of Authorizing Official: Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Typed Name and Title

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The applicant agency is the agency or organization, which is legally and financially responsible and accountable for the use and disposition of any awarded funds. Please provide the following information:

1. Full legal name of the organization or corporation as it appears on the corporate seal and as registered with the Secretary of State
2. Mailing address
3. Main telephone number
4. Fax number, and email address, if any
5. Principal contact person for the application (person responsible for developing application)
6. Total program cost

The funding application and all required submittals must include the signature of an officer of the applicant agency who has the legal authority to bind the organization. The signature, typed name and position of the authorized official of the applicant agency must be included as well as the date on which the application is signed.

**Applicant Information Form (continuation)**

*PLEASE LIST THE AGENCY CONTACT PERSONS RESPONSIBLE FOR COMPLETION AND SUBMITTAL OF:*

**Contract and Legal Documents/Forms:**

|  |  |  |
| --- | --- | --- |
|  |  |  |
|  Name |  Title |  Tel. No. |
|  |  |  |
|  Street |  Town |  Zip Code |
|  |  |
|  Email |  Fax No. |

**Program Progress Reports:**

|  |  |  |
| --- | --- | --- |
|  |  |  |
|  Name |  Title |  Tel. No. |
|  |  |  |
|  Street |  **Town** |  Zip Code |
|  |  |
|  Email |  Fax No. |

**Financial Expenditure Reporting Forms:**

|  |  |  |
| --- | --- | --- |
|  |  |  |
|  Name |  Title |  Tel. No. |
|  |  |  |
|  Street |  Town |  Zip Code |
|  |  |
|  Email |  Fax No, |
| **Incorporated:** [ ] YES [ ] NO | **Agency Fiscal Year:** |  |
|  |
| **Type of Agency: [ ]** Public **[ ]** Private  **[ ]** Other, Explain: |  |
|  |  |
|  **[ ]** Profit  **[ ]** Non-Profit |  |
| **Federal Employer I.D. Number:** |  | **Town Code No:** |       |
| **Medicaid Provider Status:** [ ] YES[ ] NO | **Medicaid Number:** |  |
| **Minority Business Enterprise (MBE): [ ]** YES **[ ]** NO |
| **Women Business Enterprise (WBE): [ ]** YES **[ ]** NO  |

**Performance and Outcome Measures**

NOTE: These are the minimum outcome measures the Department will require awardees to report. The Department reserves the right to request additional metrics be tracked and reported as necessary.

**Component 1**

Goal 1

* Increase the knowledge and skills of dental professionals in identified Dental HPSA sites to address common modifiable risk factors of childhood obesity and dental decay experience through nutrition screening, counseling, and referral

Outcome Measures

* 1:1 By August 2022, 90% of identified dental providers in the targeted Dental HPSA sites provide general nutrition screening to all pediatric patients 0-21 years of age annually.
* 1:2 By August 2022, 75% of pediatric patients seen by identified dental providers in targeted Dental HPSA sites are provided nutrition screening annually.
* 1:3 By August 2022, 90% of pediatric patients’ ages 0-21 years old with nutrition screening scores greater than one will be provided nutrition counseling by identified dental providers in the targeted Dental HPSA sites.
* 1:4 By August 2022, 75% of pediatric patients’ ages 0-21 years old with high nutrition screening scores will be provided a referral to a primary medical professional and/or a dietitian for follow-up by identified dental providers in the targeted Dental HPSA sites.

Goal 2

* Establish specific Dental HPSA site practice workflows, referral and tracking mechanisms, and bi-directional flow of relevant client information

Outcome Measures

* 2:1 By August 2020, complete a practice assessment outlining IT and practice workflow design needs to support the project
* 2:2 By August 2021, adopt at least one IT modification and one practice redesign modification in support of the project.
* 2:3 By August 2022, have operational referral, tracking and bi-directional information flows.
* 2:4 By August 2022, 90% of clients and/or families report satisfaction with the care coordination aspects of the model.
* 2:5 By August 2022, 90% of dental providers report satisfaction with the care coordination aspects of the model.

Goal 3

* Institute a payment policy and billing strategy to actively monitor and recommend changes in the payment environment.

Outcome Measures

* 3:1 By August 2020, commit to sustainability planning.
* 3:2 By August 2022, finalize a plan to sustain the program beyond grant period.

**Component 2**

Goal 1

* Integrate oral health and medical operations at FQHC(s) to address patients at risk for type 2 diabetes and oral disease.

Outcome Measures

* 1:1 By August 2023, 100% of targeted patients receive a prediabetes screening.
* 1:2 By August 2023, 100% of identified at risk patients are referred to primary care for follow up.

**Budget Summary Instructions**

* 1. **Position Schedule #2a**
		1. Complete the schedule for all positions to be funded even if currently vacant.
		2. Complete one Position Schedule #2a for each Program/Fund to be included in the Budget.
	2. **Personnel** (lines #1 - #2)
		1. Line #1 **Salary and Wages:** Enter the total salary charged, as listed on Position Schedule 2a.
		2. Line #2 **Fringe Benefits Line:** Enter the total fringe benefits charged, as listed on Position Schedule 2a.
	3. Line #8 **Contractual (Subcontracts):**  Provide the total of all subcontracts and complete Subcontractor Schedule.
	4. Lines #3 - #7, #9, and #10: Complete categories as appropriate,
	5. Line #11: Other Expenses are any other types of expense that do not fit into the categories listed.

For example: Equipment. Please note that the state’s definition of equipment is tangible personal property with a normal useful life of at least one year and a value of at least $5,000 or more.

* 1. **Audit Costs:** The cost of audits made in accordance with OMB Circular A133 (Federal Single Audit) are allowable charges to Federal awards. The cost of State Single Audits (CGS 4-23 to 4-236) are allowable charges to State awards. Audit costs are allowable to the extent that they represent a pro-rata share of the cost of such audit. Audit costs charged to Department of Public Health contracts **must be budgeted, reported and justified as an audit cost line item within the Administrative and General Cost category.**
	2. **Administrative and General Costs,** Line Item #12
		1. Are defined as those costs that have been incurred for the overall executive and administrative offices of the organization or other expenses of a general nature that do not relate solely to any major cost objective of the overall organization. Examples of A&G costs include salaries of executive directors, administrative & financial personnel, accounting, auditing, management information systems, proportional office costs such as building occupancy, telephone, equipment, and office supplies. Please review the OPM website on Cost Standards for more information at: <http://www.opm.state.ct.us/finance/pos_standards/coststandards.htm>.
		2. **Administrative and General Costs** must be itemized on the Budget Justification Schedule. Costs that have a separate line item in the Budget Summary may not be duplicated as an Administrative and General Cost. For example, if the Budget Summary includes an amount for telephone costs, this cannot also be included as an Administrative and General Cost.
	3. **Other Program Income** list any other program income, if appropriate, such as in-kind contributions, fees collected, or other funding sources and include brief explanation on Budget Justification.
	4. **Multiple Funding Period Contracts:** Please complete a full budget for each Funding Period of the contract, clearly indicating the Period on each form. Absent other instructions, assume level funding for the second year.

**Budget Justification Schedule B**

* 1. Please provide a brief explanation for each line item listed on the Budget Summary. This must include a detailed breakdown of the components that make up the line item and any calculation used to compute the amount.

|  |  |  |
| --- | --- | --- |
| **Line Item (Description)** | **Amount** | **Justification - Breakdown of Costs** |
| **Travel** | $730 | 1,659 miles @ .44 = $730.00 outreach workers going to meetings and site visits. |

* 1. For contractors who have subcontracts, a brief description of the purpose of each subcontract must be provided. Use additional sheets as necessary.

\*\*\**Please note: If Laboratory Services is a line item on the primary or subcontract budget, please supply a justification as to why a private laboratory is being used as opposed to the Connecticut State Laboratory.*

**Subcontractor Schedule A--Detail**

* 1. All subcontractors used by each program must be included, if it is not known who the subcontractor will be, an estimated amount and whatever budget detail is anticipated should be provided. (Submit the actual detail when it is available). A separate subcontractor schedule must be completed for each program included in the contract. For example: The contract is providing both a Needle Exchange program and an AIDS Prevention Education Program and Subcontractor “A” is providing services to both program there must be a separate budget for Subcontractor “A” for each.
	2. Detail of Each Subcontractor:
		1. Choose a category below for each subcontract using the basis by which it is paid:

[ ]  A. Budget Basis [ ]  B. Fee for Service [ ]  C. Hourly Rate.

* + 1. Choose whether the subcontractor is a minority or woman owned a business:
		2. [ ]  MBE [ ]  WBE [ ]  Neither
		3. Provide the detail for each subcontract just as for the primary contract budget referencing the corresponding program of the contract. Detail must be provided for each subcontractor listed in the Summary.

Note: If space allowed is not sufficient for large or complex subcontract budgets, the primary Budget Summary format may be copied and used instead.

**Budget Summary Form**

\*USE IF APPLYING FOR COMPONENT 1 FUNDING ONLY

**Applicant’s Organization Name**

**FUNDING PERIOD: 2/1/2020 to 8/31/2020**

**Contract Period: 2/1/2020-8/31/2022**

**Budget Summary: Component 1**

|  |  |  |
| --- | --- | --- |
| **Program:** | **Comp. 1** | Total |
| **Fund:** | **HRSA** |  |
|  |  |  |
| **1. Salaries & Wages** |       |       |
| **2. Fringe Benefits** |       |       |
| **3. Travel** |       |       |
| **4. Training** |       |       |
| **5. Educational Materials** |       |       |
| **6. Office Supplies** |       |       |
| **7. Medical Materials** |       |       |
| **8. Contractual****(Sub-Contracts)\*\*** |       |       |
| **9. Telephone** |       |       |
| **10. Advertising** |       |       |
| **11. Other Expenses (list)** |       |       |
| **a.**  |       |       |
| **b.** |       |       |
| **c.** |       |       |
| **d.** |       |       |
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| **f.** |       |       |
| **g.** |       |       |
| **h.** |       |       |
| **i.** |       |       |
| **12. Administrative and General Costs** |       |       |
| **Total DPH Grant** |       |       |
|  |  |  |
| **Other Program Income** |       |       |
|  |       |       |
|  |       |       |
|  |       |       |

\*\*Complete Sub-contractor Schedule A

**Budget Justification Schedule B\***

\*USE IF APPLYING FOR COMPONENT 1 FUNDING ONLY

**Applicant’s Organization Name**

**FUNDING PERIOD: 2/1/2020 to 8/31/2020**

**Contract Period: 2/1/2020-8/31/2022**

**Budget Justification Schedule B**

**Program/Site:** Component 1/HRSA

|  |  |  |
| --- | --- | --- |
| **Line Item (Description)** | **Amount** | **Justification including Breakdown of Costs** |
|       |       |       |
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**Position Schedule #2a**

\*USE IF APPLYING FOR COMPONENT 1 FUNDING ONLY

**Applicant’s Organization Name**

**FUNDING PERIOD: 2/1/2020 to 8/31/2020**

**Contract Period: 2/1/2020-8/31/2022**

**Position Schedule #2a**

**Program/Fund**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Position Description and Staff Person Assigned** | **Site/ Location** | **Hours wk/ wks per Year** | **Hourly Rate** | **Total Salary Charged** | **Fringe Benefit Rate %** | **Total Fringe Benefits** |
| 1. Position:

Name:       |       |      /      |       |       |      % |       |
| 1. Position:

Name:       |       |      /      |       |       |      % |       |
| 1. Position:

Name:       |       |      /      |       |       |      % |       |
| 1. Position:

Name:       |       |      /      |       |       |      % |       |
| 1. Position:

Name:       |       |      /      |       |       |      % |       |
| 1. Position:

Name:       |       |      /      |       |       |      % |       |
| 1. Position:

Name:       |       |      /      |       |       |      % |       |
| 1. Position:

Name:       |       |      /      |       |       |      % |       |
| 1. Position:

Name:       |       |      /      |       |       |      % |       |
| 1. Position:

Name:       |       |      /      |       |       |      % |       |
| 1. Position:

Name:       |       |      /      |       |       |      % |       |
| 1. Position:

Name:       |       |      /      |       |       |      % |       |
| 1. Position:

Name:       |       |      /      |       |       |      % |       |
| 1. Position:

Name:       |       |      /      |       |       |      % |       |
| 1. Position:

Name:       |       |      /      |       |       |      % |       |
| 1. Position:

Name:       |       |      /      |       |       |      % |       |
| **Totals** |  |  |  |       |  |       |

**\*Attach resumes and job descriptions for all Professional Staff**

**Subcontractor Schedule A-Detail**

\*USE IF APPLYING FOR COMPONENT 1 FUNDING ONLY

**Applicant’s Organization Name**

**FUNDING PERIOD: 2/1/2020 to 8/31/2020**

**#1**

Subcontractor Name:

Address:

Telephone: (     ) (     -     )

Select One: **A** [ ]  Budget Basis **B** [ ]  Fee-for-Service **C** [ ]  Hourly Rate

Indicate One: [ ]  MBE [ ]  WBE [ ]  Neither

|  |  |  |
| --- | --- | --- |
| **Program:** | **Comp 1** | **Total** |
| **Fund:** | **HRSA** |  |
| Line Item(s) |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
| **Total Subcontract Amount:** |  |  |

**#2**

Subcontractor Name:

Address:

Telephone: (     ) (     -     )

Select One: **A** [ ]  Budget Basis **B** [ ]  Fee-for-Service **C** [ ]  Hourly Rate

Indicate One: [ ]  MBE [ ]  WBE [ ]  Neither

|  |  |  |
| --- | --- | --- |
| **Program:** | **Comp 1** | **Total** |
| **Fund:** | **HRSA** |  |
| Line Item(s) |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
| **Total Subcontract Amount:** |  |  |

**#3**

Subcontractor Name:

Address:

Telephone: (     ) (     -     )

Select One: **A** [ ]  Budget Basis **B** [ ]  Fee-for-Service **C** [ ]  Hourly Rate

Indicate One: [ ]  MBE [ ]  WBE [ ]  Neither

|  |  |  |
| --- | --- | --- |
| **Program:** | **Comp 1** | **Total** |
| **Fund:** | **HRSA** |  |
| Line Item(s) |  |  |
|  |  |  |
|  |  |  |
| **Total Subcontract Amount:** |  |  |

**Budget Summary Form**

\*USE IF APPLYING FOR COMPONENT 1 AND COMPONENT 2 FUNDING

**Applicant’s Organization Name**

**FUNDING PERIOD: 2/1/2020 to 8/31/2020**

**Contract Period: 2/1/2020-8/31/2023**

**Budget Summary: Component 1 and 2**

|  |  |  |  |
| --- | --- | --- | --- |
| **Program:** | **Comp. 1** | **Comp. 2** | Total |
| **Fund:** | **HRSA** | **CDC** |  |
|  |  |  |  |
| **1. Salaries & Wages** |       |       |       |
| **2. Fringe Benefits** |       |       |       |
| **3. Travel** |       |       |       |
| **4. Training** |       |       |       |
| **5. Educational Materials** |       |       |       |
| **6. Office Supplies** |       |       |       |
| **7. Medical Materials** |       |       |       |
| **8. Contractual****(Sub-Contracts)\*\*** |       |       |       |
| **9. Telephone** |       |       |       |
| **10. Advertising** |       |       |       |
| **11. Other Expenses (list)** |       |       |       |
| **a.** |       |       |       |
| **b.** |       |       |       |
| **c.** |       |       |       |
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| **12. Administrative and General Costs** |       |       |       |
| **Total DPH Grant** |       |       |       |
|  |  |  |  |
| **Other Program Income** |       |       |       |
|  |       |       |       |

\*\*Complete Sub-contractor Schedule A

**Budget Justification Schedule B\***

\*USE IF APPLYING FOR COMPONENT 1 AND COMPONENT 2 FUNDING

**Applicant’s Organization Name**

**FUNDING PERIOD: 2/1/2020 to 8/31/2020**

**Contract Period: 2/1/2020-8/31/2023**

**Budget Justification Schedule B (part 1)**

**Program/Site:** Component 1/HRSA

|  |  |  |
| --- | --- | --- |
| **Line Item (Description)** | **Amount** | **Justification including Breakdown of Costs** |
|       |       |       |
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**Budget Justification Schedule B\***

\*USE IF APPLYING FOR COMPONENT 1 AND COMPONENT 2 FUNDING

**Applicant’s Organization Name**

**FUNDING PERIOD: 2/1/2020 to 8/31/2020**

**Contract Period: 2/1/2020-8/31/2023**

**Budget Justification Schedule B (part 2)**

**Program/Site:** Component 2/CDC

|  |  |  |
| --- | --- | --- |
| **Line Item (Description)** | **Amount** | **Justification including Breakdown of Costs** |
|       |       |       |
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**Position Schedule #2a**

\*USE IF APPLYING FOR COMPONENT 1 AND COMPONENT 2 FUNDING

**Applicant’s Organization Name**

**FUNDING PERIOD: 2/1/2020 to 8/31/2020**

**Contract Period: 2/1/2020-8/31/2023**

**Position Schedule #2a (part 1)**

**Component 1/HRSA**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Position Description and Staff Person Assigned** | **Site/ Location** | **Hours wk/ wks per Year** | **Hourly Rate** | **Total Salary Charged** | **Fringe Benefit Rate %** | **Total Fringe Benefits** |
| 1. Position:

Name:       |       |      /      |       |       |      % |       |
| 1. Position:

Name:       |       |      /      |       |       |      % |       |
| 1. Position:

Name:       |       |      /      |       |       |      % |       |
| 1. Position:

Name:       |       |      /      |       |       |      % |       |
| 1. Position:

Name:       |       |      /      |       |       |      % |       |
| 1. Position:

Name:       |       |      /      |       |       |      % |       |
| 1. Position:

Name:       |       |      /      |       |       |      % |       |
| 1. Position:

Name:       |       |      /      |       |       |      % |       |
| 1. Position:

Name:       |       |      /      |       |       |      % |       |
| 1. Position:

Name:       |       |      /      |       |       |      % |       |
| 1. Position:

Name:       |       |      /      |       |       |      % |       |
| 1. Position:

Name:       |       |      /      |       |       |      % |       |
| 1. Position:

Name:       |       |      /      |       |       |      % |       |
| 1. Position:

Name:       |       |      /      |       |       |      % |       |
| 1. Position:

Name:       |       |      /      |       |       |      % |       |
| 1. Position:

Name:       |       |      /      |       |       |      % |       |
| **Totals** |  |  |  |       |  |       |

**\*Attach resumes and job descriptions for all Professional Staff**

**Position Schedule #2a**

\*USE IF APPLYING FOR COMPONENT 1 AND COMPONENT 2 FUNDING

**Applicant’s Organization Name**

**FUNDING PERIOD: 2/1/2020 to 8/31/2020**

**Contract Period: 2/1/2020-8/31/2023**

**Position Schedule #2a (part 2)**

**Component 2/CDC**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Position Description and Staff Person Assigned** | **Site/ Location** | **Hours wk/ wks per Year** | **Hourly Rate** | **Total Salary Charged** | **Fringe Benefit Rate %** | **Total Fringe Benefits** |
| 1. Position:

Name:       |       |      /      |       |       |      % |       |
| 1. Position:

Name:       |       |      /      |       |       |      % |       |
| 1. Position:

Name:       |       |      /      |       |       |      % |       |
| 1. Position:

Name:       |       |      /      |       |       |      % |       |
| 1. Position:

Name:       |       |      /      |       |       |      % |       |
| 1. Position:

Name:       |       |      /      |       |       |      % |       |
| 1. Position:

Name:       |       |      /      |       |       |      % |       |
| 1. Position:

Name:       |       |      /      |       |       |      % |       |
| 1. Position:

Name:       |       |      /      |       |       |      % |       |
| 1. Position:

Name:       |       |      /      |       |       |      % |       |
| 1. Position:

Name:       |       |      /      |       |       |      % |       |
| 1. Position:

Name:       |       |      /      |       |       |      % |       |
| 1. Position:

Name:       |       |      /      |       |       |      % |       |
| 1. Position:

Name:       |       |      /      |       |       |      % |       |
| 1. Position:

Name:       |       |      /      |       |       |      % |       |
| 1. Position:

Name:       |       |      /      |       |       |      % |       |
| **Totals** |  |  |  |       |  |       |

**\*Attach resumes and job descriptions for all Professional Staff**

**Subcontractor Schedule A-Detail**

\*USE IF APPLYING FOR COMPONENT 1 AND COMPONENT 2 FUNDING

**Applicant’s Organization Name**

**FUNDING PERIOD: 2/1/2020 to 8/31/2020**

**Contract Period: 2/1/2020-8/31/2023**

**#1**

Subcontractor Name:

Address:

Telephone: (     ) (     -     )

Select One: **A** [ ]  Budget Basis **B** [ ]  Fee-for-Service **C** [ ]  Hourly Rate

Indicate One: [ ]  MBE [ ]  WBE [ ]  Neither

|  |  |  |  |
| --- | --- | --- | --- |
| **Program:** | **Comp 1** | **Comp 2** | **Total** |
| **Fund:** | **HRSA** | **CDC** |  |
| Line Item(s) |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
| **Total Subcontract Amount:** |  |  |  |

**#2**

Subcontractor Name:

Address:

Telephone: (     ) (     -     )

Select One: **A** [ ]  Budget Basis **B** [ ]  Fee-for-Service **C** [ ]  Hourly Rate

Indicate One: [ ]  MBE [ ]  WBE [ ]  Neither

|  |  |  |  |
| --- | --- | --- | --- |
| **Program:** | **Comp 1** | **Comp 2** | **Total** |
| **Fund:** | **HRSA** | **CDC** |  |
| Line Item(s) |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
| **Total Subcontract Amount:** |  |  |  |

**#3**

Subcontractor Name:

Address:

Telephone: (     ) (     -     )

Select One: **A** [ ]  Budget Basis **B** [ ]  Fee-for-Service **C** [ ]  Hourly Rate

Indicate One: [ ]  MBE [ ]  WBE [ ]  Neither

|  |  |  |  |
| --- | --- | --- | --- |
| **Program:** | **Comp 1** | **Comp 2** | **Total** |
| **Fund:** | **HRSA** | **CDC** |  |
| Line Item(s) |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
| **Total Subcontract Amount:** |  |  |  |

**Component 1 Work Plan Form**

Year 1 February 1, 2020 through August 31, 2020

(Maximum 6 sides of paper – 3 sheets double-sided for year 1 work plan table and narrative for years 2-3)

|  |  |  |  |
| --- | --- | --- | --- |
| **Activities** | **Staff Responsible** | **Deliverables** | **Time Frame****(Quarter 1,2,3 or 4)** |
|  |  |  |  |
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**Years 2 – 3 Narrative:**

**Component 2 Work Plan Form**

Year 1 February 1, 2020 through August 31, 2020

(Maximum 4 sides of paper – 2 sheets double-sided for year 1 work plan table and narrative for years 2-4)

|  |  |  |  |
| --- | --- | --- | --- |
| **Activities** | **Staff Responsible** | **Deliverables** | **Time Frame****(Quarter 1,2,3 or 4)** |
|  |  |  |  |
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**Years 2 – 4 Narrative:**

|  |  |
| --- | --- |
| armbear | **STATE OF CONNECTICUT****CONSULTING AGREEMENT AFFIDAVIT** |

*Affidavit to accompany a State contract for the purchase of goods and services with a value of $50,000 or more in a calendar or fiscal year, pursuant to Connecticut General Statutes §§ 4a-81(a) and 4a-81(b)*

**INSTRUCTIONS:**

**If the bidder or vendor has entered into a consulting agreement, as defined by Connecticut General Statutes § 4a-81(b)(1):**  Complete all sections of the form. If the bidder or contractor has entered into more than one such consulting agreement, use a separate form for each agreement. Sign and date the form in the presence of a Commissioner of the Superior Court or Notary Public. **If the bidder or contractor has not entered into a consulting agreement, as defined by Connecticut General Statutes § 4a-81(b)(1):** Complete only the shaded section of the form. Sign and date the form in the presence of a Commissioner of the Superior Court or Notary Public.

Submit completed form to the awarding State agency with bid or proposal. For a sole source award, submit completed form to the awarding State agency at the time of contract execution.

This affidavit must be amended if there is any change in the information contained in the most recently filed affidavit not later than (i) thirty days after the effective date of any such change or (ii) upon the submittal of any new bid or proposal, whichever is earlier.

**AFFIDAVIT:** [Number of Affidavits Sworn and Subscribed On This Day: \_\_\_\_\_]

I, the undersigned, hereby swear that I am a principal or key personnel of the bidder or contractor awarded a contract, as described in Connecticut General Statutes § 4a-81(b), or that I am the individual awarded such a contract who is authorized to execute such contract. I further swear that I have not entered into any consulting agreement in connection with such contract, **except for the agreement listed below**:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Consultant’s Name and Title Name of Firm (if applicable)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Start Date End Date Cost

Description of Services Provided: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is the consultant a former State employee or former public official? ⬜ YES ⬜ NO

If YES: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Name of Former State Agency Termination Date of Employment

Sworn as true to the best of my knowledge and belief, subject to the penalties of false statement.

|  |  |  |
| --- | --- | --- |
|  |  |  |
| Printed Name of Bidder or Vendor | **Signature of Chief Official or Individual** | **Date** |
|  |  |  |
|  |  | Dept. of Public Health |
|  | Printed Name (of above) | Awarding State Agency |

**Sworn and subscribed before me on this \_\_\_\_\_\_\_ day of \_\_\_\_\_\_\_\_\_\_\_\_, \_\_\_\_\_\_\_ .**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Commissioner of the Superior Court**

**or Notary Public**

**STATE OF CONNECTICUT**

**DEPARTMENT OF PUBLIC HEALTH**

OFFICE OF COMMISSIONER

**AFFIRMATIVE ACTION**

**CONTRACT COMPLIANCE POLICY STATEMENT**

The Department of Public Health (DPH) is an Affirmative Action/Equal Employment Opportunity employer, in compliance with all state and federal laws and shall comply with the Contract Compliance Regulations *and* CGS 4a-60 Nondiscrimination and affirmative action provisions in contracts of the state and political subdivisions other than municipalities. Consistent with the Contract Compliance Regulations of Connecticut State Agencies, Sections 46a-68j-21through 46a-68j-43, DPH encourages bidders, contractors, subcontractors, and suppliers to:

* Develop and follow a plan of affirmative action to achieve or exceed parity of employment with the applicable labor market
* Develop and follow an apprenticeship program complying with Sections 46a-68-1 to 46a-68-17 of the Administrative Regulations of Connecticut State Agencies, inclusive
* Submit employment statistics contained in the "Employment Information Form", indicating that the composition of its workforce is at or near parity when compared to the race/sex composition of the workforce in the relevant labor market area
* Develop and follow a plan to set aside a portion of the contract for legitimate minority business enterprises per Section 46a-68j-30(10)(E) of the Contract Compliance Regulations

DPH considers bidders success in these factors in reviewing the bidder's qualifications under the Contract Compliance requirements. Accordingly, any individual or organization that desires to do business with DPH shall:

* Not discriminate or permit discrimination against any protected class person or protected group in the performance of contracts
* Not engage in discriminatory practices *or* permit discriminatory practices in their workplace
* Cooperate with the Connecticut Commission *on* Human Rights and Opportunities in all activities
* In all contract solicitations or advertisements, state that they are an "affirmative action-equal opportunity employer"
* Sign a Notification to Bidders Form, and complete a workforce analysis questionnaire necessary for the contract award process

DPH notifies bidders, contractors, subcontractors, and suppliers of this policy and will not knowingly do business with any contractor, subcontractor or supplier of materials who unlawfully discriminates against members of any class protected under state or federal law. Contractors whose overall employment statistics are not reflective of the general employment area may be required to show good faith efforts to ensure that their personnel policies and practices do not have a discriminatory impact.



**NOTIFICATION TO BIDDERS**

The contract to be awarded is subject to contract compliance requirements mandated by Sections 4a-60 and 4a-60a of the Connecticut General Statutes; and, when the awarding agency is the State, Sections 46a-71 (d) and 46a-81i (d) of the Connecticut General Statutes. There are Contract Compliance Regulations codified at Section 46a-68j-21 through 46a-68j-43 of the Regulations of Connecticut State agencies, which establish a procedure for the awarding of all contracts covered by Sections 4a-60 and 46a-71 (d) of the Connecticut General Statutes.

According to Section 46a-68j-30 (9) of the Contract Compliance Regulations, every agency awarding a contract subject to the contract compliance requirements has an obligation to “aggressively solicit the participation of legitimate minority business enterprises as bidders, contractors, subcontractors and suppliers of materials.” “Minority Business Enterprise” is defined in Section 4a-60 of the Connecticut General Statutes as a business wherein fifty-one percent or more of the capital stock, or assets belong to a person or persons: “(1) Who are active in the daily affairs of the enterprise; (2) Who have the power to direct the management and policies of the enterprise; and, (3) Who are members of a minority, as such term is defined in subsection (a) of Section 32-9n.” “Minority” groups are defined in Section 32-9n of the Connecticut General Statutes as “(1) Black Americans ... (2) Hispanic Americans ... (3) Women ... (4) Asian Pacific Americans and Pacific Islanders; or (5) American Indians.” The above definitions apply to the contract compliance requirements by virtue of Section 46a-68j-21 (11) of the Contract Compliance Regulations.

The awarding agency will consider the following factors when reviewing the bidder’s qualifications under the contract compliance requirements.

1. the bidder’s success in implementing an affirmative action plan;
2. the bidder’s success in developing an apprenticeship program complying with Sections 46a-68-1 to 46a-68-18 of the Connecticut General Statutes, inclusive;
3. the bidder’s promise to develop and implement a successful affirmative action plan;
4. the bidder’s submission of EEO-1 data indicating the composition of its workforce is at or near parity when compared to the racial and sexual composition of the workforce in the relevant labor market area; and,
5. the bidder’s promise to set aside a portion of the contract for legitimate minority business enterprises. See Section 46a-68j-30 (10) (E) of the Contract Compliance Regulations.

**INSTRUCTION**: Bidder must sign acknowledgment below line and return acknowledgment to Awarding Agency along with the bid proposal.

The undersigned acknowledges receiving and reading a copy of the “Notification to Bidders” form.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Signature Date

On behalf of:

|  |
| --- |
| **WORKFORCE ANALYSIS** |
| Contractor Name: | Total Number of CT employees: |
| Address: | Full Time: | Part Time: |
|  |  |
| Complete the following Workforce Analysis for employees on Connecticut worksites who are: |
| Job Categories | Overall Totals(sum of all cols. male & female) | White(not of Hispanic Origin) | Black(not of Hispanic Origin) | Hispanic | Asian or Pacific Islander | American Indian or Alaskan Native | People withDisabilities |
|  | Male | Female | Male | Female | Male | Female | Male | Female | Male | Female | Male | Female |
| Officials &Managers |  |  |  |  |  |  |  |  |  |  |  |  |
| Professionals |  |  |  |  |  |  |  |  |  |  |  |  |
| Technicians |  |  |  |  |  |  |  |  |  |  |  |  |
| Office &Clerical |  |  |  |  |  |  |  |  |  |  |  |  |
| Craft Workers(skilled) |  |  |  |  |  |  |  |  |  |  |  |  |
| Operatives(semi-skilled) |  |  |  |  |  |  |  |  |  |  |  |  |
| Laborers(unskilled) |  |  |  |  |  |  |  |  |  |  |  |  |
| Service Workers |  |  |  |  |  |  |  |  |  |  |  |  |
| Totals Above |  |  |  |  |  |  |  |  |  |  |  |  |
| Totals 1 year Ago |  |  |  |  |  |  |  |  |  |  |  |  |
| FORMAL ON-THE-JOB TRAINEES (Enter figures for the same categories as are shown above) |
| Apprentices |  |  |  |  |  |  |  |  |  |  |  |  |
| Trainees |  |  |  |  |  |  |  |  |  |  |  |  |
| EMPLOYMENT FIGURES WERE OBTAINED FROM: | Visual Check: | Employment Records | Other: |
|  |
| 1. Have you successfully implemented an Affirmative Action Plan? [ ]  YES [ ]  NO Date of implementation:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ If the answer is “No”, explain.1. a) Do you promise to develop and implement a successful Affirmative Action? [ ]  YES [ ]  NO [ ]  Not Applicable Explanation:2. Have you successfully developed an apprenticeship program complying with Sec. 46a-68-1 to 46a-68-18 of the Connecticut Department of Labor Regulations, inclusive: [ ]  YES [ ]  NO [ ]  Not Applicable Explanation: |
| 3. According to EEO-1 data, is the composition of your work force at or near parity when compared with the racial and sexual composition of the work force in the relevant labor market area? [ ]  YES [ ]  NO Explanation: |

4. If you plan to subcontract, will you set aside a portion of the contract for legitimate minority business enterprises?

 [ ]  YES [ ]  NO Explanation:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Contractor’s Authorized Signature Date