DC | HEALTH

GOVERNMENT OF THE DISTRICT OF COLUMBIA

DEPARTMENT OF HEALTH

COMMUNITY HEALTH ADMINISTRATION &

OFFICE OF HEALTH EQUITY

Advancing Health Literacy to Reduce Health Disparities Related to COVID-19 and Preventable Disease

REQUEST FOR APPLICATIONS

RFA# CHA_AHLC_02.11.2022

SUBMISSION DEADLINE:

FRIDAY, MARCH 11, 2022, BY 6:00 PM

The Department of Health (DC Health) reserves the right without prior notice, to reduce or cancel one or more programs listed in this Request for Applications (RFA). DC Health reserves the right to reject all applications, adjust the total available funds or cancel the RFA in part or whole. Funding levels for the total program and budget amounts of individual awards shall be contingent upon continued receipt of funding by DC Health, as well as any reduction, elimination or reallocation of funds by a federal grantor, the Executive Office of the Mayor (EOM) and/or the Department of Health. Any adjustments shall be in accordance with authorizing legislation for the use of funds, all DC municipal regulations for grant-making and the applicable federal and DC Health terms of agreement.

DC DEPARTMENT OF HEALTH

Community Health Administration &
Office of Health Equity

NOTICE OF FUNDING AVAILABILITY (NOFA)

RFA# CHA_ AHLC_02.11.2022
Health Literacy and Health Disparities in COVID-19 Projects

The District of Columbia, Department of Health (DC Health) is requesting proposals from qualified applicants to provide services in the program and service areas described in this Notice of Funding Availability (NOFA). This announcement is to provide public notice of the Department of Health's intent to make funds available for the purpose described herein. The applicable Request for Applications (RFA) will be released under a separate announcement with guidelines for submitting the application, review criteria and DC Health terms and conditions for applying for and receiving funding.

General Information:

Funding Opportunity Title:	Advancing Health Literacy to Reduce Health Disparities Related to COVID-19 and Beyond
Funding Opportunity Number:	FO-CHA-PG-00004-059
Program RFA ID#:	CHA_AHLC_02.11.2022
Opportunity Category:	Competitive
DC Health Administrative Unit:	Community Health Administration
DC Health Program Bureau	Health Literacy and Health Disparities in COVID-19 Projects
Program Contact:	LaVerne H. Jones Public Health Advisor covid-19.vaccine@dc.gov
Program Description:	DC Health aims to close health literacy (HL) gaps in the District of Columbia, particularly among Black/African American residents and Limited English Proficient populations, who have been disproportionately affected by COVID-19; recognizing that closing health literacy gaps are essential to promoting health equity, decreasing disparities, and driving improved health outcomes more generally. To make this a reality, DC Health plans to build a comprehensive people-centered population Health Literacy model. Funding under this RFA will support the implementation of community-based culturally and linguistically appropriate equity-informed health literacy engagement and intervention efforts, designed to build trust, promote COVID-19

	health literacy and awareness, together with increased access to COVID-19 testing and vaccination resources.
Eligible Applicants	Community-based organizations licensed and operating in the District of Columbia.
Anticipated # of Awards:	6
Anticipated Amount Available:	$1,200,000
Annual Floor Award Amount:	$20,000
Annual Ceiling Award Amount:	$200,000

Funding Authorization

Legislative Authorization	42 U.S.C. § 300u-6, (Section 1707 of the Public Health Service Act)
Associated CFDA#	93.137
Associated Federal Award ID#	CPIMP211294-01-00
Cost Sharing / Match Required?	No
RFA Release Date:	February 11, 2022
Pre-Application Conference	Visit DC Health's Eventbrite page for the virtual meeting information, https://OGMDCHealth.eventbrite.com
Letter of Intent Due date:	Not applicable
Application Deadline Date:	March 11, 2022
Application Deadline Time:	6:00 p.m.
Links to Additional Information about this Funding Opportunity	DC Grants Clearinghouse https://communityaffairs.dc.gov/content/community-grant-program#4 DC Health EGMS https://dcDC Health.force.com/GO__ApplicantLogin2

Notes:

1. DC Health reserves the right to issue addenda and/or amendments subsequent to the issuance of the NOFA or RFA, or to rescind the NOFA or RFA.
2. Awards are contingent upon the availability of funds.
3. Individuals are not eligible for DC Health grant funding.
4. Applicants must have a DUNS #, Tax ID#, be registered in the federal Systems for Award Management (SAM) and the DC Health Enterprise Grants Management System (EGMS)
5. Contact the program manager assigned to this funding opportunity for additional information.

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District of Columbia Department of Health

RFA Terms and Conditions

v11.2016

The following terms and conditions are applicable to this and all Requests for Applications issued by the District of Columbia Department of Health (DC Health) and to all awards, if funded under this RFA:

A. Funding for a DC Health subaward is contingent on DC Health's receipt of funding (local or federal) to support the services and activities to be provided under this RFA.

B. DC Health may suspend or terminate an RFA pursuant to its own grant making rule(s) or any applicable federal regulation or requirement.

C. The RFA does not commit DC Health to make any award.

D. Individual persons are not eligible to apply or receive funding under any DC Health RFA.

E. DC Health reserves the right to accept or deny any or all applications if the DC Health determines it is in the best interest of DC Health to do so. An application will be rejected if it does not comply with eligibility requirements, formatting or submission requirements outlined in the RFA. DC Health shall notify the applicant if it rejects that applicant's proposal for review.

F. DC Health reserves the right to issue addenda and/or amendments subsequent to the issuance of the RFA, or to rescind the RFA. The prospective applicant is responsible for retrieving this information via sources outlined in the RFA (e.g. DC Grants Clearinghouse).

G. DC Health shall not be liable for any costs incurred in the preparation of applications in response to the RFA. The Applicant agrees that all costs incurred in developing the application are the applicant's sole responsibility. No funds already awarded the applicant under other instruments or agreements shall be used by the applicant to fund the preparation of the application.

H. DC Health may conduct pre-award on-site visits to verify information submitted in the application and to determine if the applicant's facilities are appropriate for the services intended.

I. DC Health shall determine an applicant's eligibility by way of local and federal registries for excluded parties searches and documents and certifications submitted by the applicant.

J. The Applicant Organization must obtain a Data Universal Numbering System (DUNS) number to apply for funding and register for the federal System for Award Management (SAM) at www.sam.gov prior to award.

K. DC Health reserves the right to require registry into local and federal systems for award management at any point prior to or during the Project Period. This includes DC Health electronic grants management systems, for which the awardee will be required to register and maintain registration of the organization and all users.

L. DC Health may enter into negotiations with an applicant and adopt a firm funding amount or other revision of the applicant's proposal that may result from negotiations.

M. DC Health shall establish terms of agreement for an award funded under this RFA. If funded, the applicant will receive a Notice of Grant Award (NOGA). The NOGA will establish the Project Period (i.e., the total number of years for which funding has been approved) and define any segments of the Project Period (e.g. initial partial year, or a 12-month budget period). The NOGA shall outline conditions of award or restrictions.

N. Continuation of funding, if awarded shall be based on availability of funds, documented satisfactory progress in interim and annual reports, continued eligibility and determination that the continued funding and activities is in the best interest of the District of Columbia.

O. DC Health shall provide the citations to the local or federal statute/s and implementing regulations that authorize the award; all applicable District of Columbia and Federal regulations, including OMB Circulars 2 CFR 200 (effective December 26, 2014) and Department of Health and Services (HHS) published 45 CFR Part 75, and supersedes requirements for any funds received and distributed by DC Health under legacy OMB circulars A-102, A-133, 2 CFR 180, 2 CFR 225, 2 CFR 220, and 2 CFR 215; payment provisions identifying how the awardee will be paid for performing under the award; reporting requirements, including programmatic, financial and any special reports required by the funding Agency; and compliance conditions that must be met by the awardee.

P. If there are any conflicts between the terms and conditions of the RFA and any applicable federal or local law or regulation, or any ambiguity related thereto, then the provisions of the applicable law or regulation shall control and it shall be the responsibility of the applicant to ensure compliance.

Additional information about grants management policy and procedures may be obtained at the following site: https://oca.dc.gov/page/division-grants-management or click here: Citywide Grants Manual and Sourcebook.

If your agency would like to obtain a copy of the **DC Health RFA Dispute Resolution Policy,** please visit the DC Health Office of Grants Management webpage, here. Any additional questions regarding the RFA Dispute Resolution Policy may be directed to doh.grants@dc.gov. Your request for this document will not be shared with DC Health program staff or reviewers.

1. CHECKLIST FOR APPLICATIONS

☐ Applicants must be registered in the federal Systems for Award Management (SAM) and the DC Health Enterprise Grants Management System (EGMS).
☐ Complete your EGMS registration **two weeks** prior to the application deadline.
☐ Start constructing and uploading your application components into EGMS at least a week prior to the application deadline.

- The complete **Application Package** should include the following:
    - Certificate of Clean Hands dated within 60 days of the application deadline
    - Current business license or certificate of licensure or proof to transact business in local jurisdiction
    - Current Certificate of Insurance
    - Copy of Cyber Liability Policy
    - IRS Tax-Exempt Determination Letter (for nonprofits only)
    - IRS 990 Form from most recent tax year (for nonprofits only)
    - Current list of Board of Directors, on letterhead, signed and dated by a certified official from the Board (this cannot be the Executive Director)
    - Assurances, Certifications and Disclosures (Appendix B)
    - Project Narrative
    - Proposal Abstract
    - Budget Table
    - Budget Justification
    - Organization Chart
    - Work Plan
    - Staffing Plan
    - Two (2) Letters of Commitment

☐ Documents requiring signature have been signed by an agency head or AUTHORIZED Representative of the applicant organization.
☐ The Applicant needs a DUNS number to be awarded funds. Go to Dun and Bradstreet to apply for and obtain a DUNS # if needed.
☐ The Project Narrative is written on 8½ by 11-inch paper, **1.0 spaced**, **Arial or Times New Roman font using 12-point type** *(11 –point font for tables and figures)* **with a minimum of one-inch margins**. **Applications that do not conform to these requirements will not be forwarded to the review panel.**
☐ The application proposal format conforms to the "Proposal Components" (See section 6.2) listed in the RFA.
☐ The proposed budget is complete and complies with the budget forms provided in the RFA. The budget narrative is complete and describes the categories of items proposed.
☐ The proposed work plan and other attachments are complete and comply with the forms and format provided in the RFA.
☐ Submit your application via EGMS by **6:00pm** on the deadline of **03/11/2022.**

2. GENERAL INFORMATION

2.1 KEY DATES

- Notice of Funding Announcement Date: **January 28, 2022**
- Request for Application Release Date: **February 11, 2022**
- Pre-Application Meeting Date: **visit https://OGMDCHealth.eventbrite.com**
- Application Submission Deadline: **March 11, 2022**
- Anticipated Award Start Date: **May 1, 2022**

2.2 OVERVIEW

The mission of DC Health is to promote health, wellness, and equity across the District and protect the safety of residents, visitors, and those doing business in the nation's capital. The agency is responsible for identifying health risks; educating the public; preventing and controlling diseases, injuries, and exposure to environmental hazards; promoting effective community collaborations; and optimizing equitable access to community resources.

DC Health's Office of Health Equity, Community Health Administration, and Office of Communication and Community Relations will jointly lead the Advancing Health Literacy to Reduce Health Disparities Related to COVID-19 and Preventable Disease Program, with the goal of closing health literacy gaps to advance health equity and improve outcomes in COVID-19 and other preventable diseases. The three offices will leverage their experience and expertise in community engagement, health messaging, strategic planning and program development and implementation to support community-based organizations in addressing gaps in knowledge about disease prevention, health care management and health communications.

The Office of Health Equity (OHE) addresses the root causes of health disparities, beyond healthcare and health behaviors, by supporting projects, policies and research that will enable every resident to achieve their optimal level of health -- regardless of where they live, learn, work, play or age. The OHE achieves its mission by informing, educating, and empowering people about health issues and facilitating multi-sector partnerships to identify and solve community health problems related to the social determinants of health.

The Community Health Administration (CHA) promotes healthy behaviors and healthy environments to improve health outcomes and reduce disparities in the leading causes of mortality and morbidity in the District. CHA's approach targets the behavioral, clinical, and social determinants of health through evidence-based programs, policy, and systems change with an emphasis on vulnerable and underserved populations.

DC Health's Office of Communications and Community Relations (OCCR) guides the Agency's internal and external communication, which includes the use of logos and marks, visual identity, media relations, interviews, social media, crisis/risk communication, language access, website, distribution of mass emails, community relations activities, displays and signage. OCCR has developed these guidelines for the effective management of DC Health's communications efforts, and shall routinely communicate these to all Agency staff, partners and grantees. While DC Health Senior Deputy Directors, managers, and staff serve as the subject matter experts for programs/services, OCCR will lead the branding process by working with each Administration

to ensure that the proper communication tools are used to disseminate messaging and highlight the successes of each entity and, ultimately, DC Health.

DC Health is committed to proactively leading and engaging District partners in eliminating health disparities, achieving health equity, and attaining health literacy to improve the health and well-being of all residents. In doing so, we apply the updated equity informed national framework focused on addressing both personal health literacy and organizational health literacy, as defined below.

Personal Health Literacy

Personal health literacy refers to the degree to which individuals are able to find, understand, and use information and services to inform health-related decisions and actions for themselves and others.[1] This new definition, introduced in Healthy People 2030, shifts the focus from people's ability to just understand health information to ensuring that people can also apply it to guide well-informed, health-related decisions for themselves and others.

Organizational Health Literacy

Organizational health literacy refers to the degree to which organizations equitable engage individuals to find, understand, and use information and services to inform health-related decisions and actions for themselves and others.[2] By adopting this definition, the public health community acknowledges that the producers of health information and services have a responsibility to advance the personal literacy of the communities that they serve.

Social Determinants of Health

[1] "How Does Healthy People Define Health Literacy." Office of Disease Prevention and Health Promotion. Office of Disease Prevention and Health Promotion. Accessed January14, 2022. https://health.gov/our-work/healthy-people/healthy-people-2030/health-literacy-healthy-people-2030

[2] "How Does Healthy People Define Health Literacy." Office of Disease Prevention and Health Promotion. Office of Disease Prevention and Health Promotion. Accessed January14, 2022. https://health.gov/our-work/healthy-people/healthy-people-2030/health-literacy-healthy-people-2030 Office of Disease Prevention and Health Promotion. Accessed January14, 2022. https://health.gov/our-work/healthy-people/healthy-people-2030/health-literacy-healthy-people-2030

The public health community has long understood that there is a link between the health of populations and communities, as well as individual residents and social determinants of health, including the social, environmental, and economic conditions within which they reside and interact. Social determinants of health include factors related to education, employment, income, housing, transportation, access to healthy food, access to health care, outdoor environment, and community safety, and the structural context within which they interact. Systemic racism operates at different levels of society and is the driving force behind health inequities. To address health outcomes associated with social determinants of health, applicants should understand the role these factors play in individual and community health and strive to implement small, focused interventions that consider and aim to address the impacts of social determinants of health.

In order to achieve health equity, or the highest level of health for all District residents, we must be intentional about addressing social and structural determinants of health and eliminating health disparities.

2.3 Source of Grant Funding

Funding is made available under the Federal Award Identification CPIMP211294, Advancing Health Literacy in the District of Columbia to Enhance Equitable Community Responses to COVID-19, and NH231P922596, Immunizations and Vaccine for Children-COVID and VFC Supplemental Funds.

2.4 AWARD INFORMATION

2.4.1 Amount of Funding Available

The total funding amount of $1,200,000 will be made available for up to six (6) awards for a project period of two years. Funding in the second project year will be commensurate with the level of effort required.

2.4.2 Performance and Funding Period

The projected project period is May 1, 2022 – April 30, 2024. Year 1 budget period is May 2022 – April 2023. After the first 12-month budget period, there will be up to one more budget period. The number of awards, budget periods and award amounts are contingent upon the continued availability of funds and recipient performance.

2.4.3 Eligible Organizations/Entities

Community-based organizations, licensed and operating in the District of Columbia, are eligible for this award. Priority will be given to those organizations with a demonstrated track record of successfully working with the priority population and demonstrated impact/improvement in at least one social determinant of health.

2.4.4 Non-Supplantation

Recipients may supplement, but not supplant, funds from other sources for initiatives that are the same or similar to the initiatives being proposed in this award.

2.4.5 Application Page Limit

The Project Narrative should not exceed **ten (10) pages**.

3. BACKGROUND

3.1 Demographic Overview

The District of Columbia (DC or the District) is an ethnically diverse and compact geographic area measuring 61 square miles and comprised of a population of 705,749 residents. This represents a 21% increase since 2000 (579,059)[3]. The District of Columbia is divided into eight geographical wards, with the smallest population in Ward 2 (77,855 residents) and the largest population in Ward 6 (99,786 residents). Wards 3 and 4 have the largest proportion of adults ages 18-64 at 18% and 15%, respectively. Wards 7 and 8 have the largest proportion of youth aged 0-18 (24% and 30%). Lastly, the wards with the largest proportions of adults over age 65 are Wards 1 and 2 (80% and 84%).

While the median household income in the District is $86,420, Wards 7 and 8 have median income levels at $44,318 and $35,245, respectively, demonstrating the economic disparities that exist in the city. In addition, educational attainment varies across the geographic locations in the District with 12% and 17% of Ward 7 and Ward 8 residents, respectively, attaining a bachelor's degree or higher, compared to 87% of Ward 3 residents and 86% of Ward 1 residents.[4]

[3] https://data.census.gov/cedsci/table?q=&t=Age%20and%20Sex&g=0400000US11&y=2019&tid=ACSST1Y2019.S0101

[4] U.S. Census Bureau; American Community Survey, 2019 American Community Survey 5-Year Estimates, Tables S0101, B02001, S1901, S1501

Table 1: ACS 5-years (2015-2019) Average Estimations.

Ward	Population	Youth aged 0- 18	Adults aged 18-64	Adults 65 and older	Black/ African American	White	All Hispanic	Median Household Income	Educational Attainment (Bachelor's Degree or Higher) Among Population 25 years and over
1	83,811	13%	7%	80%	28%	53%	19%	$102,882	71%
2	77,855	6%	10%	84%	10%	73%	12%	$111,064	86%
3	82,737	16%	18%	66%	8%	79%	11%	128,670	87%
4	89,992	22%	15%	63%	49%	30%	22%	$94,810	52%
5	90,172	17%	14%	69%	63%	27%	10%	$71,782	49%
6	99,786	14%	10%	75%	30%	61%	7%	$114,363	75%
7	81,946	24%	13%	63%	92%	3%	3%	$45,318	21%
8	86,384	30%	9%	61%	89%	6%	4%	$35,245	17%

The DC Health inaugural Health Equity Report (2018), which introduced a 51-statistical neighborhood (51-SN) method of analysis, highlighted improved but disparate health outcomes in the District. These disparities are primarily tied to differences in income, place, and race. A racial dissimilarity index (RDI) score of 70.9 underscored the extent of racial and economic segregation. A 21-year difference between the neighborhood with the highest life expectancy and that with the lowest, correlated with inequity across social and structural determinants, and persistent, disproportionate health outcomes that negatively affect black and brown populations and neighborhoods.

3.2 COVID-19 Disproportionate Impact on Populations & Geographic Areas

Preexisting socioeconomic inequities, layered with COVID-19, have accentuated disparities among vulnerable populations and health outcomes have followed anticipated patterns. Cumulative incidence, mapped to 51-SN show differential rates and spread. Early rates in the pandemic showed Black/African American residents dying almost 7 times more often than Hispanic/Latinx and non-Hispanic (NH) white residents. This rate has remained consistent throughout the pandemic. Most deaths occurred in the 60+ age range and geographically concentrated to the east/southeast, where vaccination rates are the lowest in the city. In contrast, low prevalence and death rates and high vaccine uptake rates typify the northwest section of the city, populated predominately by NH white residents.

In 2020, COVID-19 was the 3rd leading cause of death in the District (Figure 1). While the remaining leading causes of death were similar to those observed in 2019, there were increases in deaths due to other causes such as:

- **Diabetes Mellitus**: Deaths up by **36%** in 2020, compared to 2019.

- **Accidents:** Including deaths due to drug overdoses, up by **29%** in 2020 as compared to 2019.
- **Influenza and Pneumonia:** Deaths up by **20%** in 2020, compared with 2019.
- **Assault (Homicide):** Deaths up by **20%** in 2020, compared with 2019.
- **Chronic Lower Respiratory:** Deaths up by **18%** in 2020, compared with 2019.
- **Heart Diseases:** Deaths up by **12%** in 2020, compared 2019.

Possible reasons for these increased number of non-COVID-19 deaths include poor continuity of preventative and chronic disease care management, higher incidence of risk behaviors due to pandemic-related stress and trauma, or lower quality of high acuity healthcare delivery services due to healthcare resources being focused on the COVID-19 pandemic.

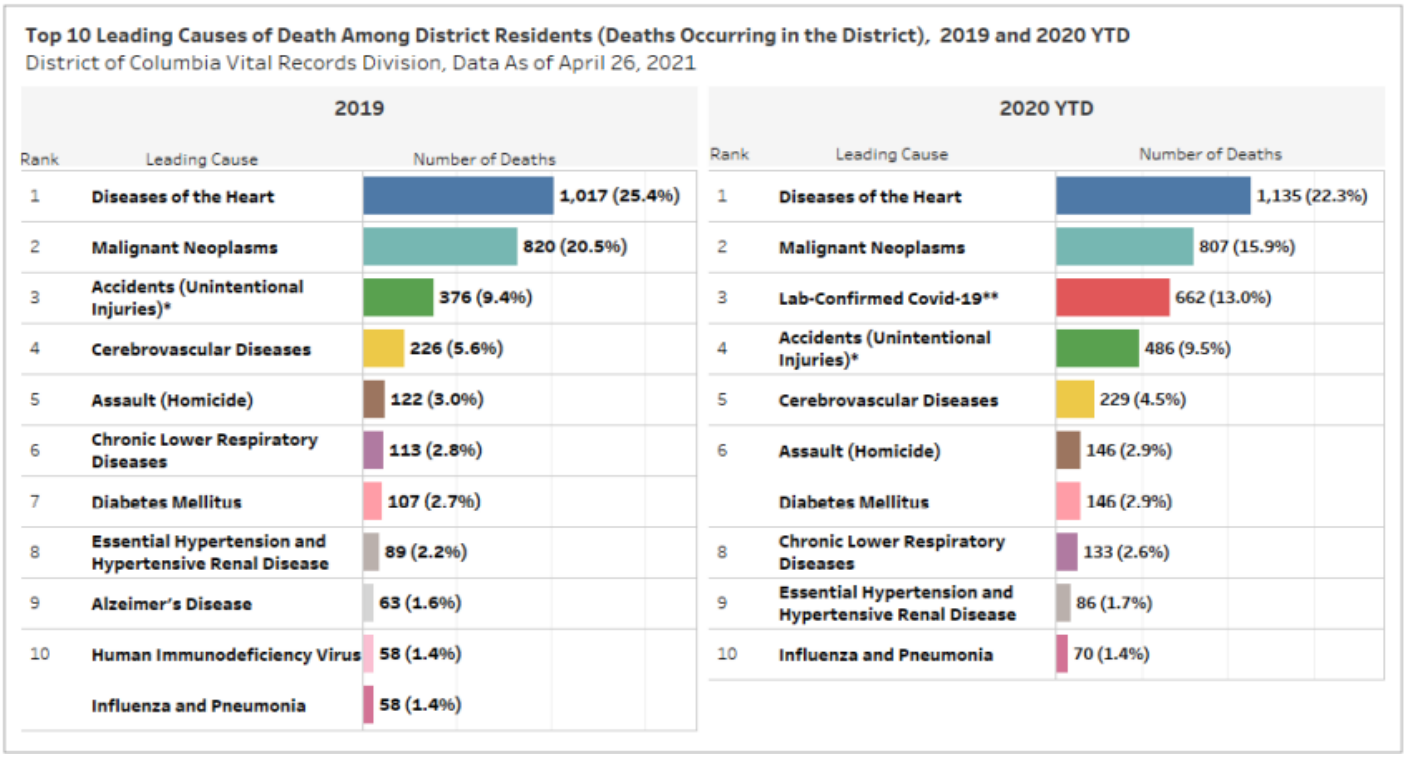

Figure 1: Preliminary Assessment of Leading Causes of Death in 2020 Among DC Residents[5]

[5] Data Source: 2019 and 2020 YTD DC Mortality Data; Vital Records Division, Center for Policy Planning and Evaluation, D.C. Department of Health; data as of 4/26/21. Data are preliminary and subject to change. The 2020 District resident death count is likely an undercount because some death records for deaths occurring in Jan-July 2020 may not have been filed yet. Deaths to DC-residents that occurred in other states are not included, because DC VRD has not yet received ICD-10 cause of death codes for many of these records. Leading cause categories are based on underlying cause of death ICD-10 codes; these codes were grouped according to the National Center for Health Statistics (NCHS) Selected 113 Cause of Death categories (dc.gov/nchs/data/nvsr/nvsr68/nvsr68_06-

These inequities and disparities were exacerbated by the COVID -19 pandemic. Black/African American residents were more likely to be diagnosed with the disease and to die from it. In an effort not to return to the "pre-pandemic" normal, DC Health seeks to improve strategies that address all health needs in the District with a focus on health equity and the underlying causes of health disparities.

3.3 Health Disparities

Racial and ethnic minorities, and other groups that experience health disparities continue to bear disproportionate burdens of disease and illness, despite scientific and technological discoveries that have improved the health of the U.S. population overall. Social determinants of health—the conditions in which people are born, grow, live, work, and age—shape individual, community, and population health and wellbeing across the life course. Populations that experience health disparities generally have higher levels of cumulative exposure to adverse social and structural factors such as poverty, lower-quality education, less access to healthy food, chronic and acute psychosocial stress, less access to health care resources, and lifelong exposure to discrimination and structural racism, in addition to physical, biological and environmental hazards.

Conversely, access to the health promoting aspects of the environment, such as opportunities for health-enhancing physical activity and buffers against hazardous exposures, is often disproportionately lower in these populations. Inequitable distribution of health-promoting social determinants across various populations is understood as a significant contributor to persistent and pervasive health disparities and inequities. A focus on health equity calls for reducing or eliminating factors that put populations experiencing health disparities at a disadvantage, and for increasing factors that increase the likelihood for achieving positive health outcomes. Tackling the complex drivers of health disparities requires strong partnerships between researchers, community representatives, community organizations, health service providers, public health agencies, policymakers, and other stakeholders to ensure that relevant and culturally/contextually appropriate programs and services are delivered and that sustainable community- and system-level changes that promote health equity are implemented and evaluated.

In addition to engaging underserved populations and/or populations at increased risk through culturally acceptable approaches, interventions, and implementation strategies to reduce health disparities must address the life circumstances and social, cultural, and structural environments that may pose challenges to reducing health risks. Interventions are not likely to produce sustained reductions in population health risk if they are solely focused on individual-level knowledge, attitudes, behaviors, or risk factors. Multilevel intervention components that address two or more levels of influence on health and behavioral outcomes and that involve peers, social networks, partners, family members, school systems, community members, community- or faith-based organizations, healthcare systems, community clinics, and service providers, are needed.

508.pdf). In 2020 YTD, 77% of deaths were due to the Top 10 Leading Causes, and in 2019, 75% of deaths were due to the Top 10 Leading Causes.

3.4 HEALTH LITERACY

One of the overarching goals of Healthy People 2030 is to "eliminate health disparities, achieve health equity, and attain health literacy to improve the health and well-being of all." The national initiative addresses both personal health literacy and organizational health literacy and defines them as:

- **Personal health literacy** is the degree to which individuals have the ability to find, understand, and use information and services to inform health-related decision and actions for themselves and others.
- **Organizational health literacy** is the degree to which organizations equitable enable individuals to find, understand and use information and services to inform health-related decisions and actions for themselves and others.

These revised health literacy definitions emphasize an individual's ability to *use* health information rather than simply understand it and acknowledges that organizations have a responsibility to address health literacy.[6]

Low health literacy has been linked to poorer health outcomes, increased hospitalization and readmission, lower rates of preventative care services and less healthy choices. Research has shown that health literacy interventions can result in improved health literacy and lead to changes in health behavior.

Health literacy offers a roadmap to vaccine confidence and acceptance. This is critical because up-to-date vaccination (vaccination and boosters) is key to reducing hospitalizations and protecting the health of communities. The effect of health literacy on vaccination influences attitudes and perceptions and bridges trust in the vaccine and the vaccinator, driving the decision to get vaccinated. Vaccine literacy expands the health literacy roadmap to creating simpler communication systems that integrate vaccination as an integral part of health systems.[7] Gathering information about vaccination that can be understood leads to informed decision making, independent of social and economic needs. Communication and knowledge dissemination align with the principles of health literacy. In addition to increasing vaccine confidence, health literacy strategies promote uptake of recommended vaccines for adults and children.

3.5 COMMUNITY-BASED ORGANIZATIONS

DC Health has identified community-based organizations (CBOs) as key partners in the advancement of health literacy in the District, with the aim to reduce health disparities. Many CBOs deliver services that are culturally tailored and respond to the social and economic needs that impact District residents. They are often in regular contact with residents, building

[6] https://health.gov/our-work/national-health-initiatives/healthy-people/healthy-people-2030/health-literacy-healthy-people-2030

[7] Biasio L. R. (2019). Vaccine literacy is undervalued. *Human vaccines & immunotherapeutics*, *15*(11), 2552–2553. https://doi.org/10.1080/21645515.2019.1609850

trust, comfort, and rapport. CBOs provide information to residents on how to identify and navigate local resources and are uniquely positioned to connect residents with health resources.

4. PURPOSE

DC Health seeks proposals from qualified community-based organizations (CBOs) that will serve as a bridge between the community and health care organizations by working collaboratively with DC Health and other community stakeholders to identify and implement health and vaccine literacy best practices to drive organizational practice change and increase vaccine confidence and uptake to reduce health disparities and improve health outcomes overall across the District. The purpose of this funding is to support and demonstrate use of sustainable interventions to close health literacy (HL) gaps, particularly among Black/African American residents (45.4%) and Limited English Proficient populations (5.7%), critical to increasing vaccine confidence and improving outcomes for COVID-19 and preventable disease. Community-based organizations are requested to develop and implement strategies to provide information to residents that help them make well-informed health decisions and to link them to resources that facilitate and make these choices easier. Health literacy strategies transcend specific diseases, and while the immediate goal is to reduce COVID-19 disparities and improve vaccination/booster uptake, the purpose of this intervention is to increase capacity for CBOs to be health literate organizations in their communities. Organizations should develop strategies to:

- Improve COVID-19 vaccination uptake, as identified in the District of Columbia Immunization Information System (DOCIIS), among priority populations
- Increase COVID-19 testing rates among priority populations
- Increase vaccine confidence by addressing vaccine mistrust
- Increase the percentage of individuals among the priority populations receiving and using vaccine literacy, COVID-19 information and beyond
- Increase the number of referrals to chronic disease prevention and management programs
- Increase the number of residents attending health promotion workshops on topics including but not limited to COVID-19, and
- Improve the overall knowledge and self-efficacy of residents on various health-related topics

Applicants must demonstrate their organizational capacity to implement program strategies in one or both of the following focus areas:

FOCUS AREA 1:

Organizational Health Literacy Assessment and Capacity Expansion

Applicants should address how CBOs shall adopt, adapt, and scale health literacy strategies to improve prevention and management of preventable diseases, including but not limited to COVID-19. Organizations will be required to conduct an organizational health literacy self-assessment at the start of the intervention. Based on the results of the self-assessments, a health literacy plan must be developed and implemented based recommendations from DC Health and national advisors. Periodic reporting on key indicator data points outlined below will

provide information on the CBO intervention impact on COVID-19 mitigation and other health-related outcomes.

FOCUS AREA 2:

Training and Education to Promote Personal Health Literacy for Residents
Applicants should identify and implement organizational health literacy strategies that are most effective in improving health outcomes including COVID-19 vaccination/booster uptake and participation in chronic disease prevention and management programs among residents from diverse populations and with disparate health outcomes. Organizations shall include as a routine part of their regular program operation, steps to providing information on COVID-19 testing and mitigation and preventable disease to the residents whom they serve.

5. PERFORMANCE REQUIREMENTS

Applicants should propose projects that meet the criteria listed below.

5.1 TARGET POPULATION

Projects shall focus on Black/African American residents and Limited English Proficient populations whose health outcomes have been adversely and disproportionately impacted by COVID-19. Preexisting inequities due to longstanding marginalization, layered with COVID-19, have accentuated disparities among vulnerable populations, and health outcomes have followed anticipated patterns. The highest incidence rates of COVID-19 occurred proximal to immigrant communities and correlated with the highest infection rates among Latinx residents during the first and second waves. In the third wave, infection rates were highest in the south-eastern neighborhoods of the city and among Black/African American residents.
Black/African American residents also accounted for a disproportionate number of deaths compared to other racial and ethnic groups in DC. The primary geographic focus are Wards 4, 5, 7, and 8, where most vulnerable populations that have the highest rates of spread, infection, and mortality live.

5.2 LOCATION OF SERVICES

Interventions must be provided within community settings in the District of Columbia, which could include but are not limited to faith-based, service, and social organizations, serving residents of DC.

5.3 SCOPE OF WORK

The applicant shall implement a targeted, community-led approach to advancing health literacy by engaging the priority population (Black/African American residents, residents with limited English proficiency, residents of Ward 4, 5, 7, & 8) to build relationships and leverage resources within the community.

Closing health literacy gaps are essential to promoting health equity. Using health literacy best practices identified by DC Health and the Advancing Health Literacy Learning Collaborative, the applicant shall integrate organizational strategies to decrease health disparities and drive

improved health outcomes across the District. The applicant shall engage the priority populations to break down barriers to accessing health information including but not limited to, COVID-19 testing and mitigation, services related to the social and economic needs, and health care access. All strategies for the selected components should build the foundation for sustainable interventions that can be shared, duplicated, and/or expanded with minimal resources beyond the life of the grant.

Projects must document or demonstrate meaningful collaboration and partnership with local community-engaged leaders and change agents that represent the communities/populations of focus and that will be essential for development of strategic initiatives as well as acceptance, uptake, and sustainability of interventions and services proposed. Applicants should provide details on the nature and extent of their partnerships, including clearly describing the roles and responsibilities of partners and providing evidence of support from partner organizations.

5.4 PROGRAM STRATEGIES

The applicant shall implement activities during the two-year program period to support the following strategies as aligned with anticipated outcomes of the project:

- Increase the identification of effective approaches for improving health outcomes with the ultimate goal of promoting dissemination, adoption and sustainability of these approaches
- Reduce the differences in health that occur by categories such as gender, race or ethnicity, income and education, disability, neighborhood, or sexual orientation, informed by the target populations identified by the Disparity Impact Statement
- Improve health indicators that align with Healthy People 2030 objectives:
    - HC/HIT-01: Increase the proportion of adults whose health care provider checked their understanding
    - HC/HIT-02 Reduce the proportion of adults who report poor patient and provider communication
    - HC/HIT-03: Increase the proportion of adults whose health care providers involved them in them in decisions as much as they wanted
    - IID-D02: Increase the proportion of people with vaccination records in an information system
- Improve access and utilization of health care.

To accomplish the outcomes outlined above, applicants must

- Develop an organizational health literacy plan
- Participate actively in the Advancing Health Literacy Learning Collaborative (AHLC) meetings in order to engage with other community-based organizations and share best practices around building continuous organizational capacity to advance health literacy and address health disparities
- Complete regular reporting including monthly programmatic and financial reporting and end of year report
- Develop and submit a success story on the program's impact in the community to advance health literacy and reduce health disparities, including COVID-19; and

- Select and implement activities from one or both of the focus areas below

Focus Area 1: Organizational Health Literacy Assessment and Expansion
Applicants shall address how CBOs can adopt, adapt, and scale health literacy strategies to improve prevention and management of preventable diseases, including but not limited to COVID-19.

A. Organizations shall conduct an organizational health literacy assessment at the start of the intervention and periodically report on the following data points:

- **What is the organizational reach?**
  This includes data on the number, type and demographics of the residents served by your organization.
- **Where is community resource and education information distributed in the District?**
  This includes physical places where residents can access information about the health education resources and support services that organizations offer. Examples include but are not limited to organization headquarter/satellite locations, public libraries, workplace sites, places of worship, and retail locations including corner stores, grocery stores, pharmacies. Ascertaining this information would require gathering information from residents (i.e., surveys, interviews) on how they access education materials at these places
- **What digital communication outlets/tools do District residents use/access?**
  This includes places where residents can access information about the health education resources and support services that an organization offers including organizational website and social media. This could include surveying the residents your organization serves on Wi-Fi, smartphone, and computer/tablet access.
- **Where do residents access (retrieve and/or receive) informal health and service – related information?**
  This includes assessing which communication channels residents are accessing information and misinformation regarding COVID-19 disease and vaccination (i.e., community-based organizations, community recreation centers, community clinics, libraries, internet, hospitals, family, peers etc.)
- **What is the organizational staff health literacy?**
  This includes data on health communication and health literacy training for organizational staff that serve clients and communicate with District residents, and how staff are evaluated.
- **What health education initiatives are implemented by the CBO?**
  This includes the aims and descriptions of health education initiatives (must include bur not limited to initiative addressing COVID-19 vaccine uptake), health literacy technique used (i.e., availability in multiple languages, availability through multiple communication channels, etc.), and evaluation of impact (i.e., teach-back method, pre/post-test, etc.)

B. Using data (referenced above) to drive intervention strategies, the CBOs shall implement a customized organizational health literacy plan to combat misinformation about COVID-19 and/or COVID-19 vaccination, chronic disease management and accessing services to support improved health outcomes.

- **Develop a toolkit for advancing organizational health literacy**
  With technical assistance from DC Health, assemble tools to facilitate implementation of the organizational health literacy plan including communication strategies to address COVID-19 vaccine hesitancy; tolls including digital and print media and community engagement protocols for information dissemination.
- **Support social marketing campaigns**
  Engage residents in developing and implementing a social media campaign to disseminate targeted messages related to COVID-19 vaccination and boosters to key audiences including youth and residents with limited English proficiency.
- **Trusted Messengers Media Campaign (Optional)**
  Establish a team of trusted messengers who can be trained to deliver a media campaign using health literacy principles and best practices.

<u>Focus Area 2:</u> Training and Education to Promote Personal Health Literacy for Residents

Applicants should implement organizational health literacy strategies that are most effective in improving vaccination/booster uptake and participation in chronic disease prevention and management in diverse populations with disparate health outcomes. Organizations shall include as a routine part of their regular program operation, steps to providing information on COVID-19 testing and mitigation and preventable disease to the residents whom they serve.

- Implement customized organizational health literacy plan (examples include "train the trainer" model for organizational staff on health literacy that they may provide residents accurate information and know what resources to link them to and training on the teach back method to measure clients' understanding of the information shared).
- Implement customized social determinants of health (SDOH) assessment and referral process for your organization
- Track and report to DC Health the outcomes of SDOH assessments for DC residents
- Develop referral workflow for District residents into COVID vaccination appointments
- Disseminate DC Health COVID-19 messaging in priority populations including Wards 4, 5, 7, and 8 using tailored materials and various/appropriate media channels (print, web, social media, video, etc.)
- Utilize trusted members of the community such as Community Health Workers (CHWs), outreach workers, faith-based leaders, health educators, community leaders etc. to promote COVID-19 health literacy and connect District residents to COVID-19 testing (e.g., pop-up testing sites, churches, recreation centers, TestYourself DC etc.) and vaccination services within priority Wards
- Develop referral workflow for District residents into chronic disease self-management programs
- Partner with DC Health to host Chronic Disease Self-Management Workshops and attend training
- Plan events (in person or virtual) to advance health literacy (topics examples include COVID-19 vaccine hesitancy, how to locate quality health information online, talking to

your doctors and other health care providers and questions to ask to get the most out of your visit, and understanding your prescription and speaking with your pharmacist)
- Develop an evaluation plan to assess effectiveness of strategies, with technical assistance (TA) support from the DC Health evaluation team.
- (Optional) Partner with the education community to train and educate parents of school-age children using personal health literacy principles and best-practices to improve vaccine confidence

6. APPLICATION REQUIREMENTS

6.1 Eligibility Documents

Certificate of Clean Hands

This document must be dated within 60 days of the application deadline.

Current Business License

A business license issued by the Department of Consumer and Regulatory Affairs or certificate of licensure or proof to transact business in local jurisdiction.

Current Certificate of Insurance

This document must be issued by your insurance company. All DC Health grantees must meet the minimum insurance requirements as outlined in Appendix A: Minimum Insurance Requirements. Should an applicant be awarded the grant, the Office of Risk Management will conduct a review of exposures of the grantee organization based off the final approved workplan and may make changes to the insurance requirements.

Copy of Cyber Liability Policy

This document must be issued by your insurance company. All DC Health grantees must meet the minimum insurance requirements as outlined in Appendix A: Minimum Insurance Requirements. Should an applicant be awarded the grant, the Office of Risk Management will conduct a review of exposures of the grantee organization based off the final approved workplan and may make changes to the insurance requirements.

IRS Tax-Exempt Determination Letter

This applies to nonprofits only.

IRS 990 Form

This must be from the most recent tax year. This applies to nonprofits only.

Current List of Board of Directors, on letterhead, signed and dated by a certified official from the Board.

This CANNOT be signed by the executive director.

Assurances, Certifications and Disclosures

This document must be signed by an authorized representative of the applicant organization. (Appendix B: Assurances, Certifications and Disclosures).

Note: Failure to submit **ALL** of the above attachments, including mandatory certifications, will result in a rejection of the application from the review process. The application will not qualify for review.

6.2 PROPOSAL COMPONENTS

PROJECT NARRATIVE (10-page limit)

Background

Applicants must provide a description of relevant background information that includes the context of the problem.

Approach

Purpose

Applicants must describe in two to three (2–3) sentences specifically how their application will address the public health problem as described in the DC Health Background section.

Outcomes

Applicants must clearly identify the outcomes they expect to achieve by the end of the project period, as identified in the Purpose section of this RFA.

Target Population

Applicants should provide an overview of their constituent population as relevant to the project including rates of smoking, race, age and residence (ward and/or zip code) and corresponding social determinants of health. Applicants should be able to demonstrate the ability to reach the priority population and how they will be served through this project.

Project Description

This section should provide a clear and concise description of strategies and activities they will use to achieve the project outcomes and should detail how the program will be implemented. Applicants must base their strategies and activities on those described in the Scope of Work and Program Strategies.

- Describe activities for each strategy, how they will be implemented, and how they will be operationalized to achieve program goals, objectives, and outcomes.
- Describe how the proposed project meets the requirements in the Scope of Work section (please see Performance Requirements Section for more details).
- Indicate plans for sustainability of the initiative beyond the projected funding period.

Evaluation and Performance Measurement

Applicants should provide a brief description of how project goals will be assessed and monitored during implementation. Applicants should describe how key performance

measures will be collected and used to assess project outcomes. At a minimum, this shall describe:

- The applicant's experience and capacity to engage community partners and stakeholders
- How applicant will measure community engagement and its impact
- How applicant will ensure activities increase vaccine confidence in the target population
- How activities will be monitored and adapted to improve program success

Organizational Capacity

This section should provide an overview of the organizational infrastructure, mission and vision. Applicants should demonstrate capacity and infrastructure to implement **one or both focus areas described in the Program Strategies with the goal of advancing organizational and personal health literacy and reducing health disparities**. The applicant should demonstrate their previous experience and success addressing social determinants of health (education, employment, income, housing, transportation, access to healthy food, access to health care, outdoor environment, and community safety) by reducing barriers to resources through a community-centered approach. The applicant should describe the scope of current community engagement and empowerment activities and demonstrate staff capacity to conduct activities as required by this RFA. Applicants should demonstrate ability to meet performance requirements, follow project deadlines for deliverables, and provide accurate reporting. Lastly, applicants should affirm organizational leadership commitment to complete the project as proposed in the work plan.

PROJECT ABSTRACT

A one-page project abstract is required. Please provide a one-page abstract that is clear, accurate, concise, and without reference to other parts of the Project Narrative. The project abstract must be **single-spaced, limited to one page in length**, and include the following sections:

- **Problem:** Describe the problem to be addressed by the project.
- **Purpose:** State the purpose of the project.
- **Goal(s) And Objectives:** Identify the major goal(s) and objectives of the project. Objectives should be SMART.
- **Performance Metrics:** Outline outcome and process metrics and associated targets that will be used to assess grantee performance.

BUDGET TABLE

The application should include a project budget worksheet using the excel spreadsheet in District Grants Clearinghouse as noted in (Attachment 3). The project budget should be directly aligned with the work plan and project description. All expenses should relate directly to achieving grant outcomes. Budget should reflect the first budget period, May 1, 2022- March 31, 2023.

Note: the electronic submission platform, Enterprise Grants Management System (EGMS), will require additional entry of budget line items and detail. This entry does not replace the required upload of a budget narrative using the required templates.

Costs charged to the award must be reasonable, allowable and allocable under this program. Documentation must be maintained to support all grant expenditures. Personnel charges must be based on actual, not budgeted labor. Salaries and other expenditures charged to the grant must be for services that occurred during the grant's period of availability.

BUDGET JUSTIFICATION

The application should include a budget justification (Attachment 2), a narrative that explains the amounts requested for each line in the budget. The budget justification should specifically describe how each item will support the achievement of proposed objectives. The budget justification MUST be concise. Do NOT use the justification to expand the proposed project narrative.

Include the following in the Budget Justification Narrative:

Salary: Include the name of each staff member (or indicate a vacancy), position title, annual salary, and percentage of full-time equivalency dedicated to this project.

Fringe Benefits: Provide the fringe benefit rate. Indicate all positions/staff for which fringe benefits are charged.

Supplies: Funds can be used to cover provider training materials that are essential in ensuring successful program implementation.

Travel: The budget should reflect the travel expenses associated with local travel to partner sites, meetings, and activities related to implementation of the project, with breakdown of expenses, e.g., airfare, hotel, per diem, and mileage reimbursement.

Contractual: Applicants must ensure that their organization or institution has in place and follows an established and adequate procurement system with fully developed written procedures for awarding and monitoring all contracts. Applicants must provide a clear explanation as to the purpose of each contract, how the costs were estimated, and the specific contract deliverables. For each consultant, specify the scope of work for the consultant, the hourly rate, and the number of hours of expected effort. Applicants must have a written plan in place for sub-recipient monitoring and must actively monitor sub-recipients.

Other Direct Costs: Provide information on other direct costs that have not otherwise been described.

Indirect Costs: Indirect costs shall not exceed 10% of direct costs.

ORGANIZATION CHART

The organization chart is a visual representation of the staff in the applicant organization (*no template provided*.)

WORK PLAN

The Work Plan is required (Attachment 1). The work plan describes key process objectives and goals for successful program implementation. Under each objective, provide a list of the activities that will be used to achieve each of the objectives proposed and anticipated deliverables.

- The work plan should include a chronological list and description of activities to be performed. Each activity should have an identified responsible staff, target completion dates and projected outcomes
- The work plan should include process objectives and measures. Objectives should be SMART (Specific, Measurable, Achievable, Relevant, and Time-Framed)

STAFFING PLAN

The applicant's staffing plan must be submitted *(no template provided)*. The staffing plan should describe staff qualifications and include type and number of FTEs. Staff CVs, resumes, and position descriptions should be included in this section.

LETTERS OF SUPPORT

Applicant should provide a minimum of two (2) letters of support from other agencies and organizations who will partner on of the proposed project *(no template provided)*.

7. EVALUATION CRITERIA

Indicators have been developed for each review criterion to assist the applicant in presenting pertinent information related to that criterion and to provide the reviewer with a standard for evaluation. The five review criteria are outlined below with specific detail and scoring points. These criteria are the basis upon which the reviewers will evaluate the application. The entire proposal will be considered during objective review:

CRITERION 1: HEALTH AND RACIAL EQUITY

(**30 POINTS**) – Corresponds to Sections: *Background, Purpose and Target Population*

- The extent to which the applicant describes the problem within the context of the target populations: Black/African American residents and Limited English Proficient populations
- The extent to which the applicant describes the unmet needs and community assets of the residents served by the organization who are at high risk for COVID-19
- The extent to which the applicant demonstrates an understanding of the problem, potential barriers and challenges, and opportunities to address health literacy disparities
- The extent to which the applicant demonstrates an understanding of how social determinants of health and other systemic barriers limit the priority population's ability to access COVID-19 mitigations, such as vaccination, and utilize health resources
- The extent to which the applicant describes an understanding of how a lack of health literacy relates to the lack of residents accessing COVID-19 mitigations such as vaccination and other health resources

Criterion 2: Organizational Capacity

(20 POINTS) – Corresponds to Section: *Organizational Capacity*

- The extent to which the applicant describes an adequate organizational infrastructure to support implementation of the proposed strategies including leadership commitment to implement the proposed strategies
- The extent to which the applicant describes reach and established relationships with District residents within the target population and other community-based organizations serving target population
- The extent to which the applicant describes experience achieving successful outcomes and/or addressing challenges/barriers with target population
- The extent to which the applicant describes the feasibility of and experience with establishing new and engaging existing partners (i.e., government agencies and CBOs) in a cross-sector network to support the implementation and evaluation of the applicant's initiatives to advance health literacy and/or address social determinants of health
- The extent to which the applicant describes experience working to address social determinants of health (i.e., food insecurity, housing, employment, transportation, active living and physical activity, access to healthcare, housing, and safe communities)

CRITERION 3: IMPLEMENTATION FRAMEWORK

(30 POINTS) – Corresponds to Section: *Project Description*

- The extent to which the applicant's proposed project aligns with the purpose and strategies of this RFA
- The extent to which the applicant's goals are logical and feasible reached through objectives that are Specific, Measurable, Achievable, Relevant and Time-Bound (SMART)
- The extent to which the applicant describes the feasibility of the evidence-based and/or evidence-informed practice approaches that address gaps in health literacy and COVID-19 outreach efforts within target population
- The extent to which the proposed strategies will lead to sustainable improvements in health literacy, especially related to COVID risk mitigation and preventable disease
- The extent to which the applicant describes plans for community engagement and mobilization to drive project outcomes, including strategies for current or new partnerships (if any) that will be engaged to meeting program goals

CRITERION 4: EVALUATION

(20 POINTS) – Corresponds to Section: *Evaluation and Performance Measurement; Outcomes*

- The extent to which measurable indicators to monitor the project's success are specified for the program objectives
- The appropriateness of project monitoring plans that ensure reach and engagement of the priority population
- The extent and appropriateness of the proposed processes to collect qualitative and quantitative data related to project goals
- The degree of skill and experience of proposed staff or contractor to analyze data aligned to the project's goals and objectives

- The extent to which the applicant specifies a process to monitor progress and adapt strategies and objectives to improve outcomes

CRITERION 5: SUPPORT REQUESTED

(NOT SCORED) – Corresponds to Sections: *Budget and Budget Justification Narrative*

- The appropriateness of the budget for the project period in relation to the objectives, the complexity of the activities, and the anticipated results
- The adequacy of costs outlined in the budget and required resources sections
- The extent of which key personnel that have adequate time devoted to the project to achieve project objectives

8. REVIEW AND SCORING OF APPLICATION

8.1 PRE-SCREENING

All applications will be reviewed initially for completeness, formatting and eligibility requirements by DC Health personnel prior to being forwarded to the external review panel. Incomplete applications and applications that do not meet the eligibility criteria will not advance to the external review. Applicants will be notified that their applications did not meet eligibility.

8.2 EXTERNAL REVIEW PANEL

The review panel will be composed of neutral, qualified, professional individuals who have been selected for their unique experiences in public health program planning and implementation, health communications planning and evaluation, and social services planning and implementation. The panel will review, score and rank each applicant's proposal based on the criteria outlined in the RFA. Individual panel members are required to provide a summary of strengths and weaknesses found in the application.

8.3 INTERNAL REVIEW

DC Health program managers will review the individual and summary recommendations of the external review panel and make recommendations for awards. Program Managers will weigh the results of the review panel against other internal and external factors in making the final funding determinations. DC Health will also conduct an excluded parties list search (EPLS) of the organization and executives via the federal System for Award Management (SAM).

In this phase of the review process, DC Health reserves the right to request clarifying supplemental information from applicants and request on-site pre-decisional reviews for those applicants being considered for award. Any request for supplemental information or on-site visits is not a commitment by DC Health to fund the applicant.

The internal review panel prepares and submits a formal recommendation of prospective awardees, funding levels and service/activities to the DC Health Director for signature. The DC Health Office of Grants Management is responsible for certifying that all District rules and standards were followed for the RFA process.

9. POST AWARD ASSURANCES & CERTIFICATIONS

Should DC Health move forward with an award, additional assurances may be requested in the post award phase. These documents include:

- Certification Regarding Lobbying; Debarment, Suspension and Other Responsibility Matters; and Drug-Free Workplace Requirements
- Certification of current/active Articles of Incorporation from DCRA.
- Certificate of Occupancy
- Most Recent Audit and Financial Statements

Failure to submit the required assurance package will likely make the application ineligible to sign/execute grant agreements.

10. APPLICATION SUBMISSION

In order to submit an application under this funding opportunity, the applicant organization must register in EGMS and establish an account for the authorized representative.

If the applicant organization has an account already, please ensure that the Primary Account User is authorized to submit an application on behalf of the organization and his/her account is active. Currently, Secondary Account Users **do not** have submission privileges but can work in EGMS to prepare (e.g., upload documents, complete forms) the application.

IMPORTANT: When the Primary Account User is submitting an application, ensure that there are no other transactions on another device being attempted in EGMS under that Primary Account User's credentials. For security purposes, the system will only acknowledge one transaction and one of the transaction attempts may fail, if done simultaneously.

11.1 REGISTER IN EGMS

DC Health recommends that applicants create an EGMS account, establishing a Primary Account User as the authorized representative **at least two weeks** prior to the application submission deadline. There is no guarantee that the authorized representative would have an approved account if the registration process does not begin at least **two weeks** prior to the deadline. Deadline-day registrations will not be approved by the DC Health Office of Grants Management in time for submission. To register, complete the following:

IMPORTANT: WEB BROWSER REQUIREMENTS

1. **Check web browser requirements for EGMS –**EGMS is supported by the following browser versions:
    - Microsoft ® Internet Explorer ® Version 11
    - Apple ® Safari ® version 8.x on Mac OS X
    - Mozilla ® Firefox ® version 35 & above (Most recent and stable version recommended)
    - Google Chrome ™ version 30 & above (Most recent and stable version recommended)
2. **Access EGMS**: The user must access the login page by entering the following URL in to a web browser: https://dcdoh.force.com/GO ApplicantLogin2 Click the button REGISTER and following the instructions. You can also refer to the EGMS External User Guide.
3. Determine the agency's Primary User (i.e. authorized to accept terms of agreement, certify and submit documents, request and accept modifications). The Primary User will determine a Secondary User and send a notification via EGMS for him/her to set-up an account.
4. Your EGMS registration will require your legal organization name, your **DUNS # and Tax ID#** in order to complete the registration. Your EGMS registration will also require your SAM (System for Award Management) expiration date to be entered into your agency profile. Please ensure that you have an active SAM registration (www.sam.gov).
5. When your Primary Account User request is submitted in EGMS, the DC Health Office of Grants Management will review the request. If the requester is NOT the identified Executive Director, DC Health Office of Grants Management will make an additional request for the Executive Director to send an email to DC Health to confirm that the requester is the authorized representative for EGMS. When requested, your authorized representative should send to doh.grants@dc.gov the name, title, telephone number and email address of the desired Primary User for the account. **SUBJECT LINE: EGMS PRIMARY USER AGENCYNAME**. Note: The email will help to support the validation of authorized users for EGMS. DC Health official grant records will also be used. Please reply ASAP to any requests from Office of Grants Management to provide additional information, if needed.
6. Once you register, your Primary Account User will get an auto-notice to upload a "DUNS Certification" – this will provide documentation of your organization's DUNS. You can simply upload a scanned copy of the cover page of your SAM Registration.

EGMS User Registration Assistance:

Office of Grants Management at doh.grants@dc.gov assists with all end-user registration if you have a question or need assistance: Primary Points of Contact: Jennifer Prats and Clara McLaughlin (202) 442-9237. Here are the most common registration issues:

- Validation of the authorized primary account user
- Wrong DUNS, Tax ID or expired SAM registration
- Web browser

11.2 Uploading the Application

All required application documents must be uploaded and submitted in EGMS. Required documents are detailed below. All of these must be aligned with what has been requested in other sections of the RFA.

- ***Eligibility Documents***
    - Certificate of Clean Hands dated within 60 days of the application deadline
    - Current business license or certificate of licensure or proof to transact business in local jurisdiction
    - Current Certificate of Insurance
    - Copy of Cyber Liability Policy
    - IRS Tax-Exempt Determination Letter (for nonprofits only)
    - IRS 990 Form from most recent tax year (for nonprofits only)
    - Current list of Board of Directors, on letterhead, signed and dated by a certified official from the Board (this cannot be the Executive Director)
- ***Proposal Documents***
    - Proposal Abstract
    - Project Narrative
    - Budget Table
    - Budget Justification
    - Organization Chart
    - Work Plan
    - Staffing Plan
    - Two (2) Letters of Commitment
- ***Other Documents:***
    - Assurances Certifications Disclosures

11.3 Deadline

Submit your application via EGMS by 6:00 p.m., on the deadline date of Friday, March 11, 2022. Applications will **not** be accepted after the deadline.

11. PRE-APPLICATION MEETING

Please visit the Office of Grants Management Eventbrite page to learn the date/time and to register for the event.

The meeting will provide an overview of the RFA requirements and address specific issues and concerns about the RFA. Applicants are not required to attend but it is highly recommended to do so. ***Registration is required***.

- RFA Updates will also be posted on the District Grants Clearinghouse.

12. GRANTEE REQUIREMENTS

If the applicant is considered for funding based on the results of the completion and receives a Notice of Intent to Fund and subsequently accepts grants award, the following requirements are in effect:

13.1 GRANT TERMS & CONDITIONS

All grants awarded under this program shall be subject to the DC Health Standard Terms and Condition for all DC Health issued grants. The Terms and Conditions are embedded within EGMS, where upon award, the applicant organization can accept the terms.

13.2 GRANT USES

The grant awarded under this RFA shall be used exclusively to pay costs associated with the implementation of the grant. Payment requests will be monitored by DC Health to ensure compliance with the approved budget and work plan.

13.3 CONDITIONS OF AWARD

As a condition of award, a successful applicant who is issued a Notice of Grant Award (NOGA) will be required to:

1. Revise and resubmit a work plan and budget with justification in accordance with the approved scope of work and assignments prescribed by a DC Health Notice of Intent to Fund and any pre-award negotiations with assigned DC Health project and grants management personnel.
2. Meet pre-award requirements, including submission and approval of required assurances and certification documents, documentation of non-disbarment or suspension (current or pending) of eligibility to receive local or federal funds.
3. Adhere to mutually agreed upon terms and conditions of a grant agreement and Notice of Grant Award issued by the Department of Health and accepted by the grantee organization. The grant agreement shall outline the scope of work, standards, reporting requirements, fund distribution terms and any special provisions required by federal agreements.
4. Utilize performance monitoring and reporting tools developed and approved by DC Health.

13.4 INDIRECT COST

Indirect costs are costs that are not readily identifiable with a particular project or activity but are required for operating the organization and conducting the grant-related activities it performs. Indirect costs encompass expenditures for operation and maintenance of building and equipment, depreciation, administrative salaries, general telephone services and general travel and supplies.

Grant awardees will be allowed to budget for indirect costs of no more than ten percent (10%) of total direct costs.

13.5 Insurance

All applicants that receive awards under this RFA must show proof of all insurance coverage required by law prior to receiving funds.

DC Health reserves the right to request certificates of liability pre-award and post-award and make adjustments to coverage limits for programs per requirements promulgated by the District of Columbia Office of Risk Management.

13.6 COVID-19 Grantee Requirement

All applicants that receive awards under this RFA are required to ensure that their employees, agents, and subgrantees ("grantee personnel") are in compliance with Mayor's Order 2021-099, available at: https://coronavirus.dc.gov/page/mayor%E2%80%99s-order-2021-099-covid-19-vaccination-certification-requirement-district-government. Frequently asked questions about the vaccine certification requirement are made available online, here.

To ensure compliance with this item, grantees shall upload a signed attestation from an authorized representative from your organization into the organization profile in EGMS before the Notice of Grant Award is released. A template for an attestation form and step-by-step guide on how to upload the document into EGMS will be provided.

13.7 Audits

At any time or times before final payment and three (3) years thereafter, the District may have the applicant's expenditure statements and source documentation audited. Grantees subject to 2 CRF part 200, subpart F rules must have available and submit as requested the most recent audit reports, as requested by DC Health personnel.

13.8 Nondiscrimination in the Delivery of Services

In accordance with Title VI of the Civil Rights Act of 1964 (Public Law 88-352), as amended, no person shall, on the grounds of race, color, religion, nationality, sex, or political opinion, be denied the benefits of, or be subjected to discrimination under, any program activity receiving funds under this RFA.

13.9 Quality Assurance

DC Health will utilize a risk-based management and monitoring assessment to establish a monitoring plan for the grantee. Grantees will submit interim and final reports on progress, successes, and barriers.

Funding is contingent upon the Grantee's compliance with terms of the agreement and progress in meeting milestones and targets outlined in the approved work plan and evaluation plan. All programs shall be monitored and assessed by assigned project and grants management personnel. The Grantee will receive a performance rating and subject to review at any time during the budget period.

A final performance rating shall be completed by the Department of Health and provided and held for record and use by DC Health in making additional funding or future funding available to the applicant. All performance reports are subject to review and oversight by the DC Health Office of Grants Management.

13. CONTACT INFORMATION

For more information, please send inquiries to:

covid-19.vaccine@dc.gov

PRINCIPAL INVESTIGATORS

C. Anneta Arno, Ph.D., MPH

Director

Office of Health Equity

Kimberly Henderson, PhD

COVID-19 Communications, Outreach, and Community Programs Team Lead

Director of Communications and Community Relations

Office of the Director

Robin (Diggs) Perdue, MPH

Deputy Director of Strategy, Programs and Policy

Community Health Administration

14. GLOSSARY OF TERMS

Community Health Worker- a frontline public health worker who is a trusted member of a community or who has a thorough understanding of the community being served. This relationship allows CHWs to serve as a link between health and social service programs and the community to promote access to services and improve the quality and cultural competence of service delivery.

"Community Health Worker." Division for Heart Disease and Stroke Prevention. Centers for Disease Control and Prevention. Accessed January 14, 2022. https://www.cdc.gov/dhdsp/pubs/guides/best-practices/chw.htm

Cultural Competence- practices and behaviors that ensure that all patients receive high-quality, effective care irrespective of cultural background, language proficiency, socioeconomic status, and other factors that may be informed by a patient's characteristics."3 Improving the cultural competency of health materials, personal interactions, and services is an important step toward addressing low health literacy among diverse populations.

"Health Literacy and the Role of Culture." Center for Health Care Strategies, Inc. Center for Health Care Strategies. Accessed January 14, 2022. http://www.chcs.org/media/Health_Literacy_Role_of_Culture.pdf

Health Disparity - A particular type of health difference that is closely linked with social, economic, and/or environmental disadvantage. Health disparities adversely affect groups of people who have systematically experienced greater obstacles to health based on their racial or ethnic group; religion; socioeconomic status; gender; age; mental health; cognitive, sensory, or physical disability; sexual orientation or gender identity; geographic location; or other characteristics historically linked to discrimination or exclusion.

"Disparities." Disparities. Office of Disease Prevention and Health Promotion. Accessed June 29, 2021. https://www.healthypeople.gov/2020/about/foundation-health-measures/Disparities

Health equity – The attainment of the highest level of health for all people. It is the removal of any and all differences (disparities) in health that are avoidable, unfair, and unjust. It requires "valuing everyone equally with focused and ongoing societal efforts to address avoidable inequalities, historical and contemporary injustices, and the elimination of health and health care disparities." (MCHB proposed definition)

Limited English Proficient (LEP) - Individuals who do not speak English as their primary language and who have a limited ability to read, speak, write, or understand English can be limited English proficient, or "LEP." These individuals may be entitled to language assistance with respect to a particular type or service, benefit, or encounter.

Organizational Health Literacy – The degree to which organizations equitable engage individuals to find, understand, and use information and services to inform health-related decisions and actions for themselves and others.

"How Does Healthy People Define Health Literacy." Office of Disease Prevention and Health Promotion. Office of Disease Prevention and Health Promotion. Accessed January14, 2022. https://health.gov/our-work/healthy-people/healthy-people-2030/health-literacy-healthy-people-2030

Personal Health Literacy – The degree to which individuals have the ability to find, understand, and use information and services to inform health-related decisions and actions for themselves and others.

"How Does Healthy People Define Health Literacy." Office of Disease Prevention and Health Promotion. Office of Disease Prevention and Health Promotion. Accessed January14, 2022. https://health.gov/our-work/healthy-people/healthy-people-2030/health-literacy-healthy-people-2030

SMART Goal – one that is specific, measurable, achievable, results-focused, and time- bound.

Social Determinants of Health - Social determinants of health are the conditions in which people are born, live, work, play and age that influence health. The public health community has long understood that there is a link between an individual's health and the social environmental and economic conditions within which an individual resides and interacts. Social determinants of health include access to healthy foods, housing, economic and social relationships, transportation, education, employment and access to health. The higher the quality of these resources and supports, and the more open the access for all community members, the more community outcomes will be tipped toward positive health outcomes. Thus, improving conditions at the individual and community level involve improving societal conditions, Page 36 of 36 including social and economic conditions (freedom from racism and discrimination, job opportunities and food security), the physical environment (housing, safety, access to health care), the psycho-social conditions (social network and civic engagement), and psychological conditions (positive self-concept, resourcefulness and hopefulness).

Healthy People 2030, U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion. Retrieved [date graphic was accessed], from https://health.gov/healthypeople/objectives-and-data/social-determinants-health

15. ATTACHMENTS

Attachment 1: Work Plan

Attachment 2: Budget Justification

Attachment 3: Budget Table

Appendix A – Assurances and Certifications

Appendix B - Minimum Insurance Requirements

ATTACHMENT 1 – WORK PLAN

Grantee Work Plan

Agency/Organization Name:	
Program/ Grant Name:	
Project Title:	
Current Budget Request:	
Current Project Period:	
Total Budget Request:	
Total Project Period	
Primary Target Population:	
Estimated Reach:	
Programmatic Contact Person:	
Telephone:	
Email:	

Guidance:

Using the following instructions please complete the chart below:

Goal: Make sure your goals are clear and reachable, each one should be:

- Specific (simple, sensible, significant)
- Measurable (meaningful, motivating)
- Achievable (agreed, attainable)
- Relevant (reasonable, realistic and resourced, results-based)
- Time bound (time-based, time limited, time/cost limited, timely, time-sensitive)

- Objective (SMART): Measurable steps your organization would take to achieve the goal
- Key Indicator: A measurable value that effectively demonstrates how you will achieve your objective(s)
- Key External Partner: Who you work with outside of your organization to achieve the goal

- Key Activity: Actions you plan carry out in order to fulfill the associated objective
- Start Date and Completion Date: The dates you plan to complete the associated activity
- Actual Start Date and Completion Date: The dates you actually started and completed the activity
    - Note: These columns should be entered by you and submitted to your project officer at the end of the budget period
- Key Personnel: Title of individuals from your organization who will work on the activity
-

GOAL 1: *Expand the availability of health care transition (HCT) training to school-based health centers (SBHCs) and to community-based mental health providers using evidence-informed HCT interventions and tested quality improvement (QI) methodologies.*					
Measurable Objectives/Activities:					
Objective #1: *By the end of month 12, partner with School-Based Health Centers and move from customizing and piloting the Six Core Elements of HCT to full implementation in routine preventive and primary care.*					
Key Indicator(s): *Number of students completing HCT readiness assessments, preparation of article on DC SBHC transition quality improvement initiative, number of presentations of SBHC transition results locally and nationally.*					
Key External Partner(s): *DC DOH and SBHCs*					
Key Activities to Meet this Objective:	**Start Date:**	**Completion Date:**	**Actual Start Date:**	**Actual Completion Date:**	**Key Personnel (Title)**
A. *In months 1-9, continue training/coaching SBHC clinical teams as they incorporate transition into routine clinic processes.*	*10/1/17*	*6/30/18*			*Primary Investigator* *Consultant*
B.					
Objective #2:					
Key Indicator(s):					
Key External Partner(s):					
Key Activities to Meet this Objective:	**Start Date:**	**Completion Date:**	**Actual Start Date:**	**Actual Completion Date:**	**Key Personnel (Title)**

A.					
B.					
Objective #3:					
Key Indicator(s):					
Key External Partner(s):					
Key Activities to Meet this Objective:	**Start Date:**	**Completion Date:**	**Actual Start Date:**	**Actual Completion Date:**	**Key Personnel (Title)**
A.					
B.					

GOAL 2:					
Measurable Objectives/Activities:					
Objective #1:					
Key Indicator(s):					
Key External Partner(s):					
Key Activities to Meet this Objective:	**Start Date:**	**Completion Date:**	**Actual Start Date:**	**Actual Completion Date:**	**Key Personnel (Title)**
A.					
B.					
C.					
Objective #2:					

Key Indicator(s):					
Key External Partner(s):					
Key Activities to Meet this Objective:	**Start Date:**	**Completion Date:**	**Actual Start Date:**	**Actual Completion Date:**	**Key Personnel (Title)**
A.					
B.					
C.					
Objective #3:					
Key Indicator(s):					
Key External Partner(s):					
Key Activities to Meet this Objective:	**Start Date:**	**Completion Date:**	**Actual Start Date:**	**Actual Completion Date:**	**Key Personnel (Title)**
A.					
B.					
C.					
GOAL 3:					
Measurable Objectives/Activities:					
Objective #1:					
Key Indicator(s):					
Key External Partner(s):					

Key Activities to Meet this Objective:	**Start Date:**	**Completion Date:**	**Actual Start Date:**	**Actual Completion Date:**	**Key Personnel (Title)**
A.					
B.					
C.					
Objective #2:					
Key Indicator(s):					
Key External Partner(s):					
Key Activities to Meet this Objective:	**Start Date:**	**Completion Date:**	**Actual Start Date:**	**Actual Completion Date:**	**Key Personnel (Title)**
A.					
B.					
C.					
Objective #3:					
Key Indicator(s):					
Key External Partner(s):					
Key Activities to Meet this Objective:	**Start Date:**	**Completion Date:**	**Actual Start Date:**	**Actual Completion Date:**	**Key Personnel (Title)**
A.					
B.					
C.					

GOAL 4:					
Measurable Objectives/Activities:					
Objective #1:					
Key Indicator(s):					
Key External Partner(s):					
Key Activities to Meet this Objective:	**Start Date:**	**Completion Date:**	**Actual Start Date:**	**Actual Completion Date:**	**Key Personnel (Title)**
A.					
B.					
C.					
Objective #2:					
Key Indicator(s):					
Key External Partner(s):					
Key Activities to Meet this Objective:	**Start Date:**	**Completion Date:**	**Actual Start Date:**	**Actual Completion Date:**	**Key Personnel (Title)**
A.					
B.					
C.					
Objective #3:					
Key Indicator(s):					
Key External Partner(s):					

Key Activities to Meet this Objective:	**Start Date:**	**Completion Date:**	**Actual Start Date:**	**Actual Completion Date:**	**Key Personnel (Title)**
A.					
B.					
C.					

ATTACHMENT 2 –BUDGET JUSTIFICATION

Provide a narrative that explains the amounts requested for each line in the budget. The budget justification should specifically describe how each item will support the achievement of proposed objectives. This document should be submitted with the Excel budget template that was provided to you.

A. **Personnel:** Personnel costs should be explained by listing each staff member who will **(1)** be supported from funds and **(2)** in-kind contributions. If personnel costs are supported by in-kind contributions, please indicate the source of funds. Please include the full name of each staff member (or indicate a vacancy), position title, percentage of full-time equivalency, and annual salary. Personnel includes, at a minimum, the program director responsible for the oversight and day-to-day management of the proposed program, staff responsible for quality improvement activities, staff responsible for monitoring programmatic activities and use of funds, and staff responsible for data collection, quality and reporting. **Note:** Final personnel charges must be based on actual, not budgeted labor. **Fringe Benefits:** Fringe Benefits change yearly, and should be confirmed before submitting your budget. List all components that make up the fringe benefits rate.

B. **Consultants/Contractual:** Grantees must ensure that their organization or institution has in place and follows an established and adequate procurement system with fully developed written procedures for awarding and monitoring all contracts. Grantees must provide the following information in the budget justification:

1. **Name of Contractor/Consultant: Who is the contractor/consultant?**

   Include the name of the qualified contractor and indicate whether the contract is with an institution or organization if applicable. Identify the principle supervisor of the contract.

2. **Method of Selection: How was the contractor/consultant selected?**

   If an institution is the sole source for the contract, include an explanation as to why this institution is the only one able to perform contract services. If the contract is with an institution or organization, include the contract supervisor's qualifications.

3. **Period of Performance: How long is the contract period?**

   Include the complete length of contract. If the contract involves a number of tasks, include the performance period for each task.

4. **Scope of Work: What will the contractor/consultant do?**

   List and describe the specific tasks the contractor is to perform.

5. **Criteria for Measuring Contractor/Consultant Accountability: How will contractor/consultant use the funds?**

   Include an itemized line item breakdown as well as total contract amount. If applicable, include any indirect costs paid under the contract and the indirect cost rate used.

   Grantees must have a written plan in place for contractor/consultant monitoring and must actively monitor contractor/consultant.

C. **Occupancy/Rent:** This cost includes rent, utilities, insurance for the building, repairs and maintenance, depreciation, etc. Include in your description the cost allocation method used to allocate this line item.

D. **Travel:** The budget should reflect the travel expenses associated with implementation to the program and other proposed trainings or workshops, with breakdown of expenses (e.g. airfare, hotel, per diem, and mileage reimbursement).

E. **Supplies:** Provide justification of the supply items and relate them to specific program objectives. It is recommended that when training materials are kept on hand as a supply item, that it be included in the "supplies" category. **When training materials (pamphlets, notebooks, videos, and other various handouts) are ordered for specific training activities, these items should be itemized and shown in the "Other Direct Costs" category.** If appropriate, general office supplies may be shown by an estimated amount per month multiplied by the number of months in the budget period. If total supplies is over $10,000 it must be itemized.

F. **Equipment:** Provide itemized costs, specifications, quantity, unit, unit cost, and basis for cost estimate (actual cost or price quotation).

G. **Client / Participant Costs:** Includes client travel. Client/Participant costs are costs paid to (or on behalf of) participants or trainees (not employees) for participation in meetings, conferences, symposia, and workshops or other training projects, when there is a category for participant support costs in the project.

H. **Communication:** Cost estimates for any communications and dissemination activities included in the work plan should be covered in the budget.

I. **Other Direct Costs:** Other direct costs category contains items not included in the previous categories. Give justification for all the items in the "other" category (e.g., separate justification for printing, publication costs for presentations/posters, telephone, postage, software programs, computers, etc.). All costs associated with training activities should be placed in the "other direct cost" category except costs for consultant and/or contractual.

Agency/Organization Name

Budget Period __ Budget Justification

A. PERSONNEL

Position Title	Position Description

B. CONSULTANTS/CONTRACTUAL

Description of Services
1. Name of Contractor/Consultant: Who is the contractor/consultant? 2. Method of Selection: How was the contractor/consultant selected? 3. Period of Performance: How long is the contract period? 4. Scope of Work: What will the contractor/consultant do? 5. Criteria for Measuring Contractor/Consultant Accountability: How will contractor/consultant use the funds?

C. OCCUPANCY/RENT

Location of Services

D. TRAVEL

Traveler Name	Travel Destination	Reason for Travel

E. SUPPLIES

Item Name	Justification for Item	*Unit Cost of Each Item	*Number Needed	Total Amount

*Complete these columns only if supplies are over $10,000 total.

F. EQUIPMENT

Item Name	Justification for Item	Quantity	Unit	Unit Cost	Basis for cost estimate (actual cost or price quotation)

G. CLIENT/PARTCIPANT COSTS

Name of Client	Description of Services

H. COMMUNICATION

Item(s)	Purpose of Item

I. OTHER DIRECT

Type of Service	Purpose of Service

J. BUDGET SUMMARY:

Category	Cost
Personnel	
Salary	
Fringe	
Consultants/Contractual	
Occupancy	
Travel	
Supplies	
Equipment	
Client Costs	
Other Direct	
Total Direct Costs	
Indirect Costs	
Total Project Cost	**$**

ATTACHMENT 3: BUDGET TABLE

See excel spreadsheet in District Grants Clearinghouse.

APPENDIX A: MINIMUM INSURANCE REQUIREMENTS

INSURANCE

A. GENERAL REQUIREMENTS. The Grantee at its sole expense shall procure and maintain, during the entire period of performance under this contract, the types of insurance specified below. The Grantee shall have its insurance broker or insurance company submit a Certificate of Insurance to the PM giving evidence of the required coverage prior to commencing performance under this grant. In no event shall any work be performed until the required Certificates of Insurance signed by an authorized representative of the insurer(s) have been provided to, and accepted by, the PM. All insurance shall be written with financially responsible companies authorized to do business in the District of Columbia or in the jurisdiction where the work is to be performed and have an A.M. Best Company rating of A- / VII or higher. Should the Grantee decide to engage a subcontractor for segments of the work under this contract, then, prior to commencement of work by the subcontractor, the Grantee shall submit in writing the name and brief description of work to be performed by the subcontractor on the Subcontractors Insurance Requirement Template provided by the CA, to the Office of Risk Management (ORM). ORM will determine the insurance requirements applicable to the subgrantee and promptly deliver such requirements in writing to the Contractor and the CA. The Grantee must provide proof of the subcontractor's required insurance to prior to commencement of work by the subcontractor. If the Grantee decides to engage a subcontractor without requesting from ORM specific insurance requirements for the subcontractor, such subcontractor shall have the same insurance requirements as the Contractor.

All required policies shall contain a waiver of subrogation provision in favor of the Government of the District of Columbia.

The Government of the District of Columbia shall be included in all policies required hereunder to be maintained by the Grantee and its subcontractors (except for workers' compensation and professional liability insurance) as an additional insureds for claims against The Government of the District of Columbia relating to this grant, with the understanding that any affirmative obligation imposed upon the insured Grantee or its subcontractors (including without limitation the liability to pay premiums) shall be the sole obligation of the Grantee or its subcontractors, and not the additional insured. The additional insured status under the Grantee and its subcontractors' Commercial General Liability insurance policies shall be effected using the ISO Additional Insured Endorsement form CG 20 10 11 85 (or CG 20 10 07 04 **and** CG 20 37 07 04) or such other endorsement or combination of endorsements providing coverage at least as broad and approved by the PM in writing. All of the Grantee's and its subcontractors' liability policies (except for workers' compensation and professional liability insurance) shall be endorsed using ISO form CG 20 01 04 13 or its equivalent so as to indicate that such policies provide primary coverage (without any right of contribution by any other insurance, reinsurance or self-insurance, including any deductible or retention, maintained by an Additional Insured) for all claims against the additional insured arising

out of the performance of this Statement of Work by the Grantee or its subcontractors, or anyone for whom the Grantee or its subcontractors may be liable. These policies shall include a separation of insureds clause applicable to the additional insured.

If the Grantee and/or its subcontractors maintain broader coverage and/or higher limits than the minimums shown below, the District requires and shall be entitled to the broader coverage and/or the higher limits maintained by the Grantee and subcontractors.

1. Commercial General Liability Insurance ("CGL") - The Grantee shall provide evidence satisfactory to the PM with respect to the services performed that it carries a CGL policy, written on an occurrence (not claims-made) basis, on Insurance Services Office, Inc. ("ISO") form CG 00 01 04 13 (or another occurrence-based form with coverage at least as broad and approved by the PM in writing), covering liability for all ongoing and completed operations of the Contractor, including ongoing and completed operations under all subcontracts, and covering claims for bodily injury, including without limitation sickness, disease or death of any persons, injury to or destruction of property, including loss of use resulting therefrom, personal and advertising injury, and including coverage for liability arising out of an Insured Contract (including the tort liability of another assumed in a contract) and acts of terrorism (whether caused by a foreign or domestic source). Such coverage shall have limits of liability of not less than $1,000,000 each occurrence, a $2,000,000 general aggregate (including a per location or per project aggregate limit endorsement, if applicable) limit, a $1,000,000 personal and advertising injury limit, and a $2,000,000 products-completed operations aggregate limit including explosion, collapse and underground hazards.

2. Automobile Liability Insurance - The Grantee shall provide evidence satisfactory to the PM of commercial (business) automobile liability insurance written on ISO form CA 00 01 10 13 (or another form with coverage at least as broad and approved by the PM in writing) including coverage for all owned, hired, borrowed and non-owned vehicles and equipment used by the Contractor, with minimum per accident limits equal to the greater of (i) the limits set forth in the Contractor's commercial automobile liability policy or (ii) $1,000,000 per occurrence combined single limit for bodily injury and property damage.

3. Workers' Compensation Insurance - The Grantee shall provide evidence satisfactory to the PM of Workers' Compensation insurance in accordance with the statutory mandates of the District of Columbia or the jurisdiction in which the grant is performed.

   Employer's Liability Insurance - The Grantee shall provide evidence satisfactory to the PM of employer's liability insurance as follows: $500,000 per accident for injury; $500,000 per employee for disease; and $500,000 for policy disease limit.

   All insurance required by this paragraph 3 shall include a waiver of subrogation endorsement for the benefit of Government of the District of Columbia.

4. Cyber Liability Insurance - The Grantee shall provide evidence satisfactory to the PM of Cyber Liability Insurance, with limits not less than $2,000,000 per occurrence or claim, $2,000,000 aggregate. Coverage shall be sufficiently broad to respond to the duties and obligations as is undertaken by Grantee in this agreement and shall include, but not limited to, claims involving infringement of intellectual property, including but not limited to infringement of copyright, trademark, trade dress, invasion of privacy violations, information theft, damage to or destruction of electronic information, release of private information, alteration of electronic information, extortion and network security. The policy shall provide coverage for breach response costs as well as regulatory fines and penalties as well as credit monitoring expenses with limits sufficient to respond to these obligations. This insurance requirement will be considered met if the general liability insurance includes an affirmative cyber endorsement for the required amounts and coverages.

5. Medical Professional Liability - The Grantee shall provide evidence satisfactory to the PM of a Medical Professional Liability policy with limits of not less than $1,000,000 each incident and $2,000,000 in the annual aggregate. The definition of insured shall include the Grantee and all Grantee's employees and agents. The policy shall be either (1) written on an occurrence basis or (2) written on a claims-made basis. If the coverage is on a claims-made basis, Contractor hereby agrees that prior to the expiration date of Contractor's current insurance coverage, Contractor shall purchase, at Contractors sole expense, either a replacement policy annually thereafter having a retroactive date no later than the effective date of this Contract or unlimited tail coverage in the above stated amounts for all claims arising out of this Contract.

6. Professional Liability Insurance (Errors & Omissions) - The Grantee shall provide Professional Liability Insurance (Errors and Omissions) to cover liability resulting from any error or omission in the performance of professional services under this Contract. The policy shall provide limits of $1,000,000 per claim or per occurrence for each wrongful act and $2,000,000 annual aggregate. The Grantee warrants that any applicable retroactive date precedes the date the Grantee first performed any professional services for the Government of the District of Columbia and that continuous coverage will be maintained or an extended reporting period will be exercised for a period of at least ten years after the completion of the professional services.

7. Sexual/Physical Abuse & Molestation - The Grantee shall provide evidence satisfactory to the PM with respect to the services performed that it carries $1,000,000 per occurrence limits; $2,000,000 aggregate of affirmative abuse and molestation liability coverage. Coverage should include physical abuse, such as sexual or other bodily harm and non-physical abuse, such as verbal, emotional or mental abuse; any actual, threatened or alleged act; errors, omission or misconduct. This insurance requirement will be considered met if the general liability insurance includes an affirmative sexual abuse and molestation endorsement for the required

amounts. So called "silent" coverage under a commercial general liability or professional liability policy will not be acceptable.

8. Commercial Umbrella or Excess Liability - The Grantee shall provide evidence satisfactory to the PM of commercial umbrella or excess liability insurance with minimum limits equal to the greater of (i) the limits set forth in the Grantee's umbrella or excess liability policy or (ii) $2,000,000 per occurrence and $2,000,000 in the annual aggregate, following the form and in excess of all liability policies. **All** liability coverages must be scheduled under the umbrella and/or excess policy. The insurance required under this paragraph shall be written in a form that annually reinstates all required limits. Coverage shall be primary to any insurance, self-insurance or reinsurance maintained by the District and the "other insurance" provision must be amended in accordance with this requirement and principles of vertical exhaustion.

B. PRIMARY AND NONCONTRIBUTORY INSURANCE
The insurance required herein shall be primary to and will not seek contribution from any other insurance, reinsurance or self-insurance including any deductible or retention, maintained by the Government of the District of Columbia.

C. DURATION. The Grantee shall carry all required insurance until all grant work is accepted by the District of Columbia and shall carry listed coverages for ten years for construction projects following final acceptance of the work performed under this contract and two years for non-construction related contracts.

D. LIABILITY. These are the required minimum insurance requirements established by the District of Columbia. However, the required minimum insurance requirements provided above will not in any way limit the contractor's liability under this contract.

E. CONTRACTOR'S PROPERTY. Contractor and subcontractors are solely responsible for any loss or damage to their personal property, including but not limited to tools and equipment, scaffolding and temporary structures, rented machinery, or owned and leased equipment. A waiver of subrogation shall apply in favor of the District of Columbia.

F. MEASURE OF PAYMENT. The District shall not make any separate measure or payment for the cost of insurance and bonds. The Grantee shall include all of the costs of insurance and bonds in the grant price.

G. NOTIFICATION. The Grantee shall ensure that all policies provide that the CO shall be given thirty (30) days prior written notice in the event of coverage and / or limit changes or if the policy is canceled prior to the expiration date shown on the certificate. The Grantee shall provide the PM with ten (10) days prior written notice in the event of non-payment of premium. The Grantee will also provide the PM with an updated Certificate of Insurance should its insurance coverages renew during the contract.

H. CERTIFICATES OF INSURANCE. The Grantee shall submit certificates of insurance giving evidence of the required coverage as specified in this section prior to commencing work. Certificates of insurance must reference the corresponding contract number. Evidence of insurance must be submitted to the: Enterprise Grants Management System.

The PM may request and the Grantee shall promptly deliver updated certificates of insurance, endorsements indicating the required coverages, and/or certified copies of the insurance policies. If the insurance initially obtained by the Grantee expires prior to completion of the contract, renewal certificates of insurance and additional insured and other endorsements shall be furnished to the CO prior to the date of expiration of all such initial insurance. For all coverage required to be maintained after completion, an additional certificate of insurance evidencing such coverage shall be submitted to the CO on an annual basis as the coverage is renewed (or replaced).

I. DISCLOSURE OF INFORMATION. The Grantee agrees that the District may disclose the name and contact information of its insurers to any third party which presents a claim against the District for any damages or claims resulting from or arising out of work performed by the Grantee, its agents, employees, servants or subcontractors in the performance of this contract.

J. CARRIER RATINGS. All Grantee's and its subcontractors' insurance required in connection with this contract shall be written by insurance companies with an A.M. Best Insurance Guide rating of at least A- VII (or the equivalent by any other rating agency) and licensed in the District.

APPENDIX B: ASSURANCES CERTIFICATIONS & DISCLOSURES

APPLICANT / GRANTEE ASSURANCES, CERTIFICATIONS & DISCLOSURES

This section includes certifications, assurances and disclosures made by the authorized representative of the Applicant/Grantee organization. These assurances and certifications reflect requirements for recipients of local and pass-through federal funding.

A. Applicant/Grantee Representations

1. The Applicant/Grantee has provided the individuals, by name, title, address, and phone number who are authorized to negotiate with the Department of Health on behalf of the organization;
2. The Applicant/Grantee is able to maintain adequate files and records and can and will meet all reporting requirements;
3. All fiscal records are kept in accordance with Generally Accepted Accounting Principles (GAAP) and account for all funds, tangible assets, revenue, and expenditures whatsoever; all fiscal records are accurate, complete and current at all times; and these records will be made available for audit and inspection as required;
4. The Applicant/Grantee is current on payment of all federal and District taxes, including Unemployment Insurance taxes and Workers' Compensation premiums. This statement of certification shall be accompanied by a certificate from the District of Columbia OTR stating that the entity has complied with the filing requirements of District of Columbia tax laws and is current on all payment obligations to the District of Columbia, or is in compliance with any payment agreement with the Office of Tax and Revenue; (attach)
5. The Applicant/Grantee has the administrative and financial capability to provide and manage the proposed services and ensure an adequate administrative, performance and audit trail;
6. If required by DC Health, the Applicant/Grantee is able to secure a bond, in an amount not less than the total amount of the funds awarded, against losses of money and other property caused by a fraudulent or dishonest act committed by Applicant/Grantee or any of its employees, board members, officers, partners, shareholders, or trainees;
7. The Applicant/Grantee is not proposed for debarment or presently debarred, suspended, or declared ineligible, as required by Executive Order 12549, "Debarment and Suspension," and implemented by 2 CFR 180, for prospective participants in primary covered transactions and is not proposed for debarment or presently debarred as a result of any actions by the District of Columbia Contract Appeals Board, the Office of Contracting and Procurement, or any other District contract regulating Agency;
8. The Applicant/Grantee either has the financial resources and technical expertise necessary for the production, construction, equipment and facilities adequate to perform the grant or subgrant, or the ability to obtain them;

9. The Applicant/Grantee has the ability to comply with the required or proposed delivery or performance schedule, taking into consideration all existing and reasonably expected commercial and governmental business commitments;
10. The Applicant/Grantee has a satisfactory record of performing similar activities as detailed in the award or, if the grant award is intended to encourage the development and support of organizations without significant previous experience, has otherwise established that it has the skills and resources necessary to perform the services required by this Grant.
11. The Applicant/Grantee has a satisfactory record of integrity and business ethics;
12. The Applicant/Grantee either has the necessary organization, experience, accounting and operational controls, and technical skills to implement the grant, or the ability to obtain them;
13. The Applicant/Grantee is in compliance with the applicable District licensing and tax laws and regulations;
14. The Applicant/Grantee is in compliance with the Drug-Free Workplace Act and any regulations promulgated thereunder; and
15. The Applicant/Grantee meets all other qualifications and eligibility criteria necessary to receive an award; and
16. The Applicant/Grantee agrees to indemnify, defend and hold harmless the Government of the District of Columbia and its authorized officers, employees, agents and volunteers from any and all claims, actions, losses, damages, and/or liability arising out of or related to this grant including the acts, errors or omissions of any person and for any costs or expenses incurred by the District on account of any claim therefrom, except where such indemnification is prohibited by law.

B. Federal Assurances and Certifications

The Applicant/Grantee shall comply with all applicable District and federal statutes and regulations, including, but not limited to, the following:

1. The Americans with Disabilities Act of 1990, Pub. L. 101-336, July 26, 1990; 104 Stat. 327 (42 U.S.C. 12101 et seq.);
2. Rehabilitation Act of 1973, Pub. L. 93-112, Sept. 26, 1973; 87 Stat. 355 (29 U.S.C. 701 et seq.);
3. The Hatch Act, ch. 314, 24 Stat. 440 (7 U.S.C. 361a et seq.);
4. The Fair Labor Standards Act, ch. 676, 52 Stat. 1060 (29 U.S.C.201 et seq.);
5. The Clean Air Act (Subgrants over $100,000), Pub. L. 108-201, February 24, 2004; 42 USC ch. 85 et.seq.);
6. The Occupational Safety and Health Act of 1970, Pub. L. 91-596, Dec. 29, 1970; 84 Stat. 1590 (26 U.S.C. 651 et.seq.);
7. The Hobbs Act (Anti-Corruption), ch. 537, 60 Stat. 420 (see 18 U.S.C. § 1951);
8. Equal Pay Act of 1963, Pub. L. 88-38, June 10, 1963; 77 Stat.56 (29 U.S.C. 201);

9. Age Discrimination Act of 1975, Pub. L. 94-135, Nov. 28, 1975; 89 Stat. 728 (42 U.S.C. 6101 et. seq.)
10. Age Discrimination in Employment Act, Pub. L. 90-202, Dec. 15, 1967; 81 Stat. 602 (29 U.S.C. 621 et. seq.);
11. Military Selective Service Act of 1973;
12. Title IX of the Education Amendments of 1972, Pub. L. 92-318, June 23, 1972; 86 Stat. 235, (20 U.S.C. 1001);
13. Immigration Reform and Control Act of 1986, Pub. L. 99-603, Nov 6, 1986; 100 Stat. 3359, (8 U.S.C. 1101);
14. Executive Order 12459 (Debarment, Suspension and Exclusion);
15. Medical Leave Act of 1993, Pub. L. 103-3, Feb. 5, 1993, 107 Stat. 6 (5 U.S.C. 6381 et seq.);
16. Drug Free Workplace Act of 1988, Pub. L. 100-690, 102 Stat. 4304 (41 U.S.C.) to include the following requirements:
    1) Publish a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the Applicant/Grantee's workplace and specifying the actions that will be taken against employees for violations of such prohibition;
    2) Establish a drug-free awareness program to inform employees about:
        a. The dangers of drug abuse in the workplace;
        b. The Applicant/Grantee's policy of maintaining a drug-free workplace;
        c. Any available drug counseling, rehabilitation, and employee assistance programs; and
        d. The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace; and
    3) Provide all employees engaged in performance of the grant with a copy of the statement required by the law;
17. Assurance of Nondiscrimination and Equal Opportunity, found in 29 CFR 34.20;
18. District of Columbia Human Rights Act of 1977 (D.C. Official Code § 2-1401.01 et seq.);
19. Title VI of the Civil Rights Act of 1964;
20. District of Columbia Language Access Act of 2004, DC Law 15 - 414 (D.C. Official Code § 2-1931 et seq.);
21. Lobbying Disclosure Act of 1995, Pub. L. 104-65, Dec 19, 1995; 109 Stat. 693, (31 U.S.C. 1352); and
22. Child and Youth, Safety and Health Omnibus Amendment Act of 2004, effective April 13, 2005 (D.C. Law §15-353; D.C. Official Code § 4-1501.01 et seq.)(CYSHA). In accordance with the CYSHA any person who may, pursuant to the grant, potentially work directly with any child (meaning a person younger than age thirteen (13)), or any youth (meaning a person between the ages of thirteen (13) and seventeen (17) years, inclusive) shall complete a background check that meets the requirements of the District's Department of Human Resources and HIPAA.

C. Mandatory Disclosures

1. The Applicant/Grantee certifies that the information disclosed in the table below is true at the time of submission of the application for funding and at the time of award if funded. If the information changes, the Grantee shall notify the Grant Administrator within 24 hours of the change in status. A duly authorized representative must sign the disclosure certification

2. **Applicant/Grantee Mandatory Disclosures**

A. Per OMB 2 CFR §200.501– any recipient that expends $750,000 or more in federal funds within the recipient's last fiscal, must have an annual audit conducted by a third – party. In the Applicant/Grantee's last fiscal year, were you required to conduct a third-party audit?	☐ **YES** ☐ **NO**
B. Covered Entity Disclosure During the two-year period preceding the execution of the attached Agreement, were any principals or key personnel of the Applicant/Grantee / Recipient organization or any of its agents who will participate directly, extensively and substantially in the request for funding (i.e. application), pre-award negotiation or the administration or management of the funding, nor any agent of the above, is or will be a candidate for public office or a contributor to a campaign of a person who is a candidate for public office, as prohibited by local law.	☐ **YES** ☐ **NO**
C. Executive Compensation: For an award issued at $25,000 or above, do Applicant/Grantee's top five executives do not receive more than 80% of their annual gross revenues from the federal government, Applicant/Grantee's revenues are greater than $25 million dollars annually AND compensation information is not already available through reporting to the Security and Exchange Commission. *If No, the Applicant, if funded shall provide the names and salaries of the top five*	☐ **YES** ☐ **NO**
D. The Applicant/Grantee organization has a federally-negotiated Indirect Cost Rate Agreement. If yes, insert issue date for the IDCR:_____If yes, insert the name of the cognizant federal agency? _____	☐ **YES** ☐ **NO**
E. No key personnel or agent of the Applicant/Grantee organization who will participate directly, extensively and substantially in the request for funding (i.e. application), pre-award negotiation or the administration or management of the funding is currently in violation of federal and local criminal laws involving fraud, bribery or gratuity violations potentially affecting the DC Health award.	☐ **YES** ☐ **NO**

ACCEPTANCE OF ASSURANCES, CERTIFICATIONS AND DISCLOSURES

I am authorized to submit this application for funding and if considered for funding by DC Health, to negotiate and accept terms of Agreement on behalf of the Applicant/Grantee organization; and

I have read and accept the terms, requirements and conditions outlined in all sections of the RFA, and understand that the acceptance will be incorporated by reference into any agreements with the Department of Health, if funded; and I, as the authorized representative of the Grantee organization, certify that to the best of my knowledge the information disclosed in the Table: Mandatory Disclosures is accurate and true as of the date of the submission of the application for funding or at the time of issuance of award, whichever is the latter.

Date:

Sign:

NAME: INSERT NAME TITLE: INSERT TITLE

AGENCY NAME: