DC | HEALTH

GOVERNMENT OF THE DISTRICT OF COLUMBIA
MURIEL BOWSER, MAYOR

DEPARTMENT OF HEALTH COMMUNITY HEALTH ADMINISTRATION (CHA)

# Addressing Health Equity through Tobacco Control

# REQUEST FOR APPLICATIONS

## RFA# CHA_AHEP_10.29.2021
## AMENDED

## SUBMISSION DEADLINE: FRIDAY,

## DECEMBER 3, 2021 BY 6:00 p.m.

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 (DC Health)**

**Community Health Administration**

**NOTICE OF FUNDING AVAILABILITY (NOFA)**
**RFA# CHA_AHEP_10.29.2021**
**Addressing Health Equity Through Tobacco Control**
**Tobacco Control Program**

The District of Columbia, Department of Health (DC Health) is soliciting applications 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: | Addressing Health Equity Through Tobacco Control |
| Funding Opportunity Number: | FO-CHA-PG-00179-009 |
| Program RFA ID#: | CHA_AHEP_10.29.2021 |
| Opportunity Category: | Competitive |
| DC Health Administrative Unit: | Community Health Administration |
| DC Health Program Bureau | Cancer and Chronic Disease Prevention Bureau |
| Program Contact: | Carrie Dahlquist<br>Manager, Tobacco Control Program<br>202.442.9176 carrie.dahlquist@dc.gov |
| Program Description: | DC Health recognizes tobacco use, a detrimental health behavior influenced by social and environmental factors that contributes to health disparities among African Americans/blacks in the District of Columbia. Funding under this RFA will support the implementation of sustainable tobacco control strategies and activities through a community-based approach. The lead agency will (1) collaborate with key stakeholders to address policy, systems, and environmental factors that are barriers to tobacco cessation and (2) integrate tobacco control activities with multi-sector organizations addressing social needs. Applicants must demonstrate how their proposed strategies and activities will address tobacco disparities through a health equity lens and reduce barriers undermining access to resources, social support, and opportunities to pursue optimal health. |

| | |
|---|---|
| Eligible Applicants | Community or national organizations, academic institutions, or healthcare systems licensed and operating in the District of Columbia. |
| Anticipated # of Awards: | 1 |
| Anticipated Amount Available: | $300,000 |
| Floor Award Amount: | $200,000 |
| Ceiling Award Amount: | $300,000 |

**Funding Authorization**

| | |
|---|---|
| Legislative Authorization | Section 317(k)(2)(e) of the Public Service Act |
| Associated CFDA# | 93.387 |
| Associated Federal Award ID# | NU58DP006834 |
| Cost Sharing / Match Required? | No |
| RFA Release Date: | October 29, 2021 |
| Pre-Application Conference Date/Time | 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: | December 3, 2021 |
| 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<br>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.

# CONTENTS

**District of Columbia Department of Health**

**RFA Terms and Conditions**

V.10.2021

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://communityaffairs.dc.gov/content/community-grant-program.

If your agency would like to obtain a copy of the **DC Health RFA Dispute Resolution Policy, it is available at:** https://dchealth.dc.gov/service/grants-management.

## 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:
    - Table of Contents
    - Application Proposal
        - Project Abstract
        - Project Narrative
        - Work Plan
        - Project Budget
        - Budget Justification
        - Staffing Plan & Organizational Chart
        - Letters of Commitment
    - Assurances, Certifications, and Certification Documents
    - Mandatory Business Documents

- ☐ 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**. **The total size of all uploaded files may not exceed the equivalent of 50 pages when printed. Applications that do not conform to these requirements will not be forwarded to the review panel.**
- ☐ The application proposal format conforms to the "Application Elements" 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, logic model, 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 **12/3/2021.**

# GENERAL INFORMATION

## KEY DATES

- Notice of Funding Announcement Date: **October 1, 2021**
- Request for Application Release Date: **October 29, 2021**
- Application Submission Deadline: **December 3, 2021**
- Anticipated Award Start Date: **January 1, 2022**

## OVERVIEW

The mission of DC Health is to promote and protect the health, safety, and quality of life of residents, visitors, and those doing business in the District of Columbia. 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.

The Community Health Administration (CHA) within DC Health 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.

As part of that mission, DC Health's Tobacco Control Program (TCP) applies evidence-based approaches to reduce disease, disability, and death related to tobacco use. The program works closely with government, community, and clinical partners to ensure that residents of all ages can achieve health by preventing the initiation of tobacco use, promoting cessation of tobacco, eliminating exposure to secondhand smoke (SHS), and identifying and eliminating tobacco-related health disparities.

Funding under this RFA will support the implementation of tobacco control strategies and activities to address tobacco use disparities among African Americans, with a focus on those who are experiencing food insecurity in the District of Columbia. The recipient will utilize a community-based policy, systems, and environmental (PSE) change approach in collaboration with key stakeholders and guided by the latest data, best practices, and partner feedback. Applicants must demonstrate how their proposed strategies and activities will address tobacco disparities through a health equity lens that incorporates social determinants of health.

## SOURCE OF GRANT FUNDING

Funding is made available under the District of Columbia Fiscal Year 2022 Budget Support Act of 2021 and Federal Award Identification #5NU58DP006834.

## AWARD INFORMATION

### Amount of Funding Available

This RFA will make available $300,000 for one award per fiscal year. Funding each year will be commensurate on level of effort required.

### Performance and Funding Period

The projected project period is January 1, 2022 – December 31, 2025. Year 1 budget period is January 2022 – December 2022. The number of awards, budget periods and award amounts are contingent upon the continued availability of funds and recipient performance.

### Eligible Organizations/Entities

Community or national organizations, academic institutions, or healthcare systems licensed and operating in the District of Columbia. 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.

### 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.

# BACKGROUND & PURPOSE

## BACKGROUND

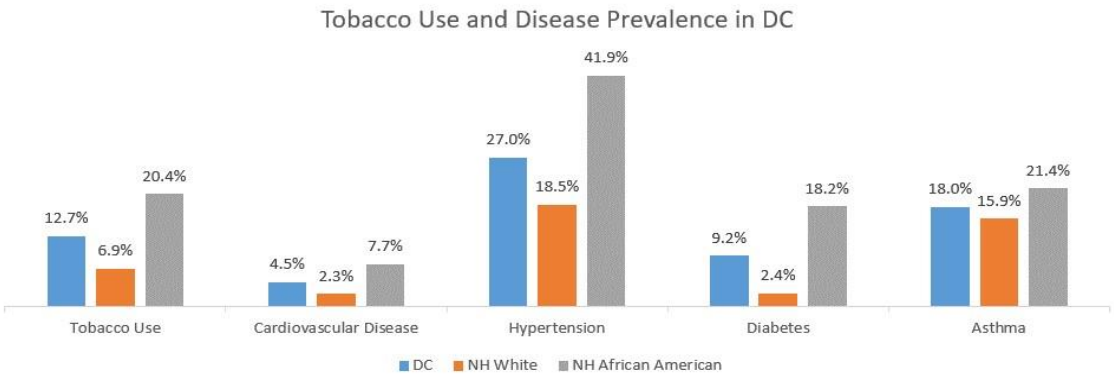
The District of Columbia ("DC or "the District") ranks better than the United States (US) average in many wealth and health metrics. In 2019, DC's median income was $86,420 compared to the national median of $68,703 in 2019.[1] Compared to the US overall, DC has higher rates of educational attainment (58.5% vs 32.1%), uninsured population (3.9% vs 9.5%), and physical activity meeting recommendations (27.2% vs 23.2%).[1, 2] Additionally, DC has lower Rates of tobacco use (12.7% vs 16%), obesity and overweight (55.9% vs 66.7%), and cardiovascular disease (4.5% vs 6.3%).[1, 2]

Further analysis reveals that these metrics, however, are not consistent across all populations. The burdens of poverty, disease, and poor health are much greater for non-Hispanic African Americans (African Americans) living in the District than for their non-Hispanic white (white) counterparts. African American residents in DC are disproportionately burdened by poverty, unemployment, and lower educational attainment than white residents. They are less likely to

[1]United States Census Bureau. Quick Facts District of Columbia. Accessed July 6, 2021. https://www.census.gov/quickfacts/fact/table/US,DC/PST045219

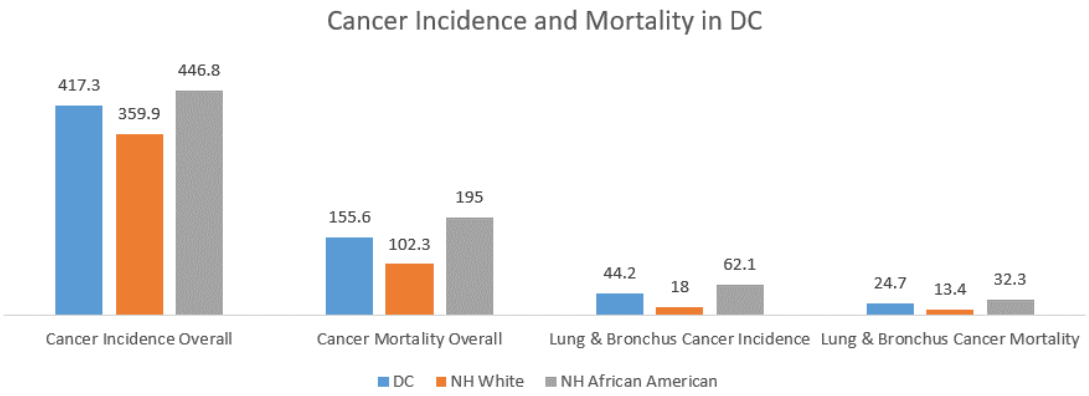
have access to nutritious foods and opportunities to engage in physical activity. Compared to white DC residents, African Americans are more likely to smoke. Chronic diseases and conditions such as heart attacks, hypertension, obesity, cancer, diabetes, and dementia are more prevalent among African Americans than whites as shown in Figures 1 and 2.

*Figure 1*: Tobacco use and disease prevalence




*Behavioral Risk Factor Surveillance System (BRFSS) 2019*

*Figure 2*: Cancer mortality and incidence




*DC Cancer Registry (2018)*

These inequities and disparities were exacerbated by the COVID-19 pandemic, with African Americans 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 better address all health needs in the District with a focus on health equity and the underlying causes of health disparities.

**The Interrelationship of Social Determinants, Tobacco Use, and Health Outcomes in DC**

A leading cause of higher morbidity and mortality among African American District residents is the disparate use of tobacco products. Though only 12.7% of District residents identify as

smokers, 20.4% of African Americans smoke compared to 6.8% of whites[2.] These disparities influence poor health outcomes resulting in cancer, diabetes, and cardiovascular disease. The disparity is mirrored in COVID-19 infections as well, where African Americans had higher incidence and mortality rates. Like many pre-existing conditions with higher prevalence in African Americans/black populations, tobacco use is a risk factor aggravating the severity of COVID-19 infection and mortality.[3] While smoking is a lifestyle choice that choice is influenced by the social and physical environments in which people live, work, and play. These environmental elements, known as *social determinants of health*, include race/ethnicity, socioeconomic status, employment, educational attainment, access to healthy foods and healthcare services, safe neighborhoods, active living, housing, and transportation. These social determinants of health impact resources, opportunities, and access to a given population and, therefore, their ability to live a smoke-free life.

Social determinants of health and their impacts are interrelated. A person with low educational attainment is less likely to have unstable employment and more likely to live in poverty. This translates to barriers accessing nutritious foods and healthcare services. Individuals experiencing food insecurity are more likely to be smokers than those who are food secure. There are several well-being metrics, each related to higher smoking rates, in which African Americans residents overall and specifically those in Wards 7 and 8 fall behind their white counterparts: socioeconomic status, educational attainment, employment, access to healthcare, food security, and active living. These disparities are grounded in the structural racism and implicit bias that have shaped our society and its institutions, resulting in limited access and opportunity for minority populations.

*Race/Ethnicity & Socioeconomic Status (SES)* The District has a minority majority in its racial/ethnic composition with 46% non-Hispanic white, 46% non-Hispanic African Americans, 11.3% Hispanic, and 4.5% Asian.[4] Within the District's eight geographical regions, Wards 7 & 8 have the highest percentage of African Americans at 91.74% and 91.84%, respectively. While the median household income for DC is $91,414, there are wide variations among racial/ethnic groups. For whites it is $143,150, with African Americans falling significantly behind at $83,179. The disparities at the ward level are even greater. In Ward 7, white household income is three times that of African Americans ($120,308 vs $38,761), while in Ward 8 it is more than double ($108,199 vs $37,335).[5] Residents within Wards 7 & 8 have the highest rates of poverty

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[2] Centers for Disease Control and Prevention. Behavioral Risk Factor Surveillance System (BRFSS) Prevalence & Trends Data 2019. [accessed Jun 30, 2021]. https://www.cdc.gov/brfss/brfssprevalence/

[3] Gupta, A. K., Nethan, S. T., & Mehrotra, R. (2021). Tobacco use as a well-recognized cause of severe COVID-19 manifestations. *Respiratory medicine*, *176*, 106233. https://doi.org/10.1016/j.rmed.2020.106233

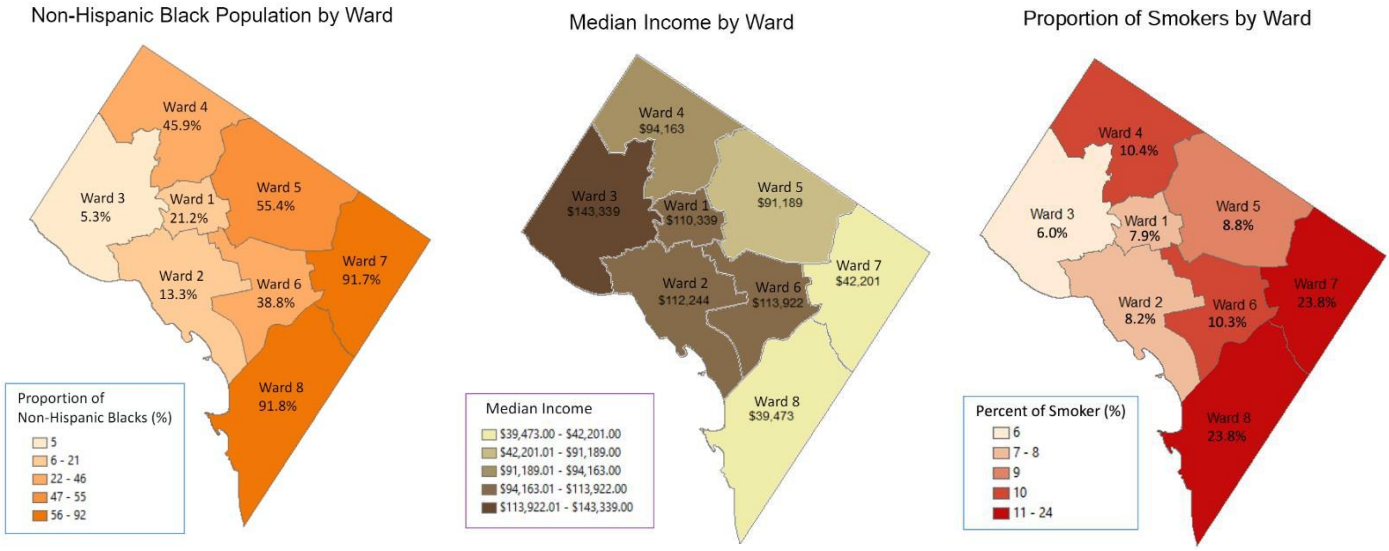
[4] United States Department of Commerce. *QuickFacts: District of Columbia Dashboard*. Accessed June 10, 2021. https://www.census.gov/quickfacts/fact/dashboard/districtofcolumbiadistrictofcolumbia,US/PST045219.

[5] DC Health Matters. *2021 Demographics: Summary Data for District of Columbia*. Accessed June 29, 2021. https://www.dchealthmatters.org/?module=demographicdata&controller=index&action=index&id=130951§ionId=.

in the District at 26.6% and 35.7%, respectively, compared to 8.4% in Ward 3.[6] People living in poverty are more likely to experience illness due to limited access to resources that support good health such as nutritious foods, a safe and clean environment, and healthcare.

Income and ward of residence, like race/ethnicity, are also closely related to smoking prevalence, as seen in Figure 3. In 2019, 25.4% of District residents with household incomes less than $35,000 smoked cigarettes; in comparison, 6.7% of residents with a household income over $75,000 smoked cigarettes.[2] Geographically, over half (53.7%) of the District residents who are current smokers reside in Wards 7 and 8. In both Wards 7 and 8, 23.8% of residents reported currently smoking, compared with only 6% in Ward 3. Smokers with lower incomes face many chronic stressors and trauma such as those related to financial hardship. The stress relief from smoking is often reported as a driver of smoking among people who use tobacco.[7] To complicate further, lower SES presents its own barriers, such as a lack of understanding of the importance of quitting, no knowledge of available cessation resources and the lack of access to medical care.

*Figure 3:* Ward Demographics



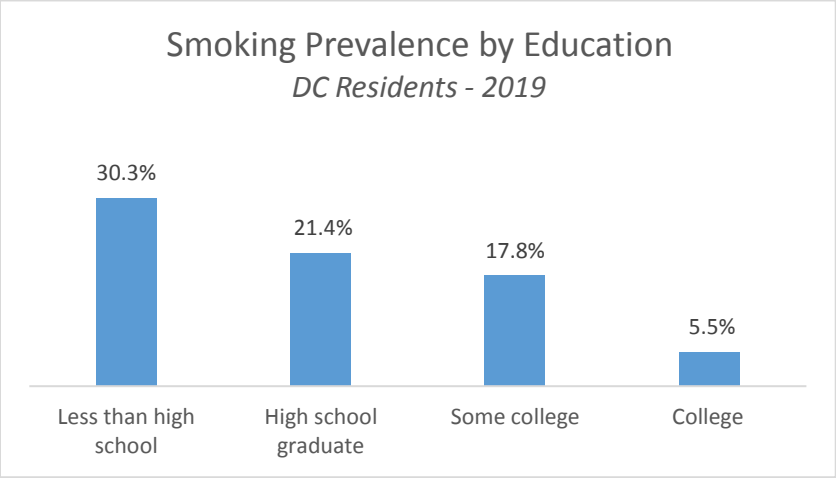

*Education, Employment, and Healthcare Access* Educational attainment is a key indicator of SES and correlates to job opportunities and employment status. Among adults aged 25 and older, African Americans in DC are less likely than whites to have completed high school, to attend college, or to graduate with a bachelor's degree or greater. The relationship between race/ethnicity and educational attainment is illustrated when comparing Ward 3 (81.38% white) with Wards 7 (91.74% African American) and 8 (91.84% African American). While 86.8% of

[6] United States Department of Health and Human Services. Overview of the State – District of Columbia – 2020. *Health Resources and Services Administration*. Accessed June 30, 2021. https://mchb.tvisdata.hrsa.gov/Narratives/Overview/258318d0-8dbe-46fd-9a77-385b6753e1c7.

[7] Kim-Mozeleski JE, Pandey R. The Intersection of Food Insecurity and Tobacco Use: A Scoping Review. *Health Promotion Practice*. 2020;21(1_suppl):124S-138S. doi:10.1177/1524839919874054

Ward 3 residents hold a bachelor's degree or higher, only 18.8% in Wards 7 and 8 have the same level of education.[8] Obtaining an education has a profound effect on health by improving understanding of complex health issues. People with more education are more receptive to health education campaigns and more likely to learn about health and health risks, improving their literacy and comprehension of complex issues critical to their wellbeing.[9] Meanwhile, lower educational attainment is associated with disproportionately higher use of tobacco (Figure 4). Residents with a high school diploma or less make up more than half (50.2%) of the current cigarette smoking population.[2] Educational attainment also influences an individual's employment prospects and thus earning power. Unemployment rates for residents within Wards 7 & 8, which have the lowest rates of educational attainment, are 16% and 18% respectively. Unemployment in Ward 3, which has the highest educational attainment, is only 4%.[8]

*Figure 4:* Smoking Prevalence by Education




*Behavioral Risk Factor Surveillance System (BRFSS) 2019*

The racial and ethnic disparities in education and employment are mirrored in access to healthcare. Although only 7.7% of the Districts residents are uninsured, many – in particular those who are African American and have low SES – grapple with poor health outcomes. While only 3.8% of white District residents lack health coverage, this number is more than double for African American residents at 10.2%.[2] Having healthcare coverage increases the likelihood that an individual will seek preventive care or care for chronic conditions. Yet even those with insurance coverage are likely to forego or delay care due to out-of-pockets costs. Health insurance alone, however, does not remove every barrier to care. More important in driving

[8] DC Health Matters. 2021 Demographics: Summary Data. Accessed June 30, 2021. https://www.dchealthmatters.org/?module=demographicdata&controller=index&action=index&id=130951&sectionId=
[9] Muennig, Dr. Peter. Issue brief. Healthier and Wealthier: Decreasing Health Care Costs by Increasing Educational Attainment. *MetLife Foundation*, November 2006. https://all4ed.org/wp-content/uploads/HandW.pdf.

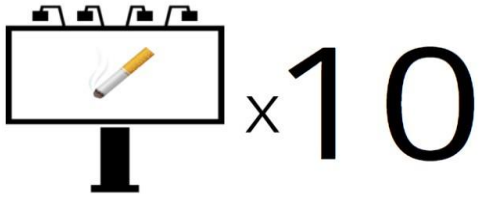
health outcomes are social determinants of health, which can also impact those with healthcare coverage. The lack of convenient and reliable transportation, low health literacy, and inflexible work schedules can prevent access to care, resulting in negative health outcomes.

**Predatory Marketing to the African American Community by the Tobacco Industry**

Smoking-related illnesses are the number one cause of death in the African American community, surpassing all other causes of death, including AIDS, homicide, diabetes, and accidents. While studies have shown that African American smokers find smoking socially unacceptable and 70% want to quit, they are less likely to be successful in a quit attempt than their white counterparts. This could be due in part to the higher rates of menthol tobacco use among African Americans. (85% compared to 29% among white smokers). Menthol's cooling sensation and anesthetic properties mask the harshness of tobacco products.[10] The higher prevalence of menthol use in African American populations is directly related to the predatory marketing tactics of the Tobacco Industry.

Historically, the tobacco industry has targeted marketing to specific populations using radio, billboard, and print ads. Research has shown a ten-fold increase in the number of tobacco advertisements in African American neighborhoods compared to other neighborhoods.[11] A 2011 study found advertisements for menthol cigarettes were more common in the magazine *Ebony* than in the magazine *People*. A subsequent study found that African American children were more likely than other children to identify advertisements for the most popular menthol cigarette brand among African Americans. Other widely known promotional tactics utilized are direct marketing and increased advertisement in African American neighborhoods and sponsorship of cultural events with large African American audiences.[12]

*Figure 7:* Targeted Advertising in African American neighborhoods




[10] Campaign for Tobacco Free Kids. Tobacco Use Among African Americans. February 21, 2021. Accessed June 23, 2021. https://www.tobaccofreekids.org/assets/factsheets/0006.pdf
[11] Truth Initiative. Tracing the Racist Tactics of the Tobacco Industry. October 16, 2020. https://truthinitiative.org/research-resources/targeted-communities/tracing-racist-tactics-tobacco-industry
[12] Truth Initiative. Tobacco Is a Social Justice Issue: Racial and Ethnic Minorities." February 3, 2017. https://truthinitiative.org/research-resources/targeted-communities/tobacco-social-justice-issue-racial-and-ethnic-minorities

To counter the effects of tobacco company marketing, community-based organizations and businesses can leverage their roles in the African Americans community to promote smoke-free environments, provide links to cessation resources, actively support and enforce smoke-free and Tobacco 21 rules and regulations, and support reduced access to tobacco products among youth and young adults.

**The Landscape of Food Access and Active Living within the District**

The pervasive issue of food insecurity continues to disproportionately affect the low-income African American community, children, and the elderly. Food insecurity is the lack of consistent access to enough food for an active, health life. Within the District, 10.6% of residents were food insecure prior to the declaration of the COVID-19 public health emergency. The rates of those experiencing food insecurity doubled to 21.1% between February 2020 and May 2020. Food insecurity was projected to be at least 16% for 2020 overall. Among vulnerable populations, such as children, elderly, and those experiencing homelessness, the rate is expected to be even higher. Aside from SES, a key driver of food insecurity is lack of access to nutritious foods. Only three full-service grocery stores serve over 150,000 residents of Wards 7 & 8 resulting in lack of convenient food access for 150,000.[13] Meanwhile, the more affluent Ward 3 has 10 times as many full-service grocery stores per 1,000 residents. The United States Department of Agriculture recognizes Wards 7 and 8 as food deserts. "Food desert" is a familiar but neutral term. Instead, "*food apartheid* more accurately captures the deliberate and racialized nature of food segregation in cities across America."[14]

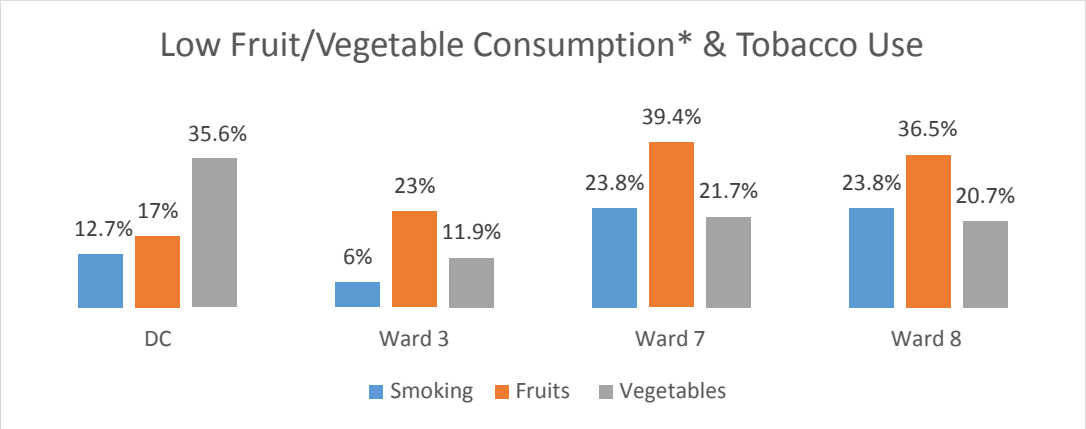
*Figure 5*: Grocery Stores by Ward


*District Office of Planning*

*Figure 6:* Low Food Consumption and Tobacco Use

[13] District of Columbia Office of Planning. *Food Access and Food Security in the District of Columbia: Responding to the COVID-19 Public Health Emergency*. Accessed June 10, 2021. https://dcfoodpolicycouncilorg.files.wordpress.com/2020/09/food-security-report-9-24-20.pdf.

[14] Toussaint, Etienne C., and Sabine O'Hara. Food, Fitness, and Fatalities. *American Bar Association*. December 14, 2020. https://www.americanbar.org/groups/crsj/publications/human_rights_magazine_home/rbgs-impact-on-civil-rights/food-fitness-and-fatalities/.

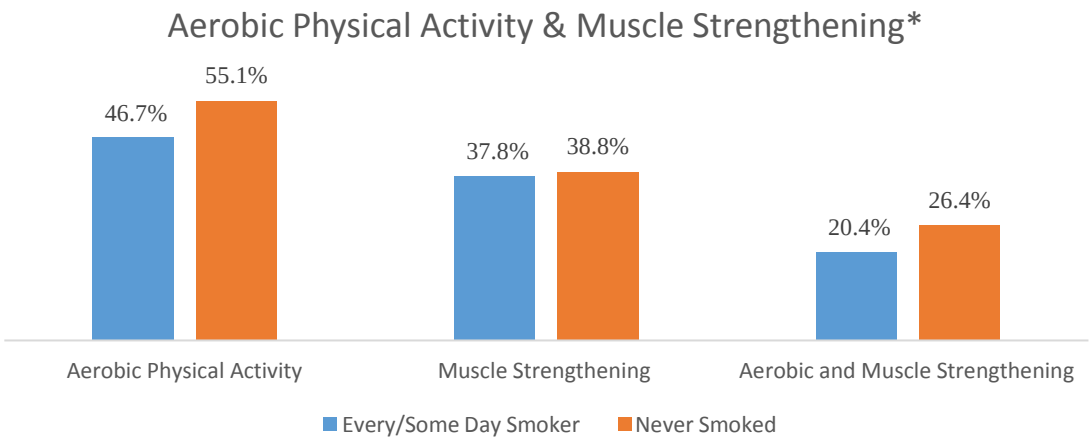



**Less than one fruit or one vegetable per day*
*Behavioral Risk Factor Surveillance System (BRFSS) 2019*

Though it seems at odds with higher rates of food insecurity in Wards 7 & 8, these wards have rates of overweight and obesity over 72%. While less than one in every ten white District residents identified as obese; one in every three African Americans in the District is.[15] Those who are food insecure, however, often rely on inexpensive high calorie/low nutrition foods that increase risk of obesity and other chronic diseases. That risk increases with physical inactivity. While 64.9% of whites in the District report getting the recommended 150 minutes of aerobic exercise each week, only 44.5% of African Americans reported the same.[2] More specifically, as shown in Figure 7, smokers are somewhat less likely to participate in aerobic and muscle strengthening than non-smokers.[2] The same social determinants of health that are associated with tobacco use – poverty, food insecurity, lower educational attainment, unemployment, and the lack of green spaces in the community – are associated with less physical activity.

*Figure 7:* Aerobic Physical Activity & Muscle Strengthening Among Smokers vs. Non-Smokers

[15] DC Health. *Obesity*. Accessed June 10, 2021. https://dchealth.dc.gov/service/obesity-overview.




**150 minutes or more aerobic physical activity per week; muscle strengthening exercises two or more times per week; meeting guidelines for aerobic and muscle strengthening exercises*
*Behavioral Risk Factor Surveillance System (BRFSS) 2019*

There is a correlation between food insecurity and tobacco use, with those having limited access to adequate food being more likely to smoke. The relationship between smoking and food insecurity is complex. Just as financial stress can contribute to smoking, so does food insecurity. Limited access to food or worrying about running out of food increases stress, which can be a trigger for smoking. Nicotine can be an appetite suppressant, which can be desired among populations who are food insecure. Withdrawal from nicotine increases hunger sensations, making smoking more appealing and possibly driving a relapse to smoking among those who have quit.[16] This can be exacerbated in food insecure populations utilizing food access programs such as WIC and SNAP. WIC- and SNAP-authorized stores are more likely than stores not participating in the programs to have tobacco advertising and price promotions that can prompt impulse buying of tobacco products.[17] Similar advertising can be found in corner stores found in in communities with residents of low socioeconomic status, creating an environment where smoking is viewed as acceptable. There are opportunities to design innovative policies that encourage stores to stock more fruits and vegetables and place them prominently at the point of sale. Because of the connection between smoking and food insecurity, addressing both together has the potential to significantly decrease morbidity and mortality related to both smoking and poor nutrition.

## Community Interventions to Support Tobacco Control

[16] Kim-Mozeleski, J. E., Pandey, R., & Tsoh, J. Y. (2019). Psychological distress and cigarette smoking among U.S. households by income: Considering the role of food insecurity. *Preventive Medicine Reports, 16*. https://doi.org/10.1016/j.pmedr.2019.100983

[17] Rust, S. M., Myers, A. E., D'Angelo, H., Queen, T. L., Laska, M. N., & Ribisi, K. M. (2019) Tobacco marketing at SNAP- and WIC-authorized retail food stores in the United States. *Health Education & Behavior, 46*(4):541-549. https://doi.org/10.1177%2F1090198119831759

*Cessation Support*

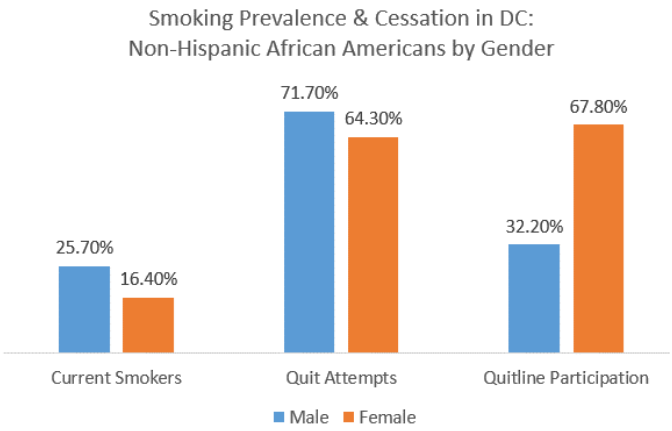
For smokers who wish to quit, there are several evidence-based treatment options available with varying rates of success. An analysis of studies on the range of therapies was used to develop *Treating Tobacco Use and Dependence: 2008 Update*. The analysis showed self-help as the least successful, with a quit rate of 9-12%. Counseling alone has a quit rate of 13-17%. Among FDA-approved medications, over-the-counter nicotine replacement therapy (NRT) alone has a quit rate of 19-26%; prescription drug bupropion XR and varenicline are slightly better at 24% and 33%. The most effective cessation therapy is the combination of counseling and medication at 26-32%, with number of counseling sessions having a direct correlation to quit rate success.

The DC Quitline offers counseling and support in a variety of formats as well as NRT to help smokers overcome physical and emotional urges to smoke. The DC Quitline (1-800-QUIT-NOW) is available to help District of Columbia residents quit tobacco at no cost. While DC Quitline provides counseling supports in several languages, a local number (202-333-4488) directly connects Spanish-speaking callers to the Quitline. Individuals can access the Quitline directly or be referred by a healthcare provider or community organization through e-referral.

The Quitline provides one-on-one private counseling sessions to District of Columbia residents. Beyond phone-based enrollment, residents can enroll for the Quitline services through text messages and the website. While the counseling and coaching services are often emphasized, the DC Quitline also offers other individualized services to residents, including Text2Quit, email and/or text messaging support, educational and quit-guide materials, and up to an 8-week supply of nicotine replacement therapy (NRT) that includes NicodermCQ patches or Commit lozenges. Provision of these services provides flexibility, allowing individuals to choose which services they would like to receive. Each resident who signs up to receive DC Quitline services may utilize one or more services to address individual needs. The overall goal of the DC Quitline is to assist District residents' cessation attempts by reducing barriers to access and to increase cessation attempts and tobacco cessation success rates in the District of Columbia. The goal of individualized services is to increase the likelihood of retention in the program by tailoring services to fit each resident's needs. (See Appendix B)

DC Quitline data shows that the majority of users (85.5%) are African Americans, the population most likely to smoke in the District. Even though African Americans attempt to quit more than their white counterparts who smoke, there is a gap in those who make a quit attempt utilizing the services of the Quitline and those who do not. This reveals an opportunity to raise awareness and utilization of this evidence-based service.

*Figure 8:* Smoking Prevalence & Cessation in Non-Hispanic African Americans by Gender




*Policy, Systems, Environmental Approaches to Tobacco Control in DC*

Public health's role is to promote, preserve, and advocate for the public's health and well-being. Organized, collaborative community effort is needed to support and promote public health.

One of the most effective interventions to reduce tobacco use is policy change. The public health landscape within DC has been impacted by laws that have reduced access to tobacco products and secondhand smoke exposure. In 2018, DC raised the cigarette excise tax to $4.50, (the highest in the nation) and began enforcement of Tobacco 21 laws restricting the sale of tobacco products to anyone 20 years and younger.[18] Through the Department of Health Functions Clarification Amendment Act of 2006, the District restricted smoking in the workplace, including governmental and private workplaces, school and childcare facilities, retail stores, and restaurants.[19] Besides legislative action, policy change can be effective in creating smoke-free environments. When the US Department of Housing and Urban Development implemented rules restricting smoking in public housing, DC Health's TCP provided support and guided other multi-unit housing properties to go smoke-free by providing policy implementation tools and cessation support resources.

Community-wide interventions, which focus on cultivating physical and social environments conducive to the pursuit of a healthy lifestyle, are needed to increase opportunities for learning and practicing healthful habits. Mass media and targeted ads, such as the CDC's national *Tips From Former Smokers*® campaign, are powerful prevention tools showing real-life health consequences of tobacco use and promoting evidence-based resources for quitting.[20] The District of Columbia Tobacco Free Coalition is a collaborative of organizations and community

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[18] Giambrone, A. D.C. Cigarette Taxes to Be Among Nation's Highest Under New Budget. *Washington City Paper*. September 30, 2020. https://washingtoncitypaper.com/article/324591/dc-cigarette-taxes-to-be-among-nations-highest-under-new-budget/.
[19] Truth Initiative. *Tobacco Use in the District of Columbia 2020*. October 27, 2020. https://truthinitiative.org/research-resources/smoking-region/tobacco-use-district-columbia-2020.
[20] Murphy-Hoefer R, Davis KC, King BA, Beistle D, Rodes R, Graffunder C. Association Between the Tips From Former Smokers Campaign and Smoking Cessation Among Adults. United States, 2012–2018. *Preventing Chronic Disease* 2020;17:200052. DOI: http://dx.doi.org/10.5888/pcd17.200052

stakeholders working to decrease tobacco morbidity and mortality through community education, advocacy, and action. The Coalition's annual week-long *DC Calls It Quits!* Initiative highlights cessation resources such as the DC Quitline and serves as a call to action to support tobacco control efforts.

Health systems change is a key strategy to support tobacco cessation in the District. By adapting workflows and clinic processes, healthcare providers assess patients for tobacco use, explain the dangers and harms associated with smoking, and guide smokers through a quit attempt. That guidance includes referral to community-based resources like the DC Quitline and cessation support groups. Furthermore, providing continuous education to providers around cessation and enabling patient reminders within electronic health records (EHR) systems is crucial to continuing the conversation and follow-up to support patients in their quit attempts.

## PURPOSE

The purpose of this funding is to reduce disparities in tobacco use and tobacco-related health outcomes in African Americans experiencing food insecurity in the District of Columbia. DC Health aims to identify a qualified organization that will serve as a tobacco control change agent by working collaboratively with community stakeholders to implement and evaluate policy, systems, and environmental change (PSEC) interventions to reduce tobacco use initiation and support tobacco cessation in the food access environment.

### Approach

To reduce the burden of tobacco on African American residents of the District who also experience food insecurity, applicants will reduce triggers to smoke and identify barriers that undermine access to resources and opportunities to pursue good health and. Culturally appropriate strategies and activities should incorporate proven public health initiatives and best practices to mitigate these barriers through a policy-systems-environmental change (PSEC) approach.

**Policy Change** Interventions that create or amend laws, ordinances, resolutions, mandates, regulations, or rules. *Examples of this type of change include:*

- Implementing a smoke-free policy in multi-unit housing
- Adapting school policies to focus on cessation support rather than penalty for youth using tobacco products on campus
- Providing technical assistance to businesses and organizations to develop and implement comprehensive tobacco control policies that include smoke-free campuses and coverage of tobacco use counseling and treatment
- Working with DC Health and other governmental agencies to ensure policies are enforced
- Engage Advisory Neighborhood Commissions to support smoke-free policies and improve access to tobacco cessation and food access resources

*This initiative should promote non-legislative smoke-free policies, such as smoke-free multi-unit housing and smoke-free public spaces that drive systems and environmental change. Lobbying and development of legislation is prohibited through this funding.*

**Systems Change** Interventions that impact all elements of an organization, institution, or system. *Examples of this type of change include:*

- Working with DC Health and other governmental agencies to institutionalize processes and procedures within systems under their purview that are supportive of tobacco cessation and healthy living goals
- Identifying and implementing processes to assess for tobacco use and referring clients of a social services agencies or CBOs addressing food access to cessation resources with referrals to other services
- Utilizing evidence-based interventions to assess patients for food insecurity and tobacco use and incorporate referrals to services and treatment in the clinical care setting
- Integrating tobacco cessation and food access messaging with other community outreach programs, such as vaccine education initiatives

**Environmental Change** Interventions that involve material or structural changes to economic, social, or physical settings. *Examples of this type of change include:*

- Promoting smoke-free public places
- Reducing predatory tobacco advertising in the community with an emphasis on WIC- and SNAP-authorized retailers while expanding public health messaging in the community

PSEC interventions support sustainable, comprehensive action to improve community health by addressing social determinants that encourage and reinforce positive lifestyle choices. This approach shifts away from merely educating the community about the health impact of tobacco to reducing access, opportunity, and acceptability of tobacco use while providing support to those who wish to quit. Activities proposed should build the foundation for sustainable interventions and change that support living smoke-free with minimal resources beyond the life of the grant.

- **Year 1**: recruit and orient project work group members, identify barriers to be addressed; develop tobacco control strategic action plan
- **Year 2 & 3**: implement activities, monitor progress, evaluate impact in the community, build capacity and sustainability of activities, identify, and promote success stories of the project
- **Year 4**: monitor sustainability of interventions, conduct program evaluation, and develop best practices toolkit and final report

**Outcomes**

| Strategies | Short Term Outcomes | Intermediate Outcomes | Long Term Outcomes |
|---|---|---|---|

| | | | |
|---|---|---|---|
| Increased multi-sector partnerships to implement PSE change activities supporting tobacco control and food access efforts<br><br>Increased engagement of community stakeholders in tobacco control efforts<br><br>Increased links to resources shared among service and community organizations, healthcare systems, and businesses | Increased referral to tobacco use cessation services<br><br>Increased utilization of DC Quitline<br><br>Increased number of smoke-free policies in businesses, organizations, faith communities, etc.<br><br>Increased public awareness of the burden of tobacco use in the African American population and the relationship to food insecurity and other social determinants of health | Increased successful quit attempts<br><br>Decreased tobacco use and dependence among DC adults<br><br>Reduced exposure to secondhand smoke | Decreased morbidity and mortality related to tobacco use<br><br>Decreased tobacco-related disparities |

Applicants shall demonstrate how the proposed project plan will measure the following key performance indicators and evaluate their impact:

**Tobacco Cessation Support**

- Number of adult smokers referred to the DC Quitline *(Required)*
- Number of adult smokers referred to the DC Quitline by organizations and agencies supporting food access *(Required)*
- Number of adult smokers referred to other community-based tobacco cessation resources *(Optional)*

**Policy, Systems, and Environmental Change** *(Required)*

- Number of organizations and agencies assessing tobacco use among clients and referring directly to the Quitline
- Number of smoke-free policies adopted by community organizations, places of worship, and/or businesses
- Number of smoking cessation support initiatives adopted by community organizations, places of worship, and/or businesses

**Community and Stakeholder Engagement** *(Applicant should select at least one)*

- Number of community organizations newly engaged in tobacco control efforts as a result of this grant
- Number of businesses newly engaged in tobacco control efforts because of this grant

# PERFORMANCE REQUIREMENTS

Applicants should propose projects that meet the criteria listed below.

## TARGET POPULATION

Projects shall focus on African Americans experiencing food insecurity. African Americans in DC have the highest prevalence of smoking, are disproportionately affected by the burden of tobacco, and are more likely to experience lack of access to adequate food. The primary geographic focus is Wards 7 and 8, which have the highest proportion of smokers and food insecure residents in the District.

## LOCATION OF SERVICES

Services 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. Organizations should demonstrate a track record of successfully working with the priority population and impact/improvement in access to healthy food options or another social determinant of health (access to healthcare services, social support services, or transportation; safe housing; job opportunities; active living opportunities; or public safety).

## SCOPE OF WORK

The applicant shall implement a targeted community-led approach engaging the priority population that seeks to build relationships and leverage resources among multiple sectors of the community. There is a strong correlation between increased rates of smoking and social determinants of health, particularly food security. The applicant shall seek to integrate tobacco control with established programs addressing food insecurity to improve access to available resources for the pursuit of a more healthful lifestyle. The applicant shall engage the community to break down barriers to access tobacco control resources.

All strategies for the selected components are required and should build the foundation for sustainable interventions that can be shared, duplicated, and/or expanded with minimal resources beyond the life of the grant.

### 4-YEAR PROGRAM STRATEGIES

The applicant shall propose activities to support the following strategies as aligned with anticipated outcomes of the project:

- Increased multi-sector partnerships to implement PSE change activities supporting tobacco control and food access efforts
- Increased engagement of community stakeholders in tobacco control and food access efforts

- Increased links to resources shared among service and community organizations, healthcare systems, and businesses

While the applicant will have latitude in developing activities to support these strategies, there are foundational activities, listed below, that must be included in the project.

**Program Year 1**
During Year 1, the selected agency or organization shall, with guidance and technical assistance from the DC Tobacco Control Program (TCP), complete the following foundational activities:

- Recruit and facilitate a workgroup of diverse stakeholders operating within the DC Tobacco Free Coalition that shall actively engage in the development, promotion, and implementation of activities related to this grant.
    - The workgroup shall serve as an interface with the broader community and serve as subject matter experts on working within the priority population, addressing social determinants of health, emphasizing food insecurity, and identifying and implementing evidence-based public health initiatives.
    - The workgroup should include stakeholders representing the following:
        - Community leadership such as Advisory Neighborhood Commissioners (ANCs)
        - Community Centers
        - DC Cancer Coalition
        - Local businesses (including grocery and corner stores)
        - Multi-disciplinary and diverse organizations (e.g., healthcare systems, faith-based organizations, fraternities and sororities, and social organizations, including those addressing food insecurity and other social determinants of health)
        - Government agencies including Department of Human Services and Department of Consumer and Regulatory Affairs
- Ensure organization staff and workgroup members complete the *Action for Policy Systems, and Environmental (PSE) Change: A Training*, available online at no cost through GW Cancer Center
- Analyze results from the DC Community Health Needs Assessment, DC Health Equity Report, Behavioral Risk Factor Surveillance System (BRFSS), DC Healthy People 2020 and United States (US) Census Data to inform development of culturally appropriate policy, systems and environmental (PSE) strategies and activities to target.
- Engage partners from Networking2Save for guidance and resources.
- Conduct an environmental scan to identify legislative and systems policies influencing tobacco use, currently available resources to address tobacco use and food insecurity, and the barriers to accessing them
- Implement and adjust as needed the strategies and activities detailed in the work plan
- Identify resources that are content-specific and socio-culturally appropriate

- Provide training opportunities on evidence-based interventions and best practices in tobacco control, PSE change, and the intersection of social determinants of health and tobacco use to project partners and community stakeholders
- Conduct a readiness assessment to identify barriers to success
- Collaborate with the DC TCP and the DC Tobacco Free Coalition community disparities workgroup to develop:
    - A memorandum of understanding (MOU) or memorandum of agreement (MOA) between the applicant and the DC Tobacco Free Coalition and between the applicant and workgroup members
    - A five-year strategic plan with measurable objectives to address tobacco-use disparities among African Americans in the District of Columbia aligned with DC Health's strategic plan, goals, and objectives
    - Detailed work plans aligned with the strategic plan featuring culturally appropriate policy, systems, and environmental (PSE) strategies and activities which seek to improve health equity in tobacco use and integrate tobacco control in programs addressing food insecurity.
- Connect with Networking2Save and the African American Tobacco Control Leadership Council for technical assistance and resources

**Program Year 2-3**

The applicant in collaboration with TCP will complete the following activities:

- Implement and adjust as needed the strategies and activities detailed in the work plan
- Identify resources that are content-specific and socio-culturally appropriate
- Provide training opportunities on evidence-based interventions and best practices in tobacco control, PSE change, and the intersection of social determinants of health and tobacco use to project partners and community stakeholders
- Conduct a readiness assessment to identify barriers to success
- Develop a sustainability plan that ensures continuous improvement to target population health beyond the life of the grant *(to be completed by the end of Year 3)*

**Program Year 4**

The applicant, in collaboration with TCP, will:

- Monitor sustainability of interventions to continue beyond the grant cycle
- Collect and analyze program and public health data (BRFSS, ATS – provided by TCP) Conduct a program evaluation and develop a best practices toolkit and final report of lessons learned to be disseminated to stakeholders

**Program Years 1-4**

For each project year, the applicant will:

- Conduct annual and trainings for staff and community partners on topics related to implicit bias; cultural competency and humility; diversity, equity, and inclusion; and data collection on social determinants of health.

  *Training modules must have DC Health approval. The applicant may budget up to 10% of the total budget (including indirect cost) for trainings offered virtually or in-person. The applicant is encouraged to explore low- or no-cost trainings such as those offered through CDC's Networking2Save.*

- Submit a minimum of one success story that conveys:
  - The impact of stakeholder engagement in strategic planning and program development (Year 1)
  - The program's impact in the community to reduce disparities in tobacco use and tobacco-related morbidity and mortality *(Years 2-4)*
- Submit quarterly and annual reports

**Resources:**

Action for Policy, Systems, and Environment Change: A Training: https://cme.smhs.gwu.edu/gw-cancer-center-/content/action-policy-systems-and-environmental-pse-change-training

The African American Tobacco Control Leadership Council: www.savingsblacklives.org

Behavioral Risk Factor Surveillance System (BRFSS): https://www.cdc.gov/brfss/brfssprevalence/index.html

CDC Best Practices Cessation in Tobacco Prevention and Control: https://www.cdc.gov/tobacco/stateandcommunity/best-practices-cessation/pdfs/best-practices-cessation-user-guide-508c.pdf

Center for Black Health & Equity: https://centerforblackhealth.org

DC Community Needs Assessment: https://ourhealthydc.org/dc-chna/

DC Health Equity Report: https://app.box.com/s/yspij8v81cxqyebl7gj3uifjumb7ufsw

DC Healthy People 2020: https://dchealth.dc.gov/page/dc-healthy-people-2020

Healthy People 2030: https://health.gov/healthypeople

Networking2Save: https://www.cdc.gov/tobacco/stateandcommunity/tobacco_control_programs/coop-agreement/index.html

Policy, Systems, and Environmental Change Resource Guide: https://smhs.gwu.edu/cancercontroltap/sites/cancercontroltap/files/PSE_Resource_Guide_FINAL_05.15.15.pdf

Seven Steps for Policy, Systems, and Environmental Change Worksheets for Action: https://smhs.gwu.edu/cancercontroltap/sites/cancercontroltap/files/PSE%20Resource%20Guide.pdf

United States (US) Census Data: https://www.census.gov/data.html

# APPLICATION REQUIREMENTS

## 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 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 logical model in the Approach 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.

- 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 reduce social acceptance and use of tobacco products in the African American 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 evidence-based or promising practices to reduce health disparities in African Americans by addressing tobacco dependence through PSE change. The applicant should demonstrate their previous success addressing social determinants of health (food security, healthcare access, housing, employment, transportation, active living, or public 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, collect data, 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.

## ADDITIONAL REQUIRED DOCUMENTS

Some of the attachments for this application will have required templates that the applications must use. The sections below will indicate which documents require the use of a template. These documents will not count towards the Project Narrative 10-page limit, however, they will count towards the overall 50-page limit.

#### 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.

#### 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 letters of support from other agencies and organizations who will partner on of the proposed project *(no template provided)*.

**PROJECT BUDGET**

The application should include a project budget using the form provided in (Attachment 2). The project budget and budget justification should be directly aligned with the work plan and project description. All expenses should relate directly to achieving grant outcomes. Budget should reflect a 12-month period.

**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). The budget justification is 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.

# 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

**(20 POINTS) –** Corresponds to Sections: *Introduction and Target Population*

- Currently serves the priority population –African Americans – described in this RFA.
- Currently serves a high proportion of residents who are tobacco users.
- Demonstrates well an understanding of the problem, potential barriers and challenges, and opportunities to address the problem.
- Proposed project aligns with the goals of this RFA and the goals are logical, attainable, and feasible.
- Demonstrates experience working to address social determinants of health (food insecurity but also including socioeconomic status, active living and physical activity, access to healthcare, housing, and safe communities).
- Understands how social determinants of health (specifically food insecurity) and systemic barriers limit the priority population's ability to access resources that support a healthy lifestyle.

- Understands how food insecurity and other social determinants of health relate to the prevalence of tobacco use in the priority population.

## Criterion 2: Capacity

**(25 POINTS) –** Corresponds to Sections: *Organization and Partnerships*

- Organizational infrastructure supports the implementation of the proposed strategies.
- Demonstrates reach and established relationships with key stakeholders and organizations within target population.
- Demonstrates plans for establishing new and engaging existing partners in a cross-sector network to support the implementation and evaluation of the applicant's program.
- Demonstrates proven experience in building capacity and mobilizing communities through policy, systems, and environment change approaches/strategies.
- Demonstrates experience and past successes working collaboratively with government agencies, community-based organizations, and ancillary community groups to implement initiatives to advance a public health goal and/or address a social determinant of health.
- Describes the importance and understanding of developing and implementing sustainable activities likely of achieving and maintaining project goals beyond the life of the grant.
- Demonstrates well the commitment from the organization's leadership to implement the proposed strategies.

## Criterion 3: Implementation Framework

**(35 POINTS) –** Corresponds to Sections: *Project Description*

- Describes evidence-based and/or best practice approaches that address social acceptability and use of tobacco within target population.
- Provides a clear description of proposed project objectives and activities that are tied to one or more PSE change strategies.
- Describes how proposed strategies will lead to improved outcomes in tobacco use and cessation.
- Provides a foundation for sustainability of efforts beyond the project funding period.
- Demonstrates how community engagement and mobilization will drive project outcomes.
- Demonstrates understand the intercorrelation of social determinants of health and tobacco use and dependence.
- Provides a detailed program narrative on activities and current or new partnerships (if any) that will be engaged to meeting program goals.

## Criterion 4: Evaluation

**(20 POINTS)** – Corresponds to Section: *Evaluation*

- Identifies measurable indicators to monitor the project's success.
- Describes how the project will be monitored to ensure reach and engagement of the priority population.

- Describes processes to collect qualitative and quantitative data related to project goals.
- Identifies skilled staff to analyze data aligned to the project's goals.
- Specifies a process to monitor progress and adapt strategies and objectives to improve outcomes.

### Criterion 5: Support Requested

(**0 POINTS**) Corresponds to Sections: *Budget and Budget Justification Narrative*

The reasonableness of the proposed budget for the project period in relation to the objectives, the complexity of the activities, and the anticipated results.

- Costs outlined in the budget and required resources sections appear reasonable given the scope of work.
- Key personnel have adequate time devoted to the project to achieve project objectives.

## REVIEW AND SCORING OF APPLICATION

### 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.

### EXTERNAL REVIEW PANEL

The review panel will be composed of neutral, qualified, professional individuals who have been selected for their unique experiences in tobacco control and smoking cessation, public health and prevention health program 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.

### 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. Those factors will include minimally a past performance review, risk assessment and eligibility assessment, including a review of assurances and certifications, and business documents submitted by the applicant, as required in the RFA. DC Health will also conduct an excluded parties list search (EPLS) of the organization and executives via the federal System for Award Management (SAM) and conduct a DC Clean Hands review to obtain DC Department of Employment Services and DC Office of Tax and Revenue compliance status.

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.

# ASSURANCES & CERTIFICATIONS

DC Health requires all applicants to submit various Certifications, Licenses, and Assurances at the time the application is submitted. Certifications and Licenses are listed in Application Preparation. DC Health classifies assurances packages as two types: those "required to be submitted along with applications" and those "required to sign grant agreements."

**A. Assurances Required to Submit Applications (Pre-Application Assurances/Mandatory Business Documents)**

- City Wide Clean Hands Compliance Status Letter (formerly Certificate of Clean Hands) not older than two months prior to the application due date.
- 501 (c) 3 certification
- Official List of Board of Directors on letterhead, for current year, signed and dated by the authorized executive of the Board (cannot be the CEO).
- Certificate of Insurance
- Copy of Cyber Liability Policy
- All applicable Medicaid Certifications
- FQHC designation letter, if applicable

- A Current Business license, registration, or certificate to transact business in the relevant jurisdiction
- Signed Assurances, Certifications & Disclosures.

**B. Assurances required for signing grant agreements for funds awarded through this RFA (Post-Award)**

- 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 either ineligible for funding consideration [required to submit assurances] or ineligible to sign/execute grant agreements [required to sign grant agreements assurances].

# APPLICATION PREPARATION

## APPLICATION PACKAGE

Only one (1) application per organization will be accepted. The total size of the applicable attachments may not exceed the equivalent of **50 pages** when printed by DC Health.

### APPLICATION PACKAGE

The following applicable attachments **are** included in the 50-page limit:

- Project Abstract
- Project Narrative (10-page limit; see page 9)
- Staffing Plan
- Organizational Chart
- Work Plan – Attachment 1
- Budget/Budget Justification – Attachment 2
- Letter(s) of Commitment from an agency currently addressing food insecurity (minimum of one)

The following attachments **are not** included in the 50-page limit:

- Table of Contents - Lists major sections of the application with quick reference page indexing. Failure to include an accurate Table of Contents may result in the application not being reviewed fully or completely.
- Assurances Certifications and Disclosures (See Appendix C): *reviewed and accepted via EGMS.* Scan and upload **one copy SIGNED** by the Agency Head or authorized official.
- DC Health Standard Grant Terms and Conditions (*Reviewed and Accepted via EGMS*)

- **Mandatory Certification Documents** (Scan and upload **ONE PDF** file containing all of the following business documents required for submission):
    i. A current business license, registration, or certificate to transact business in the District of Columbia.
    ii. 501(c) (3) certification (for non-profit organizations)
    iii. Certificate of Insurance
    iv. Copy of Cyber Liability Policy
    v. City Wide Clean Hands Compliance Status Letter (formerly Certificate of Clean hands). Clean Hands Compliance Status letter must be dated no more than 3 months prior to the due date of application.
    vi. Official list of Board of Directors for the current year and the position that each member holds on letterhead and signed by the authorized executive of the applicant organization; not the CEO.
    vii. Medicaid certifications.

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.

## 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.

### 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 may 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 –** The DC Health EGMS Portal 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 jennifer.prats@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 egms.support@dc.gov assists with all end-user registration if you have a question or need assistance: Primary Points of Contact: Arif Wadood (202) 442-5841. Here are the most common registration issues:

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

### UPLOADING THE APPLICATION

All applications documents submitted in EGMS shall be as 3 separate attachments. Required components are included in each is below. All of these must be aligned with what has been requested in other sections of the RFA.

- **Document 1** – ***Mandatory Business Documents:*** A current business license, registration, or certificate to transact business in the relevant jurisdiction, 501 (c) 3 certification (for non-profit organizations), Certificate of Insurance, Copy of Cyber Liability Policy, City Wide Clean Hands Status Letter, official signed board of directors letter on letterhead, Medicaid certifications,
- **Document 2** – ***Proposal***: table of contents, project abstract, project narrative, logic model, work plan, staffing plan, organizational chart, budget, budget justification, letters of commitment
- **Document 3 – *Other:*** Assurances Certifications Disclosures (signed), any other required documents

### DEADLINE:

Submit your application via EGMS by 6:00 p.m., on the deadline date of Monday, December **3**, 2021 Applications will not be accepted after the deadline.

## PRE-APPLICATION MEETING

Visit DC Health's Eventbrite page for the virtual meeting information, https://OGMDCHealth.eventbrite.com.

## 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:

### 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 located in the Enterprise Grants Management System, where links to the terms and a sign and accept provision is embedded.

## 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.

## 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 & Reporting tools developed and approved by DC Health.

## 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.

## INSURANCE

All applicants that receive awards under this RFA must show proof of all insurance coverages required by the Office of Risk Management (ORM) prior to receiving funds. At minimum, the awardee must meet the insurance coverage requirements outlined in the Appendix X. The coverage levels may be adjusted by ORM following issuance of the NOGA per a review of activities performed under the grant and any other grants with DC Health or other District agencies. DC Health reserves the right to request certificates of insurance pre-award and post-award and adjust coverage limits per requirements promulgated by ORM.

## 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 will be made available for additional guidance and will be updated online as additional questions are received.

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.

## 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.

## 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.

## 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 report 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.

## CONTACT INFORMATION:

### Grants Management

Brenda Ramsey-Boone
Office of Grants Monitoring & Program Evaluation
Community Health Administration
DC Department of Health
899 North Capitol Street, N.E., 3rd Floor Washington, DC 20002
brenda.ramsey-boone@dc.gov

### Program Contact

Carrie Dahlquist
Manager, Tobacco Control Program
Cancer and Chronic Disease Prevention Bureau
Community Health Administration
District of Columbia Department of Health
899 North Capitol Street, NE, 3rd. Floor
Washington, DC 20002
carrie.dahlquist@dc.gov

Jazmin Devonish
Public Health Analyst, Tobacco Control Program
Cancer and Chronic Disease Prevention Bureau
Community Health Administration
District of Columbia Department of Health
899 North Capitol Street, NE, 3rd. Floor
Washington, DC 20002
jazmin.devonish@dc.gov

# GLOSSARY OF TERMS

**Adult Tobacco Survey -** Created to assess the prevalence of tobacco use, as well as the factors promoting and impeding tobacco use among adults. The National Adult Tobacco Survey also establishes a comprehensive framework for evaluating both the national and state-specific tobacco control programs. The survey questionnaire is built around key outcome indicators from each of the following four goal areas: (1) Preventing initiation of tobacco use among young people; (2) Eliminating nonsmokers' exposure to secondhand smoke; (3) Promoting quitting among adults and young people, and (4) Identifying and eliminating tobacco-related disparities.

"National Adult Tobacco Survey (NATS)." Centers for Disease Control and Prevention. Centers for Disease Control and Prevention, December 18, 2018. https://www.cdc.gov/tobacco/data_statistics/surveys/nats/index.htm#:~:text=The%20National%20Adult%20Tobacco%20Survey,state%2Dspecific%20tobacco%20control%20programs.

**Behavioral Risk Factor Surveillance System -** BRFSS is the nation's premier system of health-related telephone surveys that collect state data about U.S. residents regarding their health-related risk behaviors, chronic health conditions, and use of preventive services. BRFSS collects data in all 50 states as well as the District of Columbia and three U.S. territories. BRFSS completes more than 400,000 adult interviews each year, making it the largest continuously conducted health survey system in the world.

"CDC - BRFSS - BRFSS Frequently Asked Questions (FAQs)." Centers for Disease Control and Prevention. Centers for Disease Control and Prevention, January 2, 2018. https://www.cdc.gov/brfss/about/brfss_faq.htm.

**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)

**Policy, Systems & Environmental (PSE) Change –** Strategies that are designed to promote healthy behaviors by making healthy choices readily available and easily accessible in the community. PSE change strategies are designed with sustainability in mind. Policy is a tool for achieving health promotion and disease prevention program goals. Systems change refers to a fundamental shift in the way problems are solved. Within an organization, systems change affects organizational purpose, function, and connections by addressing organizational culture, beliefs, relationships, policies, and goals. Environmental change strategies involve changing the economic, social, or physical surroundings or contexts that affect health outcomes.

Environmental strategies address population health outcomes and are best used in combination with other strategies.

"Policy, Systems, and Environmental Change - Rural Health Promotion and Disease Prevention Toolkit." Policy, Systems, and Environmental Change. Rural Health and Information Hub. Accessed June 29, 2021. https://www.ruralhealthinfo.org/toolkits/health-promotion/2/strategies/policy-systems-environmental.

**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

# ATTACHMENTS

Attachment 1: Work Plan

Attachment 2: Budget Justification & Budget

APPENDIX A – SUPPORTING BEST PRACTICE REFERENCES

APPENDIX B – DC QUITLINE INDIVIDUALIZED SERVICES

APPENDIX C – ASSURANCES AND CERTIFICATIONS

ATTACHMENT 1 – Work Plan

## Grantee Work Plan

| | |
|---|---|
| **Agency/Organization Name:** | |
| **Program/ Grant Name:** | |
| **Project Title:** | |
| **Total Request:** | |
| **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*<br>*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. | | | | | |

DC HEALTH
GOVERNMENT OF THE DISTRICT OF COLUMBIA

GOVERNMENT OF THE DISTRICT OF COLUMBIA
MURIEL BOWSER, MAYOR

**Budget/Budget Justification Instructions**

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 __

**Personnel**

| Name of Staff | Position Title | Percent Charge to Grant | Annual Salary | Salary Charged | Fringe Benefits Rates | Fringe Benefits Cost | Total Salary and Benefits | In-kind Contributions (Yes/No) |
|---|---|---|---|---|---|---|---|---|
| | | 0% | $ - | $ - | 0% | $ - | $ - | |
| | | 0% | $ - | $ - | 0% | $ - | $ - | |
| | | 0% | $ - | $ - | 0% | $ - | $ - | |
| | | 0% | $ - | $ - | 0% | $ - | $ - | |
| | | 0% | $ - | $ - | 0% | $ - | $ - | |
| | | 0% | $ - | $ - | 0% | $ - | $ - | |
| | | 0% | $ - | $ - | 0% | $ - | $ - | |
| | | 0% | $ - | $ - | 0% | $ - | $ - | |
| | | 0% | $ - | $ - | 0% | $ - | $ - | |
| | | 0% | $ - | $ - | 0% | $ - | $ - | |
| | | 0% | $ - | $ - | 0% | $ - | $ - | |
| | | 0% | $ - | $ - | 0% | $ - | $ - | |
| **Total Personnel** | | | **$ -** | **$ -** | | **$ -** | **$ -** | |

**Non-Personnel Costs**

| Consultants/Contractual | Total |
|---|---|
| | |
| | |
| | |
| | |

| Occupancy (List the location of each service below) | Cost | Monthly | Total |
|---|---|---|---|
| | $ - | 0 | |
| | $ - | 0 | |
| | $ - | 0 | |
| | $ - | 0 | |

| Travel (List each travelers name below) | Travel Destination | Time (Dates of Travel) | Total |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

| Supplies | Quantity | Total |
|---|---|---|
| | 0 | |
| | 0 | |
| | 0 | |

| Equipment | Quantity | Total |
|---|---|---|
| | 0 | |
| | 0 | |
| | 0 | |

| Client Costs | Total |
|---|---|
| | |
| | |
| | |

| Communication | Total |
|---|---|
| | |
| | |
| | |
| **Total Non-Personnel Cost** | **$ -** |

**Other Direct Costs**

| Type of Service | Total |
|---|---|
| | |
| | |
| | |
| | |
| **Total Other Direct Cost** | **$ -** |

| Total Direct and Indirect Costs | |
|---|---|
| Direct Cost (Personnel + Non-Personnel + Other Direct) | $ - |
| Indirect Cost (10%) | $ - |
| **Total Project Cost** | **$ -** |

# APPENDIX A – SUPPORTING BEST PRACTICE REFERENCES

**Centers for Disease Control and Prevention. Identifying and Treating Patients Who Use Tobacco: Action Steps for Clinicians. Atlanta, GA: Centers for Disease Control and Prevention, US Department of Health and Human Services; 2016**
https://millionhearts.hhs.gov/files/Tobacco-Cessation-Action-Guide.pdf

**Centers for Disease Control and Prevention. Protocol for Identifying and Treating Patients Who Use Tobacco. Atlanta, Georgia. 2016**
https://millionhearts.hhs.gov/files/Tobacco-Cessation-Protocol.pdf

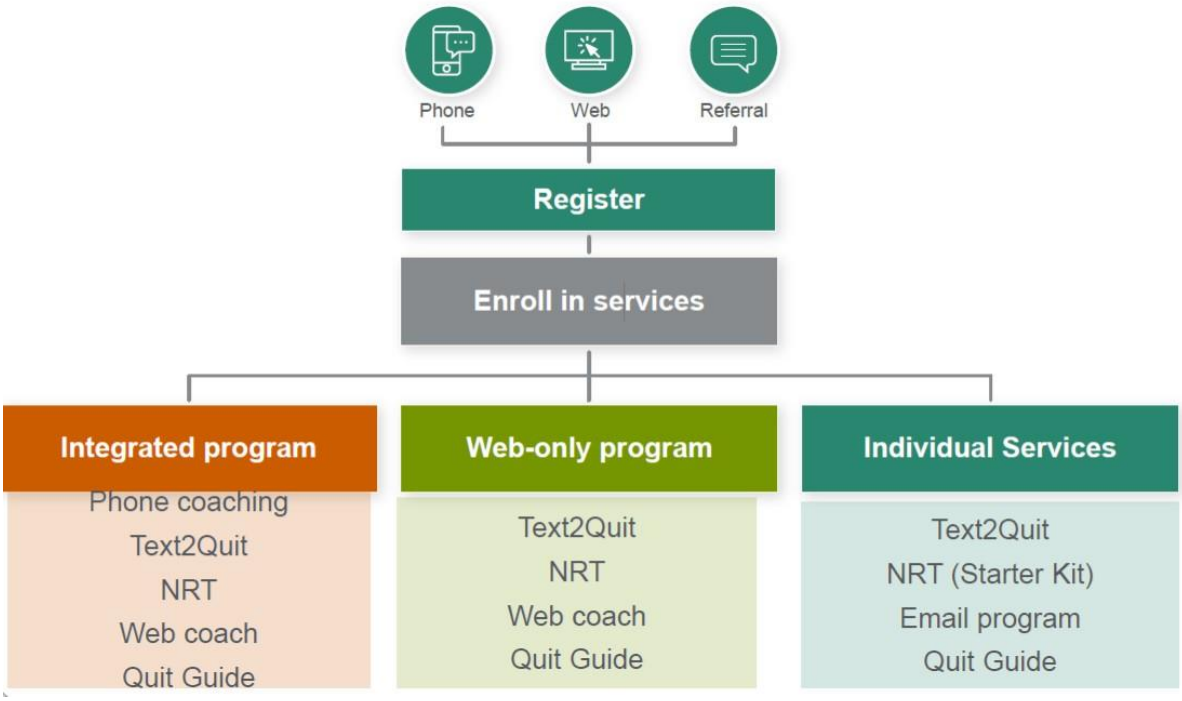
**Million Hearts®: Meaningful Progress 2012-2016—A Final Report**
https://millionhearts.hhs.gov/files/MH-meaningful-progress.pdf

**Million Hearts®: Tobacco Cessation Change Package**
https://millionhearts.hhs.gov/files/tobacco_cessation_change_pkg.pdf

# APPENDIX B – DC QUITLINE INDIVIDUALIZED SERVICES

**DC Quitline Services**

| Integrated program<br>ENROLLMENT: PHONE OR WEB | Web-only program<br>ENROLLMENT: PHONE OR WEB | Individuals Services<br>ENROLLMENT: PHONE OR WEB |
|---|---|---|
| **Materials**<br>Mailed letters and printed quit guide | **NRT** | **Materials**<br>Mailed letters and printed quit guide |
| **NRT** | **Program emails**<br>Custom messages coincide with quit date | **Options emails**<br>General resource emails |
| **Proactive phone coaching**<br>Unlimited inbound ad hoc calls | **Text2Quit**<br>Custom messages coincide with quit date | **Options NRT**<br>NRT starter kit and one follow-up call |
| **Program e-mails**<br>Custom messages coincide with quit date | **Web coach**<br>Trackers, community forums, e-lessons, videos, articles and quit plans | **Text2Quit**<br>Custom messages coincide with quit date |
| **Text2Quit**<br>Custom messages coincide with quit date | | **Web dashboard** |
| **Web coach**<br>Trackers, community forums, e-lessons, videos, articles and quit plans | | |



# APPENDIX C: 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**<br>☐ **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**<br>☐ **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.<br>~~*If No, the Applicant, if funded shall provide the names and salaries of the top five*~~ | ☐ **YES**<br>☐ **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**<br>☐ **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**<br>☐ **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: