



**CITY OF MIDDLETOWN
DEPARTMENT OF HEALTH**

**Joseph A. Havlicek, MD
Director of Health**

**Public Health
Funding Application**

Contract Funding Period
July 1, 2016 to June 30, 2017

I. INTRODUCTION



- Applicants are requested to read these instructions carefully.
- All applicants must be submitted on the forms provided or must follow this format.
- All applications and supporting documents submitted become the property of the Department of Health or the City of Middletown.
- Decisions concerning recipients and amounts of all funding awards are with in the sole discretion of the Middletown Health Department and City of Middletown Administration and are subject to availability.

Applications for contracts with a **July 1, 2016** start date must be complete and arrive at Middletown Health Department no later than **4:30 PM on Friday, February 26, 2016**.

One original and twenty (20) copies of the application must be submitted to:

**Joseph A. Havlicek, MD
Director of Health
Middletown Health Department
PO Box 1300
245 DeKoven Drive
Middletown, CT 06457**

All questions concerning the application must be directed to:

**Salvatore Nesci, R.S.
Middletown Health Department
Telephone No. (860) 638-4966
sal.nesci@middletownCT.gov**

II. INSTRUCTIONS



GENERAL

- All applications for funding must be submitted on standard application forms or in this format.
- All required information must be submitted at the time of application.
- All applications must be received by the Middletown Health Department by the required submission date.
- Each applicant must submit an original and twenty (20) copies for each application.
- All text must be typed and double-spaced. Language should be clear and concise.
- Applicants may make copies of any part of the application, which requires multiple pages and use those copied pages as originals.
- All applications must be signed by an officer of the applicant agency who is authorized to enter into contracts for the applicant agency.
- Specific instructions for each form precede each form in this package and on the disk.

REQUIRED REPORTS

- The applicant agency will be responsible for the timely submission of periodic program reports progress, data and expenditure reports and such other reports as may be required for specific programs. One original and one copy of progress and expenditure reports are to be submitted no later than thirty (30) days after the end of each reporting period. A final report shall be submitted within sixty (60) days of the end of the contract. Program specific reports must be submitted as indicated by the terms of the contract. When subcontractors are used, the subcontractor's final expenditure report, summary of services provided or other documentation substantiating payments made to the subcontractor must be submitted with the contractor's final expenditure reports.
- All required reports must include the contract name.
- All required reports must be submitted within the specified time periods to:

Joseph A. Havlicek, MD
Director of Health
Middletown Health Department
PO Box 1300
245 DeKoven Drive
Middletown, CT 06457
860-638-4960

COVER PAGE INSTRUCTIONS



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

Please provide the following information:

- Full legal name of the organization or corporation as it appears on the corporate seal and as registered with the Secretary of State
- Mailing address
- Main telephone number
- Fax number
- E-mail address
- Amount requested (may not exceed award amount indicated on first page of application package)
- Contract start date
- Contract end date

Accurate information is needed concerning the legal status of the applicant agency.

Indicate:

- Whether or not the applicant is incorporated
- The type of agency
- The applicant's fiscal year
- **New: Enter notation you would like on contract payment checks (such as your reference # or a person's name) it must be 18 characters or less.**
- The applicant's Medicaid provider status and Medicaid number, if any
- Whether the applicant is registered as a Connecticut Minority Business Enterprise and/or Women Business Enterprise
- The applicant's federal employer ID number and/or town code number
- The funding application must include the signature of an individual of the applicant agency who has the authority to apply for funding. The signature and typed or printed name and position of the authorized individual of the applicant agency must be included as well as the date on which the application is signed.



Contractor Information Page Instructions

In order for the City of Middletown to communicate effectively with the contractor, it is necessary to have accurate information about contractors' staff who are responsible for certain functions.

Please provide the name, title, address and telephone and fax number of staff persons responsible for the completion and submittal of:

- Contract and legal documents/forms
- Program progress/activity and statistical reports
- Financial expenditure reports

Please provide the program location(s) if different from the applicant agency address provided on the cover page.

GENERAL TERMS AND CONDITIONS



- 1) The contractor shall provide services for the Middletown Health Department Programs described in detail, as follows.
- 2) Such services shall be provided in accordance with the requirements of this subsection and program specifics.
- 3) The contractor shall implement the programs and services described in the Part to result in the outcomes on behalf of clients listed in each subsection below. Such outcomes shall be measured in the manner described therein. The Department shall monitor outcome results achieved pursuant to these terms and conditions.
- 4) The contractor shall submit periodic program progress, statistical and expenditure reports in the format provided by the Health Department in accordance with the following:

REPORTING PERIOD	REPORTS DUE BY
July through September	November 1, 2016
October through December	February 1, 2017
January through March	May 1, 2017
April through June	September 1, 2017

- 5) The contractor shall adhere to the budget(s) negotiated with the Department and included as Section B of this part.
- 6) The total amount of this agreement shall not exceed the amount awarded.
- 7) **New: Acknowledge program sponsorship of City of Middletown Health Grant in all promotions.**

FUNDING APPLICATION



COVER PAGE

Name of Program:

Applicant Agency

Legal Name:

Address:

Town/City, State, Zip Code:

Telephone No.:

Fax No:

E-Mail Address:

Amount Requested

Contract State Date: July 1, 2016 End Date: June 30, 2017

Agency Fiscal Year:

Minority Business Enterprise (MBE) Yes No

Federal Employer ID Number:

Incorporated Yes No

Type of Agency Public Private Non-Profit

Other Explain: _____

I certify that to the best of my knowledge and belief, the information contained in this application is true and correct, the applicant has the authority to apply for this funding, the applicant will comply with applicable state and federal laws and regulations, and I am authorized to make this application on behalf of the applicant agency.

Signature: _____ Date: _____
Name: _____ Title: _____

(Print Type)

CONTRACTOR INFORMATION



Please List the Agency Contact Person(s) Responsible For Completion and Submittal of:

Contract and Legal Documents/Forms:

Name & Title:

Address:

Town/City, State, Zip Code:

E-Mail Address:

Telephone No.: () (-)

Fax No.: () (-)

Program Progress/Activity and Statistical Data Reporting Forms:

Name & Title:

Address:

Town/City, State, Zip Code:

E-Mail Address:

Telephone No.: () (-)

Fax No.: () (-)

Financial Expenditure Reporting Forms:

Name & Title:

Address:

Town/City, State, Zip Code:

E-Mail Address:

Telephone No.: () (-)

Fax No.: () (-)

Program Location(s)**(if different than Applicant Agency Address listed above):

Location #1

Name:

Address:

Town/City, State, Zip Code:

Telephone No.: () (-)

Location #2

Name:

Address:

Town/City, State, Zip Code:

Telephone No.: () (-)

Location #3

Name:

Address:

Town/City, State, Zip Code:

Telephone No.: () (-)

**If more than 3 locations use additional pages.

Instruction Budget Summary 1

- For Line Item #1 through #6 **Personnel** provide for each position
 - a) The name of the position, name of person holding that position.
 - b) The hourly rate, and # hours per week, and # of weeks.
 - c) The fringe benefit rate.
- For Line Item #12 Contractual (Subcontracts) provide the total of all subcontracts, which must be listed on the Subcontractor Schedule.
- A Budget Justification Schedule must be completed for all line items in budget.
- Other expenses are any other types of expense that do not fit into the categories listed.
- For Line item #15, **Other Income** list any other program income such as in-kind contributions, fees collected, or other funding sources and include brief explanation on Budget Justification.

Budget Justification Schedule B

- Please provide a brief explanation for each line item listed on the Budget summary. This must include a detailed breakdown of the components that make up the line item and any calculation used to compute the amount. For example, travel must include the rate per mile and # of miles.
- For contractors who have subcontracts, a brief description of the purpose of each subcontract must be provided, although a line item justification is not necessary. Use additional sheets as necessary.

Instructions

Subcontractor Schedule A—Detail

- This form must be completed if there are subcontractors. A separate subcontractor schedule must be completed for each program included in the contract. All subcontractors used by each program must be included.
- If it is not known who the subcontractor will be, an estimated amount and whatever budget detail is anticipated should be provided. The actual detail should be submitted when it is available.

Detail of Each Subcontractor:

- For each subcontract choose the appropriate category for the type of subcontract using the basis by which it is paid:

┆ A. Budget Basis ┆ B. Fee for Service ┆ C. Hourly Rate

Then provide the detail for each subcontract referencing the corresponding number of the contract from the Summary. Detail must be provided for each subcontractor listed in the Summary.

Example A. Budget Basis:

Outreach Educator \$20/hr x 20 hrs/wk x 50 wks	\$20,000
Travel 10000 miles @ .25 cents/mile	260
Supplies	<u>500</u>
Total	\$20,760

Example B. Fee for Service:

Develop and Produce 500 videos @ \$10 each	\$ 5,000
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Example C. Hourly Rate:

Quality Assurance Review of 200 Patient Charts by Nurse Clinician 200 hours @ \$25/hour	\$ 5,000
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Note: If space allowed is not sufficient for large or complex subcontract budgets, the Budget Summary format may be copied and used instead.

PROJECT NARRATIVE



- I. Summary Project Description

- II. Goals & Objectives

- III. Program Strategy

- IV. Activities

- V. Schedule/Time Table
 - 1. Recruitment Schedule
 - 2. Implementation Schedule

- VI. Anticipated Obstacles

- VII. Resources

- VIII. Evaluation

- IX. Quarterly Reports

- X. Progress During Previous Year Operations
 - 1. Highlights of the Year
 - 2. Recruitment Process

- XI. Independent Auditors Report Required (prior to final payment)

REQUIRED INFORMATION



- **How does your project help the mission of Middletown's Board of Health? What is the project's benefit to the health of the City and its Citizens?**
- **How will you measure the success of your project?**
- **Please provide a 10-year history of grants you have received from the City of Middletown, including CDBG grants, if any.**
- **What is the total budget of the project – and what % are you requesting from the Board of Health? What are your sources of funding/revenue? (Include all revenue, i.e., grants, fees for services, etc.)**
- **Do you anticipate needing funding for your project in the future?**
- **Will Board of Health grants be used to benefit Middletown residents 100%? If not, what %?**
- **Please describe the manner in which you plan to promote/publicize your program and credit the City of Middletown Health Grant for funding support.**

Budget Period: 7/1/2016 – 6/30/2017

Program:

Category	Amount
Personnel:	
1. Name & Position:	
Calculation:	
Fringe Benefit:	
2. Name & Position: ,	
Calculation:	
Fringe Benefit: %	
3. Name & Position: ,	
Calculation:	
Fringe Benefit: %	
4. Name & Position: ,	
Calculation:	
Fringe Benefit: %	
5. Name & Position: ,	
Calculation:	
Fringe Benefit: %	
6. Name & Position: , :	
Calculation:	
Fringe Benefit: %	
7. Travel	
8. Training	
9. Educational Materials	
10. Office Supplies	
11. Medical Materials	
12. Contractual (Subcontracts)**	
13. Cellular Phone Service	
14. Advertising	
15. Other Expenses (List Below)	
A	
b.	
c.	
d.	
16a.	
Total Year One	

