

South Carolina Department of Health and Human Services
1801 Main Street
P.O. Box 8206
Columbia, South Carolina 29202-8206

Prevention Partnership Grants (GAR 08-06)

Grant Application Request: To implement or expand innovative preventive health programs and activities with documented outcomes for South Carolinians. Multiple grants in varying amounts will be awarded through a competitive process. Grants should target preventive health programs related to premature and/or pre-term births or chronic diseases associated with obesity, diabetes, hypertension, or asthma. Other initiatives specific to identified local prevention needs will also be considered.

Submittal Deadline: Friday, September 29, 2006
2:00 p.m. Eastern Daylight Savings Time

You are invited to submit Grant Proposals in accordance with the requirements described in this document. Grant Proposal(s) must be received no later than 2:00 p.m. EDST, on Friday, September 29, 2006.

Mail to:
Ernestine J. Staley, Director
Division of Contracts
South Carolina Department of Health and Human Services
Post Office Box 8206
Columbia, South Carolina 29202-8206

Or

Hand Deliver to:
Ernestine J. Staley, Director
Division of Contracts
South Carolina Department of Health and Human Services
1801 Main Street, Jefferson Square Building, 6th Floor
Columbia, South Carolina 29202-8206
(803) 898-2605

Grant Proposal(s) will be accepted at any time before but not later than 2:00 p.m. EDST on September 29, 2006. Each Grant Proposal must be signed by an official with authorization to sign on behalf of the sponsoring organization/agency. NO FAXES WILL BE ACCEPTED.

This GAR is being issued under proviso #8.32 – DHHS: Prevention Partnership Grants.

Key Events and Dates:

- | | |
|---|--------------------|
| 1. Grant Application Request (GAR) Issued | August 22, 2006 |
| 2. Deadline for Receipt of Written Questions | August 29, 2006 |
| 3. Pre-proposal conference | August 29, 2006 |
| 4. Deadline for Receipt of Formal Grant Proposal(s)
an original and six (6) copies | September 29, 2006 |
| 5. Written Notice of Intent to Award Grants | October 27, 2006 |
| 6. SCDHHS Prepares Contracts for Grantees' Signature | November, 2006 |
| 7. SCDHHS Staff Meets with Grantees | November, 2006 |

Pre-Proposal Conference

The Pre-Proposal Conference for this GAR will be held at 2:00 p.m., on Tuesday, August 29, 2006 in the conference room on 10th floor at the South Carolina Department of Health and Human Services, 1801 Main Street, Columbia, SC 29202-8206. No more than two representatives from each applying organization/agency shall attend the conference. The conference is not mandatory, but applicants are encouraged to send staff members who will be actively involved in grant preparation.

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PART I

GENERAL INFORMATION AND INSTRUCTIONS

A. Purpose

The South Carolina Legislature authorized Proviso 8.32 – DHHS: Prevention Partnership Grants in order for the South Carolina Department of Health and Human Services (SCDHHS) to implement a Prevention Partnership Grants Program with funds appropriated herein for prevention grants. *“Grants must be awarded through a competitive process to government agencies, private foundations and businesses, and/or non-profit organizations that operate preventive health programs with documented outcomes.”*

SCDHHS recognizes that every community and its needs are different and the methodology chosen to address those needs is unique. In addition, the SCDHHS recognizes the numerous ways that health prevention programs can be crafted. Therefore, SCDHHS will accept for consideration any community Grant Proposal that addresses medically, evidence-based preventive health programs targeting preterm and/or premature births or chronic diseases associated with obesity, diabetes, hypertension or asthma.

B. Eligibility

Governmental agencies, private foundations and businesses, and/or non-profit organizations that operate preventive health programs with documented outcomes are eligible to apply for the grant(s). Groups may submit more than one grant request for consideration.

C. Fiscal Agent

Applicant community groups must designate one entity as the lead applicant organization that will serve as the fiscal agent for the project.

D. Funding Restrictions

Grants will not be awarded for funding capital projects, to replace lost funding, or to support currently operating programs. Funds from this Grant shall not be used for land purchases; cost of buildings or facilities; bad debts; cost of life insurance when the Grantee is the beneficiary; late payment charges, including penalties and fines; contingency funds; contributions; entertainment; fines and penalties; actual losses which could have been covered by insurance; interest; fund raising costs; investment management costs; profit/losses on disposition of depreciable property of other capital; legal fees; or organizational promotional expenses or other expenditures specified in OMB circular A-87.

Funding for equipment may be allowable if it is an integral part of the proposed project. This will be subject to review and approval prior to implementation. Expenses that directly promote the initiative or program may be allowable, but these are also subject to review and approval.

E. Time Frame

Costs may be incurred commencing with the beginning date of the grant, December 1, 2006 through November 30, 2007.

F. Grant Proposal Constitutes Offer

By submitting a Grant Proposal, the applicant agrees to be governed by the terms and conditions described in this document, except where subsequent amendments of any grant resulting from this GAR are specifically agreed to by the parties to supersede any such provision of this GAR.

G. Awards

Grants shall be awarded to applicants whose proposals are determined most likely to positively impact South Carolinians and their health behaviors/lifestyles that also include a clear outcome measurement plan. The total amount of funds available to be awarded is \$1,000,000; grants of various dollar amounts will be awarded. SCDHHS reserves the right to reject any and all Grant Proposals that are deemed to not meet the requirements of this GAR. SCDHHS is the sole judge as to whether an applicant's Grant Proposal has or has not satisfactorily met the requirements of this GAR.

NOTE: Not meeting performance standards on a grant awarded by SCDHHS may cause a grant proposal to not be funded or discontinuation or withholding of funding.

H. Notice of Award

Each applicant will be notified by letter after all Grant Proposals have been evaluated, and funding has been allocated.

I. Amendments

If it becomes necessary to revise any part of the GAR, all amendments will be provided to all applicants. Verbal comments or discussions relative to this solicitation cannot add, delete, or modify any written provision. Any alterations must be in the form of a written amendment to all applicants.

J. Discussion/Negotiation

By submission of a Grant Proposal, the applicant agrees that during the period following issuance of the GAR and prior to the final award of a grant, the applicant shall not discuss this GAR with any SCDHHS employee, except Ms. Ernestine J. Staley, Director, Division of Contracts, at SCDHHS. Ms. Staley can be reached at (803) 898-2605.

PART II

SPECIAL INSTRUCTIONS AND CONDITIONS

A. Receipt of Grant Proposal

It is required that the Grant Proposal be submitted no later than the date and time specified in the GAR. Applicants mailing Grant Proposals should allow a sufficient mail delivery period to ensure timely receipt of their Grant Proposals by the issuing office. Any Grant Proposals received after the scheduled date and time will immediately be considered non-responsive and disqualified. Postmarks will not be considered.

B. Preparation of Grant Application

Each applicant is to submit an original and six (6) copies of the Grant Proposal, in one package under seal. Each copy of the Grant Proposal should be bound (stapled or spring clipped) in a single volume. All documentation submitted with the Grant Proposal should be bound in the single volume. Grant Proposals should not have hard covers or be spiral bound. The applicant is required to have typed on the envelope or wrapping containing the Grant Proposal the name and address of the applicant and the Grant Proposal due date of September 29, 2006.

All Grant Proposals should be completed and carefully worded and must convey all of the information requested, as outlined in Part III, Section A.

Grant Proposals should be prepared simply and economically, providing a straightforward, concise description of applicant's capabilities to satisfy the requirements of the GAR. Emphasis should be on completeness and clarity of content. Grant applications should be no more than fifteen (15) pages, excluding appendices.

C. Maintenance of Records

The Grantee must maintain an accounting system with supporting fiscal records adequate to assure that claims for funds are in accordance with this Grant Agreement and all applicable laws, regulations, and policies. The Grantee further agrees to retain all financial and programmatic records, supporting documents, statistical records and other records of recipients relating to the delivery of preventive services under the Grant Agreement, and as further required by SCDHHS, for a period of three (3) years after the expiration of the Grant Agreement. If any litigation, claim, or other actions involving the records have been initiated prior to the expiration of the three (3) year period, the records shall be retained until completion of the action and resolution of all issues which arise from it or until the end of the three (3) year period, whichever is later. This provision is also applicable to any subgrantee.

D. Inspection of Records

At any time during normal business hours and as often as SCDHHS, the State Auditor's Office, the Office of the Attorney General, the Comptroller General, and/or any of the designees of the above may deem necessary during the grant agreement period and for three (3) years after last payment under this Grant Agreement, the Grantee shall make all program and financial records available for review. These representatives shall have the right to examine and make copies, excerpts or transcripts from all records, contact information, and conduct private interviews with clients and employees, and do onsite reviews of all matters relating to service delivery as specified by the Grant Agreement. If any litigation, claim, or other action involving the records has been initiated prior to the expiration of the three (3) year period, the records shall be retained until completion of the action and resolution of all issues which arise from it or until the end of the three (3) year period, whichever is later.

E. Political Activity

The Grantee agrees that none of these funds provided under this Grant Agreement shall be used for any partisan political activity, or to further the election or defeat of any candidate for political office.

F. Safety Precautions

SCDHHS assumes no responsibility with respect to accidents, illness, or claims arising out of any work undertaken with the assistance of funds paid under this Grant Agreement. The Grantee shall take necessary steps to insure or protect itself and its personnel. The Grantee agrees to comply with all applicable local, state, federal occupational and safety acts, rules, and regulations.

G. No Obligation to SCDHHS

Neither SCDHHS nor any agent thereof on behalf of SCDHHS will be obliged in any way by any applicant response to this GAR.

H. Right of Rejection

SCDHHS reserves the right to accept or reject any or all Grant Proposals received as a result of the GAR, to negotiate with all qualified applicants, and to cancel, in part or in whole, this GAR if it is in the best interest of SCDHHS to do so.

I. Funding Availability

The total amount available for the grants for the period of December 1, 2006 through November 30, 2007 is \$1,000,000. Funding for these grants is provided by the state of South Carolina through Proviso 8.32 (DHHS: Prevention Partnership Grants) and is available for a one-year period.

J. Grant Review

All projects selected for funding will be expected to work cooperatively with SCDHHS by completing brief quarterly reports on service and activities delivered, performance outcomes, and program expenditures.

K. Termination

The parties agree that their liabilities and responsibilities shall be contingent upon the availability of funds, and that this agreement shall be terminated if such funding ceases to be available. This agreement may be canceled and terminated by either party at any time within the agreement period whenever it is determined by either party that the other has failed to comply with its obligations. Notification of termination will be sent by Certified Mail, return receipt requested.

L. Approval of Program Materials, Audio Visuals, and Presentations

The Grantee agrees to design all educational and promotional materials related to the project in a format that is easily understood and medically evidence based (including press releases).

The Grantee shall not distribute any promotional or marketing materials without prior written approval from SCDHHS. Marketing, promotional, or educational materials shall not make any assertion or statement (whether written or oral) that participation in their program will affect Medicaid benefits. Marketing materials shall not make any assertion or statement that CMS, the Federal or State government or similar entity endorses the Grantee.

Any presentation proposals, speeches, press releases, or brochures must be submitted to SCDHHS for approval at least ten business days prior to scheduled use.

PART III

SCOPE OF SERVICES FOR PREVENTION PARTNERSHIP GRANTS

A. Grant Proposal Structure and Content

The Grant Proposal must include the following sections, in this order.

1. Cover Sheet

Submit the completed cover sheet provided with this GAR.

2. Table of Contents

The following sections must be included, with page numbers:

Program Narrative:

Program Background and Problem Statement
Target Population/Project Participants
Goals and Objectives
Approach and Methodology with a Clear Timeline and Operational Plan
Summary of Applicant's Qualifications

Budget Narrative:

Staffing
Budget (Using Budget Summary Form)
Spending Plan for Grant Funds

Program Narrative

The narrative is the core of the Grant Proposal. It must be organized and self-explanatory. All narrative pages must be single-spaced, 12 PT Font, and limited to no more than fifteen (15) pages. (Submitted Grant Proposals containing more than fifteen (15) narrative pages will not be considered for review). The narrative section should be prepared as follows:

Program Background and Problem Statement:

Description of the health problem and how this healthcare prevention project will address the problem. Include a description of any existing prevention programs or initiatives already operating in the community. Applicants must define the "community" (i.e. as a county, school district, housing project, or any other specific geographic location.)

Target Population/Project Participants:

Applicants should describe any strategies that specifically target a particular segment of the population. Applicants must describe the target population for the project, including age, racial/ethnic characteristics, gender, other social or demographic characteristics, and any specific risk factors, and define why this population was chosen. The applicants will also identify specific disease states (i.e., diabetes, kidney disease, etc.) that the prevention efforts will address.

Goals and Objectives:

List the specific goals and measurable outcome objectives for the proposed preventive health project. Provide a timeline with an operational plan. In addition, describe the techniques that will be used to collect outcome data as well as any other self-evaluation processes that will be used to measure the success of the project.

Approach and Methodology:

Discuss in detail the approaches and methods for carrying out the goals and objectives of the preventive health project. The specific programs and activities along with a Program Implementation Plan must be included. Special emphasis should be placed on innovative and/or creative approaches that are specifically designed to meet the needs of the targeted population to be served. At a minimum, descriptions should include the following:

- Assurance of cultural, gender and age sensitivity and appropriateness,
- When, where, how and for whom specific activities will be provided,
- Specific programs/activities to be implemented along with staff responsibilities,
- Timeline for implementation,
- Facilities and equipment utilized,
- Evidence of collaboration with multiple community partners/organizations (Letters of commitment should be included in the Attachments section), and
- Plans for promoting the prevention program/project to potential participants.

Summary of Applicant's Qualifications:

The applicant must, upon request of SCDHHS, furnish satisfactory evidence of ability to furnish products or services in accordance with the terms and conditions of this GAR. SCDHHS reserves the right to make the final determination as to the applicant's ability to provide the services requested herein before entering into any grant.

In addition, the applicant must describe their background and experience in conducting healthcare prevention programming for the targeted population they wish to serve and the applicant must provide resumes for professional staff members that will be assigned to this project.

3. Budget Narrative:

Staffing:

Submit a job description for the staff person(s) designated to be directly responsible for the project that includes job title, responsibilities, supervisory relationships, education and any other qualifications. (Job Descriptions should be included in the Attachments section.)

Budget:

Using the Budget Summary Form, provide budget breakouts and sub-totals for the proposed project. In the budget narrative, provide a brief line-item justification for every entry. It is important that the budget summary form and narrative provide a clear picture of how resources will be utilized to conduct the proposed project. Also develop a monthly tracking process to show how the Grantee anticipates spending the requested funds.

Describe facilities, equipment, financial resources and other resources presently available to carry out the project. If equipment and/or other supplies are included in this budget, detailed descriptions and justifications must be provided, indicating lack of availability. Applicants are encouraged to utilize existing and/or donated facilities and equipment, when possible. Any changes to the original budget approved at the time of the original award must be prior approved by SCDHHS.

NOTE: Information regarding community contributions of resources is required if these resources are included in the budget. Specifically, a determination of what amounts of community contributions are cash and/or in-kind contributions must be included.

4. Attachments and Required Documents

Attachments shall consist of copies of cooperative agreements, pledges of resources, letters of support, lead applicant organizational status, and any other applicable and relevant documentation that supports and enhances the Grant Proposal.

- Properly completed W-9 IRS Tax Form
- List of Current Board Members of Governing Body
- Drug-Free Workplace Form
- Invoice on Agency letterhead for one-fourth of the total project amount

B. Reimbursement/Reporting Requirements

The Grantee shall receive four quarterly payments for implementing the preventive health program.

- The first payment will be forwarded in the first month of the Grant.
- Within the first sixty days of operation, the Grantee shall provide confirmation to SCDHHS that the Program Implementation Plan, a detailed monthly program expenditure report and spending plan has been established. Also, the Grantee shall submit an invoice for the second quarter of operations. Upon approval of the required submissions, SCDHHS will process the invoice and operating funds will be forwarded to the Grantee.
- By the end of the fifth month of operations, the Grantee must submit a progress report identifying accomplishments and program activities, expenditures by month, and the invoice for the third quarter. An overview of expected activities planned for the final two quarters must also be included.
- By the end of the eighth month, the Grantee must submit an updated progress report, program expenditures by month, a listing of activities planned for the final quarter, and the invoice for the final quarter of operations.

A final Program Report is due no later than thirty (30) days from the expiration of this grant. The format for this report is found in Part V of this GAR.

PART IV
EVALUATION CRITERIA

All Grant Proposals will be reviewed and assigned an overall score based on the criteria listed below.

<u>POINTS</u>	<u>CRITERIA</u>
55	Scope of Work and Objectives What is the specific program or primary preventive health project that is going to be delivered? Are there clearly defined objectives that are preventive in nature and would produce positive healthcare/lifestyle changes for the target audience? Is there a comprehensive approach with realistic plans for the project implementation or expansion? Are the goals and objectives for this project clearly aimed at primary prevention – actually preventing disease/risk rather than treating a disease? Does the project clearly address the identified community needs? Is the program or project innovative and creative and potentially replicable?
15	Coordination and Collaboration Is there evidence of coordination and collaboration with other community resources/organizations? Are these dollars going to be maximized in relation to existing resources? Will these dollars significantly complement an already-existing project/program? Is there documentation of cash and/or “in kind contributions” from the community and/or other agencies?
15	Performance Measurement/Outcomes Are the outcome measures clearly defined? Do these performance measures “build upon” already documented prevention programming outcomes?
15	Experience/Project Management Experience Is there documented evidence that the applicant has the capacity, experience, and expertise to deliver what is being proposed? Is there evidence that the applying organization has the ability to manage the proposed program/project? Does the applying agency have experience in fiscal management related to project/grant management?

PART V

Attachments

The following forms must be completed by each Applicant and included in the grant proposal:

- Cover Sheet
- Project Budget Summary Form
- Checklist Review
- Properly Completed W-9 IRS Tax Form
- List of Current Members of Governing Board
- Drug-Free Workplace Form
- Invoice on Agency letterhead for one-fourth of total project amount

Within two months of operation, the Grantee shall complete and submit the following:

- Revised Program Implementation Plan
- Detailed Monthly Program Expenditure Reports along with a Spending Plan
- Invoice for second payment for one-fourth of total amount allocated

At the end of five months of operation, the Grantee shall complete and submit the following:

- Progress Report
- Program Expenditure Forms (by month) and a Budget Summary
- List of Activities/Programs planned for final two quarters
- Invoice for 3rd quarter

At the end of eight months of operation, the Grantee shall complete and submit the following:

- Progress Report
- Program Expenditure Forms (by month) and a Budget Summary
- List of Activities/Programs planned for the final quarter
- Invoice for 4th quarter

At the end of the project, the Grantee shall complete and submit the following:

- Final Program Report highlighting accomplishments, Lessons Learned, Implications for Future Projects, and Performance Measures/Outcomes
- Program Expenditure Forms and a Budget Summary

Prevention Partnership Grant Proposal Cover Sheet

Project Name: _____

Brief Description: _____

Lead Applicant Organization: _____

Address: _____

County: _____

Phone Number: _____

FAX Number: _____

Contact Person: _____

Partner Organization(s): _____

**Authorized Signature of
Lead Organization:** _____

Date: _____

Prevention Partnership Grant Request Budget Request

	Grant Funds Requested	Community Resources Amount/Type	Source	Total
Personnel				
Benefits (At _____ %)				
Travel				
Equipment				
Supplies				
Program Marketing/Promotions				
Contractual				
Other (Please Specify)				

* See Part I, Section D, Funding Restrictions

Proposal Checklist Review

1. _____ Original proposal plus six (6) copies delivered to SCDHHS by 2:00 p.m. EDST on Friday, September 29, 2006.
2. _____ Each copy must contain the following:
 - _____ Completed Cover Sheet
 - _____ Table of Contents with page numbers
 - _____ Narratives: Program and Budget, including Budget Projection Summary Form
3. _____ Attachments:
 - _____ Organization's Business Status Documentation
 - _____ Letters of Collaboration/Support/Commitment
 - _____ Job Description(s)
 - _____ Resumes of Key Staff Members
 - _____ Other Pertinent Documents of Support
 - _____ Properly Completed W-9 IRS Tax Form
 - _____ Current Listing of Board Members
 - _____ Completed Drug-Free Workplace Form
 - _____ Invoice on Agency letterhead for Payment for 1st Quarter

Program Progress Report Form

Project Name: _____

Grantee Name: _____

Project Director Name: _____

Grant Report Period: _____

Executive Summary: Attach a brief description of the project along with project highlights, project outcomes, self-assessment of success of the project, strengths and weaknesses discovered during implementation/expansion.

Project Goals: By Goal and Objective, respond to the following: Describe the extent to which the implementation of this project has enabled you to meet the originally stated goals and objectives.

Performance Measures: By Performance Measure, answer the following: Are the performance outcomes being achieved with the program participants? Will the health behaviors of program participants likely be positively impacted at the conclusion of this project? Describe how/why this is/is not happening.

Prevention Partnership Expenditure Reporting Form

Applicant Organization _____
Grant Reporting Period _____

	Grant Funds Budgeted Year-to-Date	Grant Funds Expended Year-to-Date	Problem/Concerns	Reason for being over/under budget
Personnel _____ _____ _____ _____ _____ _____ _____				
Benefits (At _____ %)				
Travel				
Equipment				
Supplies				
Program Marketing/Promotions				
Contractual				
Other (Please Specify) _____ _____ _____ _____ _____ _____				

Signature of Project Administrator: _____

Date Completed: _____

DRUG-FREE WORKPLACE ACT

SECTION **44-107-10** THROUGH SECTION **44-107-90**
CODE OF LAWS OF SOUTH CAROLINA, 1976 AS AMENDED

CERTIFICATION STATEMENT

I hereby certify to the South Carolina Department of Health and Human Services (SCDHHS) that I will provide a drug-free workplace by:

1. publishing a statement notifying employees that the unlawful manufacture, distribution, dispensation, possession, or use of a controlled substance is prohibited in the person's workplace and specifying the actions that will be taken against employees for violations of the prohibition;
2. establishing a drug-free awareness program to inform employees about:
 - a. the dangers of drug abuse in the workplace;
 - b. the person'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 violations;
3. making it a requirement that each employee to be engaged in the performance of the contract be given a copy of the statement required by item 1;
4. notifying the employee in the statement required by item 1, that as a condition of employment on the contract or grant, the employee will:
 - a. abide by the terms of the statement; and
 - b. notify the employer of any criminal drug statute conviction for a violation occurring in the workplace no later than five days after the conviction;
5. notifying the using agency within ten days after receiving notice under item 4,b from an employee or otherwise receiving actual notice of the conviction;
6. imposing a sanction on, or requiring the satisfactory participation in a drug abuse assistance or rehabilitation program by any employee convicted, as required by Section **44-107-50**; and
7. making a good faith effort to continue to maintain a drug-free workplace through implementation of items **1,2,3,4,5** and 6

I also agree that, in compliance with Section **44-107-50**, I shall, within thirty days after receiving notice from an employee of a conviction pursuant to this title:

1. take appropriate personnel action against the employee up to and including termination; ~~or~~
2. require the employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for the purposes by a federal, state, or local health, law enforcement, or other appropriate agency.

Date

Authorized Signature

Revised 1/31/97

INSTRUCTIONS FOR COMPLETING DISCLOSURE OF OWNERSHIP AND CONTROL INTEREST STATEMENT (Form HCFA-1513 Modified by DHHS 10-97)

Completion and submission of this form is a condition of participation, certification, or recertification under any of the programs established by Title V, XVII, XIX, and XX, or as a condition of approval or renewal of a contractor agreement between the disclosing entity and the appropriate state agency under any of the above-titled programs, a full and accurate disclosure of ownership and financial interest is required. Failure to submit requested information may result in a refusal by the state agency to enter into an agreement or contract with any such entity or in termination of existing agreements. This form is to be completed annually.

General Instructions

For definitions, procedures and requirements, refer to the appropriate Regulations:

meV	-42CFR 51a.144
Title XVII	-42CFR 420.200-206
Title XIX	-42CFR 455.100-106
Title XX	-42CFR 228.72-73

Please answer all questions as of the current date. If the yes block for any item is checked, list requested additional information under the Remarks Section on back of form, referencing the item number to be continued. If additional space is needed use an attached sheet.

DETAILED INSTRUCTIONS

These instructions are designed to clarify questions on the form. Instructions are listed in question order for easy reference. No instructions have been given for questions considered self-explanatory.

IT IS ESSENTIAL THAT ALL APPLICABLE QUESTIONS BE ANSWERED ACCURATELY AND THAT ALL INFORMATION BE CURRENT.

Item I - Under identifying information specify in what capacity the entity is doing business as (DBA), example, name of trade or corporation.

Item II - Self-explanatory

Item III - List the names of all individuals and organizations having direct or indirect ownership interests, or controlling interest separately or in combination amounting to an ownership interest of 5 percent or more in the disclosing entity.

Direct ownership interest is defined as the possession of stock, equity in capital or any interest in the profits of the disclosing entity. A disclosing entity is defined as a Medicare provider or supplier, or other entity that furnishes services or arranges for furnishing services under Medicaid or the Maternal and Child Health program, or health related services under the social services program.

Indirect ownership interest is defined as ownership interest in an entity that has direct or indirect ownership interest in the disclosing entity. The amount of indirect ownership in the disclosing entity that is held by any other entity is determined by multiplying the percentage of ownership interest at each level. An indirect ownership interest must be reported if it equates to an ownership interest of 5 percent or more in the disclosing entity. Example: If A owns 10 percent of the stock of a corporation that owns 80 percent of the stock of the disclosing entity, A's interest equates to an 8 percent indirect ownership and must be reported.

Controlling interest is defined as the operational direction or management of a disclosing entity which may be maintained by any or all of the following devices: the ability or authority, expressed or reserved, to amend or change the corporation identity (i.e., joint venture agreement, unincorporated business status) of the disclosing entity; the ability or authority to nominate or name members of the Board of Directors or

Trustees of the disclosing entity; the ability or authority, expressed or reserved, to amend or change the by-laws, constitution, or other operating or management direction of the disclosing entity; the right to control any or all of the assets or other property of the disclosing entity upon the sale or dissolution of that entity; the ability or authority, expressed or reserved, to control the sale of any or all of the assets, to encumber such assets by way of mortgage or other indebtedness, to dissolve the entity, or to arrange for the sale or transfer of the disclosing entity to new ownership or control.

Items IV-VII - Changes in Provider Status

Change in provider status is defined as any change in management control. Examples of such changes would include: a change in Medical or Nursing director, a new Administrator, contracting the operation of the facility to a management corporation, a change in the composition of the owning partnership which under applicable State law is not considered a change in ownership, or the hiring or dismissing of any employees with 5 percent or more financial interest in the facility or in an owning corporation, or any change of ownership.

For **Items IV - VII**, if the yes block is checked, list additional information requested under Remarks. Clearly identify which item is being continued.

Item IV - (a & b) If there has been a change in ownership within the last year or if you anticipate a change, indicate the date in the appropriate space.

Item V - If the answer is yes, list name of the management firm and employer identification number (EIN), or the name of the leasing organization. A management company is defined as any organization that operates and manages a business on behalf of the owner of that business, with the owner retaining ultimate legal responsibility for operation of the facility.

Item VI - If the answer is yes, identify which has changed (Administrator, Medical Director, or Director of Nursing) and the date the change was made. Be sure to include name of the new Administrator, Director of Nursing or Medical Director, as appropriate.

Item VII - A chain affiliate is any freestanding health care facility that is either owned, controlled, or operated under lease or contract by an organization consisting of two or more free-standing health care facilities organized within or across State lines which is under the ownership or through any other device, control and direction of a common party. Chain affiliates include such facilities whether public, private, charitable, or proprietary. They also include subsidiary organizations and holding corporations. Provider-based facilities, such as hospital-based home health agencies, are not considered to be chain affiliates.

DISCLOSURE OF OWNERSHIP AND CONTROL INTEREST STATEMENT

I. Identifying Information

Name of Entity	D/B/A	Provider No.	Telephone No.
Street Address	City, County, State		Zip Code

II. Answer the following questions by checking "Yes" or "No". If any of the questions are answered "Yes", list names and addresses of individuals or corporations under **Remarks** on back of form. Identify each item number to be continued.

A. Are there any individuals or organizations having a direct or indirect ownership or control interest of five percent (5% or more) in the institution, organization, or agency that have been convicted of a criminal offense related to the involvement of such persons, or organizations in any of the programs established by Titles XVIII, XIX, or XX?

_____ Yes _____ No

B. Are there any directors, officers, agents, or managing employees of the institution, agency, or organization who have ever been convicted of a criminal offense related to their involvement in such programs established by Titles VII, XIX, or XX?

_____ Yes _____ No

C. Are there any individuals currently employed by the institution, agency, or organization in a managerial, accounting, auditing, or similar capacity who were employed by the institution's, organization's, or agency's fiscal intermediary or carrier within the previous twelve (12) months?

_____ Yes _____ No

III. (a) List names, addresses for individuals, or the EIN for organizations having direct or indirect ownership or a controlling interest in the entity. (See instructions for definition of ownership and controlling interest.) List any additional names and addresses under 'Remarks' on back of form. If more than one individual is reported and any of these persons are related to each other, this must be reported under Remarks.

Name	Address	EIN

(b) Type of Entity: _____ Sole Proprietorship _____ Partnership _____ Corporation
 _____ Unincorporated Associations _____ Other (Specify) _____ Not-for-Profit

(c) If the disclosing entity is a corporation, list names, addresses of the Directors, and EINs for corporations under Remarks.

(d) Are any owners of the disclosing entity also owners of other Medicare/Medicaid facilities? (Example, sole proprietor, partnership or members of Board of Directors). If yes, list names, addresses of individuals and provider numbers.

_____ Yes _____ No

Name	Address	Provider Number

IV. (a) Has there been a change in ownership or control within the **last year**?
If **yes**, give date _____ Yes _____ No

(b) Do you anticipate any change of ownership or control within the **year**?
If **yes**, when? _____ Yes _____ No

(c) Do you anticipate filing for **bankruptcy** within the **year**?
If **yes**, when? _____ Yes _____ No

V. Is this facility operated by a management company, or leased in **whole** or part by another organization?
If **yes**, give the date in change of operations _____ Yes _____ No

VI. Has there been a change in Administrator, Director of Nursing or Medical Director within the last year?
_____ Yes _____ No

VII. (a) Is this facility chain affiliated? (If **yes**, list name, address of Corporation, and EIN)
_____ Yes _____ No

Name _____ **EIN#** _____
Address _____

VII. (b) If the answer to Question VII.a. is No, was the facility ever affiliated with a chain?
(If YES, list Name, Address of Corporation and EIN) _____ Yes _____ No

Name _____ **EIN#** _____
Address _____

WHOEVER KNOWINGLY AND WILLFULLY MAKES OR CAUSES TO BE MADE A FALSE STATEMENT OR REPRESENTATION OF THIS STATEMENT, MAY BE PROSECUTED UNDER APPLKABLE FEDERAL OR STATE LAWS. IN ADDITION, KNOWINGLY AND WILLFULLY FAILING TO FULLY AND ACCURATELY DISCLOSE THE INFORMATION REQUESTED MAY RESULT IN DENIAL OF A REQUEST TO PARTICIPATE OR WHERE THE ENTITY ALREADY PARTICIPATES, A TERMINATION OF ITS AGREEMENT OR CONTRACT WITH THE STATE AGENCY.

Name of Authorized Representative (Typed) Title

Signature Date

Remark.

Request for Taxpayer Identification Number and Certification

Give form to the
 requester. Do NOT
 send to the IRS.

Please print or type

Name (If a joint account of you changed your name, see Specific Instructions on page 2.)	
Business name, if different from above. (See Specific Instructions on page 2.)	
Check appropriate box: <input type="checkbox"/> Individual/Sole proprietor <input type="checkbox"/> Corporation <input type="checkbox"/> Partnership <input type="checkbox"/> Other ▶	
Address (number, street, and apt. or suite no.)	Requester's name and address (optional)
City, state, and ZIP code	

Part I Taxpayer Identification Number (TIN) List account number(s) here (optional)

individuals, this is your social security number (SSN). However, if you are a resident alien OR a

Social security number

Note: If the account is in more than one name, see the chart on page 2 for guidelines on whose

Employer identification number

Part II

on page 2.)

▶

Part III

Sign Here	Signature ▶	Date ▶
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Purpose of form. A person who is required to file an information return with the IRS must get your correct taxpayer identification number (TIN) to report, for example, income paid to you, real estate transactions, mortgage interest you paid, acquisition or abandonment of secured property, cancellation of debt, or contributions you made to an IRA.

Use Form W-9, if you are a U.S. person (including a resident alien), to give your correct TIN to the person requesting it (the requester) and, when applicable, to:

1. Certify the TIN you are giving is correct (or you are waiting for a number to be issued),
2. Certify you are not subject to backup withholding, or
3. Claim exemption from backup withholding if you are an exempt payee.

If you are a foreign person, IRS **prefers** you use a Form W-8 (certificate of foreign status). After December 31, 2000, foreign persons **must** use an appropriate Form W-8.

Note: If a requester gives you a form other than Form W-9 to request your TIN, you must use the requester's form if it is substantially similar to this Form W-9.

What is backup withholding? Persons making certain payments to you must withhold and pay to the IRS 31% of such payments under certain conditions. This is called "backup withholding." Payments that may be subject to backup withholding include interest, dividends, broker and barter exchange transactions, rents, royalties, nonemployee pay, and certain payments from fishing boat operators. Real estate transactions are not subject to backup withholding.

If you give the requester your correct TIN, make the proper certifications, and report all your taxable interest and dividends on your tax return, payments you receive will not be subject to backup withholding. Payments you receive **will** be subject to backup withholding if

1. You do not furnish your TIN to the requester, or
2. You do not certify your TIN when required (see the Part III instructions on page 2 for details), or
3. The IRS tells the requester that you furnished an incorrect TIN, or
4. The IRS tells you that you are subject to backup withholding because you did not report all your interest and dividends on your tax return (for reportable interest and dividends only), or

5. You do not certify to the requester that you are not subject to backup withholding under 3 above (for reportable interest and dividend accounts opened after 1983 only).

Certain payees and payments are exempt from backup withholding. See the Part II instructions and the separate **Instructions for the Requester of Form w-9.**

Penalties

Failure to furnish TIN. If you fail to furnish your correct TIN to a requester, you are subject to a penalty of \$50 for each such failure unless your failure is due to reasonable cause and not to willful neglect.

Civil penalty for false information with respect to withholding. If you make a false statement with no reasonable basis that results in no backup withholding, you are subject to a \$500 penalty.

Criminal penalty for falsifying information. Willfully falsifying certifications or affirmations may subject you to criminal penalties including fines and/or imprisonment.

Misuse of TINs. If the requester discloses or uses TINs in violation of Federal law, the requester may be subject to civil and criminal penalties.

Specific Instructions

Name. If you are an individual, you must generally enter the name shown on your social security card. However, if you have changed your last name, for instance, due to marriage, without informing the Social Security Administration of the name change, enter your first name, the last name shown on your social security card, and your new last name.

If the account is in joint names, list first and then circle the name of the person or entity whose number you enter in Part I of the form.

Sole proprietor. You must enter your individual name as shown on your social security card. You may enter your business, trade, or "doing business as" name on the business name line.

Other entities. Enter your business name as shown on required Federal tax documents. This name should match the name shown on the charter or other legal document creating the entity. You may enter any business, trade, or "doing business as" name on the business name line.

Part I—Taxpayer Identification Number (TIN)

You must enter your TIN in the appropriate box. If you are a resident alien and you do not have and are not eligible to get an SSN, your TIN is your IRS individual taxpayer identification number (ITIN). Enter it in the social security number box. If you do not have an ITIN, see **How to get a TIN** below.

If you are a sole proprietor and you have an EIN, you may enter either your SSN or EIN. However, using your EIN may result in unnecessary notices to the requester.

Note: See the chart on this page for further clarification of name and TIN combinations.

How to get a TIN. If you do not have a TIN, apply for one immediately. To apply for an SSN, get **Form SS-5**, Application for a Social Security Card, from your local Social Security Administration office. Get **Form W-7**, Application for IRS Individual Taxpayer Identification Number, to apply for an ITIN or **Form SS-4**, Application for Employer identification Number, to apply for an EIN. You can get Forms W-7 and SS-4 from the IRS by calling 1-800-TAX-FORM (1-800-829-3676) or from the IRS's Internet Web Site at www.irs.gov.

If you do not have a TIN, write "Applied For" in the space for the TIN, sign and date the form, and give it to the requester. For interest and dividend payments, and certain payments made with respect to readily tradable instruments, generally you will have 60 days to get a TIN and give it to the requester. Other payments are subject to backup withholding.

Note: Writing "Applied For" means that you have already applied for a TIN OR that you intend to apply for one soon.

Part II—For Payees Exempt From Backup Withholding

Individuals (including sole proprietors) are not exempt from backup withholding. Corporations are exempt from backup withholding for certain payments, such as interest and dividends. For more information on exempt payees, see the separate Instructions for the Requester of Form W-9.

If you are exempt from backup withholding, you should still complete this form to avoid possible erroneous backup withholding. Enter your correct TIN in Part I, write "Exempt" in Part II, and sign and date the form.

If you are a nonresident alien or a foreign entity not subject to backup withholding, give the requester a completed Form W-8 (certification of foreign status).

Part III—Certification

For a joint account, only the person whose TIN is shown in Part I should sign (when required).

1. Interest, dividend, and barter exchange accounts opened before 1984 and broker accounts considered active during 1983. You must give your correct TIN, but you do not have to sign the certification.

2. Interest, dividend, broker, and barter exchange accounts opened after 1983 and broker accounts considered inactive during 1983. You must sign the certification or backup withholding will apply. If you are subject to backup withholding and you are merely providing your correct TIN to the requester, you must cross out item 2 in the certification before signing the form.

3. Real estate transactions. You must sign the certification. You may cross out item 2 of the certification.

4. Other payments. You must give your correct TIN, but you do not have to sign the certification unless you have been notified that you have previously given an incorrect TIN. "Other payments" include payments made in the course of the requester's trade or business for rents, royalties, goods (other than bills for merchandise), medical and health care services (including payments to corporations), payments to a nonemployee for services, payments to certain fishing boat crew members and fishermen, and gross proceeds paid to attorneys (including payments to corporations).

5. Mortgage interest paid by you, acquisition or abandonment of secured property, cancellation of debt, qualified state tuition program payments, IRA or MSA contributions or distributions, and pension distributions. You must give your correct TIN, but you do not have to sign the certification.

Privacy Act Notice

Section 6109 of the Internal Revenue Code requires you to give your correct TIN to

persons who must file information returns with the IRS to report interest, dividends, and certain other income paid to you, mortgage interest you paid, the acquisition or abandonment of secured property, cancellation of debt, or contributions you made to an IRA or MSA. The IRS uses the numbers for identification purposes and to help verify the accuracy of your tax return. The IRS may also provide this information to the Department of Justice for civil and criminal litigation, and to cities, states, and the District of Columbia to carry out their tax laws.

You must provide your TIN whether or not you are required to file a tax return. Payers must generally withhold 31% of taxable interest, dividend, and certain other payments to a payee who does not give a TIN to a payer. Certain penalties may also apply.

What Name and Number To Give the Requester

For this type of account:	Give name and SSN of:
1. Individual	The individual
2. Two or more individuals (joint account)	The actual owner of the account or, if combined funds, the first individual on the account ¹
3. Custodian account of a minw (Uniform Gift to Minors Act)	The minor ²
4. a. The usual revocable savings trust (grantor is also trustee)	The grantor-trustee ¹
b. So-called trust account that is not a legal or valid trust under state law	The actual owner ¹
5. Sole proprietorship	The owner ³
For this type of account:	Give name and EIN of:
6. Sole proprietorship	The owner ³
7. A valid trust, estate, or pension trust	Legal entity ⁴
8. Corporate	The corporation
9. Association, club, religious, charitable, educational, or other tax-exempt organization	The organization
10. Partnership	The partnership
11. A broker or registered nominee	The broker or nominee
12. Account with the Department of Agriculture in the name of a public entity (such as a state or local government, school district, or prison) that receives agricultural program payments	The public entity

¹ List first and circle the name of the person whose number you furnish. If only one person on a joint account has an SSN, that person's number must be furnished.

² Circle the minor's name and furnish the minor's SSN.

³ You must show your individual name, but you may also enter your business or "doing business as" name. You may use either your SSN or EIN (if you have one).

⁴ List first and circle the name of the legal trust, estate, or pension trust. (Do not furnish the TIN of the personal representative or trustee unless the legal entity itself is not designated in the account title.)

Note: If no name is circled when more than one name is listed, the number will be considered to be that of the first name listed.

