**ATTACHMENT F** **– ITN APPLICATION**



**ITN Application**

**Fiscal Years 2018-2021**

**BROWARD HEALTHY START COALITION, INC.**
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Fort Lauderdale, FL 33309
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**ITN LIST**

1. **Data Input Form**
2. **Part I - Application for Funds**

 **Section A.** Applicant Agency Information: Cover Sheet

 **Section B.** Certification of Accuracy and Compliance

1. **Part II**

**Section A.** Agency Detail

**Section B.** Organizational Capability

**Section C.** Proposed Staff Information

## Part III

## Section A. Additional ITN Application Requirements

## Part IV

## Section A. Performance Outcome Measures

## Part V

## Section A. Budget

**DATA INPUT FORM**

|  |  |
| --- | --- |
|  | Agency Legal Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  | CEO Email Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  | Service Applied for:Healthy Start Prenatal and Infant Pathway and Interconception Care Counseling  |
|  | Amount Requested:$\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  | In what areas of Broward County are services to be provided? (North, South, Central, or County-wide?) Or targeting zip codes with high rates of fetal/infant mortality and prematurity concentrated in several of the county’s zip codes.List of Zip Codes to be Served: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  | Proposal Contact Person: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Email\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|
|  | Name of Partner(s) or Sub-Contractors  \*if applicable\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

## APPLICATION FOR FUNDS

## Part I

**Section A.** **Applicant Agency Information: Cover Sheet**

|  |
| --- |
| **Agency Legal Name must match Agency name listed on the Florida Department of State Division of Corporation website:** [**www.sunbiz.org**](http://www.sunbiz.org)Agency Legal Name: |
| Main Administrative Address: |
| City & State:  | Zip Code: |
| Telephone Number: | Fax Number: |
| CEO/Executive Officer: Email:  | Office Phone Number: |
| Chief Financial Officer: Email:  | Office Phone Number: |
| Agency Contact Person: | Office Phone Number: |
| Contact Email: | Contact Fax Number:  |
| Type of Entity: \_\_\_\_ Corporation \_\_\_\_ Private for-Profit \_\_\_\_ Private Not-for-ProfitUnit of Government \_\_\_\_ Federal \_\_\_\_ State \_\_\_\_ County \_\_\_\_ City \_\_\_ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Licensed to do business in Florida?  Yes No N/A | 17. Federal Identification Number:  |

**Section B. Certification of Accuracy and Compliance**

I do hereby certify that all facts, figures, and representations made in the application(s) are true and correct. Furthermore, all applicable statutes, terms, conditions, regulations, and procedures for program compliance and fiscal control, including but not limited to, those contained in the Bid Solicitation and Core Contract will be implemented to ensure proper accountability of contracts. I certify that the funds requested in this application will not supplant funds that would otherwise be used for the purposes set forth in this project and are a true estimate of the amount needed to operate the proposed program. The filing of this application has been authorized by the contracting entity, and I have been duly authorized to act as the representative of the agency in connection with this application. I also agree to follow all Terms, Conditions, and applicable federal and state statutes. Further, I understand that it is the responsibility of the agency head to obtain from its governing body the authorization for the submission of this application. Evidence of this authorization must be provided within 21 days of notice of award. I further understand that such contract award may be rescinded for failure to provide such documentation.

Lastly, I hereby attest that all work contained within this proposal is the unique and original product of the agency I represent and has not been plagiarized or duplicated in any way from another agency’s work product.

**Service Provider Signature (in blue ink)**

**\_\_\_\_\_      \_\_\_\_\_**

Authorized Official’s Signature/Date Authorized Official’s Title**Part II**

**Section A. Agency Detail**

1. Provide a concise description of the Agency, including its history, years of operation, general service mission, and primary services provided. Include (A) Strategy to successfully provide services (B) Strength of your organization to provide services, (C) Weakness or challenge for providing one or more of the services. *(Limit* *500 words–approx. 1 page)*
2. Provider Service History: \_\_\_ Previous BHSC Provider (Years) \_\_\_\_\_\_\_\_\_

 (Check all funded programs that apply) \_\_\_ Existing BHSC Provider

 \_\_\_ Existing CSC Provider

 \_\_\_ Existing CSAD Provider

 \_\_\_ Existing DOH Provider

 \_\_\_ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. If you have received non-BHSC funding for similar services in the past twelve (12) months, please indicate the funding information in the chart below.

**NOTE**: Add or delete rows as necessary.

|  |  |  |  |
| --- | --- | --- | --- |
| **Funder** | **Annual****Amount** | **Contract Period (m/y – m/y)** | **Type of Service** |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

1. Is the Agency accredited? \_\_\_\_Yes \_\_\_\_ No If yes, by whom: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Level of Accreditation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Period of Accreditation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. If a Not for Profit or For Profit Organization, CEO/Executive Director’s salary: $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If a Unit of Government, Program Director’s salary:

$\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Provide a copy of your organizational chart as an appendix and indicate where the proposed program reports within your agency. The position responsible for the direct supervision of program staff should be clearly noted.
2. What is the Agency’s fiscal year? Beginning: \_\_\_\_\_\_\_\_\_\_\_ Ending: \_\_\_\_\_\_\_\_\_\_\_
3. Attach a copy of your most recent financial audit to your application completed by a CPA registered to do business in the State of Florida and conducted in accordance with Generally Accepted Accounting Principles. Smaller agencies (those agencies with annual revenues less than $500,000) may submit unaudited compiled financial statements prepared by a CPA.
4. Does the Agency carry comprehensive general liability insurance? \_\_\_\_Yes \_\_\_\_ No

If yes, state the amount: $\_\_\_\_\_\_\_\_\_\_\_\_\_

If no, or if the amount is less than $500,000, the Agency must agree to purchase a minimum of $500,000 comprehensive general liability insurance prior to contract execution. Affirm: \_\_\_\_Yes \_\_\_\_ No

1. Does the Agency carry the following types of insurance?

|  |  |  |  |
| --- | --- | --- | --- |
|  | Yes | No | Amount of Coverage |
| Professional |  |  |  |
| Property |  |  |  |
| Auto |  |  |  |

 Please indicate whether your agency will be transporting clients: ⬜ Yes ⬜ No

1. If applicable, please attach any previous monitoring reports for similar services completed within the past twelve (12) months **for non-BHSC funded programs only.**

 If not applicable, please include a statement to that effect.

1. Describe as an attachment any litigation (lawsuits) or regulatory action filed against the Agency in the last three (3) years including case name, case number, court name, current status.

 If no litigation or regulatory action has been filed, provide a statement to that effect.

1. Has the Agency been sanctioned for non-compliance, had a contract rescinded, including corrective action, with any contract, government law, or regulation within the past three years (3) years? \_\_\_Yes \_\_\_ No \_\_\_ N/A

If yes, please provide a summary of the findings with any explanatory information you would like considered and attach a labeled copy of the report to this application.

 If no, provide a statement to that effect.

**Section B. Organizational Capability**

1. Briefly describe the organization’s knowledge of the maternal child health system in Broward County and any involvement with the Children’s Strategic Plan’s Maternal Child Health Committees. (*Limit to 250 words-approx. ½ page)*
2. Briefly describe the organization’s knowledge of the most pressing challenges facing maternal child health. Please provide a perspective of the local data trends and challenges in achieving success. (*Limit to 250 words-approx. ½ page)*
3. Briefly describe the significance of the Social Determinants of Health and their impact on maternal child health and how your organization will address those determinants in the program. (*Limit to 250 words-approx. ½ page)*
4. Briefly describe the organization’s experience in the delivery of Healthy Start services in Broward County during the past five (5) years. Also describe, if applicable, the organization’s experience in the delivery of similar services within the past five (5) years. (*Limit to 250 words-approx. ½ page)*
5. If no Healthy Start services have been provided by the organization, describe the organization’s experience in the delivery of home visitation services to pregnant women and infants, birth to age 12 months in Broward County during the past five (5) years. Also describe, if applicable, the organization’s experience in the delivery of similar services, within the past five (5) years. (*Limit to 250 words-approx. ½ page)*
6. Describe the organization’s experience in the implementation of intakes, assessments, screenings tools to identify specific risk factors that involve mental health, depression, domestic violence, substance abuse, and developmental delays. Organization may also describe specialized services that enhance comprehensive prenatal and child health care such as psychosocial counseling, childbirth and breastfeeding education that optimize outcomes. (*Limit to 150 words-approx. ¼ page)*
7. Describe organization’s knowledge and experience in the provision of Interconception Care Counseling, including curriculum being used. (ICC) (*Limit to 150 words-approx. ¼ page)*
8. Provide specific strategies for how the organization will be able to serve the zip code areas you identified beginning October 1, 2018, including strategies to collaborate with other social service organizations. (*Limit to 250 words-approx. ½ page)*
9. Identify the days of the week and hours of operation, and how the schedule meets the needs of the families. (*Limit to 150 words-approx. ¼ page)*
10. Relationships with support services that are available in Broward County are necessary for the success of a program. Describe other existing support services that are available in the community you plan to serve. Demonstrate your knowledge of those services and how your program will fit into that continuum of care. Describe the history of successful community collaboration. (*Limit to 250 words-approx. ½ page)*
11. All agencies funded under this funding mechanism will be required to develop and implement a Cultural Competence plan. This plan must address culturally sensitive outreach efforts and human resource development. Discuss your commitment to a culturally competent system of care. Please attach your agency’s Cultural Competence plan. *(Limit 250 words-approx. ½ page)*

**Section C. Proposed Staff Information**

1. Describe how the program will be staffed. List all positions that will be providing direct and support services. Include the number of Staff in each position, position title (which should match your budget narratives), minimum education (including degree area), experience requirements, primary duties, and the percent of each position’s time that will be devoted to this program. Service Provider requirements for Healthy Start Services are outlined in the Healthy Start Standards and Guidelines (available at <http://www.doh.state.fl.us/family/mch/hs/hs.html>)

**NOTE**: Add or delete rows as necessary.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **# of Positions** | **Position** | **Education** | **Experience** | **Duties** | **% of Time Devoted to Position** |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |

1. Please include a timeline for hiring and training of staff that ensures services will be fully operational by October 1st, 2018. *(Limit 250 words-approx. ½ page)*
2. Identify strategies to efficiently recruit staff that will be linguistically and culturally competent to serve the English, Spanish and Creole-speaking populations residing within these zip codes.
3. Describe the organization’s practices supervising staff and knowledge on reflective supervision.
4. Consistency is important to the success of services. Explain what efforts you will make to maintain staff and reduce turn-over of trained, experienced staff within the program. Include historical turnover information for your organization and current staff recruitment and retention efforts. *(Limit 250 words-approx. ½ page)*

## Part III

**Section A. Additional ITN Application Requirements**

1. Client engagement and retention is a strong indicator of success. The ITN provides guidelines for Best Practices and non-traditional settings. Describe the organization’s protocols to achieve a high rate of acceptance rate and strategies for engaging and maintaining clients during the required services periods. Explain in detail how you plan to engage, retain clients in services and include innovative practices in this section. *(Limit 250 words-approx. ½ page)*

## Part IV

**Section A. Performance Outcome Measures**

1. Performance Measures are required by the FDOH and Healthy Start MomCare Network, Inc. Therefore, all contracted service providers are expected to meet or exceed them. BHSC reserves the right to add additional Performance Measures and details at the time of contracting. Please describe how your agency plans to comply with performance measures in the topic areas listed below.

|  |  |
| --- | --- |
| **Healthy Start Program (Prenatal, Postnatal, and Interconception Pathways)** | Successful completion of face to face Initial Assessment within the required time frame |
| Successful engagement of clients at Initial Assessment to include obtaining client consent to ongoing services |
| Successful completion of screenings (i.e., maternal depression, ASQ) using approved screening tools during required intervals |
| Successful completion of required intervention services based on results of screening tools  |
| Successful completion of face to face care coordination visits at required intervals |
| Successful completion of telephonic care coordination contacts at required intervals |
| Successful completion of face to face interconception counseling visits with documentation of medical postpartum visit and family planning method |
| Successful retention of clients receiving face to face care coordination in the Healthy Start pathways |
| Documentation of screenings, interventions, care coordination, health outcomes, etc. as required |
| Communicating with client’s primary healthcare provider within required timeframes to provide an update on Healthy Start services being provided |
| Communicating with other professionals and agencies, including health plan case managers/representatives as needed, to follow up on the status of client referrals or other needs |

The following signature indicated agreement with the Performance Measures listed above.

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

 Signature Name/Date Title

## Part V

**Section A. Budget**

1. Program Budget Summary

See **ATTACHMENT G**

1. Budget Narrative for Requested Funding

See **ATTACHMENT G**

**Note:**

|  |
| --- |
| **Copies of the following must be provided prior to contract execution, as applicable, but do not need to be attached to the application:** |
| A. | Client Non-Discrimination Policy |
| B. | Internal Revenue Service Letter certifying 501(c)3 status (if NPO) |
| C. | List of Board of Directors and Meeting Dates |
| D. | Equal Employment Opportunity Policy  |
| E. | Affirmative Action Policy  |
| F. | Americans with Disabilities Act Policy  |
| G. | Drug-Free Workplace Policy  |