# APPLICATION

## Application Checklist

The following items must be included in the application and assembled in the following order:

1. \_\_ **Cover Letter**
2. \_\_ **Application Face Sheet**
3. \_\_ **Applicant’s Response Form**
4. \_\_ **Project Budget**

Include a budget in the format provided.

Indirect costs are allowed.

1. **\_\_ Attachment A:** Memorandum of Agreement
2. **\_\_ Attachment B:** Agency Information
3. \_\_ **Federally Negotiated** **Indirect Cost Rate Approval Letter** (if applicable)

*IRS Documentation:*

1. \_\_ **IRS Letter Documenting Your Organization’s Tax Identification Number** (public agencies)

or

\_\_ **IRS Determination Letter Regarding Your Organization’s 501(c)(3) Tax‑exempt Status** (private non-profits)

and

1. \_\_ **Verification of 501(c)(3) Status Form** (private non-profits)

## Cover Letter (4 points)

**Page Limit:**

Not Applicable, use template provided

The application must include a cover letter, on agency letterhead, signed and dated by an individual authorized to legally bind the Applicant. The cover letter must include the contact information on the template. The cover letter must also indicate a clear understanding of and strong commitment to replicating the proposed pregnancy prevention program model.

Include in the cover letter:

* the legal name of the Applicant agency
* the RFA number
* the Applicant agency’s federal tax identification number
* the Applicant agency’s Unique Entity Identifier (UEI)
* the closing date for applications

(This Must be Printed on Agency Letterhead)

Date

Dear Juanella Tyler,

Describe your agency’s mission, background and current services. How does implementing the proposed pregnancy prevention model fit within your agency? Describe your commitment to comprehensive sexual health education, adolescent health, academic achievement, positive youth development, parental involvement, and community engagement.

Provide description of your commitment to the proposed pregnancy prevention program model, the proposed training requirements, and implementing one of the included evidence-based program models (FLASH or 3Rs).

If applicable, describe any other funding sources your agency is pursuing to implement a teen pregnancy prevention program. Please include your agency’s capacity to implement more than one teen pregnancy prevention program.

Executive Director:

Phone #: Email:

Provide the person who knows and understands the program and program plan written in the RFA. This person may be contacted any time during the RFA process by TPPI staff or a reviewer related to the RFA.

Name:

Phone #: Email:

Are you a current or former (within the last 5 years) NC TPPI grantee?

☐ Yes ☐ No

If “yes” please complete the following, for each program if applicable.

|  |  |  |  |
| --- | --- | --- | --- |
| **Program Name** | **Last Completed Funding Year** | **Proposed # of****Participants Served** | **Actual # of****Participants Reached threshold or largest caseload at one time for APP** |
| Adolescent Parenting Program |  | 15-20 |  |
| Adolescent Pregnancy Prevention Program  |  |  |  |
| PREPare for Success |  |  |  |
| Project REACH |  |  |  |

## Application Face Sheet

This form provides basic information about the applicant and the proposed project with the **Teen Pregnancy Prevention Initiatives, Adolescent Pregnancy Prevention Program** including the signature of the individual authorized to sign “official documents” for the agency. This form is the application’s cover page. Signature affirms that the facts contained in the applicant’s response to **RFA # A404**are truthful and that the applicant is in compliance with the assurances and certifications that follow this form and acknowledges that continued compliance is a condition for the award of a contract. Please follow the instructions below.

|  |
| --- |
| 1. Legal Name of Agency:
2. Name of individual with Signature Authority:
 |
| 1. Mailing Address (include zip code+4):
2. Address to which checks will be mailed:
 |
| 1. Street Address:
 |
| 1. Contract Administrator:

Name:Title: | Telephone Number:Fax Number:Email Address |
| 1. Agency Status (check all that apply):
 |
| 🞏 Public |  | 🞏 Private Non-Profit |  | 🞏 Local Health Department |
| 1. Agency Federal Tax ID Number:
 | 1. Agency UEI:
 |
| 1. Agency’s URL (website):
 |
| 1. Agency’s Financial Reporting Year:
 |
| 1. Current Service Delivery Areas (county(ies) and communities):
 |
| 1. Proposed Area(s) To Be Served with Funding (county(ies) and communities):
 |
| 1. Amount of Funding Requested
 |
| 1. Projected Expenditures: Does applicant’s state and/or federal expenditures exceed $500,000 for applicant’s current fiscal year (excluding amount requested in #14) Yes 🞏 No 🞏
 |
| The facts affirmed by me in this application are truthful and I warrant that the applicant is in compliance with the assurances and certifications contained in NC DHHS/DPH Assurances Certifications. I understand that the truthfulness of the facts affirmed herein and the continuing compliance with these requirements are conditions precedent to the award of a contract. The governing body of the applicant has duly authorized this document and I am authorized to represent the applicant. |
| 1. Signature of Authorized Representative:
 | 1. Date
 |

## Applicant’s Response

**Section 1**

**Community Readiness**

*Do not delete the question headers.*

Please provide your response to each question under the heading.

**Total Point Value:**

25

**Page Limit:**

6 single-spaced (excluding citation page)

* 1. **Define and describe** **the specific community or communities that will be served. (A community may be the county, town/city, school, etc.) Example: If you are serving an entire county, provide a description of that county. (3 points)**
	2. **Describe accessibility to resources and gaps that currently exist in the defined community(ies), including (4 points)**

 **a. Other teen pregnancy prevention programs;**

 **b. Youth development programs;**

 **c. Availability of youth friendly services; and**

**d. Resources for parents.**

* 1. **Provide a detailed description of the youth that will be served by this grant, the whole population served by your organization, and the organization’s staff and board. (3 points)**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  | **# youth served by grant** | **% youth served by grant** | **# people served as a whole by organization** | **% people served as a whole by organization** | **# people on staff at organization** | **# people on board of directors at organization** |
| **RACIAL/ ETHNIC** |  |  |  |  |  |  |
| African American/ Black |  |  |  |  |  |  |
| Asian American |  |  |  |  |  |  |
| Hispanic/ Latino |  |  |  |  |  |  |
| Native American |  |  |  |  |  |  |
| Pacific Islander |  |  |  |  |  |  |
| White (Non-Hispanic) |  |  |  |  |  |  |
| Other |  |  |  |  |  |  |
| **TOTAL** |  |  |  |  |  |  |
| **GENDER** |  |  |  |  |  |  |
| Female |  |  |  |  |  |  |
| Male |  |  |  |  |  |  |
| Other |  |  |  |  |  |  |
| **TOTAL** |  |  |  |  |  |  |

* 1. **How will the planned program meet the needs of the youth and the community you will serve? (2 points)**
	2. **Please describe any existing services, resources, or coalitions in the community addressing teen pregnancy prevention. How will the program model build on these existing services in the community that will be served? (3 points)**
	3. **List at least 3 examples of how you plan to engage community members in identifying the evidence-based program model curriculum and developing the program plan in Year 1? (3 points)**
	4. **Provide past examples of how you have utilized technology and/or social media to connect to the community and youth served? (2 points)**
	5. **Describe how you will provide participants’ parents/guardians with education around adolescent sexual health and how to communicate with their youth. (2 points)**
	6. **How were youth involved in planning your primary prevention program application? How do you plan to continue to engage youth in program planning throughout Year 1? (3 points)**

**Section 2**

**Program Plan**

*Do not delete the question headers.*

Please provide your response to each question under the heading.

**Total Point Value:**

6

**Page Limit:**

Not Applicable, use tables provided

* 1. **Fill in the following work plan for Year 1 of the funding period, adding additional rows as needed. Complete timeline and person responsible for proposed tasks to indicate how and when you will meet these requirements. (3 points)**

|  |  |  |
| --- | --- | --- |
| **Activities** | **Timeline****(June 1, 2023 – May 31, 2024)** | **Person Responsible**  |
| **Q1-Q2 (June-November)** | **Q3-Q4 (December-May)** |
| **J** | **J** | **A** | **S** | **O** | **N** | **D** | **J** | **F** | **M** | **A** | **M** |
| Hire appropriate staff person(s) |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Complete all mandatory trainings (curriculum, CAC, etc.) |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Establish community partnerships via MOAs and youth-friendly referral network; submit MOAs to TPPI |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Establish communication strategies with local school system and school administration (if applicable for implementation) |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Create specific strategies to recruit and retain youth |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Create specific strategies to communicate and disseminate information about the program to the community |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Recruit members for Community Advisory Council (CAC) |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Select evidence-based curriculum (FLASH or 3Rs) to implement in selected setting (school and/or community) |  |  |  |  |  |  |  |  |  |  |  |  |  |

|  |  |  |
| --- | --- | --- |
| **Activities** | **Timeline****(June 1, 2023 – May 31, 2024)** | **Person Responsible**  |
| **Q1-Q2 (June-November)** | **Q3-Q4 (December-May)** |
| **J** | **J** | **A** | **S** | **O** | **N** | **D** | **J** | **F** | **M** | **A** | **M** |
| Create a strategy to involve family, parents/guardians |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Begin implementation of Adolescent Pregnancy Prevention curriculum |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Complete at least one observation of curriculum session by Program Supervisor |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Compose and submit the program evaluation plan |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Conduct evaluation activities |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Submit itemization and financial reports monthly |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |

* 1. **Using the table below, list out the agencies you plan to partner with for program implementation.** **This should only include partner agencies that will specifically be working with you to implement the program. Include a Memorandum of Agreement (MOA) for each agency detailing the contribution of each agency in Attachment A. (3 points)**

|  |  |  |
| --- | --- | --- |
| **Name of Partner Agency** | **Briefly describe how Partner Agency will assist in program implementation** | **MOA Attached?** |
|  |  | * **Yes**
* **No**
 |
|  |  | * **Yes**
* **No**
 |
|  |  | * **Yes**
* **No**
 |
|  |  | * **Yes**
* **No**
 |
|  |  | * **Yes**
* **No**
 |

**Section 3**

**Agency Readiness**

*Do not delete the question headers.*

Please provide your response to each question under the heading.

**Total Point Value:**

10

**Page Limit:**

4single-spaced

* 1. **Using the chart below; list all of the staff positions that are necessary to implement and support the program, including the amount of time to be spent on the project. (2 points)**

|  |  |  |
| --- | --- | --- |
| **Position** | **Employee Name** | **Full Time Equivalency (FTE)** |
| Program Coordinator |  |  |
| Program Supervisor |  |  |
|  |  |  |
|  |  |  |

* 1. **What is the current level of staff turnover within your agency in the past year (use turnover rate formula below)? (3 points)**

Turnover Rate =

[# of employees who have left agency]

[total # of current employees]

x 100

**a. Describe staff turnover and engagement within your agency.**

**b. How will you work to minimize the amount of staff turnover over the course of the grant?**

* 1. **Describe your capacity to administer cost-reimbursement grant funding. Please list all funding sources, grantors, fundraising, and/or in-kind donations that will sustain Local Match requirements. (2 points)**
	2. **Using the table below, list out the agencies you plan to partner with for program referrals. List the agency(s) name in the corresponding row and denote if you currently collaborate with one or more agency listed in the referral category. Memorandum of Agreement (MOA) and letters of support are required during Year 1. (3 points)**

|  |  |  |
| --- | --- | --- |
| **Referral Category**  | **Agency(s) Name (List all agencies that cover service area)** | **Do you currently collaborate?** |
| **Contraception**  |  | * **Yes**
* **No**
 |
| **Sexual Violence/Intimate Partner Violence** |  | * **Yes**
* **No**
 |
| **Mental Health**  |  | * **Yes**
* **No**
 |
| **Substance Use** |  | * **Yes**
* **No**
 |
| **Other:**  |  | * **Yes**
* **No**
 |

## Project Budget

**Section 4**

**Budget**

**Total Point Value:**

5

**Page Limit:**

Not Applicable

Insert Budget & Justification Form

Applicants must complete the *Budget and Justification Form* for Year 1 (6/1/2023 through 5/31/2024).

Applicant must ensure that worksheet cells are expanded to expose the full narrative justification. This budget and justification can be downloaded from <http://www.teenpregnancy.ncdhhs.gov/funding> beginning September 28, 2022.

## Attachment A

**Attachment A**

**Memoranda of Agreement**

This attachment must include MOAs from Partner Agencies listed in Section 2-2.

MOAs must include specific contribution(s) from the Partner Agency to the program.

## Attachment B

**Attachment B**

**Agency Information**

This attachment must include each of the following:

* Organizational chart of the applying agency.
* List of current Board of Directors of the applying agency.

## Federally Negotiated Indirect Cost Rate Approval Letter (if applicable)

## IRS Letter

***Public Agencies:***

Provide a copy of a letter from the IRS which documents your organization’s tax identification number. The organization’s name and address on the letter must match your current organization’s name and address.

***Private Non-profits:***

Provide a copy of an IRS determination letter which states that your organization has been granted exemption from federal income tax under section 501(c)(3) of the Internal Revenue Code. The organization’s name and address on the letter must match your current organization’s name and address.

This IRS determination letter can also satisfy the documentation requirement of your organization’s tax identification number.

## Verification of 501(c)(3) Status Form

**IRS Tax Exemption Verification Form (Annual)**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, hereby state that I am \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ of
 (Printed Name) (Title)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (“Organization”), and by that authority duly given
 (Legal Name of Organization)

and as the act and deed of the Organization, state that the Organization’s status continues to be designated as 501(c)(3) pursuant to U.S. Internal Revenue Code, and the documentation on file with the North Carolina Department of Health and Human Services is current and accurate.

I understand that the penalty for perjury is a Class F Felony in North Carolina pursuant to N.C. Gen. Stat. § 14-209, and that other state laws, including N.C. Gen. Stat. § 143C-10-1, and federal laws may also apply for making perjured and/or false statements or misrepresentations.

I declare under penalty of perjury that the foregoing is true and correct. Executed on this the \_\_\_\_\_ day of \_\_\_\_\_\_\_\_\_\_\_, 20\_\_\_\_\_\_\_.

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

(Signature)