Application: Section I

Application Form – 20 points

1. **Organization Type**

🞏 Local Government Agency 🞏 5019(c)(3) Nonprofit

🞏 Departments or Divisions of the Executive Department of State Government

1. **Geographic Area of Service**

|  |  |
| --- | --- |
| 🞏 Town/City |  |
| 🞏 County |  |
| 🞏 Region |  |

1. **Applicant Organization**

|  |  |
| --- | --- |
| Name |  |
| Mailing Address |  |
| Physical Address |  |
| City |  | NV |
| Zip (9-digit zip) |  |
| Federal Tax ID |  |

1. **Program Point of Contact**

|  |  |
| --- | --- |
| Name |  |
| Title |  |
| Phone |  |
| Email |  |

 Same mailing address as section B? 🞏 Yes 🞏 No. If “no,” include the address below.

|  |  |
| --- | --- |
| Address |  |
| City |  | NV |
| Zip (9-digit zip) |  |

1. **Fiscal Officer**

|  |  |
| --- | --- |
| Name |  |
| Title  |  |
| Phone |  |
| Email |  |

 Same mailing address as section B? 🞏 Yes 🞏 No. If “no,” include the address below.

|  |  |
| --- | --- |
| Address |  |
| City |  | NV |
| Zip (9-digit zip) |  |

1. **Subcontracting of Family Planning Services**

Does your organization subcontract its family planning services? 🞏 Yes 🞏 No

|  |  |
| --- | --- |
| Subcontractor |  |
| Mailing Address |  |
| Physical Address |  |
| City |  |
| Zip (9-digit zip) |  |
| Federal Tax ID |  |

1. **Key Personnel**

|  |  |  |
| --- | --- | --- |
| Name | Title | Licensed? |
|  |  | 🞏 Yes 🞏 No |
|  |  | 🞏 Yes 🞏 No |
|  |  | 🞏 Yes 🞏 No |
|  |  | 🞏 Yes 🞏 No |
|  |  | 🞏 Yes 🞏 No |
|  |  | 🞏 Yes 🞏 No |
|  |  | 🞏 Yes 🞏 No |
|  |  | 🞏 Yes 🞏 No |

1. **Family Planning Services to Be Provided by Applicant**

🞏 The provision of education by trained personnel concerning family planning;

🞏 The distribution of information concerning family planning;

🞏 The referral of persons to appropriate agencies, organizations, and providers of health care for consultation, examination, treatment, genetic counseling, and prescriptions for the pose of family planning.

🞏 The distribution of contraceptives, the installation of contraceptive devices, and the performance of contraceptive procedures approved by the U.S. Food and Drug Administration, which must be limited to:

* Voluntary sterilization of men and women
* Surgical sterilization implants for women
* Implantable rods
* Copper-based intrauterine devices
* Progesterone-based intrauterine devices
* Injections
* Combined estrogen- and progestin -based drugs
* Progestin-based drugs
* Extended- or continuous- regimen drugs
* Estrogen-and progestin-based patches
* Vaginal contraceptive rings
* Diaphragms with spermicide
* Sponges with spermicide
* Cervical caps with spermicide
* Condoms
* Spermicide
* Combined estrogen – and progestin- based drugs for emergency contraception or progestin-based drugs for emergency contraception
* Ulipristal acetate for emergency contraception

🞏 The provision of or referral of persons for preconception health services and assistance to achieve pregnancy

🞏 The provision of or referral of persons for testing for and treatment of sexually transmitted infections.

🞏 The provision of any vaccinations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention of the U.S. Department of Health and Human Services or its successor organization.

1. **Non-Allowed Family Planning Services Provided by Applicant**

Does your organization or its subcontractors offer family planning services other than those specified in section G? 🞏 Yes or 🞏 No. If “yes,” specify below.

|  |  |
| --- | --- |
| Services |  |

Do you agree that Family planning Services Grant funds, if awarded, will not be used by your organization or its subcontractors to provide any family planning services other than those specified in section G?

🞏 Yes or 🞏 No

Do you agree to implement policies and procedures as necessary to ensure that any non-allowed family planning services disclosed in this section (H) are not paid for using Family Planning Services Grant funds, if awarded?

🞏 Yes or 🞏 No

1. **Third-Party Payers of Family Planning Services**

Does your organization or its subcontractors bill any third-party payers (e.g., insurance companies) for family planning services? 🞏 Yes or 🞏 No. If “yes,” specify below.

|  |  |  |  |
| --- | --- | --- | --- |
| Third-Party Payers | Period | Billables Received ($) | Percentage of Operating Income (%) |
| Medicaid |  |  |  |
| Other |  |  |  |
| Private Insurance |  |  |  |
| Slide/Self-Pay |  |  |  |

1. **Current Family Planning Funding**

|  |  |  |  |
| --- | --- | --- | --- |
| Funding | Type | Project Period End Date | Amount Awarded ($) |
|  |  |  |  |
|  |  |  |  |

1. **Certification by Authorized Official**

As the authorized official for the **applying agency**, I certify that the **proposed** project and **activities** described in this application meets all requirements of the legislation governing the grant as indicated by Family Planning grant and the certifications in the **Application Instructions**; that all the **information** contained in the application is correct; that the **appropriate coordination** with **affected agencies** and **organizations**, including **subcontractors**, took place; that this **agency** aggress to comply with all provisions of the applicable grant program and all other applicable **federal** and state **laws**, current or future rules, and regulations. I **understand** and agree that any award received as a result of this **application** is subject to the conditions set forth in the Statement of Grant Award.

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

Name (type/print) Phone

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

Title Email

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

Signature Date

Application: Section II

Application Narrative – 60 points

1. **Overview** (1/2 page)
2. **Availability and Accessibility of Family Planning Services** (1 Page)
3. **Statement of Need** (1 page)
4. **Goals and Objectives** (1 page)
5. **Methods of Accomplishment** (1 page)

Application: Section III

Budget – 20 points

\*Please note all applicants are required to fill out and attach **two** Section C Budget Narrative-Proposed Budget Excel templates for both State Fiscal Year (SFY) 2022 and 2023. *SFY22 Proposed Budget must be spent in its entirety by June 30th, 2022 and will not be carried forward to SFY23*.

1. **Proposed Project Budget (1/2 page)**

|  |  |
| --- | --- |
| **Category** | **Amount Requested ($)** |
| Medical and Health Personnel |  |
| Consultant/ Contract Personnel |  |
| Other Personnel |  |
| Subcontracted Services  |  |
| Medical Supplies |  |
| Medical Equipment |  |
| Other |  |
| **Total Funding Requested ($)** |  |

1. **Budget Narrative** (1-2 pages)

**Medical and Health Personnel:**

**Consultant/Contract Personnel:**

**Other Personnel:**

**Subcontracted Services:**

**Medical Supplies:**

**Medical Equipment:**

**Other:**

**\*See link to Budget Narrative below for SFY22/23**

Application: Checklist

Print and sign the completed application. Complete this checklist prior to scanning/submitting.

**Section I: Application Form**

🞏 All boxes are checked to indicate the correct answer.

🞏 All fields are completed according to instructions on pp. 2 -3

🞏 Certification is signed.

**Section II: Narrative**

🞏 Section II-1: Overview covers three points according to instruction on pp. 3-4.

🞏 Section II-2: Availability and Accessibility of Family Planning Services covers three points according to instructions on pp. 3-4.

🞏 Section II-3: Statement of Need.

🞏 Section II-4: Goals and Objectives includes projected number of services provided or clients/patients served.

🞏 Section II-5: Methods of Accomplishment includes the measurements of success.

🞏 Page limits have not been exceeded

🞏 Arial 11-point font has been retained

**Section III: Budget**

🞏 Section III-1: Proposed Project Budget reflects SFY22/23 whole dollar amounts or zeros for each category.

🞏 Section III-1: Proposed Project Budget match numbers in the Budget Narrative.

🞏 Numbers in the Proposed project Budget match numbers in the Budget Narrative.

🞏 Justifications in Section III-2: Budget Narrative match the projected numbers of services provided or clients/patients served in section 11-4: Goals and Objectives.

🞏 Page limits have not been exceeded.

🞏 Arial 11-point font has been retained.

🞏 One-inch margins have been retained.

 **Application Submission**

 🞏 Include resumes and copies of licenses of key personnel (including subcontractors).

 🞏 A single PDF will be emailed no later than 5:00 p.m. on **Monday, February 21, 2022**.