New York State Department of Health
Maternal and Infant Health Initiative
Request for Applications (RFA)
RFA# 1207271237

Responses to Questions Asked – Second and Final Posting

All updates to the Maternal and Infant Health Initiative (MIH) RFA will be posted to the New York State Department of health (NYSDOH) website at www.health.ny.gov/funding/.

The answers to questions included herein and in the "Questions and Answer #1" document posted to the NYSDOH website on 12/24/12, are the official responses by the NYSDOH from potential applications and are hereby incorporated into the MIH RFA #1207271237 issued on October 17, 2012. In the event of any conflict between the RFA and these responses, the requirements or information contained in these responses will prevail.

General Questions:

1. **Question:** When completing Attachment 11 and/or Attachment 22 Application Template(s), should each section be answered in the space below each of the text boxes, or should the narrative pieces be typed in a separate Word document to accurately monitor page restrictions? If typed directly in the Application Template, how will the page restrictions be monitored?

   Answer: The Application Template is meant to serve as a form to be filled-in. Please take note of page limits by section. The complete application should not exceed 48 single-spaced typed pages for Component A, and 40 single-spaced typed pages for Component B using a normal 12 pitch font. The page limits do not include the template itself, cover page, attestation of eligibility, budget tables and forms and attachments. Typing the narrative into a separate Word document to monitor page limits, and then cutting and pasting into the appropriate section of the template, would be a good way to monitor page limits. NYSDOH will monitor page restrictions in the same way.

2. **Question:** If we do not need all 30 pages (1 summary page plus 29 pages for strategies) for the Improvement Plan section of the Application Template for Component A, may we include additional summary pages, for example one comprehensive chart indicating the strategies for all 24 performance standards/levels/life stages combinations or a logic model, so long as we do not exceed the 30 page limit for that section?

3. **Question:** If we do not need all of the pages from one section of the Application Template (e.g. the Improvement Plan), could we extend to another section (e.g. Assessment of Community Needs and Strengths), as long as the total maximum lengths of pages (48 pages for Component A, 40 pages for Component B), is not exceeded?

4. **Question:** In addition to requested attachments, may we include other attachments, for example a thematic map indicating areas with a high pre-term birth rate and the locations of the members of our Collaborative or additional information on our partner organizations?

   Answer (Questions 2, 3 and 4): Applicants should adhere to the page limitations for each section of the Application Template. Charts and tables may be referenced in the narrative, and included as attachments, which are not counted toward the page limit.

5. **Question:** Can the application be single spaced?

   Answer: As stated on the first page of the Application Template (Attachment 11 for Component A, Attachment 22 for Component B) applications should be single-spaced, using a normal 12 pitch font.

6. **Question:** Do partnership agreements or Memorandum of Agreements/Understanding need to be fully executed at time of application?

7. **Question:** Should we provide letters from current funding agencies or MOUs from partnering agencies/ subcontractors or both?

   Answer (Questions 6 and 7): Please refer to page 17 of the RFA. Applicants should include evidence of commitment from collaborating partners such as memoranda or letters of agreement, and sub-contractual relationships reflected in the budget. It is not necessary for agreements specific to the MICHC initiative to be executed or in place at the time of the application, but it is necessary that the nature of the collaboration with partners be documented. Applicants are not required to provide letters for current funding agencies.

8. **Question:** Are for profit Article 28 facilities eligible to apply to the MIH RFA?

   Answer: No, for profit Article 28 facilities are not eligible to apply for Component A and/or B. See Addendum #3 and Attachment 11, revised February 14, 2013.

9. **Question:** The zip code level data included in the RFA lists 13322 (Clayville) as a zip code in Herkimer County. Locally we know it to belong to Oneida County, which is how it is categorized by both Oneida and Herkimer County government. Can it be moved to Oneida County in the RFA documentation, or will it remain with Herkimer County?

   Answer: NYSDOH recognizes that some zip codes may straddle more than one county. The RFA Attachments 1a and 1c will not be revised at this time; however the referenced zip code may be included by an applicant of either county.

10. **Question:** Is the maximum number of awards for Richmond County one award for Component A and one award for Component B, or a single award for both components?

    Answer: As per table 4 on page 42 of the RFA, only one award will be made in Richmond County for Component A. Component B does not limit the number of awards per county

except that, as stated on page 54 of the RFA, under #3 of the Selection and Funding Methodology, awards will be made in the following order, until all funding allocated for Component B has been distributed:

a. Within Tier 1, awards will be made in order from highest to lowest passing score, except that in this initial step, no more than one award will be made within any Tier 1 county and no additional funding will be awarded to the specific projects previously awarded MIECHV funding outside of this RFA (i.e., NFP in the Bronx, NFP in Monroe County, HFNY in the Bronx, and HFNY in Erie County).
b. All remaining passing applications from both Tiers 1 and 2 will then be combined, re-sorted into New York City (5 boroughs) vs. Rest of State, and ranked in order of decreasing score within each of these two regional groups.
c. Awards will then be made in descending order by score, alternating between Rest of State and New York City, until all available funding has been awarded.

These maximum award levels will be applied separately for Components A and B.

11. Question: Page 17 of the RFA states "Improving maternal and infant health is a key priority within the NYSDOH Prevention Agenda." How should MIH applicants support the NYSDOH Prevention Agenda?

Answer: NYSDOH recently completed an update of its Prevention Agenda, NYS' health improvement plan for 2013 through 2017, developed in partnership with more than 140 organizations across NYS. The Prevention Agenda serves as the blueprint for state and local community action to improve the health of New Yorkers and address health disparities. The plan features five priority areas: prevent chronic disease; promote healthy and safe environments; promote healthy women, infant and children; promote mental health and prevent substance abuse; and prevent HIV, sexually transmitted diseases, vaccine-preventable diseases and healthcare-associated infections. Improving health outcomes for women, infants and children is a priority for the NYS Prevention Agenda, aligning with goals of the state's Medicaid program and Title V/Maternal Child Health Services Block Grant, as well as the MIH initiative. The Prevention Agenda's State Home Improvement Plan addresses three life course periods – maternal and infant health, child health and reproductive/preconception/interconception health – with goals, objectives and indicators for each, including implementation of evidence-based home visiting as a strategy to reach high-risk families. The Prevention Agenda identifies interventions shown to be effective to reach each goal. These interventions are displayed by stakeholder groups so that each sector can identify evidence-based or promising practices they can adapt for implementation to address the specific health issues in their communities.

The Prevention Agenda seeks to be a catalyst for action as well as a blueprint for improving health outcomes and reducing health disparities. The Prevention Agenda 2013-17 is being used as a guide for the collaborative community health assessment and improvement planning required of local health departments and hospitals in every county in NYS. This planning process requires hospitals, local health departments and community partners to assess health status identify community specific priorities and develop and implement an action plan to address the priorities. The key to its success will be the active engagement of

local communities. The goals and collaborative nature of the MIH initiative align with the Prevention Agenda. The Prevention Agenda can be found on the NYSDOH website at http://www.health.ny.gov/prevention/prevention_agenda/2013-2017/.
To join a local coalition working on Prevention Agenda 2013-17 priorities and goals, use this contact list: http://www.health.ny.gov/prevention/prevention_agenda/contact_list.htm

General Budget:

12. **Question:** Should we present the amount of funds requested for each staff member and other items in the budget narrative, or should the amount of funds requested only be presented in the budget tables and forms?

    Answer: Please refer to the Budget and Staffing Plan section of the Application Templates. The Budget Narrative will describe how the proposed budget will support achievement of the proposed project including support for implementation of the proposed Improvement Plan and support of proposed staffing. It also includes a narrative description of in-kind support from both the lead agency and collaborative partners. It is not necessary to include specific budget line amounts in the Budget Narrative. The Budget Narrative/Justification Forms (B-1, B2, B-3 and B4) which are in addition to the 3-page Budget Narrative, are used to provide a justification/ explanation of the expenses included in the Budget Tables (A, A-1 and A-2). The justification on these forms should show all items of expense and the associated costs that comprise the total expense for each budget category. See the "Instructions for Completing Budget Tables and Forms" in the Application Template for additional detail.

13. **Question:** What is the federal/state funding breakdown for the grants?

    Answer: Component A contracts will be supported with a combination of state and federal funds and Component B contracts will be supported with 100% federal funding. However, there is no federal / state funding breakdown assigned to the contractor in terms of requesting reimbursement.

14. **Question:** We are a private, non-profit agency with more than 600 employees and over 75 funding contracts. The MIH application asks us to: "include an agency-wide budget, or in the case of local health units or hospitals, a department-wide budget, which provides information related to all contracts received by the agency, and personnel and other than personal service (OTPS) cost allocation. Wherever possible, include staff names to enable the reviewers to compare costs allocation." Compiling this data would put undue burden on our staff. Could our 990 and/or our audited financial statements provide you with the information needed?

    Answer: The requested agency-wide budget is for the purposes of being able to compare personnel and other than personal service (OTPS) costs that are allocated across the MIH application budget and other funding sources. For a large organization, the applicant could provide a summary budget of MIH personnel and OTPS costs demonstrating how those costs are allocated across the MIH and other funding sources supporting the MIH application budget.

Component A: Maternal and Infant Health Collaboratives (MICHC)

General Questions:

15. **Question:** The RFA states that MICHC grantees are not to conduct home visits with clients who already receive home visits from other programs such as Healthy Families NY. Does that restriction include home visits conducted by local health departments or local departments of social services?

    Answer: It is not clear to what "restriction" this question is referencing. The question appears to relate to language on page 36 of the RFA, which describes the role of Community Health Workers as a core required individual/family level strategy for the initiative, and states: "Examples of potential strategies that may be implemented through CHWs include…for clients that are not enrolled in other home visiting programs, offer and provide regular home visits that include client-centered provision of health information, modeling and demonstrating skills, and reinforcing positive health choices and behaviors…". This language is intended to serve as an example of how CHW activities may be integrated into larger community service systems. There is no specific restriction on home visits as part of a larger MICHC initiative, except that as stated on page 39 of the RFA, funds awarded under Component A of the RFA are not intended to support the direct delivery of evidence-based home visiting program services as defined in Component B of the RFA. Grantees should propose strategies that are based on their community needs assessments and that address each of the performance standards described in the Performance Standard section that begins on page 19. MICHC grant funds may not be used to supplant existing funds for currently existing staff or organization activities.

16. **Question:** Are applicants required to implement the community health worker (CHW) component in all the targeted zip codes selected?

    Answer: Please refer to page 35 of the RFA. CHW services should be available across all geographic areas targeted by the applicant. CHW services are not a distinct component of the MIH RFA. CHW services are the core individual/family level strategy required of Component A: MICHC. CHWs can also be used at a community/systems level to mobilize and coordinate community resources. CHWs may perform a combination of community outreach, home visits, group activities/workshops, and community-based supportive services to provide a source of enhanced social support and create a bridge between under-served and hard-to-reach populations and formal providers of health, social and other community services. NYSDOH's current CHW program, which will cease to exist effective September 30, 2013, traditionally focused on working with women and infants during the prenatal and postpartum periods. The MICHC initiative broadens the scope of CHWs to include ongoing support during the preconception and interconception periods to promote healthy behaviors, including initial and continuous engagement with health and community services for high-need women of reproductive age within target communities.

17. **Question:** For Component A, the RFA says applicants should "implement relevant evidence-based or best practice activities" but does not say specifically if that includes the Healthy Families NY (HFNY) model. It also says that MICHC applicants should partner with home visiting programs, including HFNY programs. Our organization currently implements HFNY. Would HFNY qualify as a model for the evidence-based activities for Component A or is the HFNY expansion only allowed for Component B?

    Answer: As stated on page 39 of the RFA, funds awarded under Component A are not intended to support the direct delivery of evidence-based home visiting program services described in Component B of the RFA. MICHC applicants are expected to coordinate with evidence-based home visiting programs in their community to develop multi-dimensional community-wide systems to improve maternal and infant health outcomes. Applicants seeking funding to support direct delivery of evidence-based home visiting services (e.g. HFNY), should apply under Component B. HFNY and other home visiting programs are appropriate partners.

18. **Question:** Our Healthy Families New York (HFNY) Manager meets all of the required qualifications for the community health worker supervisor as indicated in Attachment 13 of the RFA, however she is an LMSW not an LCSW. She did graduate from an accredited school and has experience in public health working with families and children as well as supervisory experience and is currently a program manager. She is a perfect fit for the program we are proposing but we are concerned about the LMSW/LCSW situation. Is the emphasis on the individual being a licensed professional or must the individual be specifically an LCSW? Would an LMSW that meets all the clinical requirements and job requirements qualify to serve as the CHW supervisor?

    Answer: Please refer to the Updates to RFA and Responses to Questions Asked document, posted to the NYSDOH website www.health.ny.gov/funding/ on 12/24/12, Modifications to the MIH RFA numbers 1 and 2. An individual that is an LMSW that meets the qualifications stated in Attachment 13 of the RFA, including clinical experience, would qualify as the community health worker supervisor. Please note a community health worker supervisor responsible for the supervision of a team of 4 to 6 community health workers would be a full-time supervisor under the MICHC initiative, and could not be supported simultaneously under another grant.

19. **Question**: The RFA states that the MICHC initiative will not fund transportation and child care. Are staff paid by this funding prohibited from transporting clients? Are organizations which receive MIH funding prohibited from purchasing bus tokens and taxi fare for clients?

    Answer: As stated on page 39 of the RFA, the MICHC initiative will **not** fund transportation, child care or any other services available/funded through other resources. It is appropriate for community health workers to help clients arrange child care or transportation, and to accompany clients to visits, but it is not appropriate to use MICHC funding to pay for the client's transportation or child care. If distance or transportation is identified as a barrier or issue related to utilization of services in the target community, it would be appropriate for the MICHC project to address the issue by promoting the use of Medicaid reimbursement for

transportation, for example. Medicaid pays for transportation of eligible enrollees statewide to Medicaid-covered services. For transportation of NYC Medicaid enrollees, please refer to www.nycmedicaidride.net. For transportation of Medicaid enrollees in 24 upstate counties, please refer to www.medanswering.com.

20. **Question:** Can the MICHC grant be used together with another NYS grant for perinatal outreach?

    Answer: Yes, the MICHC grant may be used in coordination with other grants for perinatal outreach however MICHC grant funds may not supplant funds currently supporting existing staff or organization activities.

21. **Question:** Would this grant be able to support the start-up of a centering pregnancy program?

    Answer: Yes. Based on the assessment of community needs, a centering pregnancy model may be an appropriate improvement strategy at the organizational-level during the prenatal / postpartum life course period to address Performance Standard 2.

22. **Question:** Can community be defined as pregnant and parenting teens?

    Answer: No. Pregnant and parenting teens would be an expected subset of the target population in the target community, but would not be considered the entire target population in the community for the MICHC initiative. The goal of the MICHC initiative is to improve maternal and infant health outcomes for Medicaid-eligible high-need low-income women and their families while reducing persistent racial, ethnic and economic disparities in those outcomes. The MICHC initiative supports the development of community-wide systems of integrated and coordinated community health programs and services to improve maternal and infant health outcomes. MICHC applicants should propose to target high-need low-income women of childbearing age in targeted communities.

23. **Question**: In regards to ongoing data collection, will contractors be responsible for developing a data system and data collection or will NYSDOH develop the database?

    Answer: Please refer to page 15 of the RFA. NYSDOH and the new Maternal and Infant Health Center of Excellence (MIH-COE) will provide guidance and technical support to grantees on performance measure development, data collection and reporting systems, and quality improvement methodology. It is expected that the NYSDOH and the MIH-COE will develop the data collection and reporting system to be used by MICHC contractors.

24. **Question:** How do you calculate the average number of Medicaid births to see if five (5) Tier 2b counties qualify to apply? We plan to submit one application and include all 5 counties.

    Answer: In order to be considered for funding, an application must propose to serve a target area that accounts for an average of 100 or more Medicaid births annually, based on 2008-10 vital statistics data included in Attachment 1c. If an applicant proposes to target multiple

Tier 2b counties, the number of Medicaid births for those zip codes may be combined to achieve the required minimum of 100 Medicaid births. The number of Medicaid births for those zip codes would be added together to determine the average number of births for the combined target area.

25. **Question:** Are we required to serve all zip codes that average more than 100 MA births in a Tier 1 county, or can we selectively choose other zip codes that average more than 100 MA births?

26. **Question:** Can we serve only targeted zip codes in one county or must we serve the entire county?

    Answer (Questions 25 and 26): As stated on page 12 of the RFA, Target Communities, an applicant must propose to serve a target area that accounts for an average of 100 or more Medicaid births annually, based on 2008-10 vital statistics data included in Attachment 1c. It is up to the applicant to define the target community and there is no requirement to serve the entire county.

27. **Question:** One of the highest need zip codes in our county includes a religious community that utilizes its own health care center, and it is our understanding that most residents go out of county for prenatal care. How do we address the fact that culturally the community would not be interested in partnering with the rest of the county to address needs?

    Answer: Please refer to response to Questions #25 and #26 above. It is up to the applicant to define the target community and there is no requirement to serve the entire county.

28. **Question:** If we propose to serve several zip codes, can we serve more communities as the grant progresses, or do all target areas need to be served in Year 1?

    Answer: An updated community assessment will be an annual grant deliverable. Grantees are expected to continuously monitor persistent and emerging needs, barriers, resources and opportunities related to maternal and infant health within target communities. If the annual updated community assessment identifies additional high-need communities, it would be appropriate to target those communities, within the parameters of the grant award amount.

29. **Question:** If we have in-kind workers paid outside this grant, can we use them to assist clients in communities with high Medicaid birth rates but outside the targeted high-need zip codes?

    Answer: To be considered in-kind to the MICHC grant, that portion of staff salary claimed as in-kind would have to support the MICHC project proposed, including the target communities proposed.

30. Question: Do we need to reach 90% of all Medicaid births within our county to receive the maximum award amount?

Answer: As stated on page 41 of the RFA, within the maximum award levels, the actual level of funding will depend on the scope of the proposed project, with specific consideration for the proportion of annual Medicaid births for the target county or counties that fall within the specific ZIP codes targeted by the applicant for the proposed project. *For example*, a project that proposes to serve a set of ZIP codes within a county that account for 90% of all annual Medicaid births within that county would be eligible to receive a higher level of funding than a project that proposes to serve a set of ZIP codes that account for 50% of all annual Medicaid births within that same county. Please note that the use of 90% versus 50% of all Medicaid births within the county in the preceding example refers to the reach of the project targeted by the applicant, not the number of clients to be served.

31. Question: The majority of MICHC strategies and activities should target Medicaid-eligible women. Are projects allowed to target ineligible women (mid to upper income) with any of the MICHC activities? If no, are projects prohibited from serving mid to upper income women with this funding? For example, a public event targeted to Medicaid eligible women and funded by MICHC funds may be attended by ineligible women.

Answer: The goal of the MICHC initiative is to improve maternal and infant health outcomes for Medicaid-eligible high-need low-income women and their families while reducing persistent racial, ethnic and economic disparities in those outcomes. As stated on page 17 of the RFA, Medicaid funding is a key source of support for Component A, and MICHC activities will primarily target Medicaid-eligible populations and individuals. Since this is a community-based initiative, it is understood that there may be secondary benefits to individuals outside your primary target population.

32. Question: If a single lead agency is funded for two counties, one in Tier 1 and one in Tier 2, does each county need a full-time MICHC Coordinator or can the counties share one full-time coordinator with appropriate allocation to each geographic region?

Answer: As stated on page 40 of the RFA, if the same organization proposes to target both Tier 1 and Tier 2 counties, separate applications must be submitted for Tier 1 and Tier 2. Separate applications are required for each Tier 1 county an applicant proposes to serve. A single application is required for single or multiple (as part of a coordinated regional/multi-county project) Tier 2 counties an applicant proposes to serve. Please refer to RFA Attachment 11, Budget and Staffing Plan. The budget, for each MICHC application should support a full-time MICHC program coordinator. The MICHC Coordinator is responsible for providing leadership to and coordination of the entire MICHC project. It would not be appropriate or feasible for the MICHC Coordinator to coordinate two MICHC projects given the size of the target communities and the complexities of the MICHC initiative.

33. Question: If an agency is funded for a Tier 1 and Tier 2b county in separate applications, will NYSDOH combine the two proposals into one "program" for contracting purposes? In this case can the lead agency use one full-time coordinator for the initiative in both counties?

Answer: If the same organization is selected to receive funding for more than one application, the awards may be rolled up into a single award and administered as a single contract. Programmatically, these would still be viewed as two distinct projects within the grantee's MIH grant contract. It would not be appropriate or feasible for the MICHC Coordinator to coordinate two MICHC projects. See the answer to Question 32 above.

34. Question: Our approach to the MICHC initiative will be to bring all of our other maternal and infant health programs under the MICHC umbrella since they all have the same ultimate goal, including our Healthy Start grant. Doing so makes sense to our organization in terms of leveraging all community resources most efficiently. From a budget standpoint, we will be able to show how other grant sources are used along with MICHC funds to do the work. Some activities will be paid entirely by one of the grants, most will be shared across funding streams to maximize the impact. Is this approach consistent with NYSDOH expectations for this grant?

Answer: We cannot comment on the details of this or other specific applicant proposals. The approach you are describing in and of itself does not sound inconsistent with the MICHC initiative. As stated on page 39 of the RFA, MICHC funding may supplement but cannot supplant funding from other sources which support existing activities. If funding is used to supplement or expand existing activities, the application budget forms should identify other sources of funds which support those activities.

35. Question: Would a university team be an eligible entity for this program?

Answer: Please refer to the Addendum #3 posted on the NYSDOH with these responses for minimum and preferred eligibility requirements. Eligible applicants include Not-for-profit Article 28 facility, community-based not-for-profit health and human service organizations, and local government agencies. A university team that does not otherwise meet one of these criteria would not be eligible to apply.

36. Question: We are a team of data mining experts and computer scientists collaborating with obstetricians and pediatricians. We are working on prediction of preterm birth and understanding its complex etiologies, including the interaction of the socio-economic factors, through mining large amounts of patient data. We also aim to devise intervention policies based on our finding regarding the combination of etiologies. Would our research be a good fit for this program?

Answer: See the Answers to Questions 34 and 35. We cannot comment on the merits of this or other specific applicant proposals. It should be noted that the MICHC initiative is a community-based public health initiative designed to improve specific key population health outcomes including preterm birth, low birth weight, infant mortality and maternal mortality by addressing maternal and infant health behaviors, supports and service systems across three

key life course stages, preconception, prenatal/postpartum and interconception. While a more in-depth analysis of local data to inform your community needs assessment and improvement strategies may be appropriate, this is not intended to be a research project. As stated on page 6 of the RFA, a Request for Proposals (RFP) is being issued to establish a new Maternal and Infant Health Center of Excellence (MIH-COE) that supports funded grantees for both Components A and B, including training of community health workers and coordination of specific data management and evaluation activities required as part of the federal MIECHV program.

37. **Question:** Would it be possible to have collaborators from outside of New York State for this program?

    Answer: There is no specific prohibition against collaborating with partners outside the State.

38. **Question:** May relevant program brochures and curriculum be appended to the application?

    Answer: Yes, relevant program brochures and curriculum may be appended to the application if referenced in the application narrative. Please note: any attachment not specifically requested as part of the application will not be considered in the scoring of the application.

Application Template:

39. **Question:** We are proposing several cross-cutting strategies that appropriately target women across the three life course stages (pre-conception, prenatal/postpartum, and inter-conception). Rather than repeating the same strategy three times (once for each life course stage), could we present it only once, noting that it is applicable to the three life stages?

40. **Question:** In the improvement plan section, if we are employing a strategy that will impact more than one stage of the life course, can we just reference the first time we describe the strategy in the subsequent boxes where that strategy will be used? For example, the CHWs will cover both the prenatal/postnatal period and the interconception period. Does this information need to be repeated? This is an issue with most of our strategies and the consequent space requirement is enormous.

    Answer: (Questions 39 and 40) Applicants should respond to each section of the Application Template and the criteria described for that section, in full. The Improvement Plan section of the Application Template requires strategies and activities at each required ecologic level (organizational/community and individual/family) for each life course stage for all 4 performance standards. The Improvement Plan section is worth a total of 30 points. An application that did not fully describe required strategies and activities at each required ecologic level, for each life course stage for all 4 performance standards, would not be eligible for the full 30 points for this section. MICHC projects will be based on comprehensive community assessments that include a critical analysis of community-level

data, needs and strengths related to each of the 4 Performance Standards: enrollment in health insurance; engagement in health care and other supportive services; coordination of risk identification, referral to appropriate services and follow-up; and promotion of healthy behaviors and elimination of risky behaviors. It would be expected that the community-level data, needs and strengths related to each Performance Standard will be different for women during each life course stage, and thus would require specific strategies and activities to appropriately address each life course stage for each Performance Standard, even if there are common elements across these strategies

41. **Question:** The Assessment of Community Needs section of the Component A Application Template asks applicants to identify the target outcomes for the target population. Does that mean the outcomes we intend to achieve with the MICHC grant, or the outcomes the target population is currently experiencing? How is this different from the description of how we decided what target population to focus on? How is the description of the risks, protective factors etc. that affect the target population health different than the same question with regard to each of the four performance standards?

    Answer: The assessment of community needs and strengths should describe maternal and infant health outcomes currently experienced by the target community and target populations. This description is distinct from the narrative description of the target community and the target population, which should focus on specific characteristics of the target community and the target population. The decision of what specific target communities and populations to focus on should flow from the results of the assessment of community needs and strengths. The fourth text box in the Assessment of Community Needs and Strengths section of the Application Template asks applicants to describe the major risk and protective factors that impact the target populations' health across the life course as they relate to the ecologic levels (individual/behavioral, family, organizational and community). The next four text boxes in this section refer to a critical analysis of community-level data, specific risk and protective factors, needs, existing resources/strengths, barriers and gaps in services as they related to each of the four Performance Standards: enrollment in health insurance; engagement in health care and other supportive services; coordination of risk identification, referral to appropriate services and follow-up; and promotion of healthy behaviors and elimination of risky behaviors.

42. **Question**: In the assessment of community needs and strengths, do we need to address each factor for each life course stage for each performance standard? If so, would you please give us definitions that distinguish between needs and barriers/gaps, and between protective factors and resources/strengths?

    Answer: Please see the answer to Question 41. The applicant should identify the resources, strengths, gaps and issues as they relate to the community and as they relate to the Performance Standards.

43. Question: What criteria will be used in determining whether an organization is a pass-through organization or a lead agency with sub-contractors? Must the MICHC Coordinator be an employee of the lead agency? What other activities must the lead agency perform to qualify as the lead agency?

Answer: Please refer to the responses to questions 23, 26 and 46 of the Updates to RFA and Response to Questions Asked, posted to the NYSDOH website on 12/24/12. The lead agency needs to have a substantial coordinating and/or implementation role, and is responsible for overseeing implementation of the overall project.

44. Question: Will interventions targeting fathers be funded under this initiative?

Answer: An applicant's Improvement Plan strategies and activities will be determined by the assessment of community needs and strengths. Specific strategies should address the needs and priorities identified through the community assessment, within the MICHC performance management framework. Specific activities involving fathers may be appropriate if they relate to achieving the Performance Standards.

45. Question: I am working on a MIH Initiative application for a New York City organization and do not quite understand the funding structure of Component A. The RFA states on page 39 that approximately $13.79 million will be available to fund approximately 20 to 25 Component A projects, with annual funding per project ranging from a maximum of $200,000 to $1,200,000. On page 42 there is a table of maximum annual award amount by county. This seems contradictory. Page 42 seems to indicate a maximum per project while page 39 indicates a per year amount. Which is it?

Answer: The maximum award amounts on page 39 and 42 are consistent. $200,000 is the maximum annual award for projects serving Tier 2b counties and $1,200,000 is the maximum annual award amount for projects serving Bronx and Kings counties. The award amounts are annual amounts per project.

46. Question: Does the reference to "Medicaid matching funds," on page 17 of the RFA mean that Medicaid will be funding the 25% portion of the awarded programs for the "offering and arranging" activities. For instance, if we are awarded $100,000, the $25,000 allocated for "offering and arranging" will technically be funded by Medicaid not the State?

Answer: "Medicaid matching funds" refers to the federal share for grant activities that have been determined to meet criteria for Medicaid administration. The exact percentage of federal share varies by type of activity. Medicaid administrative funding is a key source of support for Component A, and MICHC activities will primarily target Medicaid-eligible populations and individuals. Successful applicants will contract with NYSDOH and will be required to submit quarterly vouchers and required reports of expenditures to the NYSDOH to request reimbursement for MICHC contract activities, and will not be requesting Medicaid reimbursement for MICHC activities.

47. Question: Our organization will be offering its services as a sub-contractor for the new MICHC grant. Are we permitted to sub-contract with more than one applicant? The RFA does not address this matter directly. A maximum of two awards will be given in our county.

Answer: An MICHC applicant may subcontract with another organization for activities in support of the MICHC project. As stated on page 41 of the RFA, up to two projects may be funded for Bronx, Kings, New York and Queens counties only if the two projects have distinct (non-overlapping) target areas within the county. It is possible that the same organization may be a subcontractor of more than 1 MICHC applicant.

Budget

48. Question: As executive director, I have overall responsibility for all my organization's programs and funding that would be included in our MICHC proposal. Should I be the MICHC program manager, having both program and administrative responsibilities for this grant and our other grants, or must I have an additional position with the title of program manager? Is it ok that my salary be split among all funding sources?

49. Question: The RFA says that administrative expenses must not exceed 10% of the total grant, but there is no place in the budget forms to record what is administrative and what is program. Our external auditors calculate that split for us every year and I can explain how it is derived, but where will I have the opportunity to document it?

Answer (Questions 48 and 49): The MICHC initiative requires a dedicated full-time MICHC program coordinator. There is no requirement for a position with the title program manager. It may be appropriate to include an executive director position on the MICHC budget as in-kind support or as a percent full-time-equivalent cost allocated over other funding sources. The budget justification and budget tables and forms should make a distinction between that portion of the executive director's position which is providing programmatic support and that portion which is considered administrative support. Programmatic expenses and administrative expenses must be lined out separately. As noted, administrative expenses are limited to 10% of the total grant amount requested. Please refer to the responses to Questions 64 and 65 of the Updated to RFA and Responses to Questions Asked Document posted to the Department's website on 12/24/12.

50. Question: Can start-up costs be included in the Year 1 budget for computers and other equipment that will be used during the five-year grant period? If so, is there a funding limit for this category? These costs will not be included in the budgets for Years 2-5.

Answer: Yes. The purchases of computers and office equipment to support staff supported by the MICHC grant is appropriate to include in the Year 1 budget. There is no funding limit on equipment however the justification provided on form B-3 for the equipment should clearly be consistent with the number of full time equivalents identified in the budget.

51. Question: Can/should funds be requested for community health worker training in the budget? If so, how much should be reserved?

Answer: Please refer to the answer to Question 47 from the Updated to RFA and Responses to Questions Asked document posted to the Department's website on 12/24/12. It is not necessary to include activities or funding in Component A applications for training since all MICHC grantees will be expected to participate in NYSDOH trainings which are anticipated to be delivered through webinars and/or conference calls that will not entail travel costs for grantees. If the Assessment of Community Needs and Strengths identifies specific training topics for paraprofessionals as a need or gap, it would be appropriate to include such training in the Improvement Plan and Budget Plan. In this case, the Improvement Plan should describe and explain the need for the training to be delivered, and the Budget Plan should include the cost of and justification for the training. In addition, CHW training on specific topics could be conducted and supported at the community-level by MICHC partners.

Component B: Maternal, Infant and Early Childhood Home Visiting (MIECHV)

General Questions:

52. Question: What are the minimum eligibility requirements to apply for Component B: MIECHV?

53. Question: What are the minimum eligibility requirements to apply for the Component B: MIECHV for a Tier 1 County?

Answer (Answer to Questions 52 and 53): The Minimum Eligibility Requirements for Component B included in the Addendum #3 included on the NYSDOH website with these responses and are the same for all applicants no matter what county (Tier 1 and/or Tier 2) the applicant is proposing to serve.

54. Question: Component B applicants should either currently be implementing Nurse Family Partnership (NFP) or Healthy Families New York (HFNY) or can an applicant propose to start a new NFP or HFNY?

Answer: As stated in the Minimum Eligibility Requirements on page 44 of the RFA, applicants must propose to implement NFP or HFNY home visiting program models. Funds may be requested to establish new NFP or HFNY programs, or to expand and/or enhance established programs.

55. Question: In NYS, can Federally Qualified Health Centers (FQHC) conduct nurse home visits without being either a CHHA or LHCSA?

Answer: As stated in the Addendum #3 posted on the NYSDOH website with these responses and on page 44 of the RFA, if home visiting is provided by nurses, home visiting services must be provided by agencies that are Certified Home Health Agencies (CHHAs) or

Licensed Home Care Service Agencies (LHCSAs) approved to provide services pursuant to Article 36 of the Public Health Law. Therefore, in order to receive funds for Component B for implementation of NFP, the applicant needs to either be an approved **not-for-profit** Article 36 provider or subcontract the delivery of home visiting services to an approved **not-for-profit** Article 36 provider.

56. Question: Are applicants that receive funding through Component B eligible to apply for the Maternal and Infant Health Center of Excellence (MIH-COE) as well?

Answer: This question does not pertain to this Request for Applications. A separate Request for Proposals (RFP) will be issued to procure the new MIH-COE. Further details on eligibility criteria of future procurements are not yet known.

57. Question: Does the MIECHV RFA require applicants be able to serve all of the target area?

58. Question: Is there a quota of number of families that the MIECHV program will serve each year?

Answer (Questions 57 and 58): Applicants are required to define target service areas that include an average of 100 or more Medicaid births per year. The MIECHV programs are not expected to serve all the families within the target area. There is no requirement regarding the actual number of families to be served.

59. Question: For MIECHV application, should the Organizational Chart reflect the organization of the applicant or the applicant's corporate management, or both?

Answer: The organizational chart should show how the proposed program will be integrated within the organizational structure of the lead agency.

60. Question: If we are applying for 2 counties under Tier 1 which require separate applications, do we need to implement two NFP programs (projects), one to serve each county or can we consolidate the program to serve both counties?

Answer: If the same organization is selected to receive funding for more than one application, the awards may be rolled up into a single award and administered as a single contract. Programmatically, it may be appropriate for the two projects to be consolidated in a single "program", depending on a number of factors. This would be determined during the contract negotiation phase following the award selection process.

61. Question: We are interested in applying for Component B to implement NFP. We are a health system of 15 hospitals (Article 28 facilities), can we apply as a health system or do we need to apply under one of our hospitals?

Answer: Please refer to the updated Minimum Eligibility Requirements described in the RFA Amendment Addendum posted on the website with these responses. The lead applicant organization must meet one or more of these minimum requirements to apply. Also, note that

as stated in that same document, to implement a home visiting program in which home visits are provided by nurses (i.e. NFP program), the applicant needs to either be an approved not-for-profit Article 36 provider or subcontract with an approved not-for-profit Article 36 provider to deliver home visiting services.

62. Question: Must an applicant apply under Component A in order to provide services under Component B? How does a Component B provider coordinate with the overall program to be able to provide Part A services in order to do so and to be considered for Part B?

Answer: No. Component B applicants do not have to apply for Component A. All grantees awarded funding under Component B will be required to coordinate with other providers in their community including Component A grantees if any, to assure that home visiting services are coordinated with, and embedded within, larger community maternal, infant and child health systems. As stated on page 10 of the RFA, it is an expectation that once funded, Component A grantees and Component B grantees serving common target areas will actively collaborate to achieve shared goals of the larger Maternal and Infant Health initiative, including: coordination and integration of planning strategies such as the annual community needs assessment; development of improvement strategies; and the ongoing coordination of outreach, screening and referral, service delivery and other systems-building strategies.

63. Question: What is the process for obtaining a letter of agreement from the project model developer?

Answer: As stated on page 44 of the RFA under Section III.A Who May Apply, all applicants must include a letter from the national program developer(s) for their respective model(s) documenting agreement by the model developer to work with the applicant to establish and/or expand and implement the evidence-based home visiting program as proposed.

The contact person for organizations seeking to establish and/or expand NFP programs within NYS is:

Renee Nogales, Program Developer Northeast Region
Nurse-Family Partnership National Service Office
Renee.Nogales@nursefamilypartnership.org

For those applicants proposing implementation of the HFNY model, a letter from the NYS Office of Children and Family Services is required as the program developer. The contact person for organizations seeking to establish and/or expand HFNY programs within NYS is:

Bernadette Johnson, Program Coordinator
Healthy Families New York
NYS Office of Children and Family Services
Bernadette.Johnson@ocfs.state.ny.us

64. Question: Clarify the difference between the national program developer and OCFS program developer, and are letters of agreement needed from both of these organizations, and what is the content or structure for these letters?

Answer: The evidence-based home visiting program model know as Healthy Families America is operated in NYS by OCFS as Healthy Families New York (HFNY). The national model developer for HFNY is Healthy Families America. However, for those applicants proposing implementation of the HFNY model, a letter from the NYS Office of Children and Family Services is required as the model developer. No letter is required from Healthy Families America. The letter of agreement must document the model developer's agreement to work with the applicant to establish and/or expand and implement the evidence-based home visiting program as proposed.

65. Question: Are faith based organizations such as Catholic Charities organizations eligible to apply for Component B?

66. Question: Are there any requirements for birth control education that could limit applications from Catholic Health Care entities?

Answer (Questions 65 and 66): As stated on page 44 of the RFA, Section A. Who May Apply, Minimum Eligibility Requirements, eligible applicants include not-for-profit Article 28 facilities, not-for-profit Article 36 facilities, community-based not-for-profit organizations, local health departments, local departments of social services, or other local government agencies. Component B MIECHV projects will have to provide information consistent with the program model. Five Performance Standards (see page 48) have been established for Component B, including measurable improvements across key benchmark areas (see Attachment 21). For Benchmark 1.4, MIECHV projects are required to report on the percent of postpartum clients who received instruction on optimal birth spacing or family planning.

67. Question: Can a county expand services for HFNY even if a program is already implemented, based on the number of Medicaid births and need?

Answer: Yes. As stated on page 44 of the RFA under Minimum Eligibility Requirements, funds may be requested to establish new NFP or HFNY program, or to expand and/or enhance established NFP or HFNY programs.

68. Question: Please clarify number of awards and how its distributed in different counties

Answer: As stated on page 53 of the RFA, under **Projected Number of Awards and Funding Range**, approximately $1.18 million annually is available to fund 2 to 6 Component B projects in the range of $200,000 to $750,000 annually per project. Within this funding range, the projected caseload and typical per-client costs for the selected model will be considered in determining the size of each award. There is no separate distribution of minimum or maximum award amounts per county. Please see page 53 of the RFA for a description of the Selection and Funding Methodology.

69. Question: Can an applicant request funding for a NFP project if the county already receives MIECHV funding for a HFNY project? If yes, does the application receive less preference?

70. Question: If a HFNY project already exists within a county, will that impact our application for a NFP project?

Answer (Questions 69 and 70): The existence of another established home visiting program in a county does not influence eligibility to apply for funding through this RFA. All applications will be reviewed and scored on the basis of the criteria described in the RFA.

71. Question: For Component B, can the application be written to request funding to support both partial expansion of an existing NFP and implementation of a new HFNY? Or is Component B for only one or the other?

Answer: Please refer to the answer to Question 75 from the Updated to RFA and Responses to Questions Asked document posted to the NYSDOH website on 12/24/12. As stated on page 44 of the RFA, for Component B funding through this RFA, applicants must propose to implement NFP **or** HFNY program models. This does not preclude operation of a second home visiting model using other funding.

72. Question: If part of an existing NFP program is funded by local dollars, can a Component B application request funding to cover some of the local dollar costs and to support expansion of NFP program?

Answer: Component B funding may be used expand established programs, but as stated on page 52 of the RFA, MIECHV grant funds may not be used to supplant funds for currently existing staff or organization activities.

73. Question: Winthrop-University Hospital has submitted a letter of intent to apply for Component B. We have established a preliminary budget according to the grant guidelines and have discovered that the cost of running the program is equal to or exceeds the maximum annual grant award amount of $750,000. The RFA indicates that Nassau County will only be granted one award and the award range would be $200,000 to $750,000. Winthrop is located in Nassau County. If awarded the grant, is there any guarantee that the maximum grant award of $750,000 would be awarded?

Answer: There is no guarantee on the award amount. Please refer to page 53 of the RFA, Projected Number of Awards and Funding Range. Within the $200,000 to $750,000 funding range, the projected caseload and typical per-client costs for the selected model will be considered in determining the size of each award. It is not necessarily expected that grant funds awarded through this RFA will be sufficient to fully support a home visiting program. Please refer to Attachment 22, Component B application template, Budget Narrative which states that applicants should include 'how in-kind support from the applicant agency and partners and funding from other sources will be leveraged and effectively allocated to maximize support for the proposed project.'

74. Question: If we wish to cite data from Affordable Care Act Maternal, Infant, and Early Childhood Home Visiting Program New York State Statewide Needs Assessment, such as the last table which has the number of people served by other home visiting programs, what year should we cite? Is this 2012 data? Or 2011-12?

Answer: NYS' MIECHV Statewide Needs Assessment was developed in 2010. The data in the table titled "Home Visiting Program Capacity Statewide" referenced in Question 76 was collected in 2010.

75. Question: Page 5 of the RFA states that $1.18 million will support 2 to 6 projects for expansion, enhancement and/or establishment of specific evidence home visiting programs. However, page 54 #3a of the RFA states that within Tier 1, no additional funding will be awarded to the specific projects previously awarded MIECHV funding outside this RFA. It would seem that for the initial step in awarding contracts, existing programs will not be awarded a contract. If this is so, how can an agency expand or enhance an existing program? Perhaps it is a question of terminology. Can you please provide definitions for expansion and enhancement?

76. Question: On page 54 of the RFA, when describing the selection and funding methodology For Component B, it reads, "... no more than one award will be made within any Tier 1 county and no additional funding will be awarded to the specific projects previously awarded MIECHV funding outside of this RFA (i.e., NFP in the Bronx)." However, on page 5 of the RFA, and on page 46, It says that the "Component B MIECHV grant funding will support the establishment, expansion or enhancement of the specific evidence based programs." Since the Bronx site is a MIECHV awardee, is it eligible to apply for enhancement funding- for example, a mental health enhancement to the existing site?

Answer (Questions 75 and 76): Please refer to the response to questions #79-84 on the previous Question and Answer #1 posted 12/24/12. Existing NFP or HFNY projects <u>are</u> eligible to apply for additional funding through this RFA to expand or enhance those projects. However, initial preference for funding through this RFA will be given to projects that have not already been awarded MIECHV funding outside of this RFA. The projects previously awarded MIECHV funds outside of this RFA include: NFP in the Bronx, NFP in Monroe County, HFNY in the Bronx, and HFNY in Erie County. Note that this initial preference is limited to Step 3a of the Selection and Funding methodology described on page 53-54 of the RFA. Should funding be available to make awards beyond Step 3a, applications to expand these specific projects previously awarded MIECHV funds will be considered for additional funding.

77. Question: Has the Parent Child Home Program been added to the list of additional HRSA-designated evidence-based program?

Answer: No. See http://homvee.acf.hhs.gov/ for a current list of HRSA-designated evidence-based home visiting programs.

78. Question: In the NYS Updated Plan for a State Home Visiting Program, page 19 addresses Establishment and Implementation of Medicaid Reimbursement in 2010 through a Medicaid State Plan Amendment to provide Medicaid reimbursement for Targeted Case Management (TCM) activities of Monroe County and New York City NFP programs. Will the TCM Medicaid reimbursement also apply to the new NFP programs resulting from the Maternal and Infant Health Initiative, Component B?

Answer: The Medicaid State Plan Amendment references are specific to Monroe County and New York City NFP programs. Onondaga County has been added to the Medicaid State Plan since the Updated Home Visiting Plan was submitted. It is not known at this time whether additional NFP programs may be added to the state's approval for participation in this TCM program.

79. Question: Please clarify the 'Letters of Support' listed on the Component B Application Template. Are these referring to the letters of collaboration and cooperative agreements in the application Organizational Experience and Capacity section? How many letters should we submit?

Answer: Letters of Support will include the Letter of Agreement from the model developer, as well as any letters of collaboration and cooperative agreements or other evidence of specific commitments from partners. There is no specific required number of letters that need to be submitted.

80. Question: If possible, could you please let us know if the awards ensuing from this RFA will supplant existing HFNY contracts?

Answer: It is not clear what this question is asking. As stated on page 52 of the RFA, MIH funding cannot be used to supplant existing funds for currently existing staff or organization activities. Funds awarded through this RFA may be used to establish a new HFNY or NFP program, or to expand/enhance an existing HFNY or NFP program. Currently funded programs providing HFNY services through State general funds may use MIH funds to expand or enhance their current program.

81. Question: During the Applicant Conference Call, someone asked about the average cost per client. The indication was that it was about $4,500 - $5,000. It was presented as an approximation/guideline and that further clarification may be forthcoming. Is this now the definitive cost range? If not, has DOH determined one?

Answer: As stated on page 53 of the RFA, under **Projected Number of Awards and Funding Range**, the projected caseload and typical per-client costs for the selected model will be considered in determining the size of each award. For the purpose of calculating RFA awards, an average regional per-client cost has been identified for each respective program model. The actual costs of operating a program may vary based on a number of factors. Component B applicants should consult with the model developer contact person to ascertain typical costs n their region. See page 47 for the contact information for NFP and HFNY.

82. Question: Attachment 28 lists the staffing requirements for Healthy Families New York, however the position of "home visitor" is NOT listed. This position is referenced in other places throughout the grant, so I am wondering if the position was inadvertently omitted from Attachment 28, or if the position is no longer required. Can this be clarified for all of us?

Answer: This information was omitted on Attachment 28. An amended Attachment 28 has been posted on the website which includes a position description for a Family Support Worker who is responsible for initiating and maintaining regular contact with families in their home.

General Budget:

83. Question: When asking for fringe rate in the budget, do you want county-wide rate or department of health rate?

Answer: The fringe rate should be applied based on the applicant's official policies and procedures.

84. Question: In the Budget and Staffing Plan section of the Application Template (Attachment 22), there is a request to include resumes of key staff. Can you clarify are these resumes for key staff in the existing program?

Answer: Resumes of existing key staff identified in the overall staffing plan of the Budget Narrative should be included as attachments. The appropriate qualifications of the home visiting staff positions and home visiting supervisor positions to be hired to support the project, should be stated in the narrative.

85. Question: If the applicant is subcontracting the delivery of nurse home visiting services to a Certified Home Health Agency (CHHA) - an approved Article 36 provider - must all staff included in the NFP staffing model be employed by the CHHA provider, or could administrator and/or administrative /data entry support be employed by a lead applicant?

Answer: It is possible for the administrative support to be employed by the lead agency and for the nurse home visitors and nurse supervisors to be employed by the Article 36 provider subcontractor.

86. Question: Does an agency **have to** submit a proposal in this round of funding and be deemed "approved but not funded" to be considered for any additional MIECHV funding in the future? If so, this forces more applications than necessary from a county and makes collaborating really difficult, as everyone feels a need to be in this round, to secure a placeholder for future funding.

Answer: At this time, it is anticipated that additional MIECHV funding, if any, that becomes available will be awarded utilizing an "approved but not funded" list generated from applications submitted in response to this RFA.

87. Question: The instructions for Attachment 22, Budget Narrative Justification Forms - Form B-1 Personal Services – state "A Project Coordinator who is qualified and accessible full-time for communications, including e-mail, and attending meetings with DOH along with other appropriate staff is required." Does this mean that the Project Coordinator must work on the grant "full-time" or may the Project Coordinator be a full-time employee of the applicant but will allocate less time to the grant (as they also work on other projects) and just be accessible to NYSDOH as needed for the purposes of this grant?

88. Question: What is meant in the above Attachment 22 statement by "…along with other appropriate staff is required"?

89. Question: I understand that to implement a Nurse Family Partnership, the NFP staffing model must be adhered to. This NFP staffing model indicates that an Administrator is required. Can the Administrator be the Project Coordinator? The NFP Implementation Overview and Planning guide (Oct 2010), indicates that the time of the Administrator may be based on the number of families being served. It indicates that if the Administrator is overseeing a small program of about 200 families, the NFP program may be one of several programs for which an administrator is responsible and therefore, I would conclude that the time spent on the NFP project would not necessarily be full-time.

Answer (Questions 87, 88 and 89): The Project Coordinator referenced in the instructions for the Budget Narrative/Justification Forms - Form B-1, refers to a program manager or administrator who has overall responsibility for implementation of the project. This person could be cost allocated across other programs. The Project Coordinator can be the Administrator referenced in the Attachment 27, Nurse Family Partnership Staffing Requirements. Other appropriate staff an applicant may want to include on NYSDOH Form B-1 may be a fiscal administrator or other administrative staff with the description of duties justifying their time spent on the NFP project.

90. Question: The vendor contract that is attached, is that if we use contract RNs in the implementation only? I am assuming if we hire our own staff we would not have to use this, correct?

Answer: The question is not clear. The Compressed Sub Contractor Budget form contained in the budget forms is for use to report the budgets for any subcontracts the lead agency has established to provide services under the MIECHV initiative. If there are no subcontractors, this form does not need to be completed.

91. Question: Can each year of the five year budget have a different budgeted amount as long as the total of the five years does not exceed the maximum $750,000?

Answer: Each annual budget should total the same amount for each of the five years of budgets. The maximum award amount of $750,000 is an annual amount.

92. Question: Are start-up costs, such as desks, chairs, computers etc. allowed?

Answer: Yes.

93. Question: Attachment 22 – Instructions for Completing Budget Tables and Forms, first paragraph states "The budget should encompass the entire home visiting program, i.e. if you are proposing to expand an established home visiting program, the budget submitted with your RFA application should include the costs and sources/allocation of funding the entire program and should clearly demonstrate how requested MIH grant funds will support the expansion described in your application". Is NYSDOH asking that we include the funds of an existing program if we are applying for expansion of that program? If so, where on the budget forms would we show the current funding as opposed to the new funding that we are requesting?

Answer: Yes. If Component B funding is used to expand existing activities, the budget forms should identify Other Sources of Funds on the Budget Tables, A, A-1 and A2 which support those activities, in the column labeled "Other Sources of Funds".

94. Question: In the Budget Narrative it says to include resumes in the application. If we don't have the staffing as of yet how can we include?

Answer: The Budget and Staffing Plan section of the Application Template (Attachment 22) for Component B requires a Budget Narrative that includes a description of the overall staffing plan for the project, including home visiting staff and appropriate supervision. The appropriate qualifications required for each position should be stated. Resumes of existing key staff described in the staffing plan, such a program manager, should be included as attachments.