Appendix B:
We Choose Health Application Form

General Instructions

This document includes both the standard Illinois Department of Public Health (IDPH) Grant application form (on pp. 2-8) and the supplementary *We Choose Health* application form, which takes the place of Section 7 of the standard form.

Please fill out these forms completely using Adobe Reader and submit by e-mail along with supporting documents to DPH.WeChooseHealth@illinois.gov **no later than 5 p.m. CDT on Friday June 15, 2012**. Full, complete applications must be submitted by e-mail as outlined above. Applications received by other means will not be considered for funding. You will receive an e-mail confirmation of your submission by e-mail within two business days. If you do not receive a receipt, IDPH has not received your application.

See additional instructions on the final page.

Also, please note that we are unable to consider any supplementary material other than the requested letters of support. Limit your responses to the questions and space allotted in the form. IDPH reserves the right to disqualify any application not adhering to the submission guidelines.

FOR IDPH Use Only
Application No. _____

Date Received _____

ILLINOIS DEPARTMENT OF PUBLIC HEALTH
APPLICATION FOR PUBLIC HEALTH GRANT
Office of Policy, Planning, & Statistics
Community Transformation Grant, *We Choose Health*

IMPORTANT NOTICE: The Illinois Department of Public Health (IDPH) is requesting disclosure of information that is necessary to accomplish the statutory purposes outlined under the State Finance Act [30 ILCS 105/1 et seq.] Failure to provide the information requested may prevent this application from being processed.

Section 1. APPLICANT INFORMATION	
Legal Name of Applicant: *(Attach copy of W-9)*	
Name and Title of Principal Agent or Chief Officer: *(If more than one, attach a list of all officers)*	Name: Title: Address: Phone: Fax: E-mail:
Applicant Address: **City, State, Zip Code:** **Telephone:** **Fax:** **E-Mail:**	
Web Site:	

Section 2. APPLICANT GRANT HISTORY	
Description of Applicant Organization: *(200 Character Maximum)*	
Has this Applicant received a grant from the federal government or the State of Illinois within the last 3 years? **If yes, provide the following:** *(Add additional rows if needed)*	☐ **YES** ☐ **NO** Agency providing grant funding: Grant Number: Grant Amount: Grant Term: Brief Description of grant:

How long has Applicant been incorporated?	
Is the Applicant in "good standing" with the Illinois Office of the Secretary of State?	☐ **YES** ☐ **NO**
Has the applicant or any principal experienced foreclosure, repossession, civil judgment or criminal penalty (or been a party to a consent decree) within the past seven years as a result of any violation of federal, state or local law applicable to its business?	☐ **YES** ☐ **NO** If yes, identify the nature of the action and the disposition. If the action/proceeding is still pending or unresolved, provide a status identifying the unresolved issues. Be as descriptive as possible.
Is the applicant or any principal the subject of any proceedings that are pending, or to the best of the applicant's knowledge threatened against applicant and/or any principal that may result in any adverse change in applicant's financial condition or materially and adversely affect applicant's operations?	☐ **YES** ☐ **NO** If yes, identify the nature of the proceedings and how they may affect the applicant's financial situation and/or operations.
Does the applicant or any principal owe any debt to the State of Illinois?	☐ **YES** ☐ **NO** If yes, list the amount and reason for the debt. Attach additional documentation to explain the debt owed to the state.

Section 3. APPLICANT ORGANIZATION INFORMATION

Legal Status:	☐ Individual ☐ Sole Proprietor ☐ Partnership/Legal Corporation ☐ Tax Exempt ☐ Corporation providing or billing medical and/or health services ☐ Corporation NOT providing or billing medical and/or health services ☐ Other (describe):	☐ Governmental ☐ Nonresident alien ☐ Estate or Trust ☐ Pharmacy (Non-Corporation) ☐ Pharmacy/Funeral Home/Cemetery (Corporation) ☐ Limited Liability Company (select applicable tax classification) ☐ D = Disregarded Entity ☐ C = Corporation ☐ P = Partnership
Federal Tax Payer Identification (FEIN) Number or Social Security Number (SSN) of Applicant if not an organization:		
If applicable, list all Names and FEINS that are registered to your organization or have been registered during the last 3 years.	**Name:**	**FEIN:**
	Name:	**FEIN:**
	Name:	**FEIN:**

DUNS Number:	
Illinois Department of Human Rights Number (if applicable):	
Legislative Senate District:	
Legislative House District:	
Congressional District:	

Section 4. KEY GRANT CONTACT INFORMATION	
Grant Application Contact/Title:	
Telephone:	
Fax:	
E-Mail:	
Fiscal Contact/Title:	
Telephone:	
Fax:	
E-Mail:	

Section 5. GRANT PROJECT PROPOSAL	
Project Title:	**We Choose Health**
Brief Project Description: *(350 character maximum). Note that the Scope of Work must be completed separately.*	***We Choose Health*** is an initiative to support the implementation of sustainable, transformational strategies in the areas of healthy eating, physical activity, and tobacco prevention.
Project Period: *(Include start and end date)*	July 23, 2012 – September 29, 2013
Total Amount of Funding Requested from IDPH:	
Total Applicant Match or In-Kind Contribution:	
If subcontractors will be used under	

this grant application, provide name, address and description of services.	**(SECTION 7d)** Subcontractor name: Address: City, State, Zip: Phone: Description of services: Subcontractor name: Address: City, State, Zip: Phone: Description of services:

Section 6. GRANT BUDGET SUMMARY

(Note: This section is for summary purposes only. A detailed budget is required. See Section 7)

Budget Line Items Requested	**Requested Grant Budget Amount**	**Applicant Match of In-Kind Contribution**
Personal Services *(Includes Salary and Wages)*		
Fringe Benefits (Percent use for calculation _____%)		
Contractual Services		
Travel		
Commodities/Supplies		
Printing		
Equipment		
Telecommunications		
Grand Total	0	0
If the proposed budget includes Personal Services (Salary or Wage) related costs, please indicate the type of documentation that will be maintained and used to allocate staff costs to the grant.	☐ Time Sheets ☐ Cost allocation plans ☐ Certifications of time allocable to grant ☐ Other, please describe _____ ☐ Not applicable to this grant application	

Section 7. GRANT SCOPE OF WORK

For *We Choose Health*, please complete the forms beginning on page 8 of this document.

Name of Grant Program *We Choose Health*

Legal Name of Applicant _____

Section 8. APPLICANT CERTIFICATION

Under penalty of perjury, I certify that I have examined this application and the document(s), proposal(s), and statement(s) submitted in conjunction herewith, and that to the best of my information and belief, the information contained herein is true, accurate, correct, and complete. I represent that I am the person authorized to submit this application on behalf of the applicant, and that I am authorized to execute a legally binding grant agreement on behalf of the applicant if this grant application is approved for funding.

I, hereby release to IDPH, the rights to use photographs and/or written statements of information, regardless of the format, contained in or provided after the grant application for the purposes of publication on the IDPH web site, unless the applicant submits a written request asking that the information not be disclosed.

Applications become the property of the Department and these and late submissions will not be returned. Your application will be open to the public under the Illinois Freedom of Information Act (FOIA) (5 ILCS 140) and other applicable laws and rules, unless you request in your Application that we treat certain information as exempt. A request for confidential treatment will not supersede the Department's legal obligations under Illinois Freedom of Information Act (FOIA) (5 ILCS 140). We will not honor requests to exempt entire applications. You must show the specific grounds in FOIA or other law or rule that support exempt treatment. Regardless, we will disclose the successful Grantee's name, the substance of the application, and the budget. If you request exempt treatment, you must submit an additional copy of the application with exempt information deleted. This copy must tell the general nature of the material removed and shall retain as much of the application as possible. You will be responsible for any costs or damages associated with our defending your request for exempt treatment. You agree the Department may copy the application to facilitate evaluation, or to respond to requests for public records. You warrant that such copying will not violate the rights of any third party.

Signature	Printed Name/Title	Date

FOR DEPARTMENT USE ONLY - DO NOT WRITE BELOW THIS LINE

Type of Grant Application

Direct Appropriation ☐
Allocation by Administrative Rule ☐
Competitive Request for Application ☐
Statutory Board Review Required ☐
Formula and/or Caseload Allocation ☐
Non-Competitive ☐

Funding Source:

General Revenue Fund ☐
State Special Fund ☐
Federal ☐

Grant Application Funding Recommendation by Division/Program:

☐	Grant Application Disqualified/Not Eligible for Funding under this Award
☐	Grant Application Recommended for Funding at Full Request
☐	Grant Application Recommended for Funding at $_____.

Division Chief/Program Manager: _____ Date: _____

Grant Application Funding Recommendation Approved by:

Deputy Director _____ Date: _____

Grants Review Committee Score: _____ (Full review grants only)

Assistant Director _____ Date: _____

Section I: Applicant Information (40 points total)

A. Organization Summary and Capacity (15 points)

1. Type of applicant (check for primary applicant only; may check more than one if applicable)

- ☐ Local Health Department
- ☐ County Government
- ☐ Municipal Government
- ☐ Other Government

Specify: _____

- ☐ Public School System
- ☐ Private School System
- ☐ University

- ☐ Hospital or Hospital System
- ☐ Health Care Foundation
- ☐ Community Health Care Centers

- ☐ Non-profit
- ☐ Private Association
- ☐ Faith-based Organization
- ☐ Volunteer Organization

2. Provide a brief description of your organization, its mission, its funding, and its reach.

3. Explain how your organization will complete the proposed activities, addressing staffing, fiscal management, and linkage to other resources (e.g., other grants, integration with existing programs, etc.). Outline your organizational experience with the type of strategies described in the *We Choose Health* RFA.

4. Does your organization have the financial resources to pay for grant activities up front and wait for reimbursement?

☐ Yes ☐ No

5. Does your organization and/or coalition have the resources to commit to the required activities listed under "Deliverables and Obligations of Reward Recipients" in the Information for Applicants?

☐ Yes ☐ No

B. Coalition Information (15 points)

1. List confirmed partners in your collaboration or coalition. If you are a school district, or your coalition includes school districts, include every participating school. List any additional partners required to ensure your project's success and briefly explain how you intend to secure their involvement and support.

B.1. Continued

C. Target Population (10 points)

1. Describe the geographic reach of the project, including the total number and demographics (e.g., race/ethnicity, age, gender, socioeconomic status, disease status, other risk factors, urban/rural mix, etc.) of the population(s) you intend to impact. In the case of schools, include relevant school information, such as percent of students of free/reduced lunch programs.

C.1. Continued

2. List the counties in which your proposed activities will take place.

3. List the names of the municipalities in which your proposed activities will take place (do not include state information).

Section II: Project Proposal (60 points total)

A. Selected Strategies

1. Please indicate which strategies you are applying to implement. Each menu option applies to one or more categories: Healthy Eating and Active Living; Smoke-Free Living; Healthy and Safe Built Environments; and Social and Emotional Wellness. Applicants must choose at least one strategy addressing Healthy Eating and Active Living and at least one strategy addressing Smoke-free Living.

Healthy Eating and Active Living (must choose **at least** one)	**Smoke-free Living** (must choose **at least** one)	**Healthy and Safe Built Environments**
☐ Coordinated School Health (includes Social and Emotional Wellness)	☐ Smoke-free Multi-unit Housing	☐ Safe Routes to School
☐ Baby Friendly Hospitals	☐ Smoke-free Public Places	☐ Complete Streets
☐ Worksite Wellness		☐ Joint Use Agreements

B. Issue Statement (10 points)

Explain how chronic disease risk factors and the social determinants of health have an impact on your target population and how the menu options selected address the issues. Use data-driven statements to support your explanation (e.g., 45% of the population in Anytown is overweight or obese; 35% of adults in Any County lack health insurance; 60% of schools in District 999 do not have wellness policies.)

C. Proposed Activities and Outcomes (10 points)

Based on your proposed project(s), provide a narrative that:

- **Identifies measurable outcomes you intend to achieve over the multi-year project, including the objectives you intend to meet and the processes and behaviors you intend to have in place.**
- **Outlines specific activities over the multi-year project period that successfully advance your selected strategies.**
- **Identifies measurable outcomes you intend to achieve during the initial funded project period, including the objectives you intend to meet and the processes and behaviors you intend to have in place.**
- **Outlines specific activities during the initial funding period that successfully advance your selected strategies.**
- **Describes how you will build evaluation activities into your project activities.**

C. Continued

D. Collaboration Plan (10 points)

1. Provide a short description of the working relationship among your coalition partners, including working together in the past and how you will collaborate to successfully complete the proposed activities.

2. Attach up to 20 letters of support from your coalition partners. You MUST include letters of support from EACH local health department serving your target population. (Health department applicants do not need to submit letters of support for themselves.) IDPH strongly suggests including letters of support from any partner named in your work plans. You may also include letters from other confirmed partners and stakeholders.

Instructions: Please include digital copies (e.g., PDFs) of letters of support either by attaching them to to this application using Adobe Reader, or as separate files sent via e-mail along with your application. You may also include letters of support from other stakeholders. IDPH cannot accept letters of support sent on via fax or on paper. See the final page for additional instructions.

E. Evaluation

Program evaluation will demonstrate if the program is functioning according to program purpose and objectives. Applicants must present an evaluation plan that addresses the following elements at a minimum:

- **Current evaluation experience, including skills and knowledge of individual(s) responsible for conducting and reporting evaluation efforts.**
- **Examples of the evaluation questions; instruments/tools used; primary and secondary data sources.**
- **How your work team will analyze and report evaluation activities, results, challenges, and recommendations.**

F. Sustainability (5 points)

Describe the lasting impact of the activities you propose beyond the completion of this grant and how you propose to sustain the work beyond the funding period.

G. Work Plan (15 points)

Provide a detailed work plan for your first project year. Complete a worksheet for EACH strategy selected under IIA. Leave any unneeded worksheets blank.

Selected Strategy		Sector/Setting(s)		Timeframe	
Intervention Population Focus (Check ONE and complete information)	❑ General/Jurisdiction Wide		❑ Health Disparity Focus Specify: _____ (e.g., population by age, urban/rural, race/ethnicity, education, income, sexual orientation, disability, or other)		
Intervention Population Summary	Demographics (age, gender, race/ethnicity, income, health risk factors, disease condition rates, other)			Est. Reach (people)	
				Est. Reach (units)*	
Multi-Year Objective		Current Year Objective			

WORK PLAN

Milestone/Activities (limit 10)	Timeline	Activities Related to Health Disparities*	Short-term Outcome Measure	Evaluation Indicator/ Measure	Lead Staff	Key Partners

* If applicable

Selected Strategy		Sector/Setting(s)		Timeframe	
Intervention Population Focus (Check ONE and complete information)	❑ General/Jurisdiction Wide		❑ Health Disparity Focus Specify: _____ (e.g., population by age, urban/rural, race/ethnicity, education, income, sexual orientation, disability, or other)		
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Multi-Year Objective	sdsd		Current Year Objective	sdsdsd	

WORK PLAN

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				Est. Reach (units)*	
Multi-Year Objective			Current Year Objective		

WORK PLAN

Milestone/Activities (limit 10)	Timeline	Activities Related to Health Disparities*	Short-term Outcome Measure	Evaluation Indicator/ Measure	Lead Staff	Key Partners

* If applicable

H. Budget and Justification (10 points)

Provide a detailed budget and justification for your first project year. Wherever possible, your justification should include specific information about your proposed sub-contractors, including coalition partners who will receive funding.

Personnel Services (includes Salary and Wages)	**$**
Justification	
Fringe Benefits	**$**
Percent Used For Calculation	
Contractual Services	**$**
Justification	

Travel	**$**
Justification	
Commodities/Supplies	**$**
Justification	
Printing	**$**
Justification	
Telecommunications	**$**
Justification	
TOTAL AMOUNT REQUESTED	$ 0

Submission Instructions

When your application is complete, save a copy with the name of your organization (e.g., CaribouCountyHD.pdf, EasternHealthCenter.pdf, etc.). E-mail the saved file to DPH.WeChooseHealth@illinois.gov along with your letters of support. Include the name of your organization in the subject line.

You may attach letters of support directly to the completed application using tools in Adobe Reader. If you choose to submit letters of support as a separate attachment, please save them using the name of your organization adding "_LOS" to the file name (e.g., CaribouCountyHD_LOS.pdf, EasternHealthCenter_LOS.pdf, etc.). If possible, please submit all letters in a single attached file, but if necessary due to technical limitations, you may divide them among multiple files (e.g., CaribouCountyHD_LOS1.pdf, CaribouCountyHD_LOS2.pdf, etc.).

If you cannot sign the certification on page 7 electronically, please include a scanned signed copy. If needed, you may attach the scanned certification directly to the completed application using tools in Adobe Reader. If you choose to submit it as a separate attachment, please save it using the name of your organization, adding "_Certification" to the file name (e.g., CaribouCountyHD_Certification.pdf, EasternHealthCenter_Certification.pdf, etc.).

Proposals and supporting materials will only be accepted via e-mail. Proposals sent by USPS, courier, or fax will not be accepted.

Proposals must arrive on or before 5 p.m. CDT Friday June 15, 2012. IDPH cannot take responsibility for applications sent to the wrong e-mail address, or proposals that arrive late due to technical failures by an applicant's e-mail system. No late submissions will be accepted. Applicants are advised to send completed proposals well in advance of the deadline to ensure against technical difficulties.

After submitting your proposal, you will receive a confirmation by e-mail within two business days. If you do not receive a confirmation, IDPH has not received your proposal.

Finally, please note that we are unable to consider any supplementary material other than the requested letters of support. Limit your responses to the questions and space allotted in the form. IDPH reserves the right to disqualify any application not adhering to the submission guidelines.