**Organizational  Information**

* Name of Organization \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Main Phone Number   \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Organization's Website  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Organization's Twitter, LinkedIn, Instagram, Facebook, etc. links (any social media profiles) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Primary Contact Information**

* Name of Primary Contact (*acting project coordinator; responsible for all communications, reporting, evaluation activities; may be updated once funded\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*
* Title  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Email\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Financial Contact: If the name of the person who will handle the contract and invoicing differs from the primary contact information, please put the information below.**

* Name of Contract/Invoicing Contact \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Title  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Email \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Which of the following best describes your organization? (Select all that apply)**

* Community-based organization/faith-based organization, or other 501C3 not-for-

profit community agency/organization

* Private health care clinic
* Public health department, FQHC, free clinic
* For-profit hospital
* Academic Health Center
* Not-for-profit hospital
* Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**How many employees, contractors or sub-contractors work for the organization?**

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

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**What are the main maternal health activities or roles your organization provides? (Select all that apply)**

* Community Health Workers to provide education, outreach, and supports
* Breastfeeding/Lactation services
* Childbirth education services
* Doula services
* Nutrition services
* Mental or behavioral health services for maternal health populations
* Medical health services for maternal health populations (OB/GYN, family

medicine, pediatrics)

* Other, please describe\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Which maternal health populations do you currently work with? (Select all that apply)**

* Women's preventative care
* Prior to pregnancy
* During pregnancy
* After pregnancy (up to 12 months)

**Please indicate the insurance coverage of the population served by your organization. (The total should equal 100%, an estimate is sufficient)**

Medicaid or Medicaid managed care insurance : \_\_\_\_\_\_\_

Private insurance : \_\_\_\_\_\_\_

Un- or under-insured : \_\_\_\_\_\_\_

Other : \_\_\_\_\_\_\_

Not Sure : \_\_\_\_\_\_\_

Total : \_\_\_\_\_\_\_\_

**Please indicate the race/ethnicity of the population(s) served by your organization. (The total should equal 100%, an estimate is sufficient. We recognize there may be overlap in some of the categories).**

Non-Hispanic White : \_\_\_\_\_\_\_

African American or Black : \_\_\_\_\_\_\_

Hispanic or LatinX (any race) : \_\_\_\_\_\_\_

Asian : \_\_\_\_\_\_\_

Native American/American Indian and Alaskan Native : \_\_\_\_\_\_\_

Native Hawaiians or Other Pacific Islander : \_\_\_\_\_\_\_

Other : \_\_\_\_\_\_\_

Total : \_\_\_\_\_\_\_\_

**Select the HRSA region where your services and supports are delivered.**

* Region 1: Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, Vermont
* Region 2: New Jersey, New York, Puerto Rico, U.S. Virgin Islands
* Region 3: Delaware, Maryland, District of Columbia, Pennsylvania, West Virginia,

Virginia

* Region 4: Alabama, Florida, Georgia, Kentucky, Mississippi, North Carolina, South

Carolina, Tennessee

* Region 5: Illinois, Indiana, Michigan, Minnesota, Ohio, Wisconsin
* Region 6: Texas, Oklahoma, New Mexico, Louisiana, Arkansas
* Region 7: Iowa, Missouri, Nebraska, Kansas
* Region 8: Colorado, Montana, North Dakota, South Dakota, Utah, Wyoming
* Region 9: Arizona, California, Hawaii, Nevada, American Samoa, Federated States of

Micronesia, Guam, Marshall Islands, Northern Mariana Islands, Palau

* Region 10: Alaska, Idaho, Oregon, Washington

**Before COVID-19 what was your primary delivery method of supports or services?**

* Virtual/online with video
* Telephone/online without video
* In-person
* Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Currently during COVID-19 what is your primary method of supports or services?**

* Virtual/online with video
* Telephone/online without video
* In-person
* Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Start of Block: Tell us about your organization

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**Tell us the following information about your organization.**(Up to 350 words)

* The organization's mission
* Current supports or services offered
* Strengths of the organization
* Current challenges for the organization

*Include specific information that relates to maternal health, telehealth, and populations affected by COVID-19*

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**To get to know your organization, please either upload a short 2 - 4 minute video\* OR write 2 – 3 paragraphs that highlight the following:**

* Why your organization should receive funding for maternal telehealth supports or services?
* What makes your organization stand out?
* Anything else you would like to share?

*\*an unedited video taken with your smart phone or tablet is sufficient.*

* Submit a video
* Write 2- 3 paragraphs

**Submit video here  (link available online!)**

**OR**

**Submit paragraph here (Up to 250 words)**

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**Describe how this funding will allow your organization to increase or initiate maternal telehealth supports or services. (Up to 200 words)**

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**What is the single most important need that this funding could address, using telehealth,  to reduce maternal mortality or morbidity? (Up to 150 words)**

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**Scope of Work**  
*Upload a* ***PDF*** *of no more than 2-pages, single-spaced in 12-point font*  
  
Provide a detailed Scope of Work (SOW), as required by HRSA. The SOW should describe the main 1 - 3 activities your organization aims to implement to increase maternal telehealth supports or services by April 30, 2021. Ensure your SOW aligns with your proposed budget. *Include specific information that relates to maternal health, telehealth, and populations affected by COVID-19.* For each activity, provide the following details:   
  
1. Description of each activity, including where, how, when, by whom and for whom.   
2. The number of people who will be reached with the supports or services; supplies or materials distributed; outreach and advocacy events; etc.​​​​​ *Please note: If the population you propose to serve with these funds, differs significantly from your current population, please describe.*  
3. Identify any barriers or challenges you foresee with the activity(ies) and how the organization will address these.  
4. How success/impact will be measured.  
    
*The following document provides examples of activities that may be suitable options as the organization develops their Scope of Work.*[Telehealth Sample Activities for RFA](https://maternalhealthlearning.org/wp-content/uploads/2020/08/Sample-Activities-for-funding.final_.08-16.2020.docx)

**The following eligibility questions are required by HRSA to be answered during the RFA process.**

|  |  |  |
| --- | --- | --- |
|  | Yes (1) | No (2) |
| a. Does your organization have the capability to identify, in its accounts, all Federal awards received and expended and the Federal programs under which they were received? |  |  |
| b. Does your organization maintain internal controls to assure that it manages US Federal awards in compliance with applicable laws, regulation and the provision of contracts and grants? |  |  |
| c. Does your organization comply with all applicable law and regulations? |  |  |
| d. Is your organization able to prepare appropriate financial statements, including the schedule of expenditures on federal awards? |  |  |
| e. Does your organization have any outstanding audit findings which would impact agreement costs? If there are findings, submit a copy of the most recent report that describes the findings and steps to be taken to correct the findings: folami\_cook@med.unc.edu |  |  |
| f. Is your organization and/or any participating individuals presently debarred, suspended, proposed for debarment, or declared ineligible for US Federal contracts? |  |  |
| g. Is your organization and/or any participating individuals presently indicted for, or otherwise criminally or civilly charged, by a government entity? |  |  |
| h. Has your organization and/or any participating individuals, within three (3) years, preceding this offer, had one or more contracts terminated for default by any US Federal agency? |  |  |
| i. Has your organization and/or any participating individuals, within the last three (3) years, preceding this proposed agreement, been convicted of or had a civil judgment rendered against them for commission of fraud or criminal offense in connection with obtaining, attempting to obtain, or preforming a public (Federal, state, or local government) contract or subcontract; violated US Federal or State antitrust statutes relating to the submission of offers; commissioned embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements or receiving stolen property? |  |  |

**Please complete the**[HRSA Required Letter of Intent Form](https://maternalhealthlearning.org/wp-content/uploads/2020/08/Subrecipient-Letter-of-Intent-Outging-1.pdf&nbsp;)

* **After completing the form, please upload the form here. Please save the form as follows: OrganizationName.LOI.DATE**

**Please complete the**[HRSA Required 3B Form](https://maternalhealthlearning.org/wp-content/uploads/2020/08/Attachment-3B_page-1-2-New-Form.pdf)

* **After completing the form, please upload the form here. Please save the form as follows: OrganizationName.3BForm.DATE**

**Upload a copy of your Federal Indirect Cost Rate Agreement. This should be a PDF. Please save the form as follows: OrganizationName.IndirectCostLetter.DATE.**

**If you do not have a**Federal Indirect Cost Rate Agreement**, your organization will be entitled to a 10% Indirect Cost Rate.**

**Please complete the** [Budget Form](https://maternalhealthlearning.org/wp-content/uploads/2020/08/RFA-Budge-Form-All-Pages.Highlighted.Share_.pdf)

* **After completing the form, please upload the form here. Please save the form as follows: OrganizationlName.BUDGET.DATE**   
      
  *Instructions for completing the Budget Form can be found*[Budget Form Instructions](https://maternalhealthlearning.org/wp-content/uploads/2020/08/Budget-Form-Instructions-1.pdf)

**C*ongratulations!*** ***You have reached the end of the application.***

***Please click 'next' to submit your application.***

***A completed copy of your application is available for download***

***via PDF once you submit it.***

*For more information or if you have questions, please contact Folami Cook:*   
*Phone: (919) 966-1041*

*Email: folami\_cook@med.unc.edu*

[Maternal Health Learning and Innovation Center Telehealth Project](http://https://maternalhealthlearning.org/%20telehealth/request-for-applications/)