Request for Application

COVID-19 Health Equity Pilot Projects

20-10837
State of California
California Department of Public Health
Office of Health Equity
January 14, 2021
(Revised January 21, 2021)

Table of Contents

I. Overview

Structural biases in the system, apparent in the disproportionate impact of COVID-19 on some populations, are undermining our ability to improve population health and should be fundamental and central to public health's response activities.

The California Department of Public Health (CDPH) Office of Health Equity (OHE) will award $5 million in competitive grants that will be distributed between approximately 16-30 community-based organizations (CBOs) across California led by and serving communities facing inequities[1] in Coronavirus infection and impacts, as part of a larger $499 million Epidemiology and Laboratory Capacity (ELC) Grant from the Centers for Disease Control and Prevention (CDC). The funding is part of the "Paycheck Protection Program and Health Care Enhancement Act of 2020 (P.L. 116-139, Title I)." HSC 131085a provides CDPH OHE the authority to award grants. Grant activities align with Executive Order N-25-20, Proclamation of State of Emergency (COVID-19). The CFDA number is 93.323 and the grant number is 6 NU50CK000539-01-12.

This fund source is intended to advance the State's work to close racial, ethnic, and other disparities related to COVID-19 and associated chronic conditions. CBOs will use the funding for pilot projects to reduce underlying inequities in the social determinants of health[2] that have contributed to disproportionate harm from the Coronavirus among certain communities. In many cases, this disproportionate risk of harm is due to the underlying inequities in access to health-promoting resources and services, which can be addressed by this funding source. Social determinants of health include environmental determinants, economic determinants, incarceration, homelessness, racism, classism, sexism, able-ism, homophobia, xenophobia, and other social determinants. However, biological and behavioral determinants are not allowable categories to address with this funding source.

This Grant Agreement is valid and enforceable only if sufficient funds are made available to the State by the United States Government for the term of this

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[1] "Health and mental health inequities are disparities in health or mental health, or the factors that shape health, that are systemic and avoidable and, therefore, considered unjust or unfair" (https://www.cdph.ca.gov/programs/ohe/Pages/OfficeHealthEquity.aspx).

[2] Social determinants of health are defined by the Centers for Disease Control & Prevention as "conditions in the places where people live, learn, work, and play that affect a wide range of health and quality-of life-risks and outcomes" (https://www.cdc.gov/socialdeterminants/index.htm).

agreement for the purpose of this program. In addition, this Grant Agreement is subject to any additional restrictions, limitations, or conditions enacted by the Congress or to any statute enacted by the Congress that may affect the provisions, terms, or funding of this Grant Agreement in any manner.

The parties mutually agree that if the Congress does not appropriate sufficient funds for the program, this Grant Agreement shall be amended to reflect any reduction in funds. CDPH has the option to invalidate the Grant Agreement under the 30-day cancellation clause or to amend the Grant Agreement to reflect any reduction in funds.

Priority Populations List

Priority populations facing COVID-19 inequities and/or high risk include the following but are not limited to:

A. Black and African American
B. Latinx
    - Caribbean (which includes Dominican, Cuban, Puerto Rican), Mexican, South American, Central American, or other countries/regions with Spanish influence
C. Native Hawaiian and Pacific Islanders
    - Native Hawaiian, Chamorro/Guamanian, Fijian, Marshallese, Mariana Islanders, Micronesian, Ni-Vanuatu, Samoan, Tongan
D. Asian American
    - East Asian: Chinese, Korean, Japanese, Taiwanese
    - South East Asian: Cambodian/Khmer, Hmong, Malaysian, Myanma/Burmese, Indonesian, Laos, Thai, Vietnamese
    - South Asian: Afghani, Bangladeshis/Bengali, Indian, Nepalese, Pakistani, Punjabi
    - Filipinx
E. Arab Americans and Middle Eastern and North African (MENA)
F. Indigenous: Native American/American Indian and Alaskan Native
G. Tribal communities, especially rural tribal communities
H. Unhoused or in crowded housing
I. Farmworkers
J. Immigrants & refugees
K. Low-wage and frontline essential workers
L. Low-income individuals
M. Currently or formerly incarcerated or detained people
N. Lesbian, Gay, Bisexual, Transgender, Queer and/or Questioning, Intersex, Asexual, and Two-Spirited (LGBTQ+)
O. Those in long-term care or skilled nursing facilities
P. Those exposed to high levels of air pollution
Q. Limited English Proficient (LEP)

R. People with disabilities and/or different abilities
S. Seniors with disabilities and/or different abilities, living alone, linguistically isolated, in poverty, seniors of color
T. Intersections of these characteristics
    - Example: Black immigrant families who are low-income and live in crowded housing
    - Example: Chinese and Vietnamese Americans facing deadly discrimination, who are immigrants, low-income, exposed to high levels of air pollution, and LEP
    - Example: Seniors who are low income, immigrants, and unhoused

If the Applicant's proposal is serving a population not on the Priority Population List, then the Applicant will need to justify the priority population chosen for this initiative through quantitative and/or qualitative data and/or information that can show that the population is experiencing disproportionate risk of COVID-19 undertreatment/hospitalization, infection, illness, or death.

While these disproportionately affected groups experience intersecting causal factors, racism is a major contributor to the risk of harm, with the pandemic exposing and worsening racial disparities. There is nothing inherent or biological about the increased risk, and "race" is not biologically real but socially constructed. Dr. Camara Phyllis Jones defines race as a system of structuring opportunity and assigning value based on phenotype ("race"), that unfairly disadvantages some individuals and communities, unfairly advantages other individuals and communities, and undermines realization of the full potential of the whole society through the waste of human resources. [3]

Structural racism affects the distribution of and access to resources and opportunities such as employment, housing, education, and quality healthcare. Low-income communities of color are overrepresented in the low-wage and non-medical essential workforce, with less access to paid leave and other worker protections critical to preventing the spread of COVID-19. Income inequality increases the risk of exposure to the virus, due to crowded living conditions, inability to work from home, greater use of public transportation, and the need to travel farther from home to obtain essentials. Individuals in or near poverty experience greater health impacts and have lower life expectancies. COVID-19 places a magnifying glass on pernicious social and health inequities. The confluence of systemic inequities like racism, income inequality,

[3] Camara Jones, MD, MPH, PhD. Confronting institutionalized racism. *Phylon*. 2003;50(1-2):7-22

xenophobia/immigration status, homophobia/transphobia, homelessness, etc., can exacerbate vulnerability and susceptibility to the health risks associated with COVID-19. Well-documented racial and ethnic disparities in the prevalence of chronic conditions among communities of color due to racism resulting in inequitable living conditions and chronic stress further increase the risk of morbidity and mortality from COVID-19.

II. Award Information

- Applicants can request from a minimum of $50,000 and up to a maximum of $300,000.
    - Tier 1: $50,000 - $99,999
    - Tier 2: $100,000 - $199,999
    - Tier 3: $200,000 - $300,000
- The terms of the resulting Grant Agreement will be about 19 months in duration, ending November 17, 2022. Spending must be completed by November 17, 2022.
- The anticipated project start date referenced in the Request for Application (RFA) Time Schedule may vary due to the time required to finalize the Agreements, obtain signatures, and process the Agreements between awardees and CDPH OHE. Awardees are not authorized to begin work until the Agreement is finalized. Work conducted outside the effective start and end date of the Agreement will not be eligible for reimbursement.
- This funding can be used to augment existing activities or new activities, provided that the activities comply with the requirements of this RFA by addressing the root causes of health inequities. Applicants cannot merge this funding with other ELC grant funds because each ELC funding stream is linked to specific outcomes.
- OHE believes in the strength and power of combined partnerships and collaboration. CDPH OHE encourages 1) diverse and also smaller CBOs to apply for this funding, 2) collaboration of CBOs during the planning stages and submission of a joint application (with a lead submitter and subcontractor(s)), and 3) CBOs to work together after award, though with separate Grant Agreements, activities, and budgets.

Subcontractors and Joint Applications

- CDPH welcomes both joint applications (i.e., regional or statewide) and independent applications.
- Organizations can partner with other organizations and submit a joint application, with one organization being the lead and remaining organizations being subcontractors.

- CBOs may use subcontractors, if subcontractors meet the eligibility requirements for the lead Applicant (See III. Qualifications).

III. Qualifications

Eligible Entities

- CBO Applicants MUST be a 501(c)(3) organization, or be fiscally-sponsored by an organization that is tax exempt under code 501(c)(3) of the Internal Revenue Service. The definition of "CBOs" is only limited in that the organizations must have a 501(c)3 non-profit tax exemption status.
- This requirement also applies to subcontractors.

Ineligible Entities

The following entities are ineligible to apply for this funding source and are ineligible to serve as subcontractors:

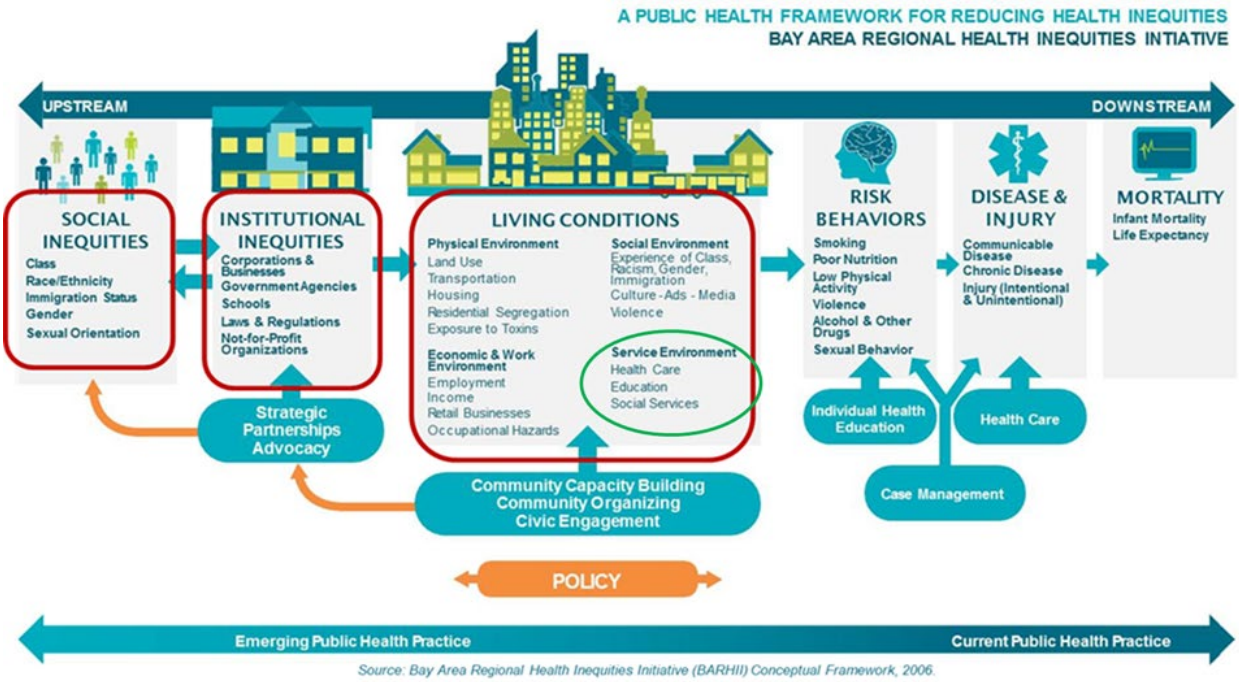
- Local Health Jurisdictions (LHJs)
    - LHJs have received large portions from the ELC grant
- Organizations from the Los Angeles County, City of Pasadena, and City of Long Beach
    - These regions have received their own separate Epidemiology and Laboratory Capacity funding from the CDC
- Hospitals, Healthcare Providers, and (Social) Health Maintenance Organizations
    - These entities have received their own separate funding and healthcare (a direct service) is not an allowable activity
- Federally Qualified Health Centers
    - These entities have received their own separate funding and healthcare (a direct service) is not an allowable activity
- Rural, Urban, and Suburban County and Private Clinics Providing Any Healthcare Service
    - These entities have received their own separate funding and healthcare (a direct service) is not an allowable activity
- Nursing Home Facilities (i.e., Long-term Care Institutions, Skilled Nursing Facilities)
    - These entities have received their own separate funding and healthcare (a direct service) is not an allowable activity
- Academic Institutions
    - These entities have received their own separate funding
- Research Organizations
    - These entities have received their own separate funding and research is not an allowable activity

- Union Organizations
    - These entities are funded through member dues
- Federally Recognized Tribes
    - Tribal entities have received separate COVID-19 funding. The original award from the CDC to CDPH only allows community-based organizations and not federally recognized tribes as applicants

Activities

This is an opportunity for CBOs to address underlying inequities affecting COVID-19 risk, through policy, systems, and environmental changes such as engaging communities, supporting service navigation, improving health status and opportunities across social determinants of health. CBOs will develop pilot projects through strategies to address the underlying inequities in California's communities that have been further exposed by the COVID-19 pandemic. These interventions that can be a community-defined best practice, evidence-based, or innovative, will support those who are disproportionately affected, in terms of discrimination, risk, exposure, and access to resources to be, and stay safe. CBOs could also be engaged to work with local health departments on COVID-19's disproportionate health impact on Blacks, Indigenous, Latinx, Native Hawaiian, Pacific Islanders, and other heavily impacted communities and populations of essential workers, particularly frontline low-wage workers. These pilot projects will build strategies and resources as best practices to be shared with communities across the State.

Framework



Source: Bay Area Regional Health Inequities Initiative (BARHII) Conceptual Framework, 2006.

This is the Bay Area Regional Health Inequities (BARHII) framework, which CDPH OHE has adopted as its guiding framework. Proposed activities must fall within the three "upstream" categories on the left side of the graphic (shown in red boxes) that have the strongest influence on health and COVID-19 health outcomes: 1) Social Inequities, 2) Institutional Inequities, and 3) Living Conditions. The lists in each category are examples, but are not the only areas allowable in addressing inequities and living conditions. The strategies can be, but are not limited to, the following (shown in blue and orange bubbles): strategic partnerships, advocacy, community capacity building, community organizing, civic engagement, and (non-legislative) policy change.

Downstream activities that address risk behaviors, individual health education, case management or health care through downstream strategies (individual health education, case management, and health care) are NOT allowable. Provision of direct services such as healthcare, education, and social services, identified in the green circle are also NOT allowable. However, an Applicant can propose an activity where there is a system or innovative solution to address the lack of such services (Refer to Example 16 in the next section Examples of Potential Pilot Projects). Allowable activities will have an upstream approach to addressing COVID-19, rather than downstream response and rescue activities.

Each pilot project can have multiple activities. However, only 1 pilot project per applicant is permissible.

Categories for Allowable Activities

Activities can address any of the following categories:

1. Social Inequities based on
    a. Class
    b. Race/Ethnicity
    c. Immigration Status
    d. Gender
    e. Sexual Orientation
2. Institutional Inequities embedded in
    a. Corporations and Businesses
    b. Government Agencies
    c. Laws and Regulations (lobbying is prohibited)
    d. Not-for-Profit Organizations
3. Living Conditions
    a. Physical Environment
        i. Land Use
        ii. Transportation
        iii. Housing
        iv. Residential Segregation
        v. Exposure to Toxins
    b. Economic & Work Environment
        i. Employment
        ii. Income
        iii. Retail Businesses
        iv. Occupational Hazards
    c. Social Environment
        i. Classism
        ii. Racism
        iii. Gender discrimination
        iv. Xenophobia/Anti-Immigrant bigotry
        v. Culture –Ads – Media
        vi. Violence, including domestic violence
    d. Service Environment (identified by green circle in graphic) - Direct services such as health care provision and educational services are not allowable, but development of innovative systems of coordination or means of increasing access, such as to undocumented immigrants, non-benefited workers, or incarcerated or detained people could be. Refer to Example 16 in the next section Examples of Potential Pilot Projects.
        i. Health Care
        ii. Education
        iii. Social Services

Examples of Potential Pilot Projects

1. Tools to reduce risk of disease transmission for agricultural workers that are culturally appropriate and account for the unique disease risks of this community. This can be a system or policy change allowing for safe transportation options to the job site.
2. Projects to reduce risk at correctional and detention facilities, given the severity of COVID-19 outbreaks among the incarcerated, detained, and among prison staff. Projects can include eliminating fees for phone calls and copays for medical visits; setting policies for cleaning/sanitation with non-toxic cleaning supplies; creating guidelines for quarantines so they do not result in more restrictive environments such as solitary confinement; developing decarceration policies; and services for decarcerated people to transition to stability with assistance for basic needs.
3. Develop strategies to reduce inequality in wealth and income, one of the strongest determinants of health inequities.
4. Outreach about how to receive public benefits and not be considered a public charge.
5. Connect clients to non-governmental relief funds or services for priority populations, including vulnerable elderly, undocumented families, low income workers, and others.
6. Work with municipalities to accelerate or prioritize projects, programs, or policies that were already identified in previous local planning processes (such as active transportation master plan, general plan, trails/open space master plan, climate action plan) and would help to improve safety, health, access, or ability to physically distance, in underinvested neighborhoods.
7. Create mutual aid networks to provide community volunteer support in providing and delivering essential supplies such as food and medicine to more medically vulnerable community members, and in changing systems to guarantee these services long-term.
8. Work with local jurisdictions to create more outdoor space and safer corridors for essential travel by foot or bike, and organize or promote the concept with the jurisdiction and the public. These can be temporary or low-cost measures such as pop-up/temporary bike lanes, converting pedestrian crossing signals to be automated instead of requiring people to touch/push the button, ensure clear signage and wayfinding, implement traffic calming measures.
9. Address the unique needs of children and youth in the child welfare system who may experience exacerbated pandemic-related challenges including disruption of services, increased financial hardship and caregiver stress, separation from family and friends, fear of or illness or death of close connections due to COVID-19.
10. Enact universal basic income programs for residents, to ensure they can stay housed, fed, and healthy even if they lose their jobs or get sick.

11. Develop strategies to shorten homelessness by stopping its criminalization.
12. Expand, enhance, and ensure access to childcare support for low-income essential workers and low-income families.
13. Create and implement a model to address the impacts of COVID-19 on a vulnerable community with environmental justice concerns, such as in some tribal reservations that may lack complete indoor plumbing and potable water compared to most U.S. homes.
14. Develop alternatives for safe transportation in rural tribal lands where public transportation may not be adequate.
15. Expand access to paid leave because of health benefits it could bring to low-wage essential or vulnerable workers.
16. Develop a system using public transportation to deliver food and protective personnel equipment (PPE) to low income immigrant families. (Note: This funding source cannot be used for direct services such as the bus or food, but can be used to set up the system.)
17. Plan or develop a local food hub to connect farmers directly with people or institutions needing food, to address increased food insecurity during the pandemic.
18. Work with departments of public health and social services to set up one-stop shops at familiar, safe locations such as schools or community centers to provide referrals for health care, mental health, food, housing, legal services, etc.
19. Work with employers and groups of workers to expand job security such as right of return to jobs, provision of benefits, systems to maintain safety and distancing in the workplace, etc.
20. Establish a transformative justice program as an alternative to incarceration, to both reduce risk of infection, and prevent or reduce long-term involvement with the justice system. Individuals will attend a justice program with physical distancing measures in place or include virtual attendance options.
21. Reduce exposure to air pollution in overburdened communities. Studies have suggested that chronic air pollution significantly worsens sequelae from infection with SARS CoV-2 (the virus that causes the illness COVID-19).
22. Create opportunities for safe social connections or employment for people with disabilities and/or different abilities to assist with economic and employment challenges for this community.
23. Address disproportionate policing of transgender people of color to prevent justice involvement for transgender people who experience disproportionate discrimination and violence.
24. Assure implementation of State law (SB 132) allowing incarcerated transgender, non-binary and intersex people to be housed and searched in a manner consistent with their gender identity.

25. Collaborate with local health departments to engage with CBOs and grassroots organizations to address inequities in social determinants of health, such as homelessness, xenophobia, and racism.
26. Develop budget models that focus investments on community health measures (i.e., change funding focus from policing and incarceration to behavioral health and/or housing services).
27. Develop systems to provide income support to low-income populations while awaiting COVID-19 test results, and while quarantining and isolating
28. Develop strategies to house unhoused people in vacant housing (e.g., land trusts, negotiations with financial institutions or public entities owning vacant housing).
29. Create systems for returning land and resources to Indigenous stewards (e.g., land and monetary donations curated by organizations such as the Sogorea Te Land Trust). This would foster economic security, a key determinant of health, and address legacies of racial discrimination.
30. Create systems for beneficiaries of race and wealth privilege to share resources with descendants of Africans forced into slavery, managed and distributed by Black people. This would foster economic security, a key determinant of health, and address legacies of racial inequities.
31. Establish structures, processes, or funding mechanisms to support employee-owned and managed cooperative businesses, which typically provide increased safety in working conditions, economic security, and empowerment for employees.
32. Develop systems to provide information and support to workers regarding their rights to organize in labor unions, which strive to negotiate added benefits and workplace safety protections for workers.
33. Improve workplace safety for low-wage workers (addressing risks of both COVID-19 infection and injuries).
34. Support undocumented immigrants to receive support services (income, food, housing, utilities, education, employment, health) that reduce their vulnerability.
35. Assist workers and employers to implement the new CalOSHA Emergency Temporary Standard that requires that employers develop a written COVID-19 Prevention Plan, pay full wages and benefits and honor seniority for workers who stay home due to work-related COVID-19, and gives workers the right to participate in management decision-making to prevent SARS-CoV-2 (the virus that causes the illness COVID-19) exposure in the workplace.
36. Implement interventions that reduce or end deadly discrimination (e.g., Asian American and Pacific Islander (AAPI) hate, Black infant mortality, institutional discrimination against Latinx, attacks against transgender people, etc.), as discrimination reduces access to health services as well social determinants of health such as employment and housing.

37. Create Public Health Councils of workers in high-risk occupations (such as farmwork, food processing, and warehouses) allied with other third-party organizations that can help inform workers of protections that can be taken, and can help monitor employers' compliance with public health and CalOSHA orders.
38. Collaborate to extend eviction moratoria while developing longer-term affordable housing and eviction-prevention approaches, as homelessness results in worse health and shortened life span.

Awards will be made to applicants that propose activities that are geared not towards education/informational strategies, but rather towards policy, systems, and practice changes, that affect the underlying living conditions in the social determinants of health.

Funding Restrictions

The majority of the $499M ELC grant is funding local health jurisdictions, testing services, contact tracing, laboratory services, and public health surveillance. Thus, those activities will **NOT** be funded through this RFA, as they are already being covered through other parts of the ELC grant or other emergency COVID-19 funding sources.

Examples of unallowable activities receiving other funding include the following:

A. Education on behavioral strategies to reduce infection risk
B. A culturally competent, multi-lingual media campaign and outreach on topics such as face coverings, physical distancing, testing, etc.
C. Local health departments and community-based organizations to scale-up case investigation and contact tracing staff drawn from the community with a focus on disadvantaged populations
D. Staff to work with Skilled Nursing Facilities
E. Testing sites and prevention hubs for communities of color
F. Improved data systems to assess disparities by sexual orientation, gender identity, occupation, and underlying illness.
G. Special delivery of food, non-toxic sanitation supplies, and basic needs (e.g., to elderly, people with special needs, people who are homeless and do not want to receive/are not receiving emergency sheltering services, low-income)

In addition, below are other unallowable activities:

A. Research
    i. Proposed activities must be implementation only
B. Direct Services
    i. However, allowable activities can be for systems that address the ongoing lack of direct services

C. Lobbying for or against specific proposed legislation or candidates
    i. Note: Advocating for a general cause is allowable (refer to Example 15 in section Examples of Potential Pilot Projects), but advocating for an ordinance, bill, or law to pass and encouraging individuals to call their local congressional office, state representative or city councilmember is not allowed.

IV. RFA Submission Instructions

Q&A Opportunities

Once the RFA is released, CDPH will allow CBOs to submit questions regarding the RFA in two (2) separate sessions. An informational webinar going over RFA requirements will also be provided where CBOs can ask questions by typing them in the chat box. Refer to section VI. RFA Time Schedule for dates and links to where the RFA is posted.

Submission Instructions

Applicant's budget and proposal should be developed and each Applicant shall provide complete information responsive to the following requirements to the satisfaction of CDPH:

1. Application Cover Page (See Attachment 1)
2. Narrative describing the activity or activities that the organization will be implementing+
    a. The Narrative must include:
        i. Dollar amount requested (minimum $50,000 – maximum $300,000)
            - Tier 1: $50,000 - $99,999
            - Tier 2: $100,000 - $199,999
            - Tier 3: $200,000 - $300,000
        ii. Category or categories that the activities fall under
        iii. Priority population(s) to be served and description of their challenges
        iv. Region(s) to be served and description of the region
        v. Description of the Applicant's successful previous work with priority populations
        vi. Description of the cultural and linguistic competency of the Applicant organization
        vii. Description of the collaboration with other organizations or entities addressing the same or similar issues, which includes how collaboration partners and/or subcontractors will contribute to the success and effectiveness of the project. Partners may be non-funded or in-kind partners.
        viii. Description of your proposed Pilot Project Activities

b. Data statistics on the disproportionate risks to the chosen priority population(s)
    - Data is optional if prioritizing any population(s) listed in the Priority Populations List under I. Overview.
    - If the Applicant's priority population is NOT listed in the Priority Populations List under I. Overview, the Applicant is REQUIRED to provide either 1) data on disproportionate prevalence or risk and/or 2) information to demonstrate the disproportionate risk of COVID-19 for the selected population.
    - Potential data sources that can be used include but are not limited to:
        a. Healthy Places Index - OHE strongly suggests using this index, as it is the basis for the Equity metric that the State is using to allow counties to move between tiers and is also being used in the Health Equity Playbook for LHJs
        b. University of California, Los Angeles (UCLA) Data and Mapping Resources
            i. CA Neighborhood Pre-Existing Health Vulnerability and Supporting Indicators Map
            ii. COVID-19 Rates and Risk Factors by California County Dashboard
            iii. Preliminary Estimates Dashboard
        c. University of California, Berkeley report - Physical Proximity to Others in California's Workplaces: Occupational Estimates and Demographic and Job Characteristics

3. Root cause analysis (aka 5 Why's)
    a. Many of the factors that affect health are beyond an individual's control. This analysis helps identify the root cause of a problem and determines the relationship between root causes and the problems to which they lead. This analysis illuminates the societal and/or environmental context that leads to poor health. Conducting the root cause analysis will enable you to focus on the most effective strategies you can implement to benefit the population(s) you have the trust of, and have the capacity to serve.
    b. Example of a root cause analysis asking the 5 Why's
        i. *Why is Jenny sick?* Because she has an infection in her foot.
        ii. *But why does she have an infection?* Because she has a cut on her foot and it got infected.

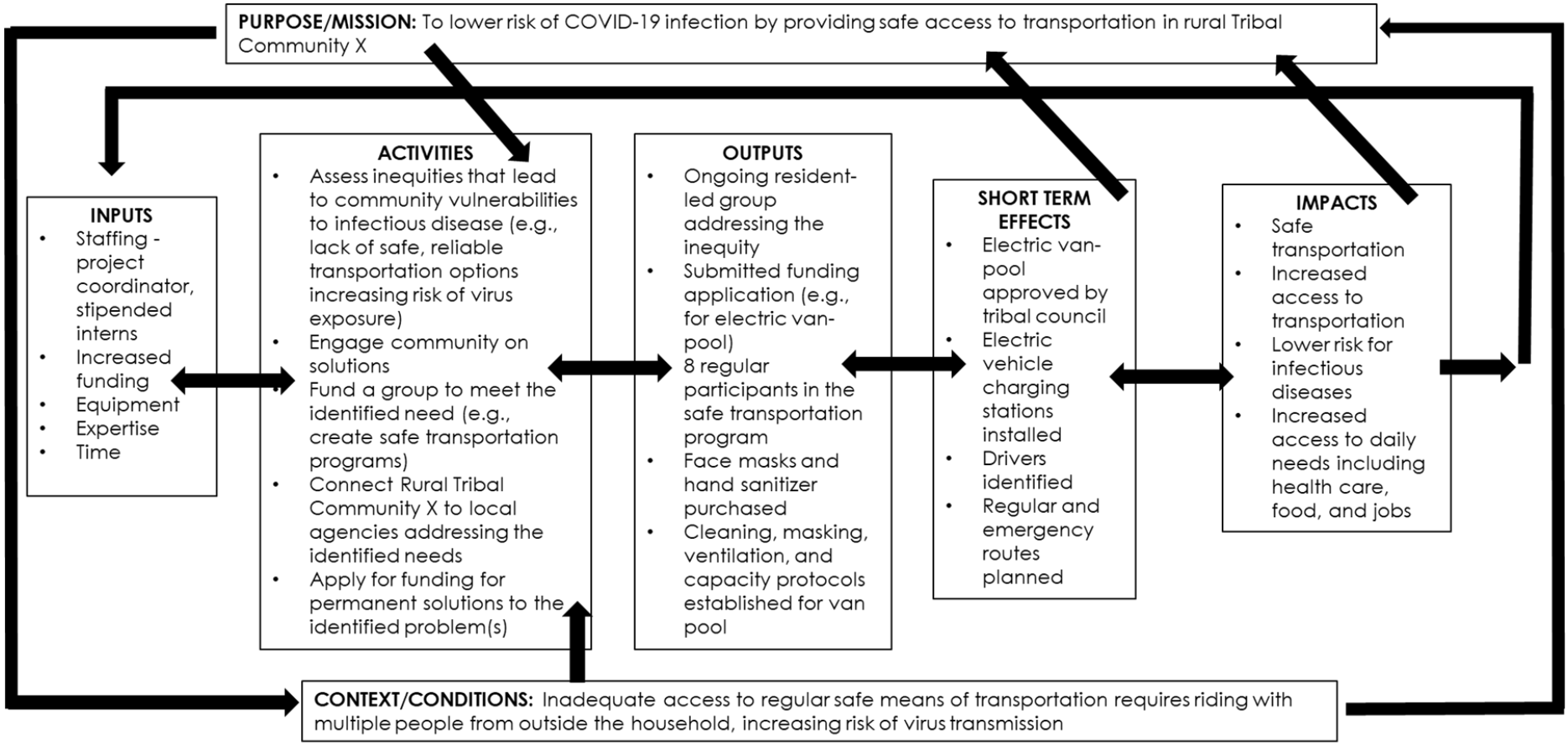
iii. *But why does she have a cut on her foot?* Because she was playing in the empty lot next to her apartment building and there was some broken glass that she stepped on.
iv. *But why was she playing in an empty lot?* Because there is no park, playground or sidewalk in her neighborhood.
v. *But why isn't there a park or playground nearby?* Because they weren't planned for when the city she lives in was designed, the city now doesn't have enough funds to construct one, and there are no requirements that developers help build one when they develop there.

c. This root cause analysis may lead you to address park equity, land use and development codes, or municipal finances and budgeting.
d. How to conduct a root cause analysis:
    i. https://www.thecompassforsbc.org/how-to-guides/how-conduct-root-cause-analysis
    ii. https://www.cms.gov/medicare/provider-enrollment-and-certification/qapi/downloads/fivewhys.pdf

4. Logic Model (aka Theory of Change, Road Map, Causal Chain, Sequence of Events)
    a. In one-page or less, Applicants must explain, graphicly in a logic model and/or in narrative form, how the proposed activities will address underlying inequities in living conditions and ultimately result in lower risk of infection or harm from COVID-19 in the priority population(s) you serve. This is like the reverse of the root cause analysis: when you address the root cause identified, what is the sequence of events that leads to reduced COVID-19 risks? This exercise can be completed using either words (in chart form or paragraph), graphics, or a mix of both.
    b. Include at least the following components in your logic model or theory of change (See https://ctb.ku.edu/en/table-of-contents/overview/models-for-community-health-and-development/logic-model-development/main for explanation and examples)
        i. Purpose/Mission: What motivates the need for change?
        ii. Context/Conditions (barriers, constraints, political/economic climate): What is the climate in which change will take place
        iii. Inputs (funding, staff, assets, partners, etc.): What are the resources/infrastructure needed to operate the program?
        iv. Activities (interventions, strategies): What will you do with this funding (and other funding sources) to make this change? What will these activities change, and what will be the anticipated results of those changes? Please specify which activities you are using this funding vs. other funding for.

v. Outputs: What evidence is there that the activities were performed as planned? This can include potential indicators (e.g. 90% have reduced adverse mental health symptoms, 80% have increased their income, 50% secured permanent housing).
vi. Effects, results, consequences, outcomes, impacts: What kinds of changes do you envision will come about as a direct or indirect effect of the activities? i.e., reduction in COVID-19 infections, illnesses and deaths in priority population(s).

c. Example 1. – Emergency Preparedness Planning in Rural Tribal Community



d. Example 2. –
    i. Purpose/Mission: To reduce COVID-19 infection, illness, and death in jails. (Note: This example is focusing on jails as they are locally controlled, as opposed to state or federal prisons or immigrant detention centers.)
    ii. Context/Conditions: Extremely high rates of infection, illness and death in jails and prisons; a priority population with little control over contact, distancing, hygiene, personal protective equipment, etc.; high costs of incarceration.
    iii. Inputs: Grant funding; coalition of decarceration, abolition, and prison reform organizations; staffing (project coordinator, contract staff, community organizer); expertise; social networks.
    iv. Activities: Work with the local health department to delineate the increased risks to incarcerated people of COVID-19 infection and inequities (e.g., increased rates of pre-existing health conditions, inadequate isolation and distancing opportunities, under-resourced health care provision, limited interpretation for non-English speakers, etc.). Develop a proposal to shift some funding from the jail, general fund, or other source to fund staff to oversee community supervision of incarcerated people. Address safety and accountability concerns, and assure provision of housing, food, income or employment, health, and social support. Publicize these concerns and solutions through media and social networks. Meet repeatedly with local officials, judges, law enforcement, prison authorities or other decision-makers regarding the potential health and economic benefits of releasing inmates to community supervision.
    v. Outputs: A decision from the appropriate decision-making body to release inmates to community supervision, provide staffing and other support to needed support services, and monitor the effects of the program.
    vi. Effects, results, consequences, outcomes, impacts: Inmates return to families; receive support for basic needs to reduce recidivism; are able to engage in COVID-risk reduction behaviors such as distancing, masking, hygiene, and quarantining; are less exposed to the SARS-CoV2 virus (which causes the illness COVID-19); experience less infection, illness, and death than comparable incarcerated populations.
    vii. Note: This example can be displayed in multiple ways: as a chart with words, graphic and words, graphic only, paragraphs, bullets, flow chart, etc.

5. Record of Experience in Program Management
    a. Applicants must describe their previous experience in monitoring and reporting program performance and preparing reports describing program results.
    b. Awarded Applicants will be required to provide quarterly reporting on progress and performance of activities with regards to the program objective and spending. A report template will be provided by OHE to awarded entities. This reporting can include but is not limited to 1) assessments of the extent of quality of program or policy implementation; 2) indicators used to measure progress and achieve program outcomes (i.e., participation rates, physical, environmental, economic changes, policy changes, incidence, and prevalence; 3)barriers to progress; 4) lessons learned or plans to overcome barriers; and 5) program budgets. At the mid-way point and at the end of the project the awardee will provide a narrative description of the context/conditions, inputs, activities, outputs, effects/outcomes/impacts, barriers, and lessons learned, in sufficient detail for another CBO to replicate program successes and overcome barriers or challenges. The purpose of this evaluation is for awarded CBOs to provide program outcomes and results, best practices, and lessons learned to their LHJs and to the State once activities are completed. These resources and experiences can assist with other organizations and entities to replicate the work completed by these pilot projects.
    c. Applicants must demonstrate around 2 years of experience in program management. 1.5 years to 2 years of experience is acceptable. This can be a combination of staff experience (i.e. from the executive director) and the organization.

6. Program Staffing
    a. CBOs must describe the background, professional experience, including the length of time worked on projects to create policy, system, or environmental changes, and the qualifications of the staff and subcontractors (or a recruitment and hiring plan).

7. Administrative/Fiscal Experience
    a. CBOs must be able to demonstrate the capacity of being able to administratively manage the received funds. It is recommended that there be at least a part-time staff person who will be in charge of reporting, paying invoices, and overseeing the budget. This support can be in-kind or paid for by these funds.
    b. Please include the following:
        i. Overall Administrative and Fiscal Experience: Describe the Applicant's current administrative staffing pattern for

activities such as contract and grant management and oversight, payroll, bookkeeping, invoicing, and tracking of contractual, administrative, and fiscal controls. Describe the background and qualifications of key administrative staff; including their experience with monitoring government funds, and overseeing and managing the administrative and contractual functions of subcontractors and/or consultants.

ii. Fiscal and Contract/Grant Compliance: Describe the Applicant's performance within the last three (3) years with the management of government and/or non-government funds and activities, including administrative, fiscal, program, and evaluation functions such as: timely and accurate completion of deliverables; submission of fiscal, program, and evaluation documentation; subcontract/consultant monitoring; compliance with government requirements; and fiscal ability to manage payments in arrears.

iii. Audit History: Describe the Applicant's fiscal and programmatic audit history within the last three (3) years (if any). Information is to include frequency of the audits, dates of the audits, and a summary of the audit findings. Thoroughly explain any negative audit findings and their resolution. If the Applicant was audited by a governmental agency within the last three (3) years, provide the name of the government agency, the agency's contact person and phone number, the year the audit was conducted, and the audit findings and resolution.

- If the Applicant's organization has not gone through a full fiscal or programmatic audit, the Applicant can provide past documentation of a mini audit questionnaire if one was previously completed. If neither has been done before, the organization may still apply for this funding.

8. Budget overview (Refer to Attachment 2: Budget Overview and the Excel file)
    a. Applicants will complete the Budget Overview Excel template by filling out all sections of the template (personnel costs, benefits, indirect costs, subcontracting costs, and evaluation budget). Each activity in the Pilot Project Activities that results in an expenditure of funds is reflected in the budget. The proposed Budget Justification will describe how the costs associated with the implementation of the proposed Pilot Project Activities were determined and will include detailed descriptions and explanations for each of the line items. Indirect expenses must not exceed 25% of Total Allowable Direct Costs (including total personnel: salary + benefits).

b. If funds from another source are contributing to the implementation of the Pilot Project Activities, budget activities are clearly identified as "In-Kind" and specify the source of the in-kind funding, (e.g., federal funds, CDC grant, etc.).
c. Applicants may include any formulas in the Excel budget document, as necessary.

9. Letter of Support(s)
    a. One (1) Letter of Support is REQUIRED from the (lead) Applicant's Local Health Jurisdiction (LHJ, or local health department). The letter must briefly:
        i. Describe the capacity of the Applicant
        ii. Describe the Applicant's ability to fulfill the fiduciary and grants management functions (e.g., meet grant obligations, meet deadlines, complete required reports, prepare timely accurate invoices)
        iii. Describe the engagement of the Applicant and the LHJ
            - The letter of support from the LHJ is to ensure there is bidirectional communication with the CBO and LHJ. CBOs will be sharing their learnings on their pilot projects with their LHJ and CDPH, once projects are completed. This is to ensure there will be follow up in terms of information and resource sharing, to best benefit populations facing inequities.
        iv. For joint applications with multiple CBOs, only one (1) recommendation letter is needed from the LHJ of the lead submitter
        v. Potential authors from the LHJ can be:
            - LHJ Director
            - Assistant Director
            - Health Officer or Deputy Health Officer
            - COVID-19 Response or Infectious Disease Manager
            - Equity Manager or Equity Office
    b. A second Letter of Support is OPTIONAL
        i. Content requested is the same as for the Required Letter of Support from the LHJ
        ii. Potential authors can be from but are not limited to:
            - LHJ
            - City
            - Community partner
10. A copy of a current IRS determination letter indicating nonprofit or 501 (c)(3) tax exempt status. For an organization fiscally sponsored by a 501(c)(3) organization, please provide the documentation indicating nonprofit or 501(c)(3) status of the fiscal sponsor. Include the same documentation for any subcontractors involved with your proposal.

11. Evidence of commercial general liability insurance.
    a. The minimum amount of coverage is one million ($1,000,000)
    b. If the Applicant does not currently have general liability insurance and is selected as an awardee, the Applicant MUST obtain this in order to enter into a Grant Agreement with CDPH OHE.

Submission Length

Total submission should not exceed 20 pages, which includes the other required documents listed in the previous section.
Attachment 2: Budget Overview Excel file is not included in the 20 page count.

Submission Email

Proposals must be submitted to ELCCovidHealthEquity@cdph.ca.gov by **5pm March 2, 2021**, as reflected in the RFA Time Schedule. Proposals MUST be submitted in two (2) files: 1) Submission Package (PDF or Word) and 2) Budget Overview (Excel). Subject line must be Organization Name: Project Title.

V. Application Review Process

CDPH has created an advisory workgroup, who is involved in the development of the RFA and will also score the applications. The advisory workgroup includes representatives and public health experts of local health jurisdictions, public health organizations, academic institutions, and other non-governmental organizations.

Stage One: Administrative and Completeness Screening

Refer to Attachment 3: Prescreening Checklist

1. CDPH OHE and CDPH Racial-Health Equity Action Team will conduct an internal screening review for on-time submission and compliance with administrative requirements and completeness.
2. A late or incomplete application will be disqualified and eliminated from further evaluation.
3. Applications submitted from ineligible entities will not be reviewed
4. Omission of any required document or form, failure to use required formats for response, or failure to respond to any requirement may lead to rejection of the application prior to review.
5. CDPH may reject any or all applications and may waive any immaterial defect in any application. CDPH's waiver of any immaterial defect shall in no way excuse the Applicant from full compliance with the Grant Agreement terms if the Applicant is awarded the Grant Agreement.

Stage Two: Application Scoring

Refer to Attachment 4: Proposal Submission Scoring Rubric
Following the completion of the internal screening, the advisory workgroup and CDPH Racial-Health Equity Action Team will evaluate each application to determine responsiveness to the RFA requirements.

Stage Three: Notification of Intent to Award

Notice of Intent to Award (NOIA) Grant Agreements will be posted on the CDPH OHE website. Additionally, a letter will be e-mailed to all Applicants notifying them of the status of their application.

Dispute/Award

1. Due to the COVID-19 emergency there will be no dispute provisions with this RFA
2. A Grant Agreement may be awarded at the sole discretion of CDPH utilizing the emergency provisions consistent within Executive Order N-25-20

Stage Four: Grant Modifications

CDPH reserves the right to reject any proposed project or project component(s). Following the award notification, CDPH may require modifications to the application as a condition of the award. The awardee is required to submit a detailed Pilot Project Activities, Budget and Budget Justification in accordance with CDPH requirements, which will become part of the final grant. Upon completion and approval of these documents, the Grant Agreement documents will be submitted to CDPH for execution. Work may not commence until the Grant Agreement is fully executed and any work done before the full execution of the Grant Agreement will be deemed voluntary.

VI. RFA Time Schedule

Key activities and times for this Request for Application are presented below. This is a tentative schedule and may change at CDPH's sole discretion. All RFA information and posts are located on the OHE webpage. Any updates to this schedule will appear as an addendum to this Request for Applications.

EVENT	**DATE**
RFA released	January 14, 2021
Information Webinar. Questions must be submitted in the chat and recording will be posted.	January 20, 2021
Written Question Session #1 Submittal Deadline	January 28, 2021
Q&A Session #1 Posted	February 2, 2021
Written Question Session #2 Submittal Deadline	February 11, 2021
Q&A Session #2 Posted	February 16, 2021
Application Submission Deadline	5pm March 2, 2021
Application Screening conducted by Office of Health Equity	Complete by March 10, 2021
Advisory Workgroup to review RFAs and finalize recommendations for CDPH Directorate approval	Complete by March 24, 2021
Notice of Intent to Award (NOIA) Released	Dependent on when CDPH Directorate Approval is received (After March 24, 2021)
Grant Agreement Start Date	Dependent on when Grant Agreement is executed once NOIA is posted (After March 24, 2021 – April+)

VI. Attachments

Attachment 1: Application Cover Page

Organization's Name	Primary Contact
Address	**Phone Number**
City, State Zip	**Email**

Brief Description of Project (200 word limit)

Priority Population(s)	Geographic Target(s)
Amount Requested (Indicate Tier)	**Subcontractors (if applicable)**
Requested: Tier:	

Non-funded or In-kind Partners (if applicable)

Entity Eligibility

- Are you a 501(c)(3) organization?
  Yes ❑ No ❑
  501(c)(3) #: _____
- If no, are you fiscally sponsored by a 501(c)(3) organization?
  Yes ❑ No ❑ NA ❑

For proposals with subcontractors:

- Are subcontractors 501(c)(3) organizations?
  Yes ❑ No ❑
  501(c)(3) #(s): _____
- If no, are subcontractors fiscally sponsored by a 501(c)(3) organization?
  Yes ❑ No ❑ NA ❑

Attachment 2: Budget Overview

Budget Guidelines
This template is provided as a guide. Applicants may change or replace it to best meet their needs. Definitions of each budget category are provided on the next page. If funds from another source are contributing to the implementation of the Pilot Project Activities, budget activities are clearly identified as "In-Kind" and specify the source of the in-kind funding, (e.g., federal funds from CDC grant, etc.).

Applicants will complete the Excel attachment (not the Word document) of this budget template.

Program Budget	Budget	Description
Personnel Costs		
Benefits @ X% of Personnel Costs		X% of Personnel Costs
Non-Personnel Costs		
Rent Costs ($500 max/month)		
Indirect Costs @ X% of total allowable direct cost		X% of Direct Costs
Travel and Per Diem Costs		
Subcontracting Costs (Please provide a breakdown of subcontractor costs if there are multiple subcontractors, and if this information is available)		
Evaluation Budget @ X% of Project Budget (Optional)		X% of Project Budget
Total		

Each budget item needs to include a name for the item, a dollar amount, and a description to justify the cost. Please include the percentage (%) for categories: Benefits, Indirect Costs, and Evaluation Budget (Optional). Additional formulas may be added.

Personnel Costs are the direct operating costs for staff time devoted to fulfilling the goals of this Agreement. It may include a pro-rated portion of benefits. Line items should be provided for specific individuals and/or positions.

Benefits

The benefits line item represents the total amount of taxes and benefits (aka "fringe") related to the personnel line items above it. Enter the percentage in the Benefits description (example: "X% of Personnel Costs").

Non-Personnel Costs[4] are direct operating costs necessary to carry out the project being funded; these costs need to be explicitly connected to pilot project activities and not just routine costs.

Rent Costs have a maximum of $500/month.

Indirect Costs are those expenses that are necessary for the general operation of an organization and are not specifically identified with a particular grant, project or activity. Indirect Expenses must not exceed a maximum of 25% of Total Allowable Direct Costs (including total personnel: salary + benefits). Indirect costs can include but are not limited to janitorial services (i.e., 5% of total indirect cost), legal services (i.e., 8% of total indirect cost), etc. Enter the percentage in the Indirect Costs description (example: "X% of Direct Costs").

Travel and Per Diem Costs must adhere to the rates set by the California Department of Human Resources (CalHR): Travel Reimbursement Information https://www.calhr.ca.gov/employees/pages/travel-reimbursements.aspx.

Subcontracting Costs are costs for any subcontractors that the Applicant anticipates contracting with to fulfill the goals of this grant. Each subcontractor must be listed separately. Subcontractors must adhere to the same guidelines as the lead Applicant (maximum of 25% indirect costs, etc.).

Evaluation Budget is the cost involved in the assessment of whether resources have been used appropriately and effectively. The purpose of the evaluation is to help others replicate the successes of the project and avoid pitfalls. If applicable to your organization, enter the percentage in the Evaluation Budget description (example: "X% of Project Budget").

[4] Examples of direct vs indirect charges: https://vpresearch.louisiana.edu/pre-award/building-your-budget/direct-costs-vs-indirect-costs

Attachment 3: Prescreening Checklist

1. The priority populations or subpopulations to be served is listed in the priority populations list. (If No, must be Yes for 1A to pass.)	**Yes / No**
1A. If the priority population is/are NOT listed in the priority list, there is adequate data and/or evidence-based information provided to support the population chosen for this initiative. (If Yes for 1. then mark NA for 1A.)	**Yes / No / NA**
2. Applicant is a 501(c)(3) organization or is fiscally sponsored by a 501(c)(3)	**Yes / No**
3. Subcontractor(s) is(are) a 501(c)(3) organization or is(are) fiscally sponsored by a 501(c)(3)	**Yes / No**
4. Proposed activity is an allowable activity (i.e., implementation and not research, upstream and not downstream, etc.)	**Yes / No**
5. Proposed activity falls within the three (3) allowable categories: Social Inequities, Institutional Inequities, and Living Conditions	**Yes / No**
6. Requested amount falls into 1 of the 3 tiers: Tier 1: $50,000 - $99,999 Tier 2: $100,000 - $199,999 Tier 3: $200,000 - $300,000	**Yes / No**
7. Application Packet	
A. Application Cover page	**Yes / No**
B. Narrative	**Yes / No**
C. Root Cause Analysis	**Yes / No**
D. Logic Model/Theory of Change	**Yes / No**
E. Record of Experience in Program Management	**Yes / No**
F. Program Staffing	**Yes / No**
G. Administrative Fiscal Experience	**Yes / No**
H. Budget Overview (Excel)	**Yes / No**
I. Letter of Support from Local Health Jurisdiction	**Yes / No**
J. 501(c)(3) certification or documentation indicating fiscal sponsorship from a 501(c)(3)	**Yes / No**
K. Evidence of commercial general liability insurance or that insurance will be obtained	**Yes / No**
L. Application is 20 pages or fewer	**Yes / No**
M. Full application packet is complete(d) (Indicate Yes if all items in "Application Packet" are Yes)	**Yes / No**

Does Applicant pass the prescreening? Yes / No

Prescreen comments:

Attachment 4: Proposal Submission Scoring Rubric

Applicant Name:
Funding Tier:
Priority Population:
Geographic Location:

Applicant Component	Scoring Criterion	Points
Applicant Capability		
Demonstrated access and successful work with priority populations	The Applicant demonstrates knowledge working with priority populations and communities facing health, racial, ethnic or other inequities.	**8**
Cultural Competence	The Applicant describes how they have delivered services that are culturally competent. The Applicant explains how their proposed activity demonstrates culturally competence.	**3**
Linguistic or Communicative Competence	The Applicant describes how they have delivered services that are linguistically or communicatively competent. The Applicant explains how their proposed activity demonstrates linguistic or communicative competence.	**3**
Record of Experience in Program Management	The Applicant demonstrates around two (2) years of experience 1) monitoring and reporting program performance and 2) preparing reports describing program results. This can be a combination of staff experience (i.e., from the executive director) and the organization. 1.5-2 years of experience is acceptable, otherwise justification is needed in order to receive full points.	**4**
Program Staffing	The Applicant describes the background, professional experience, including the length of time worked on projects to create policy, system, or environmental changes, and the qualifications of the staff and subcontractors (or a recruitment and hiring plan). This description should show that the staff and subcontractors (if applicable) have the necessary qualifications and experience to successfully implement and evaluate a project	**4**

Administrative / Fiscal Experience	The Applicant demonstrates that 1) its administrative/fiscal staff have the appropriate educational background, skills, and experience to satisfactorily manage all aspects of payroll, bookkeeping, invoicing, subcontract/consultant monitoring, and other administrative controls associated with acceptance of government funds and 2) demonstrates three (3) years of satisfactory performance with administrative, fiscal, and program management of government and/or non-government funds; including timely and satisfactory submission of fiscal, program, evaluation, and subcontractor/consultant documents, fiscal stability to manage payments in arrears. If the Applicant was audited by a governmental agency within the last three (3) years, the Applicant provides the name of the government agency, the agency's contact person and phone number, the year the audit was conducted. There must be no negative audit findings. • If the Applicant's organization has not gone through a full financial audit, the Applicant may provide past documentation of a mini audit questionnaire if one was previously completed or provides a description about the organization's financial stability and responsibility of receiving federal funds.	**4**
	Subtotal	**26**
Narrative		
Pilot Project Activities – Purpose	Proposal clearly describes the activities that will be performed, and their function and purpose. The Applicant explains how the services will address the inequities that exist among the priority population.	**7**
Pilot Project Activities – Justification	There is strong justification that the objectives address a compelling need representing an underlying inequity of significance to the population of focus.	**7**

Pilot Project Activities – Social Determinants of Health	Applicant indicates the social determinants of health and underlying inequities being addressed by the proposed activity.	**10**
Priority Population	Applicant clearly identifies the priority populations or subpopulations to be served, and is listed in the priority populations list. The Applicant explains that COVID-19-related disparities exist within the affected population. If activities are not serving a population and/or community listed in the list, then data (local, epidemiological, etc.) and/or information is provided to demonstrate the disproportionate risk of COVID-19 infection, illness, or death of the priority population(s) chosen for this initiative.	***5***
Geographic Location	Applicant clearly 1) identifies the geographic location(s) being served, 2) explains the demographics in the region, and 3) justifies how this is a priority region to be served.	***5***
Root Cause Analysis	Applicant follows instructions and clearly identifies root cause(s) of the health risks they will address by asking the Five (5) Why's. The root cause analysis clearly demonstrates the relationship between a root cause and the problem and brings light to the societal and/or environmental contexts that lead to poor health.	**8**
Theory of Change	Applicant follows instructions and clearly explains in less than one page how proposed activities will address underlying inequities in living conditions and ultimately result in lower risk of infection or harm from COVID-19 for the priority population served. The Theory of Change provides the underlying rationale explaining why the proposed activities will lead to the desired change and achieve the objectives.	**8**

Innovation	The proposed activities are a creative and innovative way to use these funds with promising practices that will reduce risk of COVID-19 and its impacts among a priority population. Innovation is defined as interventions that have not or rarely been tried in the particular field that the Applicant is focusing on.	**3**
Effectiveness	The proposed activities are an effective way to use these funds with promising practices that will reduce risk of COVID-19 and its impacts amongst a priority population. The theory of change and narrative demonstrate a logical progression from the activities to the result of reduced risk of COVID-19 infection or impacts.	***5***
Collaboration	The Applicant provides evidence of collaboration with other organizations or entities addressing the same or similar issues. The Applicant describes how collaboration partners and/or subcontractors will contribute to the success and effectiveness of the project. Partners may be non-funded or in-kind.	**3**
	Subtotal	**61**
Budget and Budget Justification		
Budget Overview Attachment - Completion	The proposed budget adheres to the instructions provided in the Attachment 2: Budget Overview and is each budget category is completed in the Excel document. Each activity in the Pilot Project Activities that results in an expenditure of funds is reflected in the budget. Formulas are not broken and correctly calculate costs. Rates (%) are clearly identified for the Benefits, Indirect Costs, and Evaluation Budget (optional) categories.	**3**

Budget Justification	The proposed budget includes detailed descriptions/explanations to justify the cost for each of the line items and rates. The descriptions clearly describes how the costs associated with the implementation of the proposed Pilot Project Activities were determined. • If funds from another source are contributing to the implementation of the Pilot Project Activities, budget activities are clearly identified as "In-Kind" and specify the source of the in-kind funding, (e.g., federal funds CDC grant, etc.). Indirect Expenses must not exceed a maximum of 25% of Total Allowable Direct Costs (including total personnel: salary + benefits).	**4**
Reasonable costs	The proposed costs (budget and indirect rates) are reasonable.	**1**
Subcontractors	The proposed subcontract personnel and consultant costs are reasonable, directly support the proposed Pilot Project Activities, and are consistent with the needs of the project and level of responsibility.	**Yes / No / NA**
Travel and Per Diem	Travel and Per Diem costs are reasonable and necessary based on the proposed Pilot Project Activities. • Travel and Per Diem costs adhere to rates set by the California Department of Human Resources (CalHR): Travel Reimbursement Information https://www.calhr.ca.gov/employees/pages/travel-reimbursements.aspx	**Yes / No / NA**
	Subtotal	**8**

Letter of Support		
Letter of Support from Local Health Jurisdiction	The letter of support is from the (lead) Applicant's Local Health Jurisdiction and 1) describes the capacity of the Applicant, 2) describes the Applicant's ability to fulfill the fiduciary and grants management functions (e.g., meet grant obligations, meet deadlines, complete required reports, prepare timely accurate invoices), and 3) describes the engagement of the Applicant and the LHJ.	**5**
Optional Second Letter of Support	The second letter of support 1) describes the capacity of the Applicant, 2) describes the Applicant's ability to fulfill the fiduciary and grants management functions (e.g., meet grant obligations, meet deadlines, complete required reports, prepare timely accurate invoices), and 3) describes the engagement of the Applicant and partner(s)	**Yes / No / NA**
	Subtotal	**5**
	TOTAL	**100**