Rhode Island Department of Health
Three Capitol Hill
Providence, RI 02908-5094
www.health.ri.gov

Memo

Safe and Healthy Lives in Safe and Healthy Communities

To: Potential Mini-Grant Applicants

From: Neha Patel, Refugee Program Manager, Health Equity Institute

Date: 2/15/18

Re: **Call for 2018 Refugee and Minority Health Mini-Grant Applications**

The Rhode Island Department of Health, Health Equity Institute is offering a few mini-grants to qualified community-based organizations to support projects that promote the health of refugees and minorities in Rhode Island. Eligible applicants are **community based organizations** that demonstrate experience working with refugees and minorities and knowledge of the proposed subject matter.

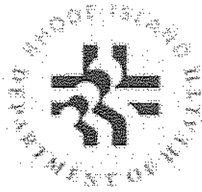
Mini-grants between the ranges of $2,000 or $4,500 will be awarded to successful applicants who propose to implement activities that accomplish at least one of the following for RI refugee and minority populations within the grant period of May 1, 2018– July 31, 2018:

1. Improving health literacy
2. Increase access to health and emotional wellness services
3. Promotes preventive health practices
4. Address social determinants of health

Applicants who focus on refugees that have arrived to Rhode Island within the last two years will be preferred, although applicants may choose to focus on serving refugees that have been in RI for longer than two years. Please note that awards are limited due to available funding. Successful applicants will be expected to provide the Institute of Health Equity with a brief final report of program accomplishments and evaluation of goals. The review criteria are included in the application document for your reference.

The mini-grant application is attached and when completed should be no longer than four pages, not including the cover letter, the budget, and the W-9 form. Therefore, the total application should not be longer than seven pages in length. **Please submit applications no later than** Friday March 23, 2018 at **3:00 pm via email (preferred method) to Neha Patel at: Neha.Patel@health.ri.gov or by fax to 401-222-1442; or hand delivered**. Once received, submissions will be reviewed by the HEI staff. The mini-grant activity period will be from May 1,2018 – July 31, 2018 and invoices will be due no later than Aug 10, 2018 in order to be reimbursed and final reports no later than Sept 1, 2018.

Attached is a revised W-9 form that you must complete and return when you submit your application. This allows the IHE to process the appropriate paperwork so your invoice can be paid at the end of the project period. You will be notified regarding the mini-grant award as well as other details prior to beginning of the grant. We look forward to hearing from you regarding this opportunity.



Executive Office of Health
Health Equity Institute
Refugee Health Program
2018 Mini-Grant Application Form

Instructions: Please read through each of the following sections and complete either in the given form or preferably, in another word document. Please refer to the review criteria document to understand how the application will be reviewed. The application form should not be longer than 4 type written pages.

SECTION I: AGENCY CAPACITY

Briefly describe your organization and your organization's experience in providing services, support, and engagement with refugee populations in RI. Describe your organization's previous experience in promoting health and wellness focused on addressing health disparities and achieving health equity.

SECTON II: SCOPE OF WORK & SUSTAINABILITY

Provide a summary of the proposed project and project goals. Discuss plans on how the project and/or related activities will continue after funding is over. If you have previously received funding from the former RI Office of Minority Health to carry out this or a similar program, please describe your success in achieving the outlined aims and goals. What were other sources of funding (if any)?

SECTION III: PERSONNEL & TIMELINE

Describe who will work on the project and their past experience working in this area. Please detail your organization's plan as it relates to this initiative along with a detailed timeline.

SECTION VI: BUDGET NARRATIVE

Please briefly describe your proposed budget expenses for this project and complete the budget form included in this project. The maximum allowable budget for this project is $4,500.00. **Note: Due to federal budget restrictions, mini-grant funds may not be used for the purchase of food or beverages.**

If you have any questions or concerns, please contact Neha Patel at 222-5940 or Neha.Patel@health.ri.gov

Return via email (preferred), fax, or in person no later than March 23, 2018 to:

Neha Patel
Refugee Program Manager
RI Department of Health, Rm. 304
Telephone: 401-222-5940
Fax: 401-222-1442
Email: Neha.Patel@health.ri.gov

Mini-Grant Budget Template

BUDGET Period: May 1, 2018-July 31, 2018	
Organization:	**Amount**
I. GRANT FUNDS: EXPENSE CATEGORY	
1. Personnel	
Sub Contracts	
Fringe Benefits: (if included, must break down cost)	
Total Personnel:	
2. Travel (local) (Rate cannot exceed 0.545/per mile)	
3. Supplies (please indicate):	
4. Printing	
5. Telephone	
6. Postage	
7. Facilities/Rental Expense	
8. Other (please indicate)	
TOTAL DIRECT COST TO GRANT	
9. INDIRECT ADMINISTRATIVE COSTS (cannot exceed 10% if no approved federal indirect cost rate)	
TOTAL AMOUNT REQUESTED ($3,000 or $4,500) – may not exceed $4,500	
II. IN_KIND CONTRIBUTIONS:	
TOTAL OF IN-KIND CONTRIBUTIONS:	

Rhode Island Department of Health
2018 Refugee Health Mini-Grant
Review Criteria

This document will be used by the Health Equity Institute (HEI) to review Mini-Grant proposals. You may use this as a guide as you prepare your Mini-Grant application; however, it is <u>not</u> part of the application form.

- **Compliance**
  - Do the proposed program activities align with Mini-Grant specifications/requirements for funded activities?
  - Does the proposed budget make acceptable use of funding?

- **Agency Capacity**
  - **General.** Is the organization well suited to carry out the program/project?

  - **Staff.** Is the staff sufficient to carry out the proposed activities? Do the organization staff/volunteers have the appropriate experience and training to carry out the program activities successfully?

  - **Approach.** Are the overall strategy and methods well-reasoned and appropriate to accomplish the specific aims of the program? Are potential problems, alternative strategies, and benchmarks for success presented?

  - **Environment.** Will the community/setting in which the work will be done contribute to the probability of success? Are the organizational support, equipment and any other physical resources available and adequate for the proposed program activities? Does this organization have access to special resources/circumstances that would enhance the work carried out in this program?

  - **Partnerships.** Will the work be carried out with the assistance of other organizations/community collaboration? If so, to what degree will these parties contribute to the proposed program/activity?

- **Scope of Work and Sustainability**
  - **Previous Program(s) and Funding.** If this organization has previously received funding from the former RI Office of Minority Health to carry out this or a similar program what were the sources of funding? How successful was the program in achieving any outlined aims and goals?

  - **Sustainability.** Assess the likelihood that the program will be sustainable throughout the grant period:

- Does the organization have the necessary resources and human capital to carry out this program?
- Is the proposed budget realistic/practical? Is the organization maximizing its use of existing resources?
- Is the demand for the services that would be provided by this proposed program great enough to carry it on into the future?

○ **Overall Program Impact/Merit.** What is the overall impact/priority score that reflects the likelihood that the proposed program/program will accomplish the outlined program/program goals

○ **Significance.** Does the proposed program address an important problem or critical barrier to address refugee health? How will the proposed program be successful in changing the factors/circumstances that contribute to this problem(s)?

○ **Innovation.** Does the proposed program provide services/opportunities that are not currently available to the communities that would be served? If not, how will the proposed program be better than what is currently available and how does this merit funding?

FORM W-9
REV 8/15

STATE OF RHODE ISLAND
FORM W-9 PAYER'S REQUEST FOR TAXPAYER IDENTIFICATION NUMBER AND CERTIFICATION

THE IRS REQUIRES THAT YOU FURNISH YOUR TAXPAYER IDENTIFICATION NUMBER TO US. FAILURE TO PROVIDE THIS INFORMATION CAN RESULT IN A $50 PENALTY BY THE IRS. IF YOU ARE AN INDIVIDUAL, PLEASE PROVIDE US WITH YOUR SOCIAL SECURITY NUMBER (SSN) IN THE SPACE INDICATED BELOW. IF YOU ARE A COMPANY OR A CORPORATION, PLEASE PROVIDE US WITH YOUR EMPLOYER IDENTIFICATION NUMBER (EIN) WHERE INDICATED.

Taxpayer Identification Number (T.I.N.)

Enter your taxpayer identification number in the appropriate box. For most individuals, this is your social security number.

Social Security No. (SSN) ______

Employer ID No. (EIN) ______

NAME ______

ADDRESS ______

CITY, STATE AND ZIP CODE ______

PAYMENT REMITTANCE ADDRESS, IF DIFFERENT FROM THE ADDRESS ABOVE

ADDRESS ______

CITY, STATE AND ZIP CODE ______

CERTIFICATION: Under penalties of perjury, I certify that:

(1) The number shown on this form is my correct Taxpayer Identification Number (or I am waiting for a number to be issued to me), **and**
(2) I am not subject to backup withholding because either: (A) I am exempt from backup withholding, or (B) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (C) the IRS has notified me that I am no longer subject to backup withholding.
(3) I am a U.S. citizen or other U.S. person (as defined by the IRS).

Certification Instructions -- You must cross out item (2) above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item (2) does not apply.

Please sign here and provide title, date and telephone number:

SIGNATURE______ **TITLE**______ **DATE**______ **TEL NO**______
Original Signature Required (Digital Signature Not Acceptable)

BUSINESS DESIGNATION:

Please Check One: Individual ☐ Corporation ☐ Trust/Estate ☐ Government/Nonprofit Corporation ☐
Partnership ☐ Medical Services Corporation ☐ Legal Services Corporation ☐
LLC Tax Classification: Single Member (Individual) ☐ Partnership ☐ Corporation ☐

TIPS:
NAME: Be sure to enter your full and correct legal name as shown on your income tax return for the SSN or EIN provided.
ADDRESS, CITY, STATE AND ZIP CODE: If you operate a business at more than one location, adhere to the following:
1) Same EIN with more than one location -- attach a list of location addresses with remittance address for each location and indicate to which location the year-end tax information return should be mailed.
2) Different EIN for each different location -- submit a completed W-9 form for each EIN and location. (One year-end tax information return will be reported for each EIN and remittance address.)

Mail Completed Form To:
Supplier Coordinator
Purchasing Department
One Capitol Hill, 2nd Floor
Providence RI 02908

Or Email To: doa.pursuppliercoordinator@purchasing.ri.gov

For State Use Only:
IRS____ RI SOS____ FED_____ Other______
RI Supplier # ______ Approved ______
Date Entered ______ Entered By______