RFA #18439 / Grants Gateway # DOH01-PICHC-2020

New York State Department of Health
Center for Community Health/Division of Family Health/ Bureau of Women, Infant and Adolescent Health

Request for Applications

Perinatal and Infant Community Health Collaboratives

KEY DATES:

Release Date: 7/28/2021
Applicant Webinar: 8/18/2021 at 2:00 PM, Eastern Standard Time
Questions Due: 8/23/2021
Questions, Answers, and Updates Posted (on or about): 9/6/2021

Applications Due: 9/27/2021 by 4:00 pm, Eastern Standard Time

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I. Introduction

The New York State Department of Health (NYSDOH) is issuing this Request for Applications (RFA) to announce the availability of approximately $14 million annually to support implementation of the Perinatal and Infant Community Health Collaboratives (PICHC) initiative. Funds will be awarded to approximately 25 programs throughout New York State (NYS) to support the development, implementation and coordination of collaborative community-based strategies to improve perinatal and infant health outcomes and eliminate racial, ethnic, and economic disparities in those outcomes. Funded programs will work to improve specific perinatal and infant health outcomes including preterm birth, low birth weight, infant mortality, and maternal mortality. The anticipated funding period is July 1, 2022 through June 30, 2027.

The goal of the PICHC initiative is to improve perinatal and infant health outcomes and eliminate racial, ethnic, and economic disparities in those outcomes. The NYSDOH is committing public health resources to communities with the highest need where impact will be greatest. Funded PICHC programs will implement collaborative community-based strategies to improve the health and well-being of individuals of reproductive age (15-44 years old) and their families with a focus on individuals in the prenatal, postpartum, and interconception periods.

PICHC programs will implement individual-level strategies to address perinatal and infant health behaviors, and community-level strategies using a collective impact approach, to address the social determinants which impact health outcomes. The core individual-level strategy is the use of community health workers (CHWs) to outreach and provide supports to high-need, low-income, and/or Medicaid-eligible individuals of reproductive age (15-44 years old) most vulnerable to, or with a previous history of, adverse birth outcomes (the priority population). Community-level strategies involve collaboration with diverse community partners, including community residents, to mobilize community action to address the social determinants impacting perinatal and infant health outcomes.

Perinatal and infant health outcomes are impacted by the social determinants of health - the conditions in which people are born, live, work, and age. Social determinants of health include factors like socioeconomic status, education, community environment, employment, social supports, and access to health services.[1] Inequities among one or more of these determinants can have significant impact on the health outcomes of individuals and entire communities. To effectively improve health outcomes, it is important to look at both disparities and social determinants of health to identify and address the root causes (i.e., racism, classism, sexism). To proactively address intersectional factors impacting racial and ethnic disparities, PICHC programs should incorporate a reproductive justice framework.

Reproductive justice is defined as the human right to maintain personal bodily autonomy, make

1 Centers for Disease Control and Prevention. Social Determinants of Health. Available at: http://www.cdc.gov/socialdeterminants/definitions.html.

choices about having children (or not), and parent children in safe and sustainable communities.[2] Reproductive justice acknowledges that an individual cannot freely make choices about their pregnancy when options are limited by oppressive circumstances or lack of access to services. Reproductive justice aims to improve perinatal health by addressing the various intersectional issues that can impact an individual's fertility and/or reproductive decision making, including but not limited to: access to contraception, comprehensive sex education, prevention and care for sexually transmitted infections, alternative birth options, adequate prenatal and pregnancy care, domestic and sexual violence assistance, adequate wages to support families, and safe homes.

Working within a reproductive justice framework, this funding opportunity seeks to address the impact of social determinants of health, and achieve health equity and systems-level change(s) through community collaborations, to mobilize a community response and engage diverse partners, including community residents.

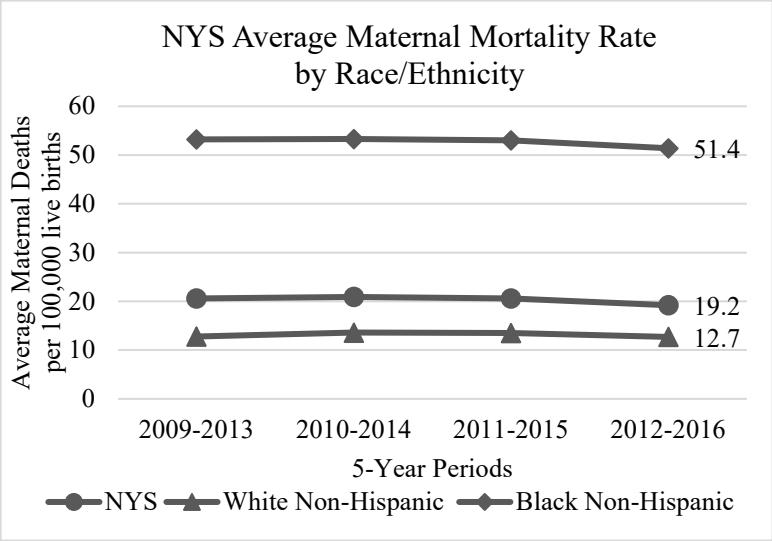
Medicaid funding is a key source of support for the PICHC initiative, and PICHC activities will primarily focus on Medicaid-eligible individuals and populations. Improving perinatal health is a key priority within the NYSDOH Prevention Agenda, Title V Maternal and Child Health Services Block Grant (MCHSBG), Maternal, Infant and Early Childhood Home Visiting (MIECHV) initiative, and the state Medicaid program.

A note on gender-based language:

The Division of Family Health recognizes and supports the experiences of gender- and sexual-minority New Yorkers, including those who are pregnant and parenting, and their families. As such, the title of this initiative has been changed accordingly; from the previous "Maternal and Infant Community Health Collaboratives (MICHC)" to Perinatal and Infant Community Health Collaboratives (PICHC). Wherever possible and applicable, this document uses gender-neutral language (i.e., "person", "individual", "client") instead of gender terms such as "woman" and "female". Data provided may be based on binary gender variables (male/female) as data for gender- and sexual-minority populations may not be available. Likewise, names of federal programs, agencies, etc., that use gender-based language cannot be changed. It is the expectation that funded applicants will serve all eligible pregnant, postpartum, and interconception individuals, and their families, regardless of race, culture, sexual orientation, biological sex, gender identity, and gender expression.

2 SisterSong, Inc.; https://www.sistersong.net/reproductive-justice (O'Mara-Eves, 2015)

Table 1: New York State Maternal Mortality



Key Population Metrics: NYS has made significant progress in improving the health of individuals and infants over the past decade, however disparities, especially among racial and ethnic minority populations continue to persist. Infant and maternal mortality rates are often used as indicators of a population's overall health. While the annual maternal mortality rate in NYS has declined 35% in recent years (from 26.0 deaths per 100,000 live births in 2008 to 16.8 deaths per 100,000 live births in 2016), the rate of maternal deaths for non-Hispanic black mothers remains close to four times the rate of maternal deaths for non-Hispanic white mothers. Reducing racial disparities in maternal mortality rates is a priority of both the 2020 NYS Title V Program, and the NYS Prevention Agenda.

Over the past two decades in NYS, both infant deaths and the infant death rate have steadily declined (from 1,728 infant deaths in 1997 to 1,026 infant deaths in 2017; from 6.7 infant deaths per 1,000 live births in 1997 to 4.5 infant deaths per 1,000 live births in 2017). Despite NYS' successes in reducing overall infant mortality, significant racial disparities persist. While the infant mortality rate is at a low of 4.5 deaths per 1,000 live births, black infants have twice the likelihood of death during the first year than white infants.

In April 2018, Governor Cuomo announced a comprehensive initiative to address maternal mortality and reduce racial disparities in outcomes. As part of this initiative, the NYSDOH conducted a series of community listening sessions across the state to engage participants in a discussion of the barriers and issues which impacted their birth experiences (*Voice Your Vision - Share Your Birth Story*). Common barriers expressed included: lack of access to healthcare, lack of information from providers, the impact of racism on the quality of care received, lack of social supports prenatally and postpartum, and lack of community services and resources. The Governor's initiative included a Taskforce on Maternal Mortality and Disparate Racial Outcomes tasked with providing expert policy advice on improving maternal outcomes, addressing racial and economic disparities and reducing the frequency of maternal mortality and morbidity in NYS. In March 2019, the Taskforce issued ten recommendations to decrease maternal mortality and morbidity and reduce racial disparities in NYS (*Recommendations to the Governor to Reduce Maternal Mortality and Racial Disparities* - March 2019). Governor Cuomo remains committed to implementing the Taskforce recommendations, which includes expansion of CHW services in NYS. In January 2021, the expansion of CHW services was further recommended by the NYS Expert Panel on Postpartum Care as a means to incorporate their recommendation of providing "access to essential wraparound and care coordination services to all birthing people in New York State through 'Stress-Free Zones'" (NYS Expert Panel on Postpartum Care Final Report - January 2021).

Priority Communities:

Priority communities were identified based on a county-level analysis, using the following indicators

related to maternal and child health and well-being: preterm birth; low birth weight; infant mortality; maternal mortality; late or no prenatal care; poverty; and disparities of these indicators by race. Composite z-scores were calculated for the rates of the indicators and for the burden (cases) of indicators with equal weights. Counties with burden z-scores above a value of 0 (i.e., indicating higher overall burden relative to the statewide values for all risk factors combined) were identified as high priority. Using this methodology, this RFA designated counties into two tiers. **Tier 1 includes the 11 highest-priority counties: Bronx; Erie; Kings; Monroe; Nassau; New York; Onondaga; Queens; Richmond; Suffolk; and Westchester**. Tier 2 includes all remaining counties. Maximum award levels were set based on these Tiers, and the Medicaid birth population within NYS counties. (**Table 2**)

Table 2: Maximum Funding by County

		County	Maximum funding per County	Base Funding	Total Variance Funding	Maximum Awards per County
Tier 1	Kings	Kings	$1,660,000	$455,000	$750,000	2
	High	Bronx, New York, Queens	$830,000	$455,000	$375,000	1
	Med	Nassau, Erie, Monroe, Suffolk	$795,000	$440,000	$355,000	1
	Low	Onondaga, Richmond, Westchester	$620,000	$320,000	$300,000	1
Tier 2	High	Albany, Broome, Chautauqua, Dutchess, Jefferson, Niagara, Oneida, Orange, Oswego, Rensselaer, Rockland, Schenectady, Sullivan, Ulster	$440,000	$320,000	$120,000	1
	Low	Remaining counties	$255,000			1

II. Who May Apply

A. Minimum Eligibility Requirements

*Please note: Applications **must** meet all the following minimum eligibility requirements to be accepted:

Applications will be accepted from Not-for-Profit 501(c)(3) organizations including, but not limited to: community-based health and human service agencies; Article 28 healthcare facilities; and local government entities, such as city and county health departments;
Applicants **must** propose to serve an area with a minimum of 200 Medicaid births (**Attachment 1**);
Applicants **must** propose to serve one Tier 1 county, **or** a single or multiple Tier 2 county(ies);
Applicants **must** be prequalified in the NYS Grants Gateway, if not exempt, on the date applications are due.

B. Preferred Eligibility Requirements

Three (3) additional points will be given to applicants that demonstrate the following:

A minimum combined 10% in-kind support in total, including from both the lead agency and community partners, in implementing the proposed program activities. In-kind support should be clearly described in the narrative section of the appropriate budget category in the Grants Gateway.

For example, if the lead agency is contributing in-kind staff effort to the project, the name, % effort and dollar equivalent of all in-kind staff should be listed in the Personal Services – Salary Narrative section, along with a description of the activities staff will conduct for the project. If a community-based partner organization is contributing the cost of meeting space for support groups, the dollar equivalent should be listed in the Space/Property: Rent Narrative section, along with a description of the type of activity(ies) the space will be used for. The combined in-kind contribution **must** be a minimum of 10% of the total funds requested in order to receive three additional points.

C. Available Funding

It is anticipated that approximately 25 awards will be made through this initiative (a total of approximately $14 million in awarded funds annually) for a five-year period contingent upon satisfactory performance and available funds. Applicants may request a maximum annual award between $255,000 to $830,000 **(see Table 2)**. Maximum awards are calculated using the base funding, plus variance funding. Variance funding will be allocated based on the proportion of Medicaid births proposed to be served within a county or counties, by zip code. For example, a project that proposes to serve zip codes within a county that account for 90% of all annual Medicaid births within that county would be eligible to receive a higher level of funding than a project that proposes to serve zip codes that account for 50% of all annual Medicaid births within that same county.

III. Project Narrative/Work Plan Outcomes

The overall goal of the PICHC initiative is to **improve perinatal and infant health outcomes and eliminate racial, ethnic and economic disparities in those outcomes.** To positively impact these outcomes, PICHC activities will seek to address behaviors, supports and service systems impacting prenatal, postpartum, and interconception health through utilization of CHW services and implementation of community collaborative strategies including community mobilization and community engagement to address the social determinants of health impacting perinatal and infant health outcomes. Funded PICHC programs will provide services in those communities where impact will be the greatest to improve perinatal and infant health outcomes and reduce racial, ethnic and economic disparities in those outcomes.

A. Performance Management

Performance management centers on a clear and focused approach to improving outcomes and the strategic use of performance standards to guide the development and implementation of improvement strategies. Performance standards are generally accepted, objective standards of measurement to which a grantee's level of performance can be compared; i.e., the standards establish the level of performance expected. Collectively, these performance standards describe the specific tangible processes and outcomes to be accomplished.

To achieve the goals of the PICHC initiative, performance management framework includes the following three performance standards:

- **Performance Standard 1:** Engage pregnant, postpartum, and interconception individuals and their infants in needed healthcare and other supportive services through timely and coordinated outreach, screening, care coordination, referral, and follow-up;
- **Performance Standard 2:** Ensure pregnant, postpartum, and interconception individuals are aware of community services, and have knowledge and skills to seek out and receive needed care; and
- **Performance Standard 3:** Strengthen community capacity to address social determinants of health through community mobilization, collaboration, and engaging those most impacted by disparities.

All PICHC activities will be guided and measured by these performance standards.

PICHC programs will support pregnant, postpartum, and interconception individuals, and their families, most impacted by social determinants of health; including those with one or more of the following characteristics:

- Low-income;
- Medicaid eligible;
- Not engaged or enrolled in healthcare services;
- Populations disproportionately impacted by racial, ethnic or economic disparities in birth outcomes;
- History of previous adverse birth outcome(s);
- Experiencing domestic and sexual violence including those in domestic violence shelters;
- Engaged in substance use (alcohol, tobacco, cannabis (marijuana), stimulants, hallucinogens, and/or opioids);
- Immigrants who are undocumented, and/or have refugee status;
- Homeless, housing insecure, or in homeless shelters;
- Involved in the criminal justice or juvenile justice/adjudication systems; and/or
- Residing in medically underserved communities and/or areas with limited social supports, including rural areas.

B. Program Components

PICHC activities seek to address behaviors, community supports and service systems impacting prenatal, postpartum, and interconception health.

As such, PICHC programs will implement two main strategies: 1) Individual-level strategies to address perinatal and infant health outcomes and behaviors; and 2) Community-level strategies to address the social determinants which impact health outcomes. The core individual-level strategy is the use of CHWs to outreach to and engage high-need, low-income, and/or Medicaid-eligible pregnant, postpartum, and interconception individuals and their families, including those not already connected to care, and facilitate connections to needed health and supportive services. Community-level strategies involve collaboration with diverse community partners, including community residents, to mobilize community action to address the social determinants impacting perinatal and infant health outcomes. Funded PICHC programs will serve those communities where impact will be the greatest to

improve perinatal and infant health outcomes and reduce racial, ethnic and economic disparities in those outcomes. The PICHC program logic model provides a summary of required activities, anticipated individual, and community-level improvements, and overall impact of the initiative, including improved health equity and birth outcomes, and healthier communities with fewer disparities. (**Attachment 2**).

To the extent possible, the objectives and standards described hereafter should allow PICHC programs to function similar to a Stress-Free Zone model of service. The concept of "Stress-Free Zones" defines a community in which birthing people are provided with a range of services including, but not limited to home visiting services, community health workers, doulas (both prenatal or antepartum and postpartum), lactation support, and family support services. Additional services or supports may be obtained via referral, or subcontract with community partners, as needed by individual birthing persons. This model works collaboratively with health care systems, often identifying clients through referrals originating from prenatal care providers and/or birthing hospitals or centers, but can also involve collaborations with community based organizations.

All PICHC programs will include the following components: Community Health Worker Services; Community Mobilization to Address Social Determinants of Perinatal Health; and General Program Information. The program component requirements are defined below to include:

1. Community Health Worker Services

PICHC programs will utilize CHWs to perform outreach, education, home visiting, advocacy, group activities, basic health screening, referral and follow-up. CHWs will also connect clients and families to needed services, and provide enhanced social support. CHWs will focus on serving prenatal, postpartum, and interconception individuals and families, prioritizing those who have experienced an adverse birth outcome, and those not already connected to care. Once an individual is enrolled, CHW services may continue until the individual's/family's needs have been met, or up to the youngest child's 2nd birthday. CHWs will help ensure early and consistent participation in preventive and primary health care services, including early prenatal care, and particularly for those pregnant, postpartum, and interconception individuals not engaged in care and other supportive services. CHWs will provide health information to increase the individual's knowledge and ability to self-advocate and make informed health care decisions. The intended outcomes are to help the family achieve an optimal level of health, self-sufficiency, and overall well-being.

CHWs will work under the direction, and supervision, of a licensed professional, either a registered nurse with a Bachelor of Science in Nursing (BSN), a licensed social worker with clinical experience (either a Licensed Master Social Worker (LMSW) or Licensed Clinical Social Worker (LCSW); or a Licensed Mental Health Counselor (LMHC). If available, the CHW Supervisor's resume describing qualifications and proper certifications should be included with the application, uploaded to the Pre-submission Upload section in the Grants Gateway. A full-time CHW Supervisor will be responsible for the supervision of a team of 4 or more CHWs. The number of CHWs utilized is dependent on the number of clients to be served. However, all PICHC programs are expected to employ a minimum of 2 CHWs. (**Attachment 3**)

Under the supervision of the CHW Supervisor, the CHW will:

a. Conduct enhanced outreach to identify and engage pregnant, postpartum, and interconception individuals and families in needed care and services, including:

- The focus should be on individuals of the highest vulnerability, who are not actively engaged in healthcare or other supportive services, and/or have a history of a previous adverse birth outcome(s);

- To maximize efforts, PICHC programs should coordinate outreach efforts with other home-visiting programs in their community, and work to ensure individuals and families are informed of all available home visiting programs, allowing them to be connected to the program that best meets their expressed needs.

b. Conduct basic health and well-being assessment screenings (using standardized evidence-based, and/or validated, screening tools) to identify and prioritize needs of the individual and families to be served, including:

- Initial assessments **must** be completed at enrollment, to develop individualized care plans;
- Assess insurance needs and assist clients with enrollment in, and utilization of health insurance/Medicaid, by connecting to an insurance navigator and/or a community health advocate, where possible; and
- As part of monitoring progress, and re-evaluating needs and priorities, clients should be continuously assessed throughout their service period.

Examples of evidence-based, and/or validated, screening tools include, but are not limited to:

- Edinburgh Postnatal Depression Scale (EPDS);
- Patient Health Questionnaire-2 (PHQ-2);
- Patient Health Questionnaire-9 (PHQ-9);
- Hurt/Insult/Threaten/Scream (HITS) screening for domestic violence;
- Screening, Brief Intervention and Referral to Treatment (SBIRT); and/or
- Ages and Stages Questionnaire.

Many validated screening tools are available from the American Academy of Pediatrics at: https://screeningtime.org/star-center/#/screening-tools#top

c. Provide information and assistance and refer clients and their families to needed services, including:

- Monitor/verify follow-up -- with both the client and the service provider -- to verify services were received within 30 days of making a referral. All referrals should be made with consideration of each client's needs, priorities, and potential barriers to accessing the referred service. All programs should have provisions in place to address emergency needs, including, but not limited to: mental health; food; shelter; and domestic and sexual violence supports;
- Assist individuals and families with accessing services including medical, dental, mental health, social services, nutrition (including maintaining a healthy weight and optimal physical activity), HIV and Sexually Transmitted Infection (STI) testing, lead poisoning screening, substance use, and domestic and sexual violence;
- Ensure clients are engaged in, and receive, needed preventive and primary health care services (e.g., prenatal, postpartum, and interconception care, family planning, immunizations, pediatric care, dental care, and care for acute, chronic, and

communicable diseases, Early Intervention (EI), WIC and other nutrition services, and midwifery services). This includes partnering with birthing hospitals, hospital systems, and Regional Perinatal Centers (**Attachment 4**) to ensure a connection to community-based services, particularly for postpartum and interconception care;
    - Ensure clients are engaged in needed support services including housing, financial aid, food stamps, emergency food, clothing, transportation, translation services, child care, and assisting families with information and resources to support healthy behaviors including safe sleep practices; and
    - Support clients in identifying and overcoming barriers to accessing services. For example, providing assistance in connecting clients to transportation, child care, advocacy and/or support in attending appointments or support group sessions. If needed, CHWs may provide appointment reminders or accompany clients to scheduled appointments.

d. Conduct home visits to assess the safety of the home environment, provide information, and support and promote healthy behaviors, including:

    - Provide home visiting services to approximately 25 clients (per funded CHW) at any given time (40 annually) and an additional 10-15 intermittent clients (clients who do not need intensive case management, but referrals to a community resource or service); and
    - Home visits should be conducted (whenever possible) at least monthly, but may occur at more frequent intervals depending on the needs of the client.
    - When necessary, remote or virtual home visits are allowed, but should be utilized sparingly and supplemental to required in-home visits; not supplanting them. Remote or virtual home visits should contain a visual component, allowing CHWs to perform a fuller assessment of the safety of the home environment.

e. Provide and/or enroll clients in education, and enhanced social supports, within the community. Possible areas of education and/or support include, but are not limited to:

    - Childbirth classes or workshops. This should include CHWs facilitating the development of a birth plan, and postpartum care plan. These plans should ensure clients have improved communication with their providers, are more knowledgeable of - and prepared for - the birth experience, including unexpected complications, and have adequate postpartum medical care, including mental health and family planning services;
    - Parenting classes or workshops (to be inclusive of all parents or caregivers);
    - Doula support services; and/or
    - Peer, or clinical support groups such as:

        - Postpartum support;
        - Breastfeeding/chestfeeding classes/workshops or support; and/or
        - Parent support. While partners and other caregivers are not the primary client focus of PICHC services, they may be included in services, and should be considered in all needs assessments.

f. Provide clients with appropriate health information on relevant perinatal health topics using techniques to ensure that clients understand information, are able to effectively communicate

with healthcare and other service providers, empower clients to make informed healthcare decisions for themselves and their families, and adopt healthy behaviors, including:

- Information should be conveyed in a way that the client understands the health need presented in a simple, meaningful, and safe way, at an appropriate reading level, and in the clients' preferred language, where possible; and
- Educational materials and/or curricula designed, mass produced, and used for instructional and informational purposes should be appropriate for the population served and medically accurate.

To support activities a-f above, the CHW Supervisor will be tasked with: include:

- Ensuring CHWs are trained on understanding the availability of community services and resources, including: how to navigate healthcare and social service systems; and the eligibility criteria for those programs. Additional trainings will include: cultural humility; anti-racism; equity in perinatal care; and working with high-need individuals and families, on topics including, but not limited to, domestic and sexual violence, mental health, substance use, and clients in crisis; and
- Providing CHWs with information on relevant health topics, including human reproductive systems; stages of pregnancy; predictors of poor birth outcomes; postpartum health; caring for a newborn; and maintaining healthy behaviors prenatally, and in the postpartum, and interconception periods.

In addition, CHW Supervisor responsibilities will include: planning and coordinating outreach activities; promoting CHW services to the community; collaborating with agency leadership to ensure information is accessible, understandable, and follows health literacy and plain language standards; and establishing relationships with other community health and social service providers for reciprocal referrals.

CHWs will be required to collect participant data and submit via the NYSDOH on-line data system including client demographics, needs identified, referrals made and needed follow-up. The data will be used by CHWs and CHW Supervisors to manage CHW services, monitor performance, document productivity, and for quality improvement and program planning. In addition, client satisfaction surveys should be used to assess the effectiveness of the CHW services in meeting client needs throughout a client's enrollment in services.

PICHC programs should support and promote collaboration amongst other home visiting programs in the community that address perinatal and infant health including, but not limited to: Nurse-Family Partnership; Healthy Families New York; Early Head Start; Healthy Start; Parents as Teachers; Family Connects; and Healthy Beginnings. Opportunities for collaboration and coordination include: ensuring coverage of high-need zip code areas; coordinated outreach activities to avoid duplication of efforts; shared training; and where possible, coordination of intake processes and eligibility determinations. If a coordinated intake system exists in the proposed community to be served, PICHCs programs should be actively engaged and work collaboratively with community partners to promote use of the system.

2. Community Mobilization to Address Social Determinants of Perinatal Health

Community-level strategies involve collaboration and participation of diverse community partners and organizations, including community residents, to mobilize community action and drive systems-level

changes to address the social determinants impacting perinatal and infant health outcomes. Achieving and sustaining community change requires a focus on systems: the organizations, institutions, structures, processes and resources that collectively are intended to support and improve – or may influence – the health of individuals and populations.

Community mobilization can raise awareness of perinatal and infant health issues, barriers, services and gaps, and motivate stakeholders, including community residents, to actively participate in discussions and decision-making, and take action to address social determinants of health. Effective community mobilization can strengthen a community's capacity to understand racial, ethnic, and economic disparities in perinatal and infant health outcomes, and work toward developing appropriate strategies to improve community supports, services, and systems.

Community engagement is another important tool used in public health to encourage community ownership and allow community residents to identify the issues impacting their health and well-being. Evidence suggests that community engagement has a positive effect on health outcomes. Members of a community are more likely to adopt healthier behaviors if they are empowered to act in all phases of program development. Community ownership of public health issues, and involvement in the design and delivery of strategies to address these issues, are more effective interventions.[3]

Civic engagement is the act of working toward making a difference in the civic life of a community, and developing the combination of knowledge, skills, values and motivation to make that difference.[4] Civic engagement can take many forms, from individual voluntarism, to organizational involvement, to electoral participation, and can include efforts to directly address an issue, work with others in a community to solve a problem, or interact with the institutions of representative democracy.[5]

To maximize collective impact and drive systems-level change, PICHC programs will implement community mobilization, community engagement and civic engagement strategies and activities. Collective impact uses community collaboration to solve complex social health problems and engages partners from across multiple sectors (economic, housing, transportation, education, health, businesses, local government, local foundations etc.) to accomplish a shared goal(s).[6]

PICHC programs will work within priority communities to facilitate and empower stakeholders, including community residents, to participate in planning, developing, and implementing community-level strategies that address the social determinants which impact perinatal and infant health, and disparities in those outcomes. These efforts are expected to result in systems-level changes, including improved access, utilization, and quality of health and social services, systems and supports, and improved coordination of services.

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3 O'Mara-Eves, A., Brunton, G., Oliver, S. et al. The effectiveness of community engagement in public health interventions for disadvantaged groups: a meta-analysis. BMC Public Health 15, 129 (2015)

4 *Civic Responsibility and Higher Education*, edited by Thomas Ehrlich, published by Oryx Press, 2000

5 Civic Engagement definition: https://www.apa.org/education/undergrad/civic-engagement

6 *Collective Impact*, Stanford Social Innovation Review, John Kania & Mark Kramer, 2011

Specifically, PICHC programs will:

a. Actively participate in an existing or lead a new community advisory board (CAB), consortium or coalition with a focus on perinatal and infant health issues. Whether existing or new, the CAB, consortium or coalition should:

    - Include diverse stakeholders from diverse community sectors including community residents, grassroots organizations, community-based service organizations, health care providers, local government, local foundations, and local businesses;
    - Identify the issues, barriers, services, and gaps impacting perinatal and infant health outcomes including racial, ethnic and economic disparities in those outcomes;
    - Identify effective strategies for addressing the social determinants impacting perinatal and infant health outcomes;
    - Have a process for informing the goals and objectives of the PICHC program including CHW services, as well as those of other participating partners and programs; and
    - Meet a minimum of quarterly per year.

Note: If the PICHC program is establishing a new CAB, programs are required to have a CAB membership comprised of at least 25% community residents, representative of the priority population(s), and be co-chaired by a community resident representative. To support community member participation, stipends, incentives, transportation reimbursement, and child care, as needed, should be provided directly by the PICHC program, and/or through support from community partners. Community resident participation should include those clients served by PICHC CHW services, as well as those served by participating partner agencies.

b. Promote civic engagement to train and support community residents in participating in the CAB and/or other community coalitions or groups:

    - Identify and engage a group of 10 to 20 community residents annually interested in civic engagement and developing leadership and advocacy skills;
    - Provide training and education to the group of community residents on such topics as self-advocacy and effective communication, data, health disparities, health and social issues, and social determinants of health, to equip community members with the skills to effectively advocate for and represent themselves and others in their communities; and
    - Facilitate participation in the CAB, consortium, coalition, or other groups working toward improved perinatal health outcomes.

c. Collaborate with diverse community partners with an interest in improving perinatal and infant health outcomes, to improve services and prevent duplication of efforts. Partners include, but are not limited to: prenatal care providers; Regional Perinatal Centers; birthing hospitals; WIC agencies; Healthy Start programs; adolescent pregnancy prevention programs; perinatal health home visiting programs, such as Healthy Families New York and Nurse-Family Partnership; Family Planning programs; local health department programs such as Early Intervention (EI) and Children and Youth with Special Health Care Needs (CYSHCN); local foundations; and other programs and services addressing and impacting perinatal and infant health outcomes. Partners are expected to collaborate on such activities as outreach, service coordination, community supports facilitating healthy behaviors, and quality improvement to:

- Increase access to prenatal, perinatal, postpartum, and interconception care with an emphasis on finding and engaging those populations that are most vulnerable to experiencing poor birth outcomes and those not currently engaged in care;
- Improve awareness of, access to, and utilization of supportive services and community resources including mental health, substance use, domestic and sexual violence, smoking cessation, newborn care, and other related perinatal and infant health services and supports;
- Promote healthy behaviors such as breastfeeding/chestfeeding, reproductive life planning, and safe sleep for infants and children; and
- Improve referrals and service coordination across programs including, but not limited to, home visiting, WIC, EI and CYSHCN programs.

To promote collaboration and coordination amongst home visiting programs, it is expected that funded programs will participate in, and/or coordinate, regular networking and training opportunities with other home visitors in the community. For example, home visitors from various programs can be convened on a regular basis for in-service trainings on common health and safety topics, including presentations from agencies such as local law enforcement, domestic and sexual violence, mental health, alcohol and substance use services, and local WIC and EI programs.

d. Up to ten percent (10%) of the total award amount may be subcontracted to other non-traditional community-based not-for-profit organizations which provide services and supports to the priority population including: faith-based, minority-focused, and advocacy agencies; community centers; grass-roots organizations; and other community-based agencies for improved outreach, awareness, access and utilization of services, service delivery or service coordination. This funding may be used to create a new service or program that fills a gap in needed services, or expand existing services, that allows for greater access for community members. For example, applicants may choose to subcontract with an agency interested in establishing a breastfeeding/chestfeeding support group where none previously existed, or subcontract with an existing agency to expand hours of operation to evenings and/or weekends, to increase accessibility. Another example may include subcontracting with an agency that will train Black, Indigenous and people of color to become certified lactation consultants. The formal subcontract should be represented in the Budget section of the Grants Gateway application and should include a detailed narrative of the activities to be funded. If the subcontractor is not known, the applicant may use 'To be determined' (TBD) in place of the name, but should include a narrative that explains their anticipated plan. NOTE: Subcontracting for CHW staff and services does not count toward the "up to ten percent (10%)" threshold. If the subcontractor is known at the time of application, a Subcontractor Information Form **(Attachment 12)** should be uploaded to the Pre-submission Uploads section of the Grants Gateway.

It is expected that the CAB/consortium/coalition and civic engagement activities will inform the collaboration activities. PICHC programs should develop a process for using community input to inform collaborative activities and for reporting back to the community on how their input was addressed. All community mobilization strategies including the CAB/consortium/coalition, civic engagement and collaboration are expected to result in activities that recognize and address the impact of community-level structural racism on perinatal and infant health outcomes, and that promote and support the delivery of culturally and linguistically respectful programs and services. These community mobilization activities are expected to result in community and systems-level changes.

3. General Program Information

PICHC programs are required to implement all activities described in the NYSDOH standardized workplan (**Attachment 5**). All programs are required to designate an individual within the organization who will be responsible for PICHC program administration, operation, and oversight. This individual will be accessible to NYSDOH full-time (including by e-mail) and attend PICHC provider trainings and meetings, along with other appropriate program staff.

Programs will ensure that all educational materials and curricula designed, mass-produced and used for instructional and informational purposes are medically accurate. Note: Medical accuracy means that medical information is verified or supported by the weight of research conducted in compliance with accepted scientific methods and published in peer-reviewed journals, where applicable, or be comprised of information that leading professional organizations and agencies with relevant expertise in the field recognize as accurate, objective and complete. In addition to medical accuracy, programs will also provide culturally appropriate information and services in multiple languages, including the use of a language line or interpreter services as appropriate.

All programming and services will be provided at times appropriate for the priority population which may include evenings and weekends, with the consideration of accessibility of transportation and child care. Programs should partner with community organizations, including NYSDOH Bureau of Women, Infant, and Adolescent Health (BWIAH)-funded Programs (**Attachment 4**), to facilitate reciprocal referrals to home visiting or other community-based supports.

All applicants should provide letters of commitment from community partners who will be engaged in collaborative activities such as outreach, service coordination, community supports facilitating healthy behaviors, and quality improvement. The letters of commitment should describe the specific role of the partner in supporting the implementation of PICHC activities. All letters of commitment should be uploaded to Pre-submission Uploads section of the Grants Gateway.

All programs will be required to participate in NYSDOH-sponsored trainings, on-line data collection system, program evaluation activities (including continuous quality improvement – CQI) and learning collaboratives established for this initiative.

All programs are required to send up to two (2) representatives to an annual NYSDOH Bureau of Women, Infant and Adolescent Health Provider Meeting, held in Albany, NY. This meeting may be held virtually at the discretion of NYSDOH.

All planned activities should be cost-effective and incorporate specific strategies that engage community members and organizations to identify and address community needs, assist the priority population to improve health literacy and achieve their health goals, and improve overall birth outcomes, consistent with the requirements of the PICHC program. “Cost-effective” is defined as the minimum amount of grant fund resources being used to achieve work plan goals and objectives. Activities need to have a clear rationale that are well-articulated as part of a larger program strategy. All program activities should be reflective of the ongoing needs assessments of both the individuals being served, and the communities in which they live. Further, all conducted activities should inform the development of ongoing needs assessments. On an annual basis, each PICHC program will be required to complete and submit to NYSDOH an updated needs assessment of their community.

Programs will report any changes in scope of services, the designated contact person, staffing levels,

space, or program sites, in writing to the NYSDOH Perinatal Health Unit, PICHC Program Manager.

To the extent possible, PICHC programs are to ensure CHWs are fairly compensated with a salary comparable to a living wage. Please refer to the NYS Department of Labor's "Occupational Wages" guidance: https://labor.ny.gov/stats/lswage2.asp.

For all proposed subcontracts, it is preferable to identify subcontracting agencies during the application process. Applicants that plan to subcontract are expected to state in the application the specific components of the scope of work to be performed through subcontracts. Applicants should note that the lead organization (contractor) will have overall responsibility for all contract activities, including those performed by subcontractors, and will be the primary contact for the NYSDOH. All subcontractor proposals will be reviewed to verify activities are in support of program goals and objectives.

This initiative will **not** fund direct services such as child care or health care. Applicants should incorporate partnerships and strategies to identify needs for such services and make referrals to address them.

Expenses for promotional items are **not** allowed. "Promotional items" are defined as articles of merchandise (often branded with a logo or slogan) which are given away to promote an agency or program as part of marketing campaigns (e.g., water bottles, tote bags, pens, T-shirts, hats, pens etc.).

Salaries for executive and administrative staff **must** be allocated as an indirect cost ("Other Expense" in the Grants Gateway). Administrative costs will be limited to a maximum of 10% of total direct costs. If utilizing a Federal Indirect Cost Rate (ICR), a completed Federally negotiated ICR Agreement **must** be uploaded to the Grants Gateway, prior to contract approval.

Funding of incentives (e.g., gift cards, coupons/vouchers, retail items, etc.) for participation in CHW Services is limited to no more than 1% of total PICHC funding.

Any ineligible budget items will be removed from the budget prior to contracting. The budget amount requested will be reduced to reflect the removal of ineligible items.

IV. Administrative Requirements

A. Issuing Agency

This RFA is issued by the NYSDOH/Division of Family Health/Bureau of Women, Infant and Adolescent Health. The NYSDOH is responsible for the requirements specified herein and for the evaluation of all applications.

B. Question and Answer Phase

All substantive questions should be submitted via email to PICHCRFA@health.ny.gov.

To the degree possible, each inquiry should cite the RFA section and paragraph to which it refers. Written questions will be accepted until the date posted on the cover of this RFA. This includes Minority and Women Owned Business Enterprise (MWBE) questions as well as questions pertaining to the MWBE forms.

Questions of a technical nature can should be directed to the Grants Gateway Team. Questions are of a technical nature if they are limited to how to prepare your application (e.g., uploads, user roles) rather than relating to the substance of the application. Some helpful links for questions of a technical nature are below. Questions regarding specific opportunities or applications should be directed to the NYSDOH contact listed on the cover of this RFA.

- https://grantsmanagement.ny.gov/resources-grant-applicants
- Grants Gateway Videos: https://grantsmanagement.ny.gov/videos-grant-applicants
- Grants Gateway Team Email: grantsgateway@its.ny.gov
  Phone: 518-474-5595
  Hours: Monday thru Friday 8am to 4pm
  (Application Completion, Policy, Prequalification and Registration questions)

- Agate Technical Support Help Desk
  Phone: 1-800-820-1890
  Hours: Monday thru Friday 8am to 8pm
  Email: helpdesk@agatesoftware.com
  (After hours support w/user names and lockouts)

Prospective applicants should note that all clarifications and exceptions, including those relating to the terms and conditions of the contract, are to be raised prior to the submission of an application.

This RFA has been posted on the NYS Grants Gateway website at: https://grantsgateway.ny.gov/IntelliGrants_NYSGG/module/nysgg/goportal.aspx and a link provided on the NYSDOH's public website at: https://www.health.ny.gov/funding/. Questions and answers, as well as any updates and/or modifications, will be posted on the Grants Gateway website. All such updates will be posted by the date identified on the cover of this RFA.

C. Letter of Interest

Submission of a Letter of Interest is not required for this RFA.

D. Applicant Webinar

An applicant webinar will be held for this project. This will be held on the date and time posted on the cover sheet of this RFA. Failure to attend the webinar will not preclude the submission of an application. The webinar will be conducted on the date and time posted on the cover page of the RFA at the web address below, with the password: **PICHCRFA2021**

https://meetny.webex.com/meetny/onstage/g.php?MTID=e276d5109e43e86737562cba421116d17

E. How to file an application

Applications **must** be submitted online via the Grants Gateway by the date and time posted on the cover of this RFA. Reference materials and videos are available for applicants applying to funding opportunities on the NYS Grants Gateway. Please visit the Grants Management website at the following web address: https://grantsmanagement.ny.gov/ and select the "Apply for a Grant" from the Apply & Manage menu. There is also a more detailed "Grants Gateway: Vendor User Guide" available in the documents section under Training & Guidance; For Grant Applicants on this page as well.

Training webinars are also provided by the Grants Gateway Team. Dates and times for webinar instruction can be located at the following web address: https://grantsmanagement.ny.gov/live-webinars.

To apply for this opportunity:

Log into the Grants Gateway

1. Log into the Grants Gateway as either a "Grantee" or "Grantee Contract Signatory".

On the Grants Gateway home page, click the "View Opportunities" button".
Use the search fields to locate an opportunity; search by State agency (NYSDOH) or enter the Grant Opportunity name Perinatal and Infant Community Health Collaboratives.
Click on "Search" button to initiate the search.
Click on the name of the Grant Opportunity from the search results grid and then select the "APPLY FOR GRANT OPPORTUNITY" button located bottom left of the Main page of the Grant Opportunity.

Once the application is complete, prospective applicants are **strongly encouraged** to submit their applications at least 48 hours prior to the due date and time. This will allow sufficient opportunity for the applicant to obtain assistance and take corrective action should there be a technical issue with the submission process. **Failure to leave adequate time to address issues identified during this process may jeopardize an applicant's ability to submit their application.** Both NYSDOH and Grants Gateway staff are available to answer applicant's technical questions and provide technical assistance prior to the application due date and time. Contact information for the Grants Gateway Team is available under Section IV. B. of this RFA.

PLEASE NOTE: Although NYSDOH and the Grants Gateway staff will do their best to address concerns that are identified less than 48 hours prior to the due date and time, there is no guarantee that they will be resolved in time for the application to be submitted and, therefore, considered for funding.

The Grants Gateway will always notify applicants of successful submission. If a prospective applicant does not get a successful submission message assigning their application a unique ID number, it has not successfully submitted an application. During the application process, please pay particular attention to the following:

- Not-for-profit applicants **must** be prequalified on the due date for this application submission. Be sure to maintain prequalification status between funding opportunities. Three of a not-for-profits' essential financial documents - the IRS990, Financial Statement and Charities Bureau filing - expire on an annual basis. If these documents are allowed to expire, the not-for-profit's prequalification status expires as well, and it will not be eligible for State grant funding until its documentation is updated and approved, and prequalified status is reinstated;
- Only individuals with the roles "Grantee Contract Signatory" or "Grantee System Administrator" can submit an application;
- Prior to submission, the system will automatically initiate a global error checking process to protect against incomplete applications. An applicant may need to attend to certain parts of the application prior to being able to submit the application successfully. Be sure to allow time after pressing the submit button to clean up any global errors that may arise. You can also run the global error check at any time in the application process. (see p.64 of the Grants Gateway: Vendor User Guide); and

- Applicants should use numbers, letters and underscores when naming their uploaded files. There cannot be any special characters in the uploaded file name. Also, be aware of the restriction on file size (10 MB) when uploading documents. Applicants should ensure that any attachments uploaded with their application are not "protected" or "pass-worded" documents.

The following table will provide a snapshot of which roles are allowed to Initiate, Complete, and Submit the Grant Application(s) in the Grants Gateway.

Role	Create and Maintain User Roles	Initiate Application	Complete Application	Submit Application	Only View the Application
Delegated Admin	X				
Grantee		X	X		
Grantee Contract Signatory		X	X	X	
Grantee Payment Signatory		X	X		
Grantee System Administrator		X	X	X	
Grantee View Only					X

PLEASE NOTE: Waiting until the last several days to complete your application online can be dangerous, as you may have technical questions. Beginning the process of applying as soon as possible will produce the best results.

Late applications will not be accepted. Applications will not be accepted via fax, e-mail, hard copy or hand delivery.

F. NYSDOH's Reserved Rights

The NYSDOH reserves the right to:

1. Reject any or all applications received in response to this RFA;
2. Withdraw the RFA at any time, at the NYSDOH's sole discretion;
3. Make an award under the RFA in whole or in part;
4. Disqualify any applicant whose conduct and/or proposal fails to conform to the requirements of the RFA;
5. Seek clarifications and revisions of applications;
6. Use application information obtained through site visits, management interviews and the state's investigation of an applicant's qualifications, experience, ability or financial standing, and any material or information submitted by the applicant in response to the agency's request for clarifying information in the course of evaluation and/or selection under the RFA;
7. Prior to application opening, amend the RFA specifications to correct errors or oversights, or to supply additional information, as it becomes available;
8. Prior to application opening, direct applicants to submit proposal modifications addressing subsequent RFA amendments;
9. Change any of the scheduled dates;
10. Waive any requirements that are not material;
11. Award more than one contract resulting from this RFA;

12. Conduct contract negotiations with the next responsible applicant, should the NYSDOH be unsuccessful in negotiating with the selected applicant;
13. Utilize any and all ideas submitted with the applications received;
14. Unless otherwise specified in the RFA, every offer is firm and not revocable for a period of 60 days from the bid opening;
15. Waive or modify minor irregularities in applications received after prior notification to the applicant;
16. Require clarification at any time during the procurement process and/or require correction of arithmetic or other apparent errors for the purpose of assuring a full and complete understanding of an offeror's application and/or to determine an offeror's compliance with the requirements of the RFA;
17. Negotiate with successful applicants within the scope of the RFA in the best interests of the State;
18. Eliminate any mandatory, non-material specifications that cannot be complied with by all applicants; and
19. Award grants based on geographic or regional considerations to serve the best interests of the State.

G. Term of Contract

Any contract resulting from this RFA will be effective only upon approval by the Office of the New York State Comptroller (OSC).

It is expected that contracts resulting from this RFA will have the following time period: **July 1, 2022 – June 30, 2027**. Continued funding throughout this five-year period is contingent upon availability of funding and state budget appropriations. NYSDOH also reserves the right to revise the award amount as necessary due to changes in the availability of funding.

A sample New York State Master Contract for Grants can be found in the Forms Menu once an application to this funding opportunity is started.

H. Payment & Reporting Requirements of Grant Awardees

1. The NYSDOH may, at its discretion, make an advance payment to not-for-profit grant contractors in an amount not to exceed 30 percent.

The grant contractor (Contractor) will be required to submit invoices and required reports of expenditures to the State's designated payment office:

dfh.boa@health.ny.gov

Contractor **must** provide complete and accurate billing invoices in order to receive payment. Billing invoices submitted to the NYSDOH **must** contain all information and supporting documentation required by the Contract, the NYSDOH and the OSC. Payment for invoices submitted by the Contractor shall only be rendered electronically unless payment by paper check is expressly authorized by the Commissioner, in the Commissioner's sole discretion, due to extenuating circumstances. Such electronic payment shall be made in accordance with OSC's procedures and practices to authorize electronic payments. Authorization forms are available at OSC's website at: http://www.osc.state.ny.us/epay/index.htm, by email at: epayments@osc.state.ny.us or by telephone at 855-233-8363. Contractor acknowledges that it will not receive payment on any claims for

reimbursement submitted under this contract if it does not comply with OSC's electronic payment procedures, except where the Commissioner has expressly authorized payment by paper check as set forth above.

Payment of such claims for reimbursement by the NYSDOH shall be made in accordance with Article XI-A of the NYS Finance Law. Payment terms will be*:* Contractor will be reimbursed for actual expenses incurred as allowed in the Contract Budget and Workplan.

1. Contractor will be required to submit the following reports to the NYSDOH to the State's designated reporting office:

   dfh.boa@health.ny.gov

Annual needs and resources assessments are due at the beginning of each funding period (July 1st) in years 2-5. Quarterly narrative reports are due 30 days after the end of each quarter. The NYSDOH on-line data system has been designed for monthly reporting. Data should be entered as close to "real time" as practicable, or within 15 days after the end of each month.

All payment and reporting requirements will be detailed in Attachment D of the final NYS Master Contract for Grants.

I. Minority & Woman-Owned Business Enterprise Requirements

For purposes of this solicitation, the New York State Department of Health hereby establishes a goal of 0% as follows:

a. For Not-for-Profit Applicants: Eligible Expenditures include any subcontracted labor or services, equipment, materials, or any combined purchase of the foregoing under a contract awarded from this solicitation.
b. For-Profit and Municipality Applicants: Eligible Expenditures include the value of the budget in total.

The goal on the eligible portion of this contract will be 0% for Minority-Owned Business Enterprises ("MBE") participation and 0% for Women-Owned Business Enterprises ("WBE") participation (based on the current availability of qualified MBEs and WBEs and outreach efforts to certified MWBE firms). A contractor ("Contractor") on the subject contract ("Contract") must document good faith efforts to provide meaningful participation by MWBEs as subcontractors or suppliers in the performance of the Contract and Contractor agrees that NYSDOH may withhold payment pending receipt of the required MWBE documentation. For guidance on how NYSDOH will determine "good faith efforts," refer to 5 NYCRR §142.8.

The directory of New York State Certified MWBEs can be viewed at: https://ny.newnycontracts.com. The directory is found on this page under "NYS Directory of Certified Firms" and accessed by clicking on the link entitled "Search the Directory". Engaging with firms found in the directory with like product(s) and/or service(s) is strongly encouraged and all communication efforts and responses should be well documented.

This RFA does not establish minimum goals for participation of minority or women-owned business. Therefore, completion of the MWBE Utilization Plan is optional (Attachment 10). Funded applicants are encouraged to engage with firms found in the directory for the acquisition of required product(s)

and/or service(s) associated with this grant.

In addition, successful awardees will be required to certify they have an acceptable Equal Employment Opportunity policy statement.

J. Limits on Administrative Expenses and Executive Compensation

On July 1, 2013, limitations on administrative expenses and executive compensation contained within Governor Cuomo's Executive Order #38 and related regulations published by the NYSDOH (Part 1002 to 10 NYCRR – Limits on Administrative Expenses and Executive Compensation) went into effect. Applicants agree that all state funds dispersed under this procurement will, if applicable to them, be bound by the terms, conditions, obligations and regulations promulgated by the NYSDOH. To provide assistance with compliance regarding Executive Order #38 and the related regulations, please refer to the Executive Order #38 website at: http://executiveorder38.ny.gov.

K. Vendor Identification Number

Effective January 1, 2012, in order to do business with NYS, you **must** have a vendor identification number. As part of the Statewide Financial System (SFS), OSC's Bureau of State Expenditures has created a centralized vendor repository called the N Vendor File. In the event of an award and in order to initiate a contract with the NYSDOH, vendors **must** be registered in the N Vendor File and have a valid N Vendor ID.

If already enrolled in the Vendor File, please be sure the Vendor Identification number is included in your organization information. If not enrolled, to request assignment of a NYS Vendor Identification number, please submit an OSC Substitute Form W-9, which can be found on-line at: http://www.osc.state.ny.us/vendor_management/forms.htm.

Additional information concerning the New York State Vendor File can be obtained on-line at: http://www.osc.state.ny.us/vendor_management/index.htm, by contacting the SFS Help Desk at 855-233-8363 or by emailing at helpdesk@sfs.ny.gov.

L. Vendor Responsibility Questionnaire

The NYSDOH strongly encourages that vendors file the required Vendor Responsibility Questionnaire online via the NYS VendRep System. The Vendor Responsibility Questionnaire **must** be updated and certified every six (6) months. To enroll in and use the New York State VendRep System, see the VendRep System Instructions available at https://www.osc.state.ny.us/state-vendors/vendrep/file-your-vendor-responsibility-questionnaire or go directly to the VendRep system online at https://www.osc.state.ny.us/state-vendors/vendrep/vendrep-system.

Vendors **must** provide their NYS Vendor Identification Number when enrolling. To request assignment of a Vendor ID or for VendRep System assistance, contact the OSC's Help Desk at 866-370-4672 or 518-408-4672 or by email at ciohelpdesk@osc.state.ny.us.

Applicants opting to complete online should complete and upload the Vendor Responsibility Attestation (**Attachment 9**) of the RFA. The Attestation is located under Pre-Submission uploads and once completed should be uploaded in the same section.

Applicants opting to complete and submit a paper questionnaire can obtain the appropriate

questionnaire from the VendRep website, www.osc.state.ny.us/vendrep, or may contact the Office of the State Comptroller's Help Desk for a copy of the paper form and upload it with their Application in the Pre-Submission uploads section in place of the Attestation.

M. Vendor Prequalification for Not-for-Profits

All not-for-profit vendors subject to prequalification are required to prequalify prior to grant application and execution of contracts.

Pursuant to the NYS Division of Budget Bulletin H-1032, dated July 16, 2014, NYS has instituted key reform initiatives to the grant contract process which requires not-for-profits to register in the Grants Gateway and complete the Vendor Prequalification process in order for applications to be evaluated. Information on these initiatives can be found on the Grants Management website.

Applications received from applicants that have not Registered and are not Prequalified in the Grants Gateway on the application due date listed on the cover of this RFA cannot be evaluated. Such applications will be disqualified from further consideration.

Below is a summary of the steps that **must** be completed to meet registration and prequalification requirements. The Vendor Prequalification Manual on the Grants Management Website details the requirements and an online tutorial are available to walk users through the process.

1. Register for the Grants Gateway

- On the Grants Management website., download a copy of the Registration Form for Administrator. A signed, notarized original form **must** be sent to the NYS Grants Management office at the address provided in the submission instructions. You will be provided with a Username and Password allowing you to access the Grants Gateway.

- If you have previously registered and do not know your Username, please email grantsgateway@its.ny.gov . If you do not know your Password, please click the Forgot Password link from the main log in page and follow the prompts.

Complete your Prequalification Application

- Log in to the Grants Gateway. **If this is your first time logging in,** you will be prompted to change your password at the bottom of your Profile page. Enter a new password and click SAVE.
- Click the *Organization(s)* link at the top of the page and complete the required fields including selecting the State agency you have the most grants with. This page should be completed in its entirety before you SAVE. A *Document Vault* link will become available near the top of the page. Click this link to access the main Document Vault page.
- Answer the questions in the *Required Forms* and upload *Required Documents*. This constitutes your Prequalification Application. Optional Documents are not required unless specified in this Request for Application.
- Specific questions about the prequalification process should be referred to your agency representative or to the Grants Gateway Team at grantsgateway@its.ny.gov.

Submit Your Prequalification Application

- After completing your Prequalification Application, click the ***Submit Document Vault*** Link located below the Required Documents section to submit your Prequalification Application for State agency review. Once submitted the status of the Document Vault will change to *In Review*.
- If your Prequalification reviewer has questions or requests changes you will receive email notification from the Grants Gateway.
- Once your Prequalification Application has been approved, you will receive a Grants Gateway notification that you are now prequalified to do business with NYS.

Vendors are strongly encouraged to begin the process as soon as possible in order to participate in this opportunity.

N. General Specifications

By submitting the "Application Form", each applicant attests to its express authority to sign on behalf of the applicant.

Contractors will possess, at no cost to the State, all qualifications, licenses and permits to engage in the required business as may be required within the jurisdiction where the work specified is to be performed. Workers to be employed in the performance of this contract will possess the qualifications, training, licenses and permits as may be required within such jurisdiction.

Submission of an application indicates the applicant's acceptance of all conditions and terms contained in this RFA, including the terms and conditions of the contract. Any exceptions allowed by NYSDOH during the Question and Answer Phase (Section IV.B.) **must** be clearly noted in a cover letter included with the application.

An applicant may be disqualified from receiving awards if such applicant or any subsidiary, affiliate, partner, officer, agent or principal thereof, or anyone in its employ, has previously failed to perform satisfactorily in connection with public bidding or contracts.
Provisions Upon Default

a. The services to be performed by the applicant shall always be subject to the direction and control of the NYSDOH as to all matters arising in connection with or relating to the contract resulting from this RFA.
b. In the event that the applicant, through any cause, fails to perform any of the terms, covenants or promises of any contract resulting from this RFA, the NYSDOH acting for and on behalf of NYS, shall thereupon have the right to terminate the contract by giving notice in writing of the fact and date of such termination to the applicant.
c. If, in the judgement of the NYSDOH, the applicant acts in such a way which is likely to or does impair or prejudice the interests of NYS, the NYSDOH acting on behalf of NYS, shall thereupon have the right to terminate any contract resulting from this RFA by giving notice in writing of the fact and date of such termination to the Contractor. In such case the Contractor shall receive equitable compensation for such services as shall, in the judgement of the State Comptroller, have been satisfactorily performed by the Contractor up to the date of the termination of this agreement, which such compensation shall not exceed the total cost incurred for the work which the Contractor was engaged in at the time of such termination, subject to audit by the State Comptroller.

V. Completing the Application

A. Application Format/Content

Please refer to the Grants Gateway: Vendor User Guide for assistance in applying for this procurement through the NYS Grants Gateway. This guide is available on the Grants Management website at: https://grantsmanagement.ny.gov/system/files/documents/2019/03/grantsgatewayvendorusermanual03-13-2019.pdf. Additional information for applicants is available at: https://grantsmanagement.ny.gov/resources-grant-applicants.

Also, you **must** use Internet Explorer (11 or higher) to access the Grants Gateway. Using Chrome or Firefox causes errors in the Work Plan section of the application.

Please respond to each of the sections described below when completing the Grants Gateway online application. Your responses comprise your application. Please respond to all items within each section. When responding to the statements and questions, be mindful that application reviewers may not be familiar with the agency and its services. Therefore, answers should be specific, succinct and responsive to the statements and questions as outlined.

- Pre-Submission Uploads

As a reminder, the following attachments need to be uploaded under the Pre-Submission Uploads section of the Grants Gateway in order to submit an application in the system:

a. Application Cover Page (Attachment 8, refer to §V.A.Bullet 2 of the RFA)
b. Vendor Responsibility Attestation (Attachment 9, refer to §IV.L. of the RFA)
c. Minority & Women-Owned Business Enterprise Requirement Forms (Attachment 10, refer to §IV.I. of the RFA)
d. Vendor Contact Form (Attachment 11)
e. Subcontractor Information Form (Attachment 12, refer to §III.B.2.d of the RFA)
f. Letters of Commitment (refer to §III.B.3 of the RFA)
g. Resume of CHW Supervisor, if available (refer to §III.B.1 of the RFA)
h. Federal ICR Agreement (if applicable, refer to §III.B.3 of the RFA)

The following attachments can be found in the Pre-Submission Uploads but are for information purposes only:

a. Medicaid Births By County (Attachment 1, refer to §II.A of the RFA)
b. Logic Model (Attachment 2, refer to §III.B of the RFA)
c. CHW Standards (Attachment 3, refer to §III.B.1 of the RFA)
d. BWIAH Programs (Attachment 4, refer to §III.B.3. of the RFA)
e. PICHC Standard Workplan (Attachment 5, refer to §III.B.3. of the RFA)
f. Grants Gateway Budget Instructions (Attachment 6, refer to §V.A.5.501. of the RFA)
g. Grants Gateway Budget Data Entry Guidelines (Attachment 7, refer to §V.A.5.501. of the RFA)

- Program Specific Questions

0. Application Cover Page (0 points)

A form is provided to serve as the cover page for the application. All requested information should be supplied on this form. Please refer to **Attachment 8.**

1. Program Summary (Maximum Score: 10 points)

The purpose of this section is for the applicant to summarize the entire proposed program.

101 – Provide a description of the county and service area(s) to be served**,** including zip code.

102 – Provide a description of the priority population(s) (as defined in Section I. Introduction) to be served by the applicant's organization through both CHW Services and Community Mobilization activities, including the estimated number of clients to be served through CHW services (individuals and families).

103 – Identify disparities in perinatal and infant health outcomes experienced by the selected priority population(s) and proposed communities.

104 – Provide a detailed description of the program design and strategies to be implemented for the individual- and community-level components of the application, including strengths, opportunities and needs of the proposed communities. Commit to serve all eligible pregnant, postpartum, and interconception individuals, and their families, regardless of race, culture, sexual orientation, biological sex, gender identity, and gender expression? (Section III.B – Program Components)

2. Organizational Experience and Capacity (Maximum Score: 15 points)

The purpose of this section is for the applicant to describe the current services offered by the applicant organization and proposed subcontractors, and their capacity to implement and administer the proposed program; and to provide evidence of prior success with similar initiatives that have included serving high-need, low income, and/or Medicaid-eligible families most vulnerable to, or with a previous history of, adverse birth outcomes.

201 – Describe the applicant organization's mission, including its experience in providing programming and services to the priority population to be served, and the range of services provided. The description should include ability to provide programming and services at times appropriate for the priority population, which may include evenings and weekends, with the consideration of accessibility of transportation and child care.

202 – Describe evidence of prior success with similar initiatives serving the priority population/community, including experience leading community initiatives that engage community members in program planning and implementation. The description should include a history of collaborations with community partners, and facilitating referrals and connections to needed health care and/or supportive services.

203 – Describe the agency's length of experience with administrative, fiscal, and programmatic oversight of government contracts, including timely and accurate submission of fiscal and program reports. Describe the applicant's current or prior collaborations with the NYSDOH.

3. Community Resources and Needs Assessment (Maximum Score: 15 points)

The purpose of this section is to determine local health and human services needs and available

resources affecting the priority population in priority communities. Applicants **must** propose to serve an area with a minimum of 200 Medicaid births per year. If Tier 2 applicants are proposing to serve more than one county, each priority community is to be clearly reflected in this section.

301 – Describe how the overall program incorporates the input of a diverse group of stakeholders, including the priority population, parents/caregivers, racial, ethnic and/or cultural minority groups, and persons with disabilities.

302 – Discuss the identified needs and resources of the priority community/communities for the proposed program, and identify gaps in services and individuals' ability to access services, and how the proposed program would fill the identified gaps (e.g. modeling a Stress-Free Zone).

303 – Provide a description of diverse community partners with interests in improving perinatal and infant health outcomes, including other home visiting programs, with whom the applicant agency/program currently has a relationship with. Describe how these partners work to improve services, prevent duplication of efforts, and coordinate networking/training efforts of peers and other home visiting programs. Identify any gaps in community partners and efforts that the agency/program will take to establish relationships with existing community organizations, including nontraditional organizations whose primary focus may not be specific to perinatal health, such as faith-based organizations, minority-focused, advocacy agencies, community centers, grass-roots organizations, local businesses and other community-based organizations.

4. Description of Program Narrative with Proposed Activities (Maximum Score: 40 points)

The purpose of this section is to describe the design and structure of the proposed program, including the activities that will be developed and implemented, and how the components will complement each other. Note: Additional information on these components can be found in Section III.B. Program Components. Responses should incorporate an overview for the proposed program in support of Performance Standards 1-3.

401 – Describe the applicant's proposed staffing structure including efforts to designate an individual who is accessible full-time to the NYSDOH by phone and e-mail to perform the essential tasks to administer the proposed program, be the lead in programmatic activities, and be responsible for the successful execution of the program/contract. Indicate the number, role(s) and qualifications of CHWs and CHW supervisor(s), staff onboarding/orientation and training (both new and existing staff), to include cultural humility and anti-racism, and staff adherence to agency policies and procedures, including case-conferencing, and how to manage emergency situations such as urgent mental health service needs.

402 – Describe how the program will implement individual-level strategies through the use of CHWs to outreach to and engage with high need, low-income, and/or Medicaid-eligible prenatal, postpartum, and interconception clients and families with an emphasis on finding those not currently engaged in care. Include: how and where enhanced outreach will be conducted; how and when basic assessment screenings will be conducted (including what standardized, evidence-based screening/assessment tools will be used); how staff will support clients in accessing needed services including a description of the active referral process, how referrals will be tracked and followed up on to ensure services were received; and what mechanism will be used to assess clients/individuals satisfaction with services received (e.g., satisfaction surveys).

403 – Describe the elements of the home visiting process, including: the approximate CHW caseload; the estimated number and frequency of home visits to be conducted; and how staff will collaborate with other home visiting programs in a coordinated intake process, where applicable.

404 – Describe the education and enhanced social support opportunities that will be made available to clients, directly through the PICHC program agency or through community-based organizations. Include a brief description of the type of class/workshop and who/what agency will provide such services.

405 – Describe how the program will support client and family engagement in healthy behaviors through providing appropriate information and resources and referrals to services, including how educational information, including written/visual and oral information, will be tailored to ensure that clients can easily understand and use the information. Include a description of steps that the agency will take to assess and address organizational policies, procedures, signage, forms and other documents, to ensure clients can easily understand and use the information provided.

406 – Describe the community mobilization and community engagement strategies (including community member participation) that the program will use, within a reproductive justice framework, to impact systems-level change and address social determinants of health (as described in Section I. – Introduction). Include how the activities will inform planning and implementation of the PICHC program (both CHW services and collaborative activities), and incorporate a feedback process to inform the community how their input has been addressed, and how the PICHC program will incorporate community partners, including other home visiting programs, into their trainings and actions on these strategies and topics.

407 – Describe the agency's role in participating in an existing (or leading a new) community advisory board (CAB) or similar organization (as described in Section III.B.2) including:

- the frequency of CAB/consortium/coalition meetings;
- the role of the applicant agency and proposed PICHC program;
- support provided by the PICHC program (financial and/or in-kind);
- a description of the diverse stakeholders and the proportion of members that are community-members;
- how community issues, barriers, services and gaps that impact perinatal outcomes will be identified; and
- what strategies are used (or for new CABs, how strategies will be identified), to address social determinants that impact perinatal and infant health outcomes.

408 – Describe how the proposed program will promote civic engagement to train and support clients and community members in participating in the CAB and/or other community coalitions and groups. Include how the program will recruit and engage community members who are interested in civic engagement and developing leadership and advocacy skills; what training and education will be provided to these community members, and how the program will facilitate community member participation in the CAB and/or other coalition/groups working toward improving perinatal and infant health outcomes.

409 – Describe the scope of service provision (akin to the Stress-Free Zone model of care where possible), either providing all services "in-house," or through partnerships with non-traditional community partners. If utilizing subcontractors, specify the components of the scope of work to be

performed through subcontracts and, if known, identify the subcontracting agencies in the application.

410 – Provide Letters of Commitment as described in Section III.B.3 – General Program Information. Letters should be signed and submitted on official letterhead, scanned into one PDF document and uploaded into the pre-submission upload section in the Grants Gateway. Upload to attachment in Pre-submission Upload

5. Budget (Maximum Score: 20 points)

All costs **must** be related to the provision of the PICHC program, as well as be consistent with the scope of services, reasonable and cost effective. Justification for each cost should be submitted in narrative form. For all existing staff, the budget justification **must** delineate how the percentage of time devoted to this initiative has been determined. THIS FUNDING MAY ONLY BE USED TO EXPAND EXISTING ACTIVITIES OR CREATE NEW ACTIVITIES PURSUANT TO THIS RFA. FUNDS MAY NOT BE USED TO SUPPLANT FUNDING FOR CURRENTLY EXISTING STAFF ACTIVITIES. ALLOCATION OF PERSONNEL COSTS TO GRANT FUNDS **MUST** BE PROPORTIONATE ACROSS REVENUE STREAMS.

501 – All applicants **must** complete the budget in the NYS Grants Gateway, assuming a start date of July 1, 2022, with a clear and appropriate justification for each line item that aligns with the scope of activities to be conducted (including a cost-effective and appropriate overall staffing pattern). The full budget period for year 1 is July 1, 2022 – June 30, 2023. Refer to **Attachments 6 and 7** for budget guidance documents.

502 – List all personal services for the program, including the individual who will perform the essential tasks required to administer the program whether funded or in-kind, be accessible for communications by phone and e-mail, be the lead in programmatic activities, and ultimately be responsible for successful completion of the program/contract. Specify a CHW Supervisor line-item, or detail how the position will be filled/responsibilities will be met. If available, the CHW Supervisor's resume describing qualifications and proper certifications should be included with the application, uploaded to the Pre-submission Upload section in the Grants Gateway. CHWs included in the budget should be fairly compensated with a salary equitable to a living wage. (Please refer to the NYS Department of Labor's "Occupational Wages" guidance: https://labor.ny.gov/stats/lswage2.asp.) The budget should also list all non-personal services related to the program, regardless of the funding source, and indicate the funding source for each line item as indicated on the budget forms.

503 – Applicants include travel expenses, or in-kind support, to attend required NYSDOH-sponsored trainings/meetings, including the requirement of sending up to two (2) representatives to an annual NYSDOH Bureau of Women, Infant and Adolescent Health Provider Meeting, held in Albany, NY

504 – Applicants may subcontract up to 10% of their awarded funding to other non-traditional community-based not-for-profit organizations which provide services and supports to the priority population. (See Section III.B.2.d for further details). This should be shown in the Budget section of the Grants Gateway application in the Contractual category and fully explained in the Contractual narrative category in the Budget section of the Grants Gateway.

505. Applicants should upload to the pre-submission upload section of the Grants Gateway a completed Federally-negotiated ICR Agreement if they are utilizing a Federal ICR. If not using a Federal ICR, applicants **must** limit indirect costs to no more than 10% of total direct costs.

6. Workplan (0 points)

601 – The objectives, tasks and performance measures have been completed for you in the Grants Gateway. For the Grants Gateway Work Plan Project Summary, applicants are instructed to insert the Project Summary as listed on page 1 of **Attachment 5 –** Standardized Work Plan. In the Grants Gateway Work Plan – Organizational Capacity section, applicants are instructed to list this as "not applicable". Any additional information entered in these areas **will not** be considered or scored by reviewers of your application.

Note: The NYSDOH will work with each funded program to monitor programs and develop tools to assess progress. All awardees will be required to participate in this process. Performance will be monitored against the baseline data collected in the first contract year and technical assistance (TA) will be provided as needed. Additional intensive TA will be provided for low performers to include a NYSDOH-approved performance-improvement plan, involving the support/guidance of a TA and training center, if available. All proposed programming will be subject to initial and ongoing review by the NYSDOH for appropriateness. Inability to adhere to performance standards, and/or comply with a Performance Improvement Plan (if applicable), may result in a reduction or loss of PICHC funding.

Please note the following considerations:

- The proposed budget should align with the scope of activities to be conducted (including an appropriate overall staffing pattern); and provide a clear and appropriate budget justification for each line item;
- It is the applicant's responsibility to ensure that all materials included in the application have been properly prepared and submitted. Applications **must** be submitted via the Grants Gateway by the date and time posted on the cover of this RFA. The value assigned to each section is an indication of the relative weight that will be given when scoring your application;
- Any ineligible budget items will be removed from the budget prior to contracting. The budget amount requested will be reduced to reflect the removal of ineligible items; and
- Expenditures will not be allowed for the purchase of major pieces of depreciable equipment, remodeling, modification or construction of structures. Limited computer and printing equipment (less than $5,000 in value) may be considered as supplies and should be listed in the "Operating Expenses" line of the budget.

7. Preferred Eligibility Criteria (Maximum Score: 3 points)

701 – Demonstrate in the appropriate section a minimum combined 10% in-kind support from the lead agency and community partners in implementing proposed program activities. In-kind support should be described in the narrative section of the appropriate budget category in the Grants Gateway.

B. Freedom of Information Law

All applications may be disclosed or used by NYSDOH to the extent permitted by law. NYSDOH may disclose an application to any person for the purpose of assisting in evaluating the application or for any other lawful purpose. All applications will become NYS agency records, which will be available to the public in accordance with the Freedom of Information Law. **Any portion of the application that an applicant believes constitutes proprietary information entitled to confidential handling, as an exception to the Freedom of Information Law, must be clearly and specifically designated in the application.** If NYSDOH agrees with the proprietary claim, the designated portion of the application

will be withheld from public disclosure. Blanket assertions of proprietary material will not be accepted, and failure to specifically designate proprietary material may be deemed a waiver of any right to confidential handling of such material.

C. Review & Award Process

Applications meeting the guidelines set forth above will be reviewed and evaluated competitively by the NYSDOH BWIAH.

It is anticipated that approximately 25 awards will be made through this initiative (a total of approximately $14 million in awarded funds annually) for a five-year period contingent upon satisfactory performance and available funds.

- All applications will be pre-screened to ensure the minimum eligibility requirements are met. Minimum eligibility requirements are listed in Section II.A. Applications that do not meet these requirements will not be reviewed for funding.
- Applications meeting the minimum eligibility criteria will be reviewed and scored by a NYSDOH team of trained reviewers using a standardized review tool developed specifically for this RFA.
- A maximum annual funding level has been established for each area, as shown in **Table 2.**
- Applicants may request a maximum annual award between $255,000 to $830,000 (**See Table 2)**. Maximum awards are calculated using the base funding plus variance funding. Variance funding will be allocated based on the proportion of Medicaid births proposed to be served within a county (ies). For example, a project that proposes to serve zip code areas within a county that accounts for 90% of all annual Medicaid births within that county would be eligible to receive a higher level of funding than a project that proposes to serve zip code areas that account for 50% of all annual Medicaid births within that same county.
- All awards will be made at the maximum award amount based on Tier and proposed service area for the applicant's proposed county or the amount requested by the applicant, whichever is lower (**Table 2**).
- Only one proposal per applicant may be submitted.
- Funding will be prioritized to Tier 1 counties, followed by Tier 2 high, and then Tier 2 low as funding allows.
- Tier 1 applicants can propose to serve only one county.
- If no applications are received for a Tier 1 county(ies), a re-procurement for those counties may be issued.
- Two awards may be funded in Kings County (25,000+ Medicaid births) as funding allows.
- Multiple applicants funded within Kings county will be required to coordinate activities.
- Tier 2 applicants **must** propose to serve an area with a minimum of 200 Medicaid births (see **Table 3** for average Medicaid births per county).
- Tier 2 applicants can propose to serve multiple counties as part of a coordinated regional/multi-county project.
- Tier 2 High awards will not exceed $440,000 regardless of the number of counties or Medicaid births to be served in the proposed service area.
- Tier 2 Low awards will not exceed $255,000 regardless of the number of counties or Medicaid births to be served in the proposed service area.
- Applications for both Tiers 1 and 2 **must** meet a minimum score of 60 to be approved.
- An application **must** be the highest scoring applicant within a county to be considered for

funding.

- In the event of a tie score within one county, the applicant with the highest score in the "Program Narrative" section will be awarded.
- In the event multiple applicants propose to serve the same county or service area, the highest scoring applicants will be funded.
- Applicants will be deemed to fall into one of three categories: (1) approved and funded, (2) not funded due to limited funds, and (3) not approved. Applications in category #2 "not funded due to limited funds" may be funded should additional funds become available.
- Applications with minor issues (missing information that is not essential to timely review and would not impact review scores) MAY be processed, at the discretion of NYSDOH, but all issues need to be resolved prior to time of award. An application with unresolved issues at the time award recommendations are made will be determined to be non-responsive and will be disqualified.
- If changes in funding amounts are necessary for this initiative, or if additional funding becomes available, funding will be modified and awarded in the same manner as outlined in the award process described.

Table 3: Medicaid Births 3-year annual average, 2015-2017

New York City	
Bronx	16,313
Kings	26,045
New York	5,740
Queens	18,032
Richmond	2,332
Rest of State	
Albany	1,180
Allegany	223
Broome	1,128
Cattaraugus	398
Cayuga	400
Chautauqua	768
Chemung	492
Chenango	255
Clinton	341
Columbia	245
Cortland	258
Delaware	144
Dutchess	950
Erie	4,226
Essex	118

Rest of State, continued	
Franklin	181
Fulton	293
Genesee	239
Greene	179
Hamilton	12
Herkimer	253
Jefferson	596
Lewis	152
Livingston	224
Madison	280
Monroe	3,793
Montgomery	307
Nassau	4,699
Niagara	945
Oneida	1,436
Onondaga	2,588
Ontario	397
Orange	2,702
Orleans	222
Oswego	720
Otsego	163

Rest of State, continued	
Putnam	209
Rensselaer	643
Rockland	3,480
Saratoga	452
Schenectady	787
Schoharie	95
Schuyler	82
Seneca	139
St Lawrence	506
Steuben	443
Suffolk	6,279
Sullivan	532
Tioga	173
Tompkins	330
Ulster	704
Warren	252
Washington	266
Wayne	428
Westchester	3,634
Wyoming	144
Yates	96

Once an award has been made, applicants may request a debriefing of their application (whether their application was funded or not funded). Please note the debriefing will be limited only to the subject application and will not include any discussion of other applications. Requests **must** be received no later than fifteen (15) business days from date of award or non-award announcement.

To request a debriefing, please send an email to PICHCRFA@health.ny.gov. In the subject line,

please write: Debriefing Request (Perinatal and Infant Community Health Collaboratives).

In the event unsuccessful applicants wish to protest the award resulting from this RFA, applicants should follow the protest procedures established by the OSC. These procedures can be found on the OSC's website at *http://www.osc.state.ny.us/agencies/guide/MyWebHelp*. (Section XI. 17.)

VI. Attachments

Please note that attachments are available in the "Pre-Submission Uploads" section of an online application and are not included in the RFA document. In order to access the online application and other required documents such as the attachments, prospective applicants **must** be registered and logged into the NYS Grants Gateway in the user role of either a "Grantee" or a "Grantee Contract Signatory".

Attachment 1: Medicaid Births by County

Attachment 2: Logic Model

Attachment 3: Community Health Worker Standards

Attachment 4: BWIAH Programs

Attachment 5: Standardized Workplan

Attachment 6: Grants Gateway Budget Instructions

Attachment 7: Grants Gateway Budget Data Entry Guidelines

Attachment 8: Application Cover Page

Attachment 9: Vendor Responsibility Attestation

Attachment 10: Minority & Women-Owned Business Enterprise Requirement Forms

Attachment 11: Vendor Contact Form

Attachment 12: Subcontractor Information Form

All attachments are located/included in the Pre-Submission Upload section of the Grants Gateway.