GRANT APPLICATION PACKAGE

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INSTRUCTIONS FOR COMPLETION OF "APPLICATION FOR GRANT FUNDS"

A. General Instructions - This is the standard form used by applicants requesting funding for a Grant. Applicants will complete all items. If an item is not applicable, write "NA". If additional space is needed insert an asterisk ("*") and submit an additional sheet.

B. Detailed Instructions and Definitions – See the Request for Application for specific instructions.

Face Sheet (Page 1): (An explanation follows for each item).

1. Name of Applicant: If the applicant is a non-profit corporation or other entity, the full name must be used, not the name of the individual completing the form.

2. Address: Official address of applicant.

3. Fiscal Contact, Title, E-mail Address and Telephone Number: The name of the individual who is responsible for the financial activities of the applicant.

4. Name of Attorney for Agency and Telephone Number: The name and telephone number of the individual who is responsible for all the legal activities of the applicant.

5. Principal Contact, Title, E-mail Address and Telephone Number: The name of the individual who will be supervising the activity on a day-to-day basis, who can make necessary decisions affecting the project, and who can officially represent the applicant.

6. Employer Identification Number: All applicants must complete this section. If you do not have an Employer Identification Number issued by the Internal Revenue Service, one must be obtained prior to submission of the application.

7. Certificate of Need Project No.: Information and an application can be secured by calling the Department of Health, Office of Certificate of Need and Healthcare Facility Licensure, at (609) 292-6552.

8. Proposed Grant Title: Use a concise descriptive title.

9, 10. Location of Project: If the project activities are located in the same facility as the official address, identify the room number. If the project activity will take place elsewhere, identify location(s) in the space provided under Site Locations.

11. Board of Directors/Trustees Inquiries (a. & b.) – Must be completed. Self-explanatory. If Yes, please provide an explanation on separate sheet.

Payment (c. & d.) – Indicate type of payment plan preferred and where payment should be sent.

12. Type of Agency: Indicate the proper description of your agency.

13. Licensure Requirement: If the applicant is required to hold a current and valid N. J. License to provide the service described in the application, indicate the type of license required and attach a copy of the official license.

14. Agency Fiscal Year Ends: Self-explanatory.

15. Agency Accounting System: Mark the appropriate box indicating the type of accounting system used by your agency when preparing financial reports.

16. **Type of Request:** Refer to the Request for Application to determine the type of request.

    a. Budget Period – The period of time for which a project is to be funded. The period covered should not be longer than 12 months unless otherwise indicated in the Request for Application.

    b. Project Period – The period of time expected to complete the project. The period covered may be longer than 12 months, if indicated in the Request for Application.

17. **Merit System Requirement:** No grant funds may be granted to any county or municipality for salaries unless they are covered by an approved merit system which, in New Jersey, is usually the New Jersey Civil Service Merit System. If a county or municipality has it's own system that has been formally accepted by the State or Federal Government, a copy of the acceptance document **MUST** accompany the application.

18. **Affirmation Action Plan:** One of the two boxes **MUST** be marked. This requirement is in compliance with New Jersey Statute 10:5-36 (P.L. 1975, C.127) entitled Affirmative Action Regulations.

19. **Supplanting Funds:** Indicate whether an award under this application will be used to replace funds which would be otherwise available from another source. If yes, explain on separate page.

20. **Cost of the Project:**

    a. Total Funds Needed - Amount needed from each contributor during the project period. Total of items 20b. and 20c.

    b. Funds Requested from State – Amount requested from the Department of Health during the project.

    c. Funds from Other Sources – Amount needed from any other sources during the project period.

    All requested funding required in this section is obtainable from the completed "Cost Summary" sheet on page 5. Figures should correspond to the net total costs on page 5.

21. **NJDOH Representative and Program (a. & b.) -** Self-explanatory.

22. **Certification:** Application must be signed by a certifying representative of the agency. This certification possesses legal authority to apply for the grant; that a resolution, motion or similar action has been duly adopted or passes as an official act of the applicant's governing body, authorizing the filing of the application, including all instructions and attachments contained therein, and directing and authorizing the person identified as the official representative of the applicant to act in connection with the applicant and to provide such additional information as may be required.

Statement of Local Governmental Public Health Partnership (Page 2):

This page is to be completed by the Local Governmental Public Health Partnership (GPHP) Chairperson (or, in the absence of a GPHP, the local health officer) in the primary jurisdiction of the public health services to be provided by the applicant. It must be completed for all grant applications with the following exception:

Grants to State agencies, College and Universities, or other Agencies that perform statewide or regional projects that do not directly impact on local health activities.

If the proposed services are to be performed statewide and have a direct impact on local health activities, please submit the "Statement of Local Governmental Public Health Partnership" to the New Jersey Health Officers Association at the following address:

New Jersey Health Officers Association
P.O. Box 1226
Sparta, NJ 07871
Telephone: (201) 373-1000
Fax: (973) 729-2635

The purpose of this page is to advise Local Governmental Public Health Partnerships and their community public health planning committees of applications for funds the Department of Health is receiving from third party applicants to provide services in the Partnership's jurisdiction, and to assure that these services are considered and appropriately included in the regional community health improvement process. It is the applicant's responsibility to forward a copy of its entire application for the Partnership's review, record and sign-off statement.

Each applicant for grant funds shall send a copy of the application at the same time as it is submitted to the Granting Agency to the appropriate Governmental Public Health Partnership (GPHP) Chairperson, or the New Jersey Health Officers Association, if the grant will have statewide impact. The Governmental Public Health Partnership (GPHP) Chairperson will have ten (10) working days from the receipt of the information to respond. If a negative response to the application is received by the Department of Health granting agency, the granting agency will shall contact the Division of Local Public Health Practice and Regional Systems Development to discuss the matter. A joint response will be prepared to the GPHP Chairperson before a grant award may be processed to Financial Services for award.

The non-submission of the Statement of Governmental Public Health Partnership form within the designated time frame will not require the granting agency to delay or suspend the grant review and award process. The applicant shall include with its application copies of documentation requesting the Governmental Public Health Partnership Statement.

The Governmental Public Health Partnership (GPH) contact list is available on the Department's website. The website link is http://nj.gov/health/lh/documents/governmental_pub_hlth_partnerships.pdf.

Need(s), Objective(s), Method(s), and Evaluation of Projects (Pages 3 &4): (Use as many pages as required to describe project.)

Assessment of Need(s) – Briefly list the need(s) which document the reason for the project.

Objective(s) of Project – Briefly list what will be done to alleviate the need(s) described above. An objective is a specific and measurable statement that summarizes expected achievement in meeting the described need.

Method(s) – List the method(s) to be used to attain objective(s) described above and note the dates of estimated completion.

Evaluation – Briefly describe how the project is to be self-evaluated.

NOTE: For new and renewal grants under $100,000 the applicant may substitute one page for these two pages stating the necessary information.

Cost Summary (Page 5):

This page is to be completed for single and multi-year grant awards requests. For each applicable cost category, complete the required schedule.

Funds and Program Income from Other Sources related to this Application (Page 6).

If applicable, data should reflect all funding necessary to meet the goals and objectives of this project.

Schedules A through K:

Schedule A – Personnel Costs and Justification.

Schedule B – Consultant Services Costs and Justification.

Schedule C – Other Cost Categories and Justification.

Schedule D – Offices and Directors List; to be completed by non-profit private agencies that are requesting initial funding from the Department. For continuation funding, agencies are required to submit only changes from the original application.

Schedule G – Certification of Non-Debarment. If applicable, agencies are required to complete this certification and retain the form in their files.

Schedule H – Certification of Lobbying. If applicable, agencies are required to complete this certification and retain the form in their files.

Schedule I – Certification Sheet (Form FS-40I). This schedule is required to be submitted with every grant application indicating compliance with the instructions received with the grant application package. It specifies several assurances that the applicant will agree to but not submit documentation with the application. These assurances apply to specific grant requirements.

Schedule J – Agency Minority Profile (Form FS-40J). This schedule is to be completed if the applicant is requesting funds from this Department for the first time or has not received funds in the last (2) years from the Department.

Schedule K – Certification Regarding Environmental Tobacco Smoke (Form FS-40K). If applicable, agencies are required to complete this certification and retain the form in their files.

C. Reference Requirements

The applicant must comply with the following administrative and financial requirements that are applicable to the various types of agencies that receive grant awards from the New Jersey Department of Health. Applicant should be familiar with these requirements prior to submission of the application. Signing the application is certification of full knowledge and agreement to abide by these requirements.

1. **Compliance requirements:** Applicable to this grant application. Copies of these requirements are provided with the request for application.

2. **Grantee's Terms and Conditions for Administration of Grant Funds:** The following cost principles mentioned in this document apply to the specific agency as noted.

    a. **Cost Principles for State and Local Governments** (OMB Circular A-87)

    b. **Cost Principles for Educational Institutions** (OMB Circular A-21)

    c. **Cost Principles for Non-Profit Organizations** (OMB Circular A-122)

    d. **Cost Principles for Hospitals** (Appendix E Title 45 CFR 74)

D. Acknowledgement

Enclosed is a postcard to acknowledge receipt of the application. The applicant is to complete the Addressee Section of the postcard by printing his/her name, address, and zip code in the spaces provided. Upon receipt of the application and postcard, the New Jersey Department of Health Representative shall complete the back portion of the postcard and return it to the applicant.

New Jersey Department of Health

APPLICATION FOR GRANT FUNDS

(TYPE OR PRINT ALL DATA)

FOR STATE USE
Spending Plan No. _____
Funding Authorization No.(s) _____ _____ _____

1. Name of Applicant

2. Street Address | City | County | State | Zip Code

3. Name and Title of Fiscal Contact | E-mail Address | Telephone No.

Street Address | City | County | State | Zip Code

4. Name of Attorney for Agency | Telephone No.

5. Name and Title of Principal Contact | E-mail Address | Telephone No.

6. Employer ID No.

7. Certificate of Need Project (if applicable) ☐ PENDING ☐ NOT REQUIRED

8. Proposed Grant Title

9. Location of Proposed Project (include county)

10. Site Locations Number

ATTACH ADDITIONAL SHEETS

11. a. Will any member of the Board of Directors/Trustees receive any direct or indirect personal or monetary gain from the funding of this grant? ☐ YES ☐ NO

b. Does any member of the Board of Directors/Trustees serve on any board, council commission, committee or Task Force which has regulatory or advising influence on the funding program? ☐ YES ☐ NO

_____ MEMBER _____ BOARD, COUNCIL, ETC.

11c. Type of payment plan preferred
☐ Cost-reimbursement ☐ Advance Payment

11d. Location where payments should be sent

12. Type of Agency (check one)
☐ PRIVATE NON-PROFIT ☐ GOVERNMENT ☐ HOSPITAL
☐ PRIVATE PROFIT ☐ OTHER (Specify) _____

13. Does the Agency Meet the following Licensure Requirements?

	YES	NO	PENDING	N/A
FOR FACILITY	☐	☐	☐	☐
FOR SERVICES	☐	☐	☐	☐
FOR PERSONNEL	☐	☐	☐	☐

14. Agency Fiscal Year End

15. Agency Accounting System:
☐ Cash Basis ☐ Other (Specify)
☐ Accrual Basis _____

16. Type of Request
☐ NEW ☐ RENEWAL OF GRANT NO.: _____
☐ MULTI YEAR GRANT ☐ MODIFICATION TO GRANT NO.:
YEAR: ☐ 1 ☐ 2 ☐ 3 _____

16a. Budget Period Mo./Day/Yr.
FROM: _____ THROUGH:

b. Project Period Mo./Day/Yr.
FROM: _____ THROUGH:

17. Is political subdivision covered by NJ Civil Service Merit System?
☐ YES ☐ NO

18. Affirmative Action Plan
☐ YES ☐ NO

19. If grant is awarded, will funds be used to replace other funds which would be available in absence of award?
☐ YES ☐ NO

COST OF PROJECT

20a. Total Funds Needed	1	b. Funds Requested from State	2	c. Funds From Other Sources	3

21a. Name of NJDOH Representative Regarding Application

21b. Program (Granting Agency)

22. CERTIFICATION – The applicant certifies that to the best of his/her knowledge and belief all data supplied in this application and attachments are true and correct, the document has been duly authorized by the governing body of the applicant and further understands and agrees that any grant received as a result of this application shall be subject to the grant conditions, and other policies, regulations and rules issued by the New Jersey Department of Health which include provisions described in grant application instructions.

NAME AND TITLE OF APPLICANT (Print)	SIGNATURE OF APPLICANT	DATE OF APPLICATION

New Jersey Department of Health
APPLICATION FOR GRANT FUNDS

STATEMENT OF LOCAL GOVERNMENTAL PUBLIC HEALTH PARTNERSHIP

To be completed by Governmental Public Health Partnership Chairperson in primary jurisdiction of applicant. (In the absence of a GPHP, this form is to be completed by the Local Health Officer.)

Name of Applicant	Proposed Grant Title	Date of Application

☐ As Chairperson of the Governmental Public Health Partnership (GPHP), I have reviewed and/or discussed the above proposed grant application with the Named Applicant, the GPHP members, and the Community Public Health Partnership, and make the following statement:

(☐ In the absence of a Governmental Public Health Partnership, as the Local Health Officer, I have reviewed and/or discussed the above proposed grant application with the Named Applicant and make the following statement:)

☐ I am in support of this application and will work to integrate this health service with others in this community, county and/or region. Comments (optional):

☐ I am not in support of this application for the following reasons:

Name, Title and Address of Governmental Public Health Partnership Chairperson (or Local Health Officer, if applicable)	
Signature of Governmental Public Health Partnership Chairperson	Date

NEED(S) AND OBJECTIVES OF PROJECTS

Name of Applicant	Proposed Grant Title	Date of Application

ASSESSMENT OF NEED(S) – List the need(s) which illustrate the reason for the project.

☐ Check here if continued on separate sheet

OBJECTIVE(S) OF PROJECT – List what will be done to alleviate need(s) described above.

☐ Check here if continued on separate sheet

METHOD(S) AND EVALUATION OF PROJECT

Name of Applicant	Proposed Grant Title	Date of Application

METHOD(S) – List the method(s) to be used to attain objectives described above and estimated completion date.

☐ Check here if continued on separate sheet

EVALUATION – Describe how the project is to be self-evaluated.

☐ Check here if continued on separate sheet

New Jersey Department of Health

APPLICATION FOR GRANT FUNDS

COST SUMMARY

Name of Applicant	Proposed Grant Title	Date of Application

For Cost Categories A through C, a SCHEDULE SHEET and JUSTIFICATION SHEET must be completed and submitted, if applicable.

Cost Category	Total Funds Needed	Grant Funds Requested from State	Funds from Other Sources	STATE USE ONLY
A. PERSONNEL COST				
Salaries / Wages				
Fringe Benefits				
B. CONSULTANT / PROFESSIONAL SERVICES COST				
C. OTHER COST CATEGORIES				
Office Expense and Related Cost				
Program Expense and Related Cost				
Staff Training and Education Cost				
Travel, Conferences and Meetings				
Equipment and Other Capital Expenditures				
Facility Cost				
Sub-Grants				
Total Direct Cost				
Indirect Cost (SEE NOTE BELOW)				
Total Costs				
Less Program Income				
Net Total Cost	1	2	3	

1-3: Figures in these areas to be entered in corresponding numbered areas on PAGE 1 of application.

NOTE: An indirect cost allowance may be awarded to any applicant provided that state or federal legislation does not prohibit it and that the applicant has an established indirect cost rate. Do you have an established indirect cost rate? ☐ Yes ☐ No

If yes, attach a letter stating approved rate, period of time, base to which rate is applied, and enter above amount of indirect cost requested for proposed grant.

New Jersey Department of Health
APPLICATION FOR GRANT FUNDS

FUNDS AND PROGRAM INCOME FROM OTHER SOURCES RELATED TO THIS APPLICATION

Name of Applicant	Proposed Grant Title	Date of Application

Code all listed fund sources as either (F) Federal Government, (S) State Government, (L) Local City/County Government, (LP) Local Private/Charity Agency, (TP) Third Party Payor or (PI) Program Income.

ATTACH ADDITIONAL SHEETS IF NEEDED

Name of Fund Source	Code	Funds Estimated Grant Period	Funds Received Preceding Grant Period
TOTAL FUNDS FROM OTHER SOURCES RELATED TO THIS APPLICATION ONLY			

New Jersey Department of Health
APPLICATION FOR GRANT FUNDS

SCHEDULE A
PERSONNEL COSTS

Name of Applicant	Proposed Grant Title	Date of Application

List all full and part-time paid staff, including fringe benefits. Justify fringe benefit costs on a separate sheet.	Standard Weekly Work Hours./Employee

IF ADDITIONAL SPACE IS NEEDED, PLEASE USE THE SCHEDULE A FORM THAT IS AVAILABLE ELECTRONICALLY AS AN INDIVIDUAL DOCUMENT.

Position Title	Incumbent Name, Vacant, or New Position	Annual Salary	Weekly Hours on Project	% of Weekly Work Time On Project	Total Funds Needed	Grant Funds Requested From State	Funds From Other Sources	STATE USE ONLY
Sub-Totals								
_____ % Fringe Benefits								
TOTAL PERSONNEL COSTS								

New Jersey Department of Health
APPLICATION FOR GRANT FUNDS

SCHEDULE A
PERSONNEL JUSTIFICATION

Name of Applicant	Proposed Grant Title	Date of Application

List, justify, and submit a curriculum vitae for each position title, excluding clerical and manual positions, in same order as listed on SCHEDULE A: PERSONNEL COSTS. Briefly describe the agency's personnel policy for salary increases on a separate sheet.

IF ADDITIONAL SPACE IS NEEDED, PLEASE USE THE SCHEDULE A FORM THAT IS AVAILABLE ELECTRONICALLY AS AN INDIVIDUAL DOCUMENT.

Position Title	Minimum Qualifications (education and experience)

New Jersey Department of Health
APPLICATION FOR GRANT FUNDS

SCHEDULE B
CONSULTANT SERVICES COSTS

Name of Applicant	Proposed Grant Title	Date of Application

List services which provide for program or client benefit and are contracted for on a cost per client, percentage or time, or number of hours basis. Examples of consultant services: accounting, medical, psychological, psychiatric, and other professional services. A copy of individual agreements will be required if an award is made.

Do consultant services demonstrate a true employer / non-employee relationship as per IRS regulations? ☐ Yes ☐ No

IF ADDITIONAL SPACE IS NEEDED, PLEASE USE THE SCHEDULE B FORM THAT IS AVAILABLE ELECTRONICALLY AS AN INDIVIDUAL DOCUMENT.

Nature of Consultant Service	**Basis for Cost Estimate (Rate X Time)**	**Total Funds Needed**	**Grant Funds Requested From State**	**Funds From Other Sources**	**STATE USE ONLY**
TOTAL CONSULTANT SERVICES COSTS					

New Jersey Department of Health
APPLICATION FOR GRANT FUNDS

SCHEDULE B
CONSULTANT SERVICES JUSTIFICATION

Name of Applicant	Proposed Grant Title	Date of Application

List and justify each consultant service in same order as on SCHEDULE B: CONSULTANT SERVICES COSTS.

IF ADDITIONAL SPACE IS NEEDED, PLEASE USE THE SCHEDULE C FORM THAT IS AVAILABLE ELECTRONICALLY AS AN INDIVIDUAL DOCUMENT.

Nature of Consultant Services	Responsibilities and/or Duties	Minimum Qualifications (education and experience)

New Jersey Department of Health
APPLICATION FOR GRANT FUNDS

SCHEDULE C
OTHER COST CATEGORIES

Name of Applicant	Proposed Grant Title	Date of Application

List other cost categories applicable to grant proposal, such as travel, supplies, equipment, and other direct expenses. A copy of lease agreement, travel regulations, and any other pertinent agreement is to be attached when requesting funds for these budget categories.

IF ADDITIONAL SPACE IS NEEDED, PLEASE USE THE SCHEDULE C FORM THAT IS AVAILABLE ELECTRONICALLY AS AN INDIVIDUAL DOCUMENT.

Other Cost Categories (specify)	Basis for Cost Estimate	Total Funds Needed	Grant Funds Requested From State	Funds From Other Sources	STATE USE ONLY
A.					
B.					
C.					
D.					
E.					
TOTAL COSTS					

New Jersey Department of Health
APPLICATION FOR GRANT FUNDS

SCHEDULE C
OTHER COST JUSTIFICATION

Name of Applicant	Proposed Grant Title	Date of Application

Justify below all items or services which are listed in SCHEDULE C: OTHER COSTS. Justify the items or services in the same order as they are listed on the schedule. Attach copy of lease agreement when requesting funds for rent. The cost allocation method should be included in the justification if a cost category is distributed among multiple funding services.

IF ADDITIONAL SPACE IS NEEDED, PLEASE USE THE SCHEDULE C FORM THAT IS AVAILABLE ELECTRONICALLY AS AN INDIVIDUAL DOCUMENT.

New Jersey Department of Health
APPLICATION FOR GRANT FUNDS

SCHEDULE D
OFFICERS AND DIRECTORS LIST

Name of Applicant	Proposed Grant Title	Date of Application

List below the name, title, and residence address of all officers and board members of applicant. Attach additional sheets if needed.

ATTACH ADDITIONAL SHEETS IF NEEDED.

Name	Title		Name	Title	
Residence Address			Residence Address		
City	State	Zip Code	City	State	Zip Code
Name	Title		Name	Title	
Residence Address			Residence Address		
City	State	Zip Code	City	State	Zip Code
Name	Title		Name	Title	
Residence Address			Residence Address		
City	State	Zip Code	City	State	Zip Code
Name	Title		Name	Title	
Residence Address			Residence Address		
City	State	Zip Code	City	State	Zip Code
Name	Title		Name	Title	
Residence Address			Residence Address		
City	State	Zip Code	City	State	Zip Code
Name	Title		Name	Title	
Residence Address			Residence Address		
City	State	Zip Code	City	State	Zip Code

SCHEDULE G

New Jersey Department of Health
APPLICATION FOR GRANT FUNDS

CERTIFICATION REGARDING DEBARMENT AND SUSPENSION

In accordance to Federal Executive Order 12549, "Debarment and Suspension," the undersigned certifies, to the best of his or her knowledge that as an applicant, this agency or its key employees:

a. are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from covered transaction by any Federal Department or agency, or by the State of New Jersey;

b. have not within a 3-year period preceding this application been convicted of or had a civil judgement rendered against them for commission of fraud or a criminal offense, in connection with obtaining, attempting to obtain, or performing a public (Federal, State, or Local) transaction or contract under a public transportation; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property.

c. are not presently indicted or for otherwise criminally or civilly charged by a governmental entity (Federal, State, or Local) with commission of any offenses enumerated in paragraph (b) of this certification; and

d. have not within 3-year period preceding this application had one or more public transactions (Federal, State, or Local) terminated for cause or default.

The applicant agrees that by submitting this application, it will obtain from all its subgrantees a certification that includes without modification paragraphs (a), (b), (c), (d), of this certification in accordance with Federal Executive Order 12549.

NAME OF AGENCY	
NAME AND TITLE OF OFFICIAL SIGNING FOR AGENCY	
SIGNATURE OF ABOVE OFFICIAL	DATE SIGNED

NOTE: The following document related to Debarment and Suspension as required by Federal regulations will be used as the basis for completion of this certification:

List of *parties excluded* from Federal Procurement or Non-Procurement Programs. This document is distributed by U.S. General Services Administration, U.S. Printing Office, Washington, D.C. This document can be acquired from the Superintendent of Documents by calling (202) 783-3238.

- TO BE RETAINED BY GRANTEE –

SCHEDULE H

New Jersey Department of Health
APPLICATION FOR GRANT FUNDS

CERTIFICATION REGARDING LOBBYING

The undersigned certifies, to the best of his or her knowledge that:

a. No grant funds awarded from State and/or Federal appropriations have been paid or will be paid, by or on behalf of the grantee, to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the making of any grant, the making of any loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any grant, loan, or cooperative agreement.

b. If any funds other than State and/or Federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this, grant, loan, or cooperative agreement, the grantee shall complete and submit the Standard Form-LLL, "Disclosure Form to Report Lobbying," in accordance with its instructions. This form can be found at the following website address: http://www.hhs.gov/oagam/oam/opportunities/rfp0202/sf111.pdf.

c. The grantee shall require that the language of this compliance requirement (certification) be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans, and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

   This requirement (certification) is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, Title 31, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

NAME OF AGENCY	
NAME AND TITLE OF OFFICIAL SIGNING FOR AGENCY	
SIGNATURE OF ABOVE OFFICIAL	DATE SIGNED

– TO BE RETAINED BY GRANTEE –

SCHEDULE I

New Jersey Department of Health
APPLICATION FOR GRANT FUNDS

CERTIFICATION SHEET

	INITIALS
I certify that this agency is in possession of and will comply with the Terms and Conditions for Administration of Grants and the applicable Cost Principles.	
I have read the Certification Regarding Debarment and Suspension (Schedule G of the Application for Grant Funds) and certify to the best of my knowledge that as an applicant this agency and its key employees are in compliance with this requirement. I will also obtain such certification from all subgrantees in accordance with Federal Executive Order 12549. This form will be maintained on file in the agency's office.	
I have read the Certification Regarding Lobbying (Schedule H of the Application for Grant Funds) and, to the best of my knowledge, certify that this agency is in compliance. This form will be maintained on file in the agency's office.	
I have read the Certification Regarding Environmental Tobacco Smoke (Schedule K of the Application for Grant Funds) and have determined that the provisions of the Pro-Children Act of 1994 apply to this agency and to the best of my knowledge, certify that this agency is in compliance with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act. This form will be maintained on file in the agency's office.	
I understand that my payments will depend on timely submission of all reports.	
I have submitted a listing of the Officers and Directors (Schedule D of the Application for Grant Funds) and their addresses and will notify you in writing within ten days of any changes as they occur. For renewal applications, I have submitted only changes from the original submission.	
I have completed and submitted the Agency Minority Profile (Schedule J of the Application for Grant Funds) at least one time during the past two years.	
The Statement of Local Governmental Public Health Partnership (Page 2 of the Application for Grant Funds) has been sent to the Local Governmental Public Health Partnership Chairperson (or Local Health Officer, if applicable) for signature on the date of our submission of the application to the New Jersey Department of Health.	
I certify that this agency is not delinquent on any Federal or State debt.	
As a non-profit corporation, I certify that this agency has 501(c)(3) status as required by the Internal Revenue Service and is registered as a charitable organization in accordance with N.J.S.A. 45:17A-18 et seq.	
I have read, understand, and will comply with the instructions received with the grant application package.	

NAME OF AGENCY	
NAME AND TITLE OF CERTIFYING OFFICIAL FOR AGENCY	
SIGNATURE OF CERTIFYING OFFICIAL	DATE SIGNED

SCHEDULE J

New Jersey Department of Health
APPLICATION FOR GRANT FUNDS

AGENCY MINORITY PROFILE

NAME AND ADDRESS OF AGENCY

The Department's Office of Minority and Multicultural Health has defined "minorities" as the four major race/ethnic minority populations (African Americans, Latinos/Hispanic, Asian/Pacific Islanders and American Indians/Eskimos) as well as linguistic minority populations who are either non-English speaking or have limited English proficiency.

Complete this form if your agency is requesting funds from this Department for the first time or has not received funds in the last two (2) years from the Department.

1. Is this a **minority-managed** organization?

☐ Yes ☐ No

a. If Yes, place a check in the applicable box(es).

☐ Black/African-American
☐ Hispanic/Latino
☐ American Indian
☐ Asian/Pacific Islander
☐ White, Not of Hispanic Origin
☐ Other

2. Is this agency serving a large minority population?

☐ Yes ☐ No

a. If Yes, place a check in the applicable box(es).

☐ Black/African-American
☐ Hispanic/Latino
☐ American Indian
☐ Asian/Pacific Islander
☐ White, Not of Hispanic Origin
☐ Other

3. Indicate all of the languages in which services are being provided by this organization, by placing a check in each applicable box:

☐ English
☐ Spanish
☐ French
☐ Creole
☐ Other

NAME OF APPLICANT	TITLE
SIGNATURE	DATE

SCHEDULE K

New Jersey Department of Health
APPLICATION FOR GRANT FUNDS

CERTIFICATION REGARDING ENVIRONMENTAL TOBACCO SMOKE

NAME AND ADDRESS OF AGENCY

Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, day care, early childhood development services, education or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments, by Federal grant, contract loan or loan guarantee. The law also applies to children's services provided in indoor facilities that are constructed, operated, or maintained with such federal funds. The law does not apply to children's services provided in private residences; portions of facilities used for inpatient drug or alcohol treatment service providers whose sole source of applicable Federal funds is Medicare or Medicaid; or facilities where WIC coupons are redeemed. Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to $1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

By signing this certification the applicant/grantee (for grants) certifies that the submitting agency will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act.

NAME OF OFFICIAL SIGNING FOR AGENCY	TITLE
SIGNATURE	DATE SIGNED

- TO BE RETAINED BY GRANTEE -