DEPARTMENT OF HEALTH AND HUMAN SERVICES

Indian Health Service

Office of Clinical and Preventive Services Maternal and Child Health Program: Project Choices Pilot Implementation and Evaluation Program for American Indian and Alaska Native Women

Announcement Type: New Limited Competition.

Funding Announcement Number: [HHS–2010–IHS–MHCEP–0001].

Catalog of Federal Domestic Assistance Number: 93.231.

Key Dates

Letter of Intent Deadline: August 26, 2010.

Application Deadline Date: September 15, 2010.

Review Date: September 17, 2010.

Earliest Anticipated Start Date: September 30, 2010.

I. Funding Opportunity Description

Statutory Authority

The Indian Health Service (IHS) is accepting competitive cooperative agreement (CA) applications for Project CHOICES Pilot Implementation and Evaluation for American Indian and Alaska Native Women (CHOICES AI/AN) . This program is authorized under: Section 301(a) of the Public Health Service Act as amended and the Snyder Act, 25 U.S.C. 1653(c), the Indian Health Care Improvement Act Public Law 94–437, as amended by Public Law 102–573 and Public Law 111–148. This program is described in the Catalog of Federal Domestic Assistance under 93.231.

Background

Alcohol use during pregnancy is an important public health concern with objectives for reducing this behavior in Healthy People 2010 [U.S. Department of Health and Human Services. Healthy People 2010. 2nd Edition. Understanding and Improving Health. Vol 1. Washington, DC: U.S. Government Printing Office, November 2000]. The 2005 U.S. Surgeon General's advisory on alcohol use in pregnancy advises women who are pregnant or considering becoming pregnant to abstain from using alcohol. Prenatal alcohol exposure can lead to a spectrum of adverse consequences for the fetus including poor birth outcomes and low birth weight. This wide range of effects is known as Fetal Alcohol Spectrum Disorders (FASD) with Fetal Alcohol Syndrome (FAS) representing the most severe condition. Children with FAS have facial abnormalities, pronounced neuro-developmental disorders, and growth deficits. The lifetime cost for one individual with FAS in 2001 was estimated to be $2 million. This is an average for people with FAS and does not include data on people with other FASDs.

Prenatal alcohol use is a leading preventable cause of birth defects and developmental disabilities in the U.S. The Centers for Disease Control and Prevention (CDC) Morbidity and Mortality Weekly Report (MMWR) dated May 2009 cites studies showing that 0.2 to 1.5 cases of fetal alcohol syndrome (FAS) occur for every 1,000 live births in certain areas of the United States. Other studies using different methods have estimated the rate of FAS at 0.5 to 2.0 cases per 1,000 live births. CDC studies find that approximately 1 in 2 childbearing-aged women report past-month alcohol use, with 1 in 8 reporting binge drinking. This figure has remained stable over a 15 year period. (The National Institute on Alcoholism and Alcohol Abuse currently defines binge drinking in women as 4 drinks or more per occasion). The Behavioral Risk Factor Surveillance System (BRFSS) 2008 state-specific weighted prevalence estimates of alcohol use among women aged 18–44 years for any use defined as one or more drinks during the last 30 days ranged from 20.4% in Utah to 68.4% in Wisconsin. For binge drinking defined as 4 or more drinks on any one occasion during the last 30 days the prevalence estimates ranged from 6.5% in Utah to 23.9% in Wisconsin.

Reported prevalence rates of FAS among American Indians and Alaska Natives (AI/AN) tend to be higher than U.S. prevalence rates of FAS overall. CDC studies have reported rates among Alaska Natives to be 3.0–5.2 per 1,000 live births. A study of FAS prevalence rates in Alaska, Arizona, Colorado, and New York for years 1995–1997 reported similar findings in Alaska Natives with a rate of 5.86 per 1,000 live births and 0.3 in non-Native populations.

Most women reduce alcohol consumption once they learn they are pregnant. However, many of the women who use alcohol and are sexually active but not using contraception will become pregnant. Furthermore, they do not recognize pregnancy until well into the first trimester after fetal organs have already been damaged by prenatal alcohol exposure. Many of the women who are using contraception are using it ineffectively increasing the risk for an alcohol-exposed pregnancy (AEP). For pregnant women 12.2% (about 1 in 8) reported any alcohol use in the past 30 days.

In January 2003, the CDC published the results of a feasibility study (Project CHOICES) intended to design and test a brief motivational intervention for reducing alcohol-exposed pregnancies among women who are at high risk for such pregnancies. CDC collaborated with three universities in the development of the study with each site identifying community-based settings with high proportions of women at risk for AEP. Six special study settings confirmed to have a high proportion of women at risk for an AEP included jails, alcohol and drug treatment centers, an inner-city obstetrics and gynecology clinic at a university-based hospital, publicly supported primary clinics in Virginia (urban) and Florida (suburban), and a media-recruited cohort of women. High risk women were defined as 18–44 years of age, fertile, sexually active and not using effective contraception, and drinking more than 7 drinks per week and/or 5 drinks per occasion in the past month. Each woman was provided with a 4-session motivation counseling intervention and a family planning consultation and services visit in a pilot study to test the feasibility of the intervention. At 6 months follow-up, 69% of women had reduced their risk for an AEP by either decreasing their drinking levels and/or instituting effective contraception. [Project CHOICES Research Group. Alcohol-exposed pregnancy: characteristics associated with risk. Am J Prev Med 2002:23:166–73.] This study was followed up by a randomized controlled trial to test the efficacy of the intervention using the same protocol developed for the feasibility study. [Floyd RL, Sobell M, Velasquez MM, et al. Preventing Alcohol-Exposed Pregnancies: A Randomized Controlled Trial. Am J Prev Med. 2007;32(1):1–10] The results of the clinical trial found that the odds of reducing risk for an AEP among women receiving an intervention were twice that of women in the control group. Currently, CHOICES is being implemented in a number of public health settings including alcohol and drug treatment centers, sexually transmitted disease (STD) clinics, and community health clinics.

Purpose

The IHS seeks to support and educate AI/AN women of child bearing years in making healthy choices while enhancing their use of effective contraceptive practices. The purpose of this limited competition announcement is to implement and evaluate the

CHOICES core intervention model with AI/AN women who meet high-risk criteria for an AEP. It has been determined that the CHOICES model as demonstrated in published studies has relevance for AI/AN communities. The IHS will fund one project as a cooperative agreement. The three year pilot will serve to determine the utility and suitability of the CHOICES model by tailoring it to the needs of AI/AN women across three settings in Native communities. The primary intervention is a brief intervention using motivational counseling techniques and family planning consultation and services in clinical and community based settings. The funded project will evaluate and further refine CDC-developed client materials intended for an AI/AN audience. This will be accomplished utilizing broad community-based oversight.

The CDC will provide technical assistance (TA) to the funded project for the training and support of health care providers who implement the evidenced-based CHOICES intervention in AI/AN communities. The CDC and IHS will provide TA to the overall evaluation plan and its implementation in the funded settings. TA will help define process measures as CHOICES is implemented in the three sites to better understand feasibility for future public health planning in AI/AN communities. A final report of the results of the intervention delivery experience will be compiled for a final report due at the end of the funding period. This report will include outcomes and lessons learned with recommendations regarding future dissemination activities for Tribes, regional stakeholders, CDC and IHS. Substantive TA will be provided by the IHS and CDC working in collaboration. See Programmatic Involvement below.

For funding, the CHOICES AI/AN project must address the following:

1. Provide state and local data demonstrating high proportions of AI/AN women of reproductive years at high risk for an AEP.

2. Describe the process for tailoring the CHOICES intervention to ensure it is culturally relevant and appropriate for women at high risk for an AEP in selected AI/AN settings.

3. Describe how local resource capacity needed to conduct the CHOICES intervention will be assessed.

4. Demonstrate knowledge of the CHOICES program and methods to ensure fidelity in the delivery of the intervention.

5. Demonstrate knowledge of the CHOICES training of providers as it is currently modeled and ability to facilitate and host training with CDC providing the trainer.

6. Demonstrate familiarity with the CHOICES client materials used during the identification and intervention or counseling phase.

7. Develop marketing initiatives for the AI/AN and IHS stakeholders that describe the intervention and its benefits to providers caring for childbearing-aged women, culturally appropriate fact sheets and promotional materials, and estimates of the resources needed to manage the intervention.

8. Describe motivational counseling as it is applied in the CHOICES model.

9. Facilitate the development and activities of a collaborative group consisting of three selected sites to provide mutual support and feedback as they implement CHOICES.

10. Facilitate selected sites as they adapt the CHOICES materials for AI/AN populations describing approaches that address social and cultural aspects and a community oversight process.

11. Demonstrate ability to develop an evaluation plan and to conduct a program evaluation using process, impact and outcome measures.

12. Demonstrate experience with cooperative agreements and collaborative work including substantive TA.

13. Describe ability to report aggregate findings from the three site(s) on core measures, and how the use of training support and client materials developed by the project could enhance public health FASD prevention work in other AI/AN communities.

14. Identify additional potential funding to sustain the agencies/tribal entities that implement the intervention.

II. Award Information

Type of Awards

Cooperative Agreement (CA).

Estimated Funds Available

The total amount of funding identified for the current fiscal year FY 2010 is approximately $200,000. Competing and continuation awards issued under this announcement are subject to the availability of funds. In the absence of funding, the agency is under no obligation to make awards funded under this announcement.

Anticipated Number of Awards

One award will be issued under this program announcement.

Project Period

Three years.

Programmatic Involvement

Substantive programmatic involvement will be provided under this CA. The IHS Maternal and Child Health (MCH) Coordinator or designee will serve as the project officer for the project. The MCH program will provide oversight and TA in the implementation and evaluation activities. The MCH program will track project achievements through participation on conference calls, development of a listserv, review of agendas, minutes, and through the conduct of site visits annually. The MCH program will provide assistance in the development of a national dissemination plan. The CDC National Center on Birth Defects and Developmental Disabilities (NCBDD) will be consulted in use and provision of the generic training materials; in the conduct of training sessions by skilled professionals; and in overall project delivery and evaluation. NCBDD will make available the CHOICES Intervention package of materials for tailoring to the needs of AI/AN women as appropriate.

III. Eligibility Information

1. Eligibility

Applicant must be one of the following: A Federally-recognized Indian Tribe as defined by 25 U.S.C. 1603(d); A Tribal organization as defined by 25 U.S.C. 1603(e); or an Urban Indian organization as defined by the Public Law 94–437, the Indian Healthcare Improvement Act (IHCIA), as amended, Title V urban health organization.

This is a limited competition.

Definitions

Indian tribe means any Indian tribe, band, nation, or other organized group or community, including any Alaska Native village or group or regional or village corporation as defined in or established pursuant to the Alaska Native Claims Settlement Act (85 Stat. 688) [43 U.S.C. 1601 *et seq.*], which is recognized as eligible for the special programs and services provided by the United States to Indians because of their status as Indians. 25 U.S.C. 1603(d).

Tribal organization means the elected governing body or any legally established organization of Indians which is controlled by one or more such bodies or by a board of directors elected or selected by one or more such bodies (or elected by the Indian population to be served by such organization) and which includes the maximum participation of Indians in all phases of its activities. 25 U.S.C. 1603(e).

Urban Indian organization means a non-profit corporate body of any Indian tribe or any legally established organization of Indians which is controlled by one or more such bodies or by a board of directors elected or selected by one or more such bodies (or elected by the Indian population to be served by such organization) and which includes the maximum participation of Indians in all phases of its activities. 25 U.S.C. 1603(h).

The applicant must include the project and a justified and itemized budget narrative as attachments to the application package. All Mandatory documents as noted under section IV.2. must be provided.

2. Cost Sharing or Matching

The Program does not require matching funds or cost sharing.

3. Other Requirements

If application budgets exceed the stated dollar amount that is outlined within this announcement it will not be considered for funding.

A letter of intent is required.

The following documentation is required:

Tribal Resolution—A resolution of the Indian Tribe served by the project must accompany the application submission. This can be attached to the electronic application. An Indian Tribe that is proposing a project affecting another Indian Tribe must include resolutions from all affected Tribes to be served. Applications by Tribal organizations will not require a specific Tribal resolution if the current Tribal resolution(s) under which they operate would encompass the proposed grant activities. Draft resolutions are acceptable in lieu of an official resolution. However, an official signed Tribal resolution must be received by the Division of Grants Management (DGM) prior to the beginning of the Objective Review. If an official signed resolution is not received by September 17, 2010, the application will be considered incomplete, ineligible for review, and returned to the applicant without further consideration. Applicants submitting additional documentation after the initial application submission are required to ensure the information was received by the IHS by obtaining documentation confirming delivery (*i.e.* FedEx tracking, postal return receipt, etc.).

Nonprofit urban IHS organizations must submit a copy of the 501(c)(3) Certificate as proof of non-profit status.

IV. Application and Submission Information

1. Obtaining Application Materials

The application package and instructions may be located at *http://www.Grants.gov* or *http://www.ihs.gov/NonMedicalPrograms/gogp/index.cfm?module=gogp_funding.*

2. Content and Form Application Submission

The applicant must include the project narrative as an attachment to the application package.

Mandatory documents for all applicants include:

- Application forms:
  - SF–424.
  - SF–424A.
  - SF–424B.
- Budget Narrative (must be single spaced).
- Project Narrative (must not exceed 10 pages).
- Font size: 12 point unreduced.
- Single spaced.
- 8 ½″ x 11″ paper.
- Page margin size: One inch.
- Tribal Resolution or Tribal Letter of Support (Tribal Organizations only).
- Letter of Support from Organization's Board of Directors (Title V Urban Indian Health Programs only).
- 501(c) (3) Certificate (Title V Urban Indian Health Programs only).
- Biographical sketches for all Key Personnel.
- Disclosure of Lobbying Activities (SF–LLL) (if applicable).
- Documentation of current OMB A–133 required Financial Audit, if applicable. Acceptable forms of documentation include:
  - E-mail confirmation from Federal Audit Clearinghouse (FAC) that audits were submitted; or
  - Face sheets from audit reports. These can be found on the FAC Web site: *http://harvester.census.gov/fac/dissem/accessoptions.html?submit=Retrieve+Records.*

Public Policy Requirements:

All Federal-wide public policies apply to IHS grants with exception of the Discrimination policy.

Requirements for Project and Budget Narratives

A. Project Narrative: This narrative should be a separate MS Word document that is no longer than 10 pages (see page limitations for each Part noted below) with consecutively numbered pages. Be sure to place all responses and required information in the correct section or they will not be considered or scored. If the narrative exceeds the page limit, only the first 10 pages will be reviewed. There are three parts to the narrative: Part A—Program Information; Part B—Program Planning and Evaluation; and Part C—Program Report. See below for additional details about what must be included in the narrative.

Part A: Program Information (3 Page Limitation)

Section 1: Needs and Current Activities

Describe the population to be served including risk characteristics for an AEP. Describe the current public health programming, clinical and community services, and settings as applicable to the population to be served. Describe their ability to participate in implementing CHOICES. Describe prior experience and past achievements in addressing women and risky drinking. Describe knowledge and experience with CHOICES programming and materials.

Section 2: Organizational Capacity

Describe organizational capacity to conduct and evaluate an intervention.

Describe ability to manage and utilize technical assistance under a cooperative agreement. Describe key personnel and their specific experience in public health interventions designed to reduce alcohol exposed pregnancies. Describe experience in producing and facilitating training sessions. Describe experience in working with advisory groups. Describe ability to review and adapt training materials for an AI/AN audience. Describe experience and ability to develop comprehensive reports including the interpretation of process, impact and outcome measures.

Part B: Program Planning and Evaluation (6 Page Limitation)

Section 1: Program Plans

This is a pilot project and as such should be designed to address feasible approaches to the implementation of CHOICES in at least three clinical and community settings that serve AI/AN women of child bearing years. Urban and Tribal settings should be included. Program plans should address culturally specific approaches. Include support structures for facilitation and oversight of the implementation and evaluation. A three-year timeline with emphasis on year one should be described. A time line may be separately appended. Plan should include accountabilities for project monitoring, training schedule(s), materials review and revision if necessary, and the implementation plan for roll out at each site in year one of this three year project.

Section 2: Program Evaluation

Applicants will need to demonstrate their ability to evaluate this program as described in the literature, reporting and aggregating the findings from their pilot site(s) on a variety of measures over time. Measures should include a 6 month follow-up of women assessing reduced risk for an AEP by either decreasing their drinking levels and/or instituting effective contraception.

Part C: Program Report (1 Page Limitation)

Section 1: Reporting Capabilities

Describe reporting capacity and experience. Describe the reports, accompanying materials and exhibits that would be anticipated during the first year of the CHOICES pilot and throughout the project period. Append examples. Include description of training and client materials relevant to urban Indian and tribal settings and potential barriers to their development. Describe how all materials will be made available for local use in hard-copy as well as electronic. Applicant must describe how this project could be expanded nationally.

Section 2: Prior Accomplishments

Describe major activities and lessons learned over the past 12 to 24 months related to reducing AEP. Describe goals and key objectives achieved.

B. Budget Narrative: This narrative must describe the budget requested and match the scope of work described in the project narrative for Project Year I. It should be itemized and justified. The page limitation should not exceed 3 pages. Separate one page budgets for each of the Project Years II and III should be provided.

3. Submission Dates and Times

Applications must be submitted electronically through Grants.gov by September 15, 2010 at 12 midnight Eastern Standard Time (EST). Any application received after the application deadline will not be accepted for processing, and it will be returned to the applicant(s) without further consideration for funding.

If technical challenges arise and assistance is required with the electronic application process, contact Grants.gov Customer Support via e-mail to *support@grants.gov* or at (800) 518–4726. Customer Support is available to address questions 24 hours a day, 7 days a week (except on Federal holidays). If problems persist, contact Paul Gettys, Division of Grants Policy (DGP) (*Paul.Gettys@ihs.gov*) or call (301) 443–5204. Please be sure to contact Mr. Gettys at least ten days prior to the application deadline. Please do not contact the DGP until you have received a Grants.gov tracking number. In the event you are not able to obtain a tracking number, call the DGP as soon as possible.

If an applicant needs to submit a paper application instead of submitting electronically via Grants.gov, prior approval must be requested and obtained (see 6. Electronic Submission Requirements for additional information). The waiver must be documented in writing (e-mails are acceptable), before submitting a paper application. A copy of the written approval must be submitted along with the hardcopy that is mailed to the DGM (Refer to Section IV to obtain the mailing address). Paper applications that are submitted without a waiver will be returned to the applicant without review or further consideration. Late applications will not be accepted for processing will be returned to the applicant and will not be considered for funding.

Letters of Intent: Due August 26, 2010.

A Letter of Intent (LoI) is required from each entity that plans to apply for funding under this announcement. The LoI must be submitted to the Division of Grants Management to the attention of Denise Clark by August 26, 2010. Please submit all letters of intent via fax to (301) 443–9602. Your LoI must reference the funding opportunity number, application deadline date, and your eligibility status. The letter must be signed by the authorized organizational official within your entity.

4. Intergovernmental Review

Executive Order 12372 requiring intergovernmental review is not applicable to this program.

5. Funding Restrictions

- Pre-award costs are/are not allowable pending prior approval from the awarding agency. However, in accordance with 45 CFR Part 74 and 92, pre-award costs are incurred at the recipient's risk. The awarding office is under no obligation to reimburse such costs if for any reason the applicant does not receive an award or if the award to the recipient is less than anticipated.
- The available funds are inclusive of direct and appropriate indirect costs.
- Only one grant/cooperative agreement will be awarded per applicant.
- IHS will not acknowledge receipt of applications.

6. Electronic Submission Requirements

The preferred method for receipt of applications is electronic submission through Grants.gov. However, should any technical challenges arise regarding the submission, please contact Grants.gov Customer Support at (800) 518–4726 or *support@grants.gov.* The Contact Center hours of operation are 24 hours a day, 7 days a week. It is closed on all Federal holidays. The applicant must seek assistance at least fifteen days prior to the application deadline. Applicants that do not adhere to the timelines for Central Contractor Registry (CCR) and/or Grants.gov registration and/or requesting timely assistance with technical issues will not be a candidate for paper applications. Use the *http://www.Grants.gov* Web site to submit an application electronically and select the "Apply for Grants" link on the homepage. Download a copy of the application package, complete it offline, and then upload and submit the application via the Grants.gov Web site. Electronic copies of the application may not be submitted as attachments to e-mail messages addressed to IHS employees or offices.

Applicants that receive a waiver to submit paper application documents must follow the rules and timelines that are noted below. The applicant must seek assistance at least ten days prior to the application deadline.

Applicants that do not adhere to the timelines for Central Contractor Registry (CCR) and/or Grants.gov registration and/or request timely assistance with technical issues will not be considered for a waiver to submit a paper application.

Please be aware of the following:

- Please search for the application package in Grants.gov by entering the CFDA number or the Funding Opportunity Number. Both numbers are located in the header of this announcement.
- Paper applications are not the preferred method for submitting applications. However, if you experience technical challenges while submitting your application electronically, please contact Grants.gov Support directly at: *http://www.Grants.gov/CustomerSupport* or (800) 518–4726. Customer Support is available to address questions 24 hours a day, 7 days a week (except on Federal holidays).
- Upon contacting Grants.gov, obtain a tracking number as proof of contact. The tracking number is helpful if there are technical issues that cannot be resolved and waiver from the agency must be obtained.

• If it is determined that a waiver is needed, you must submit a request in writing (e-mails are acceptable) to *GrantsPolicy@ihs.gov* with a copy to *Tammy.Bagley@ihs.gov.* Please include a clear justification for the need to deviate from our standard electronic submission process.

• If the waiver is approved, the application should be sent directly to the DGM by the deadline date of September 15, 2010.

• Applicants are strongly encouraged not to wait until the deadline date to begin the application process through Grants.gov as the registration process for CCR and Grants.gov could take up to fifteen working days.

• Please use the optional attachment feature in Grants.gov to attach additional documentation that may be requested by the DGM.

• All applicants must comply with any page limitation requirements described in this Funding Announcement.

• After you electronically submit your application, you will receive an automatic acknowledgment from Grants.gov that contains a Grants.gov tracking number. The DGM will download your application from Grants.gov and provide necessary copies to the appropriate agency officials. Neither the DGM nor the Maternal and Child Health Program will notify applicants that the application has been received.

E-mail applications will not be accepted under this announcement.

Dun and Bradstreet (D&B) Data Universal Numbering System (DUNS)

Applicants are required to have a DUNS number to apply for a grant or cooperative agreement from the Federal Government. The DUNS number is a unique nine-digit identification number provided by D&B, which uniquely identifies your entity. The DUNS number is site specific; therefore each distinct performance site may be assigned a DUNS number. Obtaining a DUNS number is easy and there is no charge. To obtain a DUNS number, you may access it through the following Web site *http://fedgov.dnb.com/webform* or to expedite the process call (866) 705–5711.

Another important fact is that applicants must also be registered with the Central Contractor Registry (CCR) and a DUNS number is required before an applicant can complete their CCR registration. Registration with the CCR is free of charge. Applicants may register online at *http://www.ccr.gov.* Additional information regarding the DUNS, CCR, and Grants.gov processes can be found at: *http://www.Grants.gov.*

Applicants may register by calling 1(866) 606–8220. Please review and complete the CCR Registration worksheet located at *http://www.ccr.gov.*

V. Application Review Information

Points will be assigned to each evaluation criteria adding up to a total of 100 points. A minimum score of 70 points is required for funding. Points are assigned as follows:

1. Evaluation Criteria

Program Information 20 Points

Service population is described including risk characteristics for an Alcohol Exposed Pregnancy (AEP). Current clinical and community services and settings are detailed. Experience of the Project Choices (CHOICES) program is described. Ability to facilitate training, use of CHOICES materials, and ability to conduct implementation and evaluation of a project is described. Ability to adapt the materials for cultural acceptability for an AI/AN version while maintaining fidelity to the CHOICES model is described. Organizational capacity and key personnel are described.

Program Planning 30 Points

Project plan to implement CHOICES in three sites is described including enrollment and outreach activities. Approaches to address culture specific issues are described. Support structures for oversight of the implementation and evaluation are described. A three-year timeline with emphasis on year one is described and appended. Project monitoring activities are detailed.

Program Evaluation 30 Points

Evidence based CHOICES measures are described in the evaluation plan. Measures include a 6 month follow-up methodology for women to assess risk reduction and/or institution of effective contraception. Accountabilities for evaluation are described including process, impact, and outcome measures.

Program Report 10 Points

Reporting plan is outlined. The anticipated CHOICES materials adapted in Project Year I training and implementation phase are described. Materials development, enhancement and revisions are clearly described. Individual pilot site updates and program evaluation measures have clear expectations and timelines. Development of a communications plan separate from the semi-annual reports with project officer; other consultants and advisors; and pilot sites is described.

Budget 10 points

A categorical budget is provided. Budget is itemized and is accompanied by a justified narrative for each item. Costs are reflective of the goals and objectives of the project.

2. Review and Selection

Each application will be prescreened by the DGM staff for eligibility and completeness as outlined in the funding announcement. Incomplete applications and applications that are non-responsive to the eligibility criteria will not be referred to the Objective Review Committee. Applicants will be notified by DGM, via letter, to outline the missing components of the application.

To obtain a minimum score for funding, applicants must address all program requirements and provide all required documentation. Applicants that receive less than a minimum score will be informed via e-mail of their application's deficiencies. An Executive Summary Statement outlining the strengths and weaknesses of the application will be provided to these applicants. The Executive Summary Statement will be sent to the Authorized Organizational Representative that is identified on the face page of the application.

Applications that meet eligibility requirements, are complete, and conform to this announcement will be subject to the competitive objective review and evaluation by an Ad Hoc Review Committee of Tribal, IHS, and other Federal or non-Federal reviewers. Applications will be reviewed against criteria. Reviewers will assign a numerical score to each application which will be used to rank applications. The review process will be directed by the DGM staff to ensure compliance with the HHS and IHS grant review guidelines.

VI. Award Administration Information

1. Award Notices

The Notice of Award (NoA) will be initiated by the DGM and will be mailed via postal mail to each entity that is approved for funding under this announcement. The NoA will be signed by the Grants Management Officer and this is the authorizing document for which funds are dispersed to the approved entities. The NoA will serve as the official notification of the grant award and will reflect the amount of Federal funds awarded for the purpose of the grant, the terms and conditions of the award, the effective date of the

award, and the budget/project period. The NoA is the legally binding document and is signed by an authorized grants official within the IHS.

2. Administrative Requirements

Grants are administered in accordance with the following regulations, policies, and OMB cost principles:

A. The criteria as outlined in this Program Announcement.

B. Administrative Regulations for Grants:

- 45 CFR, Part 92, Uniform Administrative Requirements for Grants and Cooperative Agreements to State, Local and Tribal Governments.
- 45 CFR, Part 74, Uniform Administrative Requirements for Grants and Agreements with Institutions of Higher Education, Hospitals, and other Non-profit Organizations.

C. Grants Policy:

- HHS Grants Policy Statement, Revised 01/07.

D. Cost Principles:

- Title 2: Grant and Agreements, Part 225—Cost Principles for State, Local, and Indian Tribal Governments (OMB A–87).
- Title 2: Grant and Agreements, Part 230—Cost Principles for Non-Profit Organizations (OMB Circular A–122).

E. Audit Requirements:

- OMB Circular A–133, Audits of States, Local Governments, and Non-profit Organizations.

3. Indirect Costs

This section applies to all grant recipients that request reimbursement of indirect costs in their grant application. In accordance with HHS Grants Policy Statement, Part II–27, IHS requires applicants to obtain a current indirect cost rate agreement prior to award. The rate agreement must be prepared in accordance with the applicable cost principles and guidance as provided by the cognizant agency or office. A current rate covers the applicable grant activities under the current award's budget period. If the current rate is not on file with the DGM at the time of award, the indirect cost portion of the budget will be restricted. The restrictions remain in place until the current rate is provided to the DGM.

Generally, indirect costs rates for IHS grantees are negotiated with the Division of Cost Allocation *http://rates.psc.gov/* and the Department of Interior (National Business Center) *http://www.aqd.nbc.gov/services/ICS.aspx.* If your organization has questions regarding the indirect cost policy, please call (301) 443–5204 to request assistance.

4. Reporting Requirements

Failure to submit required reports within the time allowed may result in suspension or termination of an active grant, withholding of additional awards for the project, or other enforcement actions such as withholding of payments or converting to the reimbursement method of payment. Continued failure to submit required reports may result in one or both of the following: (1) The imposition of special award provisions; and (2) the non-funding or non-award of other eligible projects or activities. This requirement applies whether the delinquency is attributable to the failure of the grantee organization or the individual responsible for preparation of the reports.

The reporting requirements for this program are noted below.

A. Progress Reports

Program progress reports are required semi-annually of each funding year. These reports will include a brief comparison of actual accomplishments to the goals established for the period, or, if applicable, provide sound justification for the lack of progress, and other pertinent information as required/outlined in award letter. A final report must be submitted within 90 days of expiration of the budget/project period.

B. Financial Reports

Semi-annual Financial Status Reports (FSR) reports must be submitted within 30 days after the budget period ends.

Final FSRs are due within 90 days of expiration of the project period. Standard Form 269 (long form for those reporting on program income; short form for all others) will be used for financial reporting.

Federal Cash Transaction Reports are due every calendar quarter to the Division of Payment Management, Payment Management Branch, Department of Health and Human Services at: *http://www.dpm.gov.* Failure to submit timely reports may cause a disruption in timely payments to your organization.

Grantees are responsible and accountable for accurate reporting of the Progress Reports and Financial Status Reports which are generally due semi-annually. Financial Status Reports (SF–269) are due 90 days after each budget period and the final SF–269 must be verified from the grantee records on how the value was derived.

Telecommunication for the hearing impaired is available at: TTY (301) 443–6394.

VII. Agency Contacts

Grants (Business):

Mr. Andrew Diggs, 801 Thompson Ave., Reyes Bldg., Suite 360, Rockville, MD 20852, Telephone: (301) 443–5204, E-mail: *Andrew.Diggs@ihs.gov.*

Program (Programmatic/Technical):

Judith Thierry, 801 Thompson Ave., Reyes Bldg., Suite 300, Rockville, MD 20852, Telephone: (301) 443–5070, E-mail: *Judith.Thierry@ihs.gov.*

The Public Health Service (PHS) strongly encourages all grant and contract recipients to provide a smoke-free workplace and promote the non-use of all tobacco products. In addition, Public Law 103–227, the Pro-Children Act of 1994, prohibits smoking in certain facilities (or in some cases, any portion of the facility) in which regular or routine education, library, day care, health care or early childhood development services are provided to children. This is consistent with the HHS mission to protect and advance the physical and mental health of the American people.

Dated: August 12, 2010.

Randy Grinnell,

Deputy Director, Indian Health Service.

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Resources and Services Administration

Statement of Organization, Functions and Delegations of Authority

This notice amends Part R of the Statement of Organization, Functions and Delegations of Authority of the Department of Health and Human Services (HHS), Health Resources and Services Administration (HRSA) (60 FR 56605, as amended November 6, 1995; as last amended at 75 FR 48980–48983 dated August 12, 2010).

This notice reflects organizational changes in the Health Resources and Services Administration. Specifically, this notice updates the Bureau of Health Professions (RP) functional statement as a result of the Affordable Care Act, to better align functional responsibility to improve coordination and functional management; establishing clear lines of authority, responsibility, and accountability for resources and effectiveness; improving programmatic and administrative efficiencies; and optimizing use of available staff resources.