Idaho Supports Oral Health Workforce Activities
Subgrant Solicitation Application 2021

Organization: Click or tap here to enter text.	Tax ID Number: Click or tap here to enter text.
Contact Name: Click or tap here to enter text.	Contact Title: Click or tap here to enter text.
Address: Click or tap here to enter text.	City & Zip: Click or tap here to enter text.
Contact Phone: Click or tap here to enter text.	Contact Email: Click or tap here to enter text.
Person Completing Application: Click or tap here to enter text.	Role: Click or tap here to enter text.
D-U-N-S Number: Click or tap here to enter text. *(Dun & Bradstreet (D&B) provides a D-U-N-S Number, a unique nine-digit identification number, for each physical location of your business. D-U-N-S Number assignment is FREE for all businesses required to register with the U.S. Federal government for contracts or grants.)*	

Applications must be received by 5:00 p.m. M.T., Friday, April 23, 2021

A minimum of three individuals will score all applications. Application scores will be based on the entity's ability to illustrate capacity in the areas listed below.

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1. **<u>Current Environment:</u>**
   Please briefly describe the current environment: internal/external (e.g., existing efforts to address Dental HPSAs, state or federal funding already received by your program, political climate, and organizational culture). *[18 points]*

Click or tap here to enter text.

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2. **<u>Reach:</u>**
Please describe the location of where the project will be carried out, potential overall reach/target population, outline proposed objectives, and list associated metrics/outcomes. When writing the objective, please ensure they are ***'SMART'***. Referring to them being **S**pecific, **M**easurable, **A**chievable, **R**ealistic and, **T**imely (or time-bound) describing what an individual, team, or organization is hoping to achieve. *[18 points]*

Click or tap here to enter text.

<u>Example SMART Objective</u>: By August 31, 2021, identify two assisted living facilities to implement a teledentistry and silver diamine fluoride project.

<u>Example Metric/Outcome:</u> Two facilities identified.

Objective 1: Click or tap here to enter text.
Metrics/Outcome: Click or tap here to enter text.
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Objective 2: Click or tap here to enter text.
Metrics/Outcome: Click or tap here to enter text.
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Objective 3: Click or tap here to enter text.
Metrics/Outcome: Click or tap here to enter text.
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Objective 4: Click or tap here to enter text.
Metrics/Outcome: Click or tap here to enter text.
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3. Potential Barriers and/or Challenges:

Please briefly describe any potential barriers or challenges to implementation (e.g., staff buy-in, competing priorities, number of employers, limited staff time, etc.) and how your organization might overcome them. *[18 points]*

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4. Implementation Resources Available:

Please list or summarize the resources available to facilitate successful implementation (e.g., partnership with an organization, other funding). *[18 points]*

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5. **Roles and Responsibilities:**
Identify key individuals who will assist in the development and implementation of the selected activities and overall project. Each individual identified in the following table will be required to attend a kick-off conference call on Tuesday, June 1, 2021. *See the solicitation document for more information.*
[18 points]

Role	Key Person Name, Job Title, and Credentials
Project Director	Click or tap here to enter text.
Supervising Dentist	Click or tap here to enter text.
Organizational Decision-Maker (e.g. COO or CEO)	Click or tap here to enter text.
Other key staff *optional* (e.g. dental hygienist)	Click or tap here to enter text.
Other key staff *optional* (e.g. practice manager)	Click or tap here to enter text.
Other key staff *optional* (e.g. dental assistant)	Click or tap here to enter text.
Other key staff *optional*	Click or tap here to enter text.
Other key staff *optional*	Click or tap here to enter text.
Other key staff *optional*	Click or tap here to enter text.
Other key staff *optional*	Click or tap here to enter text.

6. **Budget:**
Please provide a budget that follows the template provided on pages 8 – 11. Include a justification narrative to support each budget item requested. Please ensure the budget allocation addresses the following (see solicitation document for more information). *[10 points]*
    - Personnel time to address the selected project strategies/activities listed in the solicitation
    - Personnel time to participate in routine subgrantee calls
    - Personnel time to complete required reporting
    - Funds to support any marketing, media, or other operating costs

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7. **Priority Counties:**
   Please list the Dental Health Professional Shortage Areas (Dental HPSAs) you plan to serve with the project.
   [Reviewed, not scored – will be assessed as met vs. unmet]

Click or tap here to enter text.

8. **Letter of Support:** *(as part of the appendices)*
   Please include a letter of support from the administration of the applicant's organization (i.e., CEO, CFO, Executive Director, etc.). Letters of support can make an application more competitive and demonstrates an organizational commitment to the project.
   [Reviewed, not scored – will be assessed as met vs. unmet]

Applications must be sent electronically to:
Kelli Broyles, Health Program Specialist, at Kelli.Broyles@dhw.idaho.gov.

Applications must be received by 5:00 p.m. Friday, April 23, 2021.
All material submitted or developed becomes the property of the Idaho Department of Health and Welfare's Bureau of Community and Environmental Health (BCEH).

Any materials developed and printed within the scope of this grant are required to use the following language. "This [project/publication/program/website, etc.] [is/was] supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) as part of a financial assistance award totaling $569,295 with 70% funded by HRSA/HHS and $169,295 and 30% funded by non-government source(s). The contents are those of the author(s) and do not necessarily represent the official views of, nor an endorsement, by HRSA/HHS, or the U.S. Government."

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Budget Narrative Template

Budget Summary

Item	Total Amount
A. Personnel	$ Amount Here
B. Operating	$ Amount Here
C. Indirect costs	$ Amount Here
TOTAL REQUESTED	**$ Amount Here**

Itemized Budget

A. Personnel

Personnel	Total Hourly Rate*	Number of Hours	Total	Amount Requested
Name, Job Title, Credentials Click or tap here to enter text.	$Rate/Hour	# of Hours Here	$ Amount Here	$ Amount Here
Name, Job Title, Credentials Click or tap here to enter text.	$Rate/Hour	# of Hours Here	$ Amount Here	$ Amount Here
Name, Job Title, Credentials Click or tap here to enter text.	$Rate/Hour	# of Hours Here	$ Amount Here	$ Amount Here
Name, Job Title, Credentials Click or tap here to enter text.	$Rate/Hour	# of Hours Here	$ Amount Here	$ Amount Here
Name, Job Title, Credentials Click or tap here to enter text.	$Rate/Hour	# of Hours Here	$ Amount Here	$ Amount Here
Name, Job Title, Credentials Click or tap here to enter text.	$Rate/Hour	# of Hours Here	$ Amount Here	$ Amount Here
Name, Job Title, Credentials Click or tap here to enter text.	$Rate/Hour	# of Hours Here	$ Amount Here	$ Amount Here
Name, Job Title, Credentials Click or tap here to enter text.	$Rate/Hour	# of Hours Here	$ Amount Here	$ Amount Here
Name, Job Title, Credentials Click or tap here to enter text.	$Rate/Hour	# of Hours Here	$ Amount Here	$ Amount Here
Name, Job Title, Credentials Click or tap here to enter text.	$Rate/Hour	# of Hours Here	$ Amount Here	$ Amount Here
TOTAL REQUESTED				**$ Amount Here**

*Please include fringe

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Personnel Justification:
For each line item listed above, please provide a justification for each personnel and the amount requested.

Name	*Justification*
Name	Click or tap here to enter text.
Name	Click or tap here to enter text.
Name	Click or tap here to enter text.
Name	Click or tap here to enter text.
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B. Operating: (May include program marketing, printing costs, patient education materials, facility rentals, travel costs, etc.)

Expense Description	Unit Description**	Cost	Number of Units	Total	Amount Requested
Patient Education Materials	Unit Description.	$ Amount Here	# of Units	$ Amount Here	$ Amount Here
Supplies	Unit Description.	$ Amount Here	# of Units	$ Amount Here	$ Amount Here
Equipment	Unit Description.	$ Amount Here	# of Units	$ Amount Here	$ Amount Here
Other Item (Optional)	Unit Description.	$ Amount Here	# of Units	$ Amount Here	$ Amount Here
Other Item (Optional)	Unit Description.	$ Amount Here	# of Units	$ Amount Here	$ Amount Here
Other Item (Optional)	Unit Description.	$ Amount Here	# of Units	$ Amount Here	$ Amount Here
Other Item (Optional)	Unit Description.	$ Amount Here	# of Units	$ Amount Here	$ Amount Here
Other Item (Optional)	Unit Description.	$ Amount Here	# of Units	$ Amount Here	$ Amount Here
Other Item (Optional)	Unit Description.	$ Amount Here	# of Units	$ Amount Here	$ Amount Here
Other Item (Optional)	Unit Description.	$ Amount Here	# of Units	$ Amount Here	$ Amount Here
Other Item (Optional)	Unit Description.	$ Amount Here	# of Units	$ Amount Here	$ Amount Here
Other Item (Optional)	Unit Description.	$ Amount Here	# of Units	$ Amount Here	$ Amount Here
Other Item (Optional)	Unit Description.	$ Amount Here	# of Units	$ Amount Here	$ Amount Here
Other Item (Optional)	Unit Description.	$ Amount Here	# of Units	$ Amount Here	$ Amount Here
TOTAL REQUESTED					**$ Amount Here**

**unit description: brief description of the type of education materials, supplies, equipment, etc.

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Operating Justification:

For each line item listed above, please provide a brief justification.

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C. **Indirect Costs:**
Please provide a justification of indirect costs, if included in the budget. This can include a copy of an approved cost allocation plan or a copy of an approved indirect rate. The subgrantee can also elect to charge a de minimis rate of 10% of modified total direct costs.

Click or tap here to enter text.

D. **Project Match:** (Match may be in the form of salaries, fringe, indirect costs, dental procedures, equipment or supplies, and mobile clinic or program space. For questions regarding match please contact Kelli Broyles at Kelli.Broyles@dhw.idaho.gov)

Item	Total Amount
D. Personnel	$ Amount Here
E. Operating	$ Amount Here
F. Indirect costs	$ Amount Here
G. Meeting Space, Dental Procedures, Equipment or Supplies	$ Amount Here
Other Item (Optional)	$ Amount Here
Other Item (Optional)	$ Amount Here
Other Item (Optional)	$ Amount Here
Other Item (Optional)	$ Amount Here
TOTAL MATCH	**$ Amount Here**

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