

**HIV EMERGENCY RELIEF PROGRAM
PART A GRANT
APPLICATION FOR METROPOLITAN ATLANTA FUNDS
Fiscal Year 2014**

Legal Name of Applicant Organization:

Name:

Address (include Street, City, County, State, and Zip Code):

Street:

City:

County:

Zip Code:

Person to Contact on Matters Involving this Application:

Name:

Phone Number:

Fax Number:

Email Address:

Proposed Priority Service Areas and Funding Amount Requested Per Service Priority Area
(See Application Guidance p. 7 for Priority Area Categories):

Priority Category	Part A Funds Requested*	Support Services Breakdown	
Primary Care:	\$	FA:	\$
Oral Health:	\$	EA:	\$
Local AIDS Pharmaceutical Assistance:	\$	PS:	\$
Case Management:	\$	MT:	\$
Mental Health:	\$	LS:	\$
Substance Abuse:	\$	LA:	\$
Support Services:	\$	CC:	\$
TOTAL	\$	TOTAL**	\$

*Note: These totals must equal the requests on F3: Budget Summary by Priority Category.

** This total must be entered into Support Services category request column.

Individual Authorized to Enter into Contracts on Agency's Behalf:

Name:

Title:

Signature of Above-Listed Authorized Representative and Date Signed:

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By initialing each item below, the individual authorized to enter into contracts on behalf of the applicant agency certifies that s/he has **reviewed the initialed section** for completeness and accuracy and approves its content.

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APPLICATION CHECKLIST

By initialing each item below, the individual authorized to enter into contracts on behalf of the applicant agency certifies the information included in each initialed section.

INITIALS ▽	I certify that:	Guidance reference page
	The application packet is complete	p. 14
	<p>The application narrative complies with all formatting and technical requirements:</p> <ul style="list-style-type: none"> • Forms: The document is submitted on the required Microsoft Word and Excel forms, with no alterations made to those forms • Line spacing: 1.5 or 2 (exception: Abstract and Budget Justification are single spaced) • Page numbers: Every page in the application, beginning with the cover page, is numbered sequentially • Font: Times New Roman • Font size: 12 (exception: Tables, Excel spreadsheets, and footnotes may use font size 10) • Length: No section of the narrative exceeds the page limits listed in the table of contents • Photos: None are included • Oversized documents: None are included (exception: Excel files are printed on legal size -- 8.5 x 14 inch -- paper) 	p. 15
	No required information is being included in a cover letter (all cover letters are discarded unread).	p. 17

APPLICATION CHECKLIST

	<p>Grant funds will not be used to:</p> <ul style="list-style-type: none"> • Replace (i.e. used instead of) current state and local HIV-related funding or in-kind resources • Supplant or replace (i.e. used instead of) the resources of institutional inpatient settings, such as hospitals and nursing homes that are already devoted to the support of personnel providing HIV-related services • Purchase or improve land, or to purchase, construct or make permanent improvements to any building beyond minor remodeling • Make payments directly to recipients of services • Provide items or services for which payment has already been made or can reasonably be expected to be made by third party payers, including Medicaid, Medicare, and/or other state or local entitlement programs, prepaid health plans, or private insurance • Pay for out-of-state travel. • Fund research projects or clinical trials • Pay for fund-raising activities (including salaries, supplies, etc.) • Purchase of vehicles without written Grant Management Officer (GMO) approval • Pay for non-targeted marketing promotions or advertising about HIV services that target the general public (poster campaigns for display on public transit, TV or radio public service announcements, etc.) or for broad scope awareness activities about HIV services that target the general public • Influence or attempt to influence members of Congress and other Federal personnel • Fund outreach activities that have HIV prevention education as their exclusive purpose • Pay for foreign travel 	p. 7
	Any charges for services will be on a sliding fee schedule that is in compliance with RW guidelines and made available to the public.	p. 8
	The agency and its RW supported clients will participate in a community-based continuum of care	p. 8
	The agency will provide monthly expenditure reports, itemizing disbursement of grant funds, accompanied by the appropriate supporting documentation; the first report to be submitted 45 days after the contract effective date	p. 11
	The agency will provide quarterly program reports documenting progress in implementing program goals and objectives, including the number and the demographic characteristics of clients served, and reporting any issues or problems that have impeded program implementation.	p. 11

APPLICATION CHECKLIST

	<p>The agency complies with the Non-Discrimination Policy of Fulton County, Georgia</p> <p>Employment opportunities and conditions of employment at the agency will be free from discrimination due to race, color, creed, national origin, sex, sexual orientation, religion, or disability.</p> <p>The agency will comply with Federal and State laws, rules and regulations of the County’s policy relative to non-discrimination in client and client service practices because of political affiliation, religion, race, color, sex, handicap, age, sexual orientation, or national origin.</p> <p>The agency will provide services without regard to ability to pay or the current or past health condition of an individual, and in settings accessible to low-income persons.</p>	p. 58
	<p>The agency will include, without modification, the text of the non-discrimination policy described above in all documents relating to the programs and services provided through the funding proposed with this application.</p>	p. 58
	<p>All agency personnel providing services with funds received as a result of this application have reviewed and will comply with the Public Health Service requirements concerning DEBARMENT AND SUSPENSION, DRUG-FREE WORKPLACE, LOBBYING, AND THE PROGRAM FRAUD CIVIL REMEDIES ACT available on the Ryan White website: http://www.fultoncountyga.gov/ryan-white-home.</p>	p. 58

Applicant Agency:

1. ABSTRACT (5 page limit, single spaced)

Agency mission statement and year agency founded:

Breakdown and specific use of requested funds:

Justification of need for requested funds:

What the requested funds will be used to accomplish:

Description of the population to be served with funds requested:

The SMART outcome objectives, by priority category, for all services and activities for which funds are being requested – include Process Measures only:

Applicant Agency:

2. SUMMARY OF HIV SERVICES (no page limit)

Current HIV Services

Column 3: For each service, provide # HIV **clients** supported by this service in 2013. First provide # of HIV clients supported by all Ryan White funds = 132. Then provide # of HIV clients supported with all other sources of funding in 2013 (+ 200*). These numbers = total # HIV clients supported by this service or 332. *Source of other funds, i.e., state funds.

Currently funded applicants should use CAREWare data for calendar year (CY) 2013.

Column 4: For each service, provide # **Employees** and **volunteers** providing this service in 2013. # RW-funded **employees** providing service in 2013 (all Ryan White) (+ # of employees funded through other means*) = total employees providing this service (+ # of volunteers providing this service). *Source of other funds, i.e., SAMHSA

Columns 4, 5, and 6: Information provided in these columns should be based on the FY2013 contract or budget period for the different fund sources.

Name of HIV service (year service began)	Purpose of service.	# HIV clients supported by this service in CY2013	# Employees and volunteers providing this service in 2013	Amount provided for this service by RW Part A (only) in 2013	Priority Categories under which request was funded (amount per priority category) by RW Part A (only) in 2013

Proposed HIV Services

Column 3: For each service, provide the # HIV **clients** to be supported by this service in 2014. First provide # of HIV clients to be supported by all Ryan White funds = 150. Then provide # of HIV clients to be supported with all other sources of funding in 2014 (+ 220*). These numbers = total # HIV clients to be supported by this service in 2014 or 370. *Source of other funds, i.e., state funds.

Column 4: For each service, provide # **Employees** and **volunteers** to provide this service in 2014. # RW-funded **employees** to provide service in 2014 (all Ryan White) is 6.5 (+ # of employees to be funded through other means*) 3.5 = total employees providing this service or 10 (+ # of volunteers providing this service) or 35. *Source of other funds, i.e., state funds or SAMHSA.

Name of HIV service (year service began)	Purpose of service	# HIV clients to be supported by this service in 2014	# Employees and volunteers to provide service in 2014	Amount requested for this service from RW Part A (only) in 2014	Priority Categories under which funds are requested (amt per priority category) for RW Part A (only) in 2014

Applicant Agency:

3. ACTIVITIES DESCRIPTION (limit = 6 pages)

3a. Describe in detail the proposed activities and services for which funds are being requested. Provide total dollar amounts requested for each activity/service.

3b. Describe what will be accomplished if the proposed activities and services are funded.

Applicant Agency:

4. HIV/AIDS CLIENT DEMOGRAPHICS (fill in table below)

	Calendar Year								
	2012(actual CY12)			2013 (actual CY13)			2014 (projected to be served with FY2014 Part A funds)		
Total #									
Gender # (%)	Males: Females: Trans:			Males: Females: Trans:			Males: Females: Trans:		
Age	Age	# (%)	#(% F)	Age	# (%)	#(% F)	Age	# (%)	#(% F)
	0 – <2 yr:			0 – <2 yr:			0 – <2 yr:		
	2-12 yrs:			2-12 yrs:			2-12 yrs:		
	13-24 yrs:			13-24 yrs:			13-24 yrs:		
	25-44 yrs:			25-44 yrs:			25-44 yrs:		
	45-64 yrs:			45-64 yrs:			45-64 yrs:		
	65+ yrs			65+ yrs			65+ yrs		
Race # (%)	Black: Caucasian: Other:			Black: Caucasian: Other:			Black: Caucasian: Other:		
Ethnicity # (%)	Hispanic: Non-Hispanic:			Hispanic: Non-Hispanic:			Hispanic: Non-Hispanic:		

% = number (percent of total)

#(%F) = (percent of total who are Female)

Applicant Agency: _____

5. GOALS AND OBJECTIVES BY PRIORITY CATEGORY (no page limit)

Following the format below, create and fill in one or more tables per Priority Category for which funding is requested

PRIORITY CATEGORY:	
GOAL:	
SMAART Outcome Objectives and their associated funding requests:	
1.	
Budget items requested:	Total \$ amount
	\$
	\$
2.	
Budget items requested:	Total \$ amount
	\$
	\$
3.	
Budget items requested:	Total \$ amount
	\$
	\$

Applicant Agency: _____

PRIORITY CATEGORY:
GOAL:

SMAART Outcome Objectives and their associated funding requests:	
4.	
Budget items requested:	Total \$ amount
	\$
	\$

5.	
Budget item requested:	Total \$ amount
	\$
	\$

6.	
Budget item requested:	Total \$ amount
	\$
	\$

Applicant Agency:

6. FUNDING REQUEST JUSTIFICATION (limit = 2 pages)

Explain why your agency should receive funding for the services and activities you are proposing.

7. ORGANIZATIONAL CAPACITY (limit = 7 pages)

7a. Cultural Competence

- Provide a narrative that **addresses each** of the “Elements of Cultural Competence” listed below:

Service/Project Description and Need Justification:

Experience or Track Record of Involvement with the Target Population:

Community Representation:

Language and Communication:

Staff Qualifications and Training:

- List any additional aspects of target population-specific culture in which your agency will need to become competent in order to best serve your current and future clients and, for each aspect, describe the activities the agency staff will undertake in order to become competent.

7b. Infrastructure

Describe the infrastructure resources (staffing, space, equipment, materials, etc.) that are already in place to provide the activities and services being proposed in this application.

Describe the additional infrastructure resources (staffing, space, equipment, materials, etc.) needed if the agency is to provide the activities and services being proposed in this application.

7c. Quality Management Activities

Provide a list of staff members responsible for quality management activities at the agency and a description of each person’s individual role.

Explain the process used to monitor compliance with EMA quality management standards and indicators (including describing all of the different types of quality management data that is collected, who collects it, and how each is collected -- e.g. chart review, client satisfaction surveys, CAREWARE, etc.). Give the frequency of each monitoring activity.

Describe past projects undertaken to improve program quality and what improvements resulted from them.

Describe current projects being implemented to improve program quality.

7d. Coordination of Services with Other Providers

Provide a list of providers with which your agency works to ensure access to comprehensive care for agency clients (including prevention counseling, medical case management, mental health, substance abuse, oral health and support services) and describe the services each partner agency provides to your clients.

Indicating for each whether the activity is current (already in place) or new (proposed for the future), provide a description of your agency’s activities to coordinate programs and services with other providers. Include details of your process to document that referral appointments are kept.

8. REGULATORY PROCEDURES (limit = 6 pages)

8a. Letters of Agreement

Provide a list of those agencies named in section 7d above with which you have a formal Letter of Agreement in place. Divide the list into two groups as below (Note: agencies may appear on more than one list) and put copies of all Letters of Agreement in Appendix C.:

- **Your agency’s services take place at the following providers’ location:**
 -
 -
 -

- **Your agency’s services are contingent on referrals from the following providers:**
 -
 -
 -

8b. Ensuring Access to and Retention in Primary Care

Provide the agency's policy concerning the provision of services for clients whose primary care status is unknown or who are not currently in primary care.

Describe how the agency documents which clients are and are not currently receiving primary care. Include details about who is responsible for documenting that care is or is not being received and how often documentation occurs.

Describe how the agency facilitates access to care for those clients who have never been in primary care or who are currently lost to follow up. Include details about who is responsible for this activity, the timeline for enrollment into primary care, procedures for verifying that enrollment has taken place, and activities for ensuring that enrolled clients remain in primary care in the future.

8c. Client Income Eligibility

Describe in detail, from the time a client first presents at or is referred to the agency until the process is completed, your agency's procedures for determining eligibility for Ryan White services and documenting that eligibility. Include details about who is responsible for collecting the information, when and how often it is collected, what type(s) of documentation is reviewed, and where the information is recorded.

8d. Payer of Last Resort

Describe in detail your agency's policy(ies) and process(es) for determining if the client has a third party payer. Include details about who is responsible for making the determination, when and how often it occurs, what type(s) of documentation is reviewed, and where the information is recorded.

Applicant Agency:

Describe your policy(ies) and process(es) for how you will work to enroll clients in programs for which they are eligible.

8e. Collection of Fees

Provide the agency's policy concerning collecting fees/payments/charges from clients.

If fees are collected, describe how the agency ensures that the fees charged directly to clients are in line with Ryan White requirements, when fees are collected, how funds are used by the agency, and how collection and expenditure of funds is monitored.

Describe how funds collected from other payers (e.g., private insurance, Medicaid, etc.) are used by your agency to further support provision of services and how the collection and expenditure of funds is monitored.

Provide a list of all third-party payers (as Appendix D) along with the services covered.

Applicant Agency:

FINANCIAL INFORMATION

Applicant Agency:

[Note: if you are requesting indirect costs in Budget section J, insert a copy of your HRSA approved indirect cost rate information in place of this page. If you are not requesting indirect costs, eliminate this page.]

Applicant Agency:

F1A. BUDGET JUSTIFICATION: AGENCY SERVICES

Note: Read the instructions in the Guidance very carefully before filling in this section

A. PERSONNEL

Salary

Salary Justification Table: [Insert name of Priority Category/Subcategory]

POSITION #:	POSITION TITLE	DETAILED JOB DESCRIPTION SPECIFIC TO PRIORITY CATEGORY	SMAART OUTCOME OBJECTIVE(S) (list #s from Section 5)

Fringe Rate

The fringe rate is: ___% of salaries and wages. See details below:

Fringe Category	Fringe % (Full-Time Employees)	Fringe % (Part-Time Employees)
FICA		
Health/Dental Insurance		
Life Insurance		
Unemployment Insurance		
Workers' Compensation		
Other: (Specify)		
Other: (Specify)		
TOTAL:		

B. MATERIALS/SUPPLIES

ADAP Justification Table

PRIORITY CATEGORY	LINE-ITEM	ESTIMATED COST PER MONTH	# OF CLIENTS RW (other)*	SMAART OUTCOME OBJECTIVE(S) (list #s from Section 5)
AIDS Pharm. Assist.	ARVs	\$		
AIDS Pharm. Assist.	Non-ARVs	\$		

* The number of clients for which Part A funding is requested (the # of clients to be served by other patient assistance programs)

Provide a detailed description of how the estimated cost per month was calculated:

Applicant Agency:

Provide a detailed description of how you calculated the number of monthly clients for which Part A funding for ADAP meds (ARVs + Non ARVs) is being requested:

Provide a detailed description of how you calculated the number of ADAP-eligible monthly clients to be served by other patient assistance programs:

Describe the process that your agency uses to ensure that medications are obtained at the PHS 340(b) Price Level or better:

Other Medications Justification Table

PRIORITY CATEGORY	LINE-ITEM	ESTIMATED COST PER MONTH	# OF CLIENTS	SMAART OUTCOME OBJECTIVE(S) (list #s from Section 5)
Primary Care	Non-ADAP	\$		
Oral Health	Medications	\$		
Mental Health	Medications	\$		

Provide a detailed description of how you calculated the estimated cost per month (do this separately for each Priority Category for which funds are requested):

Provide a detailed description of how you calculated the number of monthly clients for which Part A funding is being requested (provide a separate description for each Priority Category):

Describe the process that your agency uses to ensure that medications are obtained at the PHS 340(b) Price Level or better:

Other Supplies Justification Table

PRIORITY CATEGORY	PRIORITY SUB-CATEGORY	SUB LINE ITEM	SMAART OUTCOME OBJECTIVE(S) (list #s from Section 5)
Primary Care	N/A	Medical Supplies	
Oral Health	N/A	Medical Supplies	
Mental Health	N/A	Medical Supplies	
		Office Supplies	
		Office Supplies	

Applicant Agency:

C. PRINTING

Printing Justification Table

PRIORITY CATEGORY	PRIORITY SUB-CATEGORY	ITEM DESCRIPTION	SMAART OUTCOME OBJECTIVE(S) (list #s from Section 5)

D. EQUIPMENT

Equipment Justification Table

PRIORITY CATEGORY	PRIORITY SUB-CATEGORY	LINE ITEM	ITEM DESCRIPTION	SMAART OUTCOME OBJECTIVE(S) (list #s from Section 5)
		Office		
		Office		
		Facility		
		Facility		

E. EMPLOYEE TRAVEL

Local Travel Justification Table

POSITION #:	PRIORITY CATEGORY	PRIORITY SUB-CATEGORY	SPECIFIC PURPOSE OF TRAVEL OR PARKING	SMAART OUTCOME OBJECTIVE(S) (list #s from Section 5)

F. MEDICAL (CLIENT) TRANSPORTATION

Client Transportation Justification Table

METHOD OF TRAVEL	DESTINATION	COST / TRIP (# OF TRIPS / MONTH / CLIENT)	# CLIENTS	SMAART OUTCOME OBJECTIVE(S) (list #s from Section 5)

Applicant Agency:

Justify the purpose and method of travel for each destination for which funds are requested:

Describe how the cost per trip and the number of trips per month per client was calculated for each method of travel and destination.

G. SPACE

Space Justification Tables

PRIORITY CATEGORY	PRIORITY SUB-CATEGORY	SUB LINE-ITEM	TYPE OF SPACE (PURPOSE)	SQUARE FEET (COST PER SQUARE FOOT)	SMAART OUTCOME OBJECTIVE(S) (list #s from Section 5)
		Rent			
		Rent			

PRIORITY CATEGORY	PRIORITY SUB-CATEGORY	SUB LINE-ITEM	TYPE	SMAART OUTCOME OBJECTIVE(S) (list #s from Section 5)
		Utility	Gas	
		Utility	Electric	
		Utility	Phone	
		Utility	Water/Sewer	

H. AUDIT

Audit/Independent Financial Statement Justification Table

PRIORITY CATEGORY	PRIORITY SUB-CATEGORY	SMAART OUTCOME OBJECTIVE(S) (list #s from Section 5)

Applicant Agency:

I. INSURANCE

Insurance Justification Table

PRIORITY CATEGORY	PRIORITY SUB- CATEGORY	TYPE OF INSURANCE	SMAART OUTCOME OBJECTIVE(S) (list #s from Section 5)

J. OTHER:

Cell Phone Justification Table

PRIORITY CATEGORY	PRIORITY SUB- CATEGORY	PERSONNEL POSITION #	ITEM DESCRIPTION / PURPOSE	SMAART OUTCOME OBJECTIVE(S) (list #s from Section 5)

Other Items Justification Table

PRIORITY CATEGORY	PRIORITY SUB- CATEGORY	ITEM DESCRIPTION / PURPOSE	SMAART OUTCOME OBJECTIVE(S) (list #s from Section 5)

Applicant Agency:

F1B. BUDGET JUSTIFICATION: SUBCONTRACT SERVICES

Note: Read the instructions in the Guidance very carefully before filling in this section

UNIT OF SERVICE SUBCONTRACTS

Unit of Service Subcontracts Justification Table

PRIORITY CATEGORY	PRIORITY SUB-CATEGORY	TYPE OF SERVICE	ITEM DESCRIPTION / PURPOSE	SMAART OUTCOME OBJECTIVE(S) (list #s from Section 5)

OTHER SUBCONTRACTS

A. Salary

Salary Justification Table: Subcontract Services

POSITION #:	POSITION TITLE	DETAILED JOB DESCRIPTION SPECIFIC TO PRIORITY CATEGORY	SMAART OUTCOME OBJECTIVE(S) (list #s from Section 5)

Fringe Rate

The fringe rate is: ___% of salaries and wages. See details below:

Fringe Category	Fringe % (Full-Time Employees)	Fringe % (Part-Time Employees)
FICA		
Health/Dental Insurance		
Life Insurance		
Unemployment Insurance		
Workers' Compensation		
Other: (Specify)		
Other: (Specify)		
TOTAL:		

B. MATERIALS/SUPPLIES

ADAP Justification Table

PRIORITY CATEGORY	LINE-ITEM	ESTIMATED COST PER MONTH	# OF CLIENTS RW (other)*	SMAART OUTCOME OBJECTIVE(S) (list #s from Section 5)
AIDS Pharm. Assist.	ARVs	\$		
AIDS Pharm. Assist.	OIs	\$		

* The number of clients for which Part A funding is requested (the # of clients to be served by other patient assistance programs) e.g. 25 (15)

Provide a detailed description of how the estimated cost per month was calculated:

Provide a detailed description of how you calculated the number of monthly clients for which Part A funding for ADAP meds (ARVs + Non ARVs) is being requested:

Provide a detailed description of how you calculated the number of ADAP-eligible monthly clients to be served by other patient assistance programs:

Describe the process that your agency uses to ensure that medications are obtained at the PHS 340(b) Price Level or better:

Other Medications Justification Table

PRIORITY CATEGORY	LINE-ITEM	ESTIMATED COST PER MONTH	# OF CLIENTS	SMAART OUTCOME OBJECTIVE(S) (list #s from Section 5)
Primary Care	Non-ADAP	\$		
Oral Health	Medications	\$		
Mental Health	Medications	\$		

Provide a detailed description of how you calculated the estimated cost per month (do this separately for each Priority Category for which funds are requested):

Provide a detailed description of how you calculated the number of monthly clients for which Part A funding is being requested (provide a separate description for each Priority Category):

Applicant Agency:

Describe the process that your agency uses to ensure that medications are obtained at the PHS 340(b) Price Level or better:

Other Supplies Justification Table

PRIORITY CATEGORY	PRIORITY SUB-CATEGORY	SUB LINE ITEM	SMAART OUTCOME OBJECTIVE(S) (list #s from Section 5)
Primary Care	N/A	Medical Supplies	
Oral Health	N/A	Medical Supplies	
Mental Health	N/A	Medical Supplies	
		Office Supplies	
		Office Supplies	
		Office Supplies	

C. PRINTING

Printing Justification Table

PRIORITY CATEGORY	PRIORITY SUB-CATEGORY	ITEM DESCRIPTION	SMAART OUTCOME OBJECTIVE(S) (list #s from Section 5)

D. EQUIPMENT

Equipment Justification Table

PRIORITY CATEGORY	PRIORITY SUB-CATEGORY	LINE ITEM	ITEM DESCRIPTION	SMAART OUTCOME OBJECTIVE(S) (list #s from Section 5)
		Office		
		Office		
		Facility		
		Facility		

Applicant Agency:

E. EMPLOYEE TRAVEL

Local Travel Justification Table

POSITION #:	PRIORITY CATEGORY	PRIORITY SUB-CATEGORY	SPECIFIC PURPOSE OF TRAVEL OR PARKING	SMAART OUTCOME OBJECTIVE(S) (list #s from Section 5)

F. MEDICAL (CLIENT) TRANSPORTATION

Client Transportation Justification Table

METHOD OF TRAVEL	DESTINATION / PURPOSE	# CLIENTS	SMAART OUTCOME OBJECTIVE(S) (list #s from Section 5)

G. SPACE

Space Justification Table

PRIORITY CATEGORY	PRIORITY SUB-CATEGORY	SUB LINE-ITEM	SQUARE FEET	COST PER SQUARE FOOT	SMAART OUTCOME OBJECTIVE(S) (list #s from Section 5)
		Rent			
		Rent			

PRIORITY CATEGORY	PRIORITY SUB-CATEGORY	SUB LINE-ITEM	TYPE	SMAART OUTCOME OBJECTIVE(S) (list #s from Section 5)
		Utility	Gas	
		Utility	Electric	
		Utility	Phone	
		Utility	Water/Sewer	

H. AUDIT

Audit/Independent Financial Statement Justification Table

PRIORITY CATEGORY	PRIORITY SUB-CATEGORY	SMAART OUTCOME OBJECTIVE(S) (list #s from Section 5)

I. INSURANCE

Insurance Justification Table

PRIORITY CATEGORY	PRIORITY SUB-CATEGORY	TYPE OF INSURANCE	SMAART OUTCOME OBJECTIVE(S) (list #s from Section 5)

J. OTHER

Other Items Justification Table

PRIORITY CATEGORY	PRIORITY SUB-CATEGORY	ITEM DESCRIPTION / PURPOSE	SMAART OUTCOME OBJECTIVE(S) (list #s from Section 5)

Applicant Agency:

**In place of this blank page, insert Sections F2-F6 (Excel spreadsheets).
Number the inserted pages.**

**Insert Appendices A, B, C, and D after the Excel spreadsheets.
Number the inserted pages.**