# ATTACHMENT 2: LETTER OF INTEREST FORMAT

Sandra J. Rhoades, RD, MPH
Director, Homes Administration Unit
New York State Department of Health
Division of Nutrition
Child and Adult Care Food Program
150 Broadway, 6th Floor West
Albany, NY 12204-2719

Re: RFA # 1010130338
RFA Title: Eat Well Play Hard - Day Care Homes (EWPH-DCH)

Dear Ms. Rhoades:

This letter is to indicate our interest in the above Request for Applications (RFA) and to request:
*(please check one)*

☐ that our organization be notified, via the e-mail address below, when any updates, official responses to questions, or amendments to the RFA are posted on the Department of Health website: http://www.health.ny.gov/funding/.

E-mail address: _____

☐ that our organization is unable or prefers not to use the Department of Health's website and requests the actual documents containing any updates, official responses to questions, or amendments to the RFA be mailed to the address below:

_____
_____
_____

Sincerely,

_____

Organization Name: _____

CACFP Agreement Number: _____

Date: _____

# ATTACHMENT 3: APPLICATION CHECKLIST

It is recommended that you complete this checklist to ensure that each application is properly completed and that all of the following components are included:

1. _____ Application Cover Sheet (Attachment 4) - completed and signed

2. _____ Statement of Need (1-2 pages)

3. _____ Program Activities/Work Plan (2-4 pages)

4. _____ Budget and Justification (Attachments 5a to 5d)

5. _____ Budget justification (2-3 pages)

6. _____ Cost Allocation Plan, if requesting Administrative or Allocated Expenses

7. _____ Vendor Responsibility Attestation (Attachment 7)

If you are applying as a coalition include:

8. _____ Letter of Agreement, signed by the Executive Director of each partnering CACFP sponsoring organization of DCHs. In the letter indicate, the partner DCH sponsoring organization service area counties to receive EWPH-DCH.

Please remember to submit *two* original signed applications and *three* copies of the application.

# ATTACHMENT 4: APPLICATION COVER SHEET

Eat Well Play Hard - Day Care Homes

Organization Name: _____ CACFP Agreement #: _____

Address: _____

Telephone: _____ Fax: _____

Project Director Name: _____

Project Director Title: _____ Project Director Signature: _____

Project Director E-mail: _____

Name and title of person authorized to enter into a contract with the NYS DOH (if different from Project Director):

_____

Signature of individual authorized to enter into a contract with NYS DOH:

_____

Total funding requested (not to exceed $85,000): _____

County/Borough or Counties/Boroughs served by Applicant Organization:

_____

Federal Tax Identification Number: _____

Charities Registration Number: _____

Project is a collaboration with other CACFP Organizations: _____ Yes _____ No

If Yes, Complete Chart Below:

| Name of Partner Organization | Partner CACFP Organizations' Counties to Receive *EWPH-DCH* |
|---|---|
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# ATTACHMENT 5a: BUDGET SUMMARY
## Eat Well Play Hard - Day Care Homes

Organization Name: _____

Contract Period: July 1, 2011 – June 30, 2012

| PERSONAL SERVICE (PS): (from worksheet) | |
|---|---|
| List Name and Positions/Titles | AMOUNT |
| _____ | $_____ |
| _____ | $_____ |
| _____ | $_____ |
| _____ | $_____ |
| _____ | $_____ |
| _____ | $_____ |
| _____ | $_____ |
| _____ | $_____ |
| TOTAL PERSONAL SERVICE | $_____ |
| FRINGE BENFITS @ _____% | $_____ |
| A. TOTAL PERSONAL SERVICE AND FRINGE BENEFITS | $_____ |
| OTHER THAN PERSONAL SERVICE (OTPS): | AMOUNT |
| Operating Costs (from worksheet) | $_____ |
| Provider Resource Kit Supplies | $_____ |
| Consulting Services (specify) | $_____ |
| Travel | $_____ |
| Conference Fees and associated travel (specify) * | |
| | $_____ |
| B. SUBTOTAL OTHER THAN PERSONAL SERVICE | $_____ |
| | |
| C. ALLOCATED EXPENSES (from worksheet) | $_____ |
| | |
| D. TOTAL OTHER THAN PERSONAL SERVICE AND ALLOCATED EXPENSES | $_____ |
| GRAND TOTAL REQUESTED (A+D) | $_____ |
| *Requires prior approval from CACFP | |

# ATTACHMENT 5b: PERSONAL SERVICE BUDGET WORKSHEET

Instructions:

(1) Enter the title of the position for which funds are requested.
(2) Specify the name of the person currently serving in the position. If there is no incumbent, enter "Vacant." For new positions, include a job description and justification for the establishment of the position. A job description must be supplied for all positions funded in full or in part by EWPH-DCH.
(3) Enter the percent of time that each position will devote to the EWPH-DCH grant.
(4) Enter the amount of funding needed to support the position for twelve (12) months regardless of the funding source. If the salary is expected to increase during the budget period, use two lines to report the old and new salaries.
(5) Enter the employee's hourly rate of pay.
(6) Enter the amount of funding requested for the position using grant funding. This amount must be equal to or less than the result of multiplying column (3) times column (4).

All amounts must be rounded to the nearest dollar. If additional space is required, use a photocopy of this form. All entries in columns (1) (2) and (6) must be transferred to the Personal Service section of the Budget.

| (1) Position Title | (2) Incumbent | (3) % Time Devoted to Grant | (4) Annual Salary | (5) Hourly Wage | (6) Amount Requested |
|---|---|---|---|---|---|
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| **Total Personal Service Amount Requested $ _____** | | | | | |

# ATTACHMENT 5c: OPERATING COSTS WORKSHEET

Receipts, invoices or other documentation must be kept for all purchases.

| Item | Total Amount |
|---|---|
| Office Supplies | |
| Furniture (Specify)* | |
| Computer Equipment/Software (Specify)* | |
| RD Equipment and Supplies (Specify) | |
| Printing/Copying | |
| Postage | |
| Other (Specify)* | |
| ****TOTAL OPERATING COSTS** | |

* Requires prior approval from CACFP

# ATTACHMENT 5d: ADMINISTRATIVE OR ALLOCATED EXPENSES WORKSHEET

Reimbursement can only cover the EWPH-DCH share of these costs as determined by your cost allocation plan. Allocated costs must be fully justified.

| Item | Annual Cost Allocated to EWPH-DCH |
|---|---|
| Insurance, (Specify) | |
| Custodial Services | |
| Utilities (Electric, Gas, Water) | |
| Office Rent (or Use Allocation, if owned) | |
| Telephone, Cell Phones and Internet Access | |
| Equipment Rental (Specify) | |
| Other (Specify)* | |
| **TOTAL ALLOCATED EXPENSES | |

* Requires prior approval from CACFP

** Administrative/Allocated costs will be limited to a maximum of 12% of Total Personal Service and Fringe Benefits (A) and the Subtotal for Other Than Personal Service (B).

# ATTACHMENT 6: SAMPLE WORK PLAN FORMAT

## Eat Well Play Hard - Day Care Homes

| Activity Description | Lead Person | Month | | | | | | | | | | | | Deliverables |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | 07/11 | 08/11 | 09/11 | 10/11 | 11/11 | 12/11 | 01/12 | 02/12 | 03/12 | 04/12 | 05/12 | 06/12 | |
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# ATTACHMENT 7: VENDOR RESPONSIBILITY ATTESTATION

To comply with the Vendor Responsibility Requirements outlined in Section IV, Administrative Requirements, H. Vendor Responsibility Questionnaire, I hereby certify:

**Choose one:**

☐ An on-line Vender Responsibility Questionnaire has been updated or created at OSC's website: https://portal.osc.state.ny.us within the last six months.

☐ A hard copy Vendor Responsibility Questionnaire is included with this application and is dated within the last six months.

☐ A Vendor Responsibility Questionnaire is not required due to an exempt status. Exemptions include governmental entities, public authorities, public colleges and universities, public benefit corporations, and Indian Nations.

Signature of Organization Official: _____

Print/type Name: _____

Title: _____

Organization: _____

Date Signed: _____