DEPARTMENT OF HEALTH AND HUMAN SERVICES

Support and Capacity Building for an Expansion of the Medical Reserve Corps and a Demonstration of the Public Health Service Auxiliary

AGENCY: Medical Reserve Corps (MRC) Program, Office of Force Readiness and Deployment, Office of the Surgeon General, Office of Public Health and Science, Office of the Secretary, Department of Health and Human Services.

ACTION: Notice.

Announcement Type: Urgent Single-eligibility Cooperative Agreement.

Catalog of Federal Domestic Assistance Number: 93.008.

DATES: Application Availability Date: June 12, 2006. Application Deadline: July 12, 2006.

SUMMARY: This announcement is made by the United States Department of Health and Human Services (HHS or Department), Medical Reserve Corps (MRC) program, located within the Office of the Secretary, Office of Public Health and Science (OPHS), Office of the Surgeon General (OSG), Office of Force Readiness and Deployment (OFRD).

Background Information: During his January 2002 State of the Union address, President George W. Bush called on all Americans to dedicate at least two years—the equivalent of 4,000 hours of their time—to provide volunteer service to others. To help every American answer the call to service, the President created the USA Freedom Corps, and charged it with strengthening and expanding service opportunities for volunteers to protect our homeland, to support our communities, and to extend American compassion around the World. Simultaneously, the President also created the Citizen Corps, within the Department of Homeland Security (DHS), as a way to offer Americans new opportunities to get involved in their communities through emergency preparation and response activities. Along side Citizen Corps are several partner programs that share the common goal of helping communities prevent, prepare for, and respond to crime, natural disasters, and other emergencies. These partner programs include: Community Emergency Response Teams (CERT), also under DHS; Neighborhood Watch and Volunteers in Police Service, under the direction of the Department of Justice; Fire Corps; and the Medical Reserve Corps.

The MRC is a nationwide network of community-based, citizen volunteer units, which have been initiated and established by local organizations for their communities. MRC units are local assets to meet locally determined needs. Medical and public health volunteers in the MRC can utilize their professional expertise to contribute to local public health initiatives, such as those meeting the Surgeon General's priorities for public health, on an ongoing basis and to supplement the existing response capabilities of the community in emergencies. Communities across the country are beginning to recognize that strengthening the everyday public health infrastructure will improve preparedness.

The MRC was developed following the events of September 11, 2001, when many medical and public health professionals showed up at the disaster sites to support the response efforts and were mostly turned away due to identification, credentialing, and liability issues. One of the primary functions of the MRC is to resolve issues of pre-identifying and preparing volunteer health professionals for emergencies. The MRC brings volunteers—health professionals and others—together to supplement existing local resources in cities, towns, and counties throughout the United States.

MRC volunteers include medical and public health professionals such as physicians, nurses, pharmacists, dentists, veterinarians, physician assistants, nurse practitioners, paramedics, EMTs, mental health workers, and epidemiologists. Many other community members—interpreters, chaplains, office workers, legal advisors, etc.—can fill key support positions. Many of these professionals have active practices in a variety of settings; others are in training; some are retired; and yet others are licensed but do not maintain an active practice.

As this is a community-based program, each MRC is responsible for determining its own structure and developing its own policies and procedures. MRC units may be established and implemented by local government agencies, non-governmental organizations, or other non-profit entities. Partnerships with local medical, public health and emergency management entities are essential.

The MRC Demonstration Project (started in FY 2002 and continued in FY 2003) provided start-up grants to 166 communities across the US. Other communities have been encouraged to establish MRC units without HHS funding support. As of May 19, 2006, there were 431 MRC units in 49 States, the District of Columbia, Guam, and the U.S. Virgin Islands, with more than 75,000 volunteers.

The OSG has lead responsibility within HHS for the development of the MRC. OSG undertook this responsibility in March 2002 and subsequently created the MRC Program Office, with a mission to provide national and regional leadership, in partnership with key stakeholders, to facilitate local efforts to establish, implement, and sustain MRC units.

The MRC program office facilitates the formation and implementation of MRC units in communities across the nation by coordinating mechanisms for information sharing and providing forums for discussions of promising practices and lessons learned. The major MRC program office activities include policy development, interagency coordination, program management, grants management, contract oversight, technical assistance, and outreach.

Since its inception, the MRC program office has:

Implemented the MRC Demonstration Project, which awarded small grants (of up to $50,000 per year for 3 years) to help jump start the establishment of local MRC units. Forty-two grants were awarded in September 2002 and an additional 124 grants were awarded in October 2003.

Encouraged the development of MRC units in communities outside of the MRC Demonstration Project. As of May 19, 2006, over 260 additional communities have registered MRC units without receiving grant funding through the MRC program office. Developed a technical assistance contract to provide valuable expert advice to developing and established MRC units. A series of technical assistance documents were written to serve as a guide for local leaders to assist with establishment and implementation of MRC units.

Established an MRC Web site (*http://www.medicalreservecorps.gov*) with resources for developing and established MRC units. The Web site includes an electronic message board and document clearinghouse to allow MRC communities to share information.

Held consultation meetings with numerous governmental and non-governmental organizations at the local, State, regional, and national levels.

Displayed the MRC exhibit booth at professional conferences to boost awareness of the program.

Conducted leadership conferences at the national and regional levels to facilitate coordination, cooperation, and information sharing.

Coordinated the MRC response following the 2005 Hurricanes. An

estimated 6,000 MRC volunteers supported the response and recovery efforts in their local communities. In the hardest hit areas, and as the storm forced hundreds of thousands of Americans to flee the affected areas, MRC volunteers were ready and able to help when needed and were there to assist as evacuees were welcomed into their communities. These volunteers spent countless hours helping the many people whose lives were upended by these disastrous events. During the 2005 Hurricane Response, MRC volunteers throughout the nation served their local communities by:

Establishing medical needs shelters to serve medically fragile and other displaced people;

Staffing and providing medical support in evacuee shelters and clinics;

Filling in locally at hospitals, clinics and health departments for others who were deployed to the disaster-affected regions;

Immunizing responders prior to their deployment to the disaster affected regions;

Staffing a variety of response hotlines created after the hurricanes hit;

Raising funds for those affected by the hurricanes;

Teaching emergency preparedness to community members; and

Recruiting more public health and medical professionals who can be credentialed, trained and prepared for future disasters that may affect their hometowns or elsewhere.

In addition to this local MRC activity, over 1,500 MRC members expressed a willingness to deploy outside their local jurisdiction on optional missions to the disaster-affected areas with their state agencies, the American Red Cross (ARC) and the U.S. Department of Health and Human Services (HHS). Of these, approximately 200 volunteers from 25 MRC units were hired by HHS as unpaid temporary Federal employees and more than 400 volunteers from over 80 local MRC units have been deployed to support ARC disaster operations in areas along the Gulf coast.

Future Direction: Though the MRC was developed as a network of local, community-based assets established to meet locally determined needs, much national attention has been focused on the program in light of its astounding growth and its response following the 2005 Hurricanes. This attention has led to a call for an expansion of the MRC program. For example, in 2005 the White House Homeland Security Council charged HHS to establish systems to pre-enroll, credential, train, and deploy MRC members who are willing to provide emergency health and medical services after a catastrophic event. More recently, in the February 2006 *Federal Response to Hurricane Katrina: Lessons Learned* document, the White House recommended that ''HHS should organize, train, equip, and roster medical and public health professionals in preconfigured and deployable teams'' to include the PHS Commissioned Corps, members of the MRC, and other Federal partners.

In support of the President's national strategies, in keeping with the National Response Plan and consistent with the charge from the Homeland Security Council, this single-eligibility cooperative agreement with the National Association of County and City Health Officials (NACCHO) will support HHS efforts to expand the capacity of MRC units throughout the nation. All work will be closely coordinated with OSG, the MRC program office, State coordinators, MRC regional coordinators, Regional Health Administrators and other Federal officials. NACCHO will begin by providing capacity-building support to all interested MRC units.

NACCHO will also assist with the development of a comprehensive operational manual and support OSG efforts in credentialing, verifying backgrounds, badging, assessing levels of training, and utilizing MRC members who are willing and able to deploy with HHS as unpaid temporary Federal employees on national-level responses (keeping in mind that any employment of individuals is under the authority of HHS and will follow Federal employment standards). This subset of MRC members will be referred to as the ''Public Health Service Auxiliary.'' In addition, a Demonstration Project of the Public Health Service Auxiliary will be initiated, primarily targeting MRC units in geographic locations in the vicinity of the proposed PHS Rapid Deployment Force (RDF) teams: Washington DC/Baltimore; Georgia/North Carolina/South Carolina; Texas/Oklahoma; and Arizona/New Mexico.

Ultimately, this cooperative agreement with NACCHO will enhance the collaboration and coordination between OSG and community/state public health and emergency agencies to support and increase the MRC capacity to meet local, state and national needs.

I. Funding Opportunity Description

Authority: This program is authorized by sections 311(c)(1) and 319A of the Public Health Service Act, as amended, 42 U.S.C. sections 243(c)(1) and 247d–1.; and, funded under Public Law 109–149.

The primary purpose of the MRC program office, in OSG, is to provide national and regional leadership, in partnership with key stakeholders, to facilitate local efforts to establish, implement, and sustain MRC units. The MRC has developed as a means to organize medical, public health and other volunteers in support of existing programs and resources to improve the health and safety of communities and the nation.

A major goal of the MRC program is to encourage integration and coordination with local, State, and Federal Partners, including public health, medical, emergency management and other agencies and organizations. A further objective is for the coordinated involvement of MRC members in a national-level response.

The purposes of this single-eligibility cooperative agreement with NACCHO are to:

Enhance the capacity of MRC units throughout the nation to meet identified local needs for public health and safety;

Increase awareness and understanding of the MRC;

Enhance cooperation between OSG and local/state/national authorities to support and increase MRC capacity; and

Demonstrate the feasibility of the Public Health Service (PHS) Auxiliary concept in meeting surge personnel needs during national-level responses.

Recipient Activities

NACCHO will:

Use its networking channels, newsletters, conferences, summits and other mechanisms to increase awareness and understanding of the MRC;

Enable the facilitation of information sharing between MRC units by providing logistical support (travel, lodging, per diem, etc.) for a representative from each MRC unit to attend the annual MRC National Leadership and Training Conference and Regional MRC meetings;

Further MRC units' ability to meet local public health needs by providing capacity-building assistance and necessary support for purchases of select equipment and supplies (i.e. individual and team go-kits, emergency vests, etc.);

Develop a comprehensive operational manual and assist HHS/OSG with the institution of requirements, standards and processes for utilizing MRC volunteers on national-level responses as members of the Public Health Service Auxiliary. The following items will be incorporated:

Credentialing standards and requirements should be aligned with the proposed State registries (under the

HRSA/Emergency System for the Advanced Registration of Volunteer Health Professionals (ESAR–HP) program) and in keeping with goals of the MRC/ESAR–VHP integration project.

Background checks on the MRC/PHS Auxiliary members should be facilitated in order to meet Federal requirements (Homeland Security Presidential Directive-12) Unique/standardized badges for MRC/PHS Auxiliary members may be necessary. Training and the assessment of MRC member competency should be closely aligned with work currently being conducted.

Processes and procedures for utilizing MRC members in responses outside their local jurisdiction should be closely aligned with the goals of the MRC/ESAR–VHP integration project.

Conduct a Demonstration Project of the PHS Auxiliary, initially by providing additional capacity-building support to targeted MRC units (primarily those in geographic locations in a 200-mile vicinity of the proposed PHS Rapid Deployment Force teams: Washington DC/Baltimore; Georgia/North Carolina/South Carolina; Texas/Oklahoma; and Arizona/New Mexico) that have members who are willing and able to deploy on national-level responses;

Facilitate the interaction between the MRC/PHS Auxiliary members and the PHS RDF teams by assisting in the design and implementation of joint training exercises; and Participate in the annual MRC National Leadership and Training Conference and Regional MRC meetings.

OSG/MRC Activities

OSG and MRC program staff will be substantially involved with the design and implementation of all activities conducted under this cooperative agreement with NACCHO. In general, MRC program staff will provide background information, expert assistance and ongoing oversight. MRC program staff and Regional Coordinators will also provide liaison to local and State MRC leaders, as well as to Federal officials. In addition, OSG and the MRC program will:

Use its networking channels, presentations, newsletters and other mechanisms to increase awareness and understanding of the MRC;

Facilitate information sharing between MRC units by conducting the annual MRC National Leadership and Training Conference and Regional MRC meetings;

Work closely with NACCHO, OFRD, and other HHS partners on the development and implementation of the Public Health Service Auxiliary Demonstration;

Identify and target MRC units that have members who are willing and able to deploy on national-level responses as the Public Health Service Auxiliary; and

Coordinate activities between NACCHO, MRC units and the PHS RDF teams.

II. Award Information

The MRC expansion will be supported through a single-eligibility cooperative agreement mechanism. Using this mechanism, the OSG anticipates making only one award in FY 2006. The anticipated start date for the new award is August 1, 2006, and the anticipated period of performance is August 1, 2006 through September 30, 2009. Approximately $8,225,000 is available for the first 12-month period.

Throughout the project period, the commitment of OSG to the continuation of funding will depend on the availability of funds, evidence of satisfactory progress by the recipient (as documented in required reports), demonstrated commitment of the recipient to the goals of the MRC program, and the determination that continued funding is in the best interest of the Federal Government.

III. Eligibility Information

1. Eligible Applicants

The only eligible applicant for this funding opportunity is the National Association of County and City Health Officials (NACCHO). In making this award, OSG/MRC will be able to capitalize on NACCHO's status as a national-level nonprofit organization with significant local, state and national networking connections. NACCHO has relevant experience in working with local organizations, particularly in the areas of capacity-building, strengthening public health infrastructure and improving public health preparedness. NACCHO also has relevant experience in working with Federal agencies.

2. Cost Sharing or Matching

Neither cost sharing nor matching funds are required for this program.

3. Other

If an applicant requests a funding amount greater than the ceiling of the award range, the application will be considered non-responsive, and will not enter into the review process. The applicant will be notified that the application did not meet the submission requirements.

IV. Application and Submission Information

1. Address To Request Application Package

Application kits may be requested by calling (240) 453–8822 or writing to the Office of Grants Management, Office of Public Health and Science, Department of Health and Human Services, 1101 Wootton Parkway, Suite 550, Rockville, MD 20852. Applicants may also fax a written request to the OPHS Office of Grants Management at (240) 453–8823 to obtain a hard copy of the application kit. Applications must be prepared using Form OPHS–1.

2. Content and Form of Application Submission

Application: Applicants must use Grant Application Form OPHS–1 and complete the Face Page/Cover Page (SF424), Checklist, and Budget Information Forms for Non-Construction Programs (SF424A). In addition, the application must contain a project narrative, submitted in the following format:

Maximum number of pages: 50. If the narrative exceeds the page limit, OSG will only review the first 50 pages within the page limit;

Font size: 12-point, unreduced;

Double-spaced;

Paper size: 8.5 by 11 inches;

Page-margin size: One inch;

Number all pages of the application sequentially from page one (Application Face Page) to the end of the application, including charts, figures, tables, and appendices;

Print only on one side of page; and

Hold application together only by rubber bands or metal clips, and do not bind it in any other way.

The narrative should address activities to be conducted over the entire project period and must include the following items in the order listed:

Table of Contents

Executive Summary: Describe key aspects of the Background, Objectives, Program Plan, Evaluation Plan, and Budget. The summary is limited to three (3) pages.

Background:

Understanding of the Requirements. The narrative should include a discussion of the organization's understanding of the need, purpose and requirements of this cooperative agreement. The discussion should be sufficiently specific, detailed and complete to clearly and fully demonstrate that the applicant has a thorough understanding of all the

technical requirements of this announcement.

Organizational Experience. The narrative should provide a summary of organizational experience and include a description of any similar projects implemented to work with local community-based organizations, particularly in the areas of capacity-building, strengthening public health infrastructure and improving public health preparedness.

Objectives. The narrative should include objectives stated in measurable terms, including baseline data, improvement targets and time frames for achievement for the project period.

Program Plan. The program plan must demonstrate that the organization has the technical expertise to carry out the requirements of this announcement.

Methods and Techniques. The plan should contain sufficient detail to clearly indicate the proposed means for conducting the work, and include a complete explanation of the techniques and procedures the applicant will use. Specific activities and strategies planned to achieve each objective should be described. The role of any partner organizations in the project should be described. The applicant should also discuss any anticipated problem areas and recommend potential solutions.

Staffing and Management. The applicant must provide a description of project staffing and management, with time lines and sufficient detail to ensure that it can meet the requirements in a timely and efficient manner. The narrative should provide a description of the proposed project staff, including resumes and job descriptions for key staff, qualifications and responsibilities of each staff member, and percent of time each will commit to the project. It should also provide a description of duties for any proposed consultants. Résumés must be limited to three pages per person.

Evaluation Plan. The applicant must clearly delineate how program activities will be evaluated and provide measures of effectiveness that will demonstrate the accomplishment of the objectives of this cooperative agreement and progress toward the goals of the MRC program. The evaluation plan must be able to produce documented results that demonstrate whether and how the strategies and activities funded under this cooperative agreement made a difference in building the capacity of the MRC program to meet the needs of local communities and the nation. The description should include data collection and analysis methods, demographic data to be collected, process measures which describe indicators to be used to monitor and measure progress toward achieving projected results, outcome measures to show the project has accomplished planned activities, and impact measures that demonstrate achievement of the objectives.

Budget Justification. The budget justification will not count against the stated page limit, but will be limited to 10 pages and must comply with the criteria for applications. The applicant must submit, at a minimum, a cost proposal fully supported by information adequate to establish the reasonableness of the proposed amount. The budget request must include funds for key project staff to attend an annual MRC Leadership and Training Conference.

The applicant may include additional information in the application appendices, which will not count toward the narrative page limit. This additional information includes the following: Curricula Vitae, Résumés, Organizational Charts, Letters of Support, etc.

An agency or organization is required to have a Dun and Bradstreet Data Universal Numbering System (DUNS) number to apply for a grant or cooperative agreement from the Federal government. The DUNS number is a nine-digit identification number, which uniquely identifies business entities. Obtaining a DUNS number is easy, and there is no charge. To obtain a DUNS number, access *http://www.dunandbradstreet.com,* or call 1–866–705–5711.

3. Submission Dates and Times

To be considered for review, applications must be received by the Office of Grants Management, Office of Public Health and Science, by 5 p.m. Eastern Time on July 12, 2006. Applications will be considered as meeting the deadline if they are received on or before the deadline date. The application due date in this announcement supercedes the instructions in the OPHS–1.

Submission Mechanisms

The Office of Public Health and Science (OPHS) provides multiple mechanisms for the submission of applications, as described in the following sections. Applicants will receive notification via mail from the OPHS Office of Grants Management confirming the receipt of applications submitted using any of these mechanisms. Applications submitted to the OPHS Office of Grants Management after the deadlines described below will not be accepted for review. Applications which do not conform to the requirements of the grant announcement will not be accepted for review and will be returned to the applicant.

Applications may only be submitted electronically via the electronic submission mechanisms specified below. Any applications submitted via any other means of electronic communication, including facsimile or electronic mail, will not be accepted for review. While applications are accepted in hard copy, the use of the electronic application submission capabilities provided by the OPHS eGrants system or the Grants.gov Website Portal is encouraged.

Electronic grant application submissions must be submitted no later than 5 p.m. Eastern Time on the deadline date specified in the **DATES** section of the announcement using one of the electronic submission mechanisms specified below. All required hardcopy original signatures and mail-in items must be received by the OPHS Office of Grants Management no later than 5 p.m. Eastern Time on the next business day after the deadline date specified in the DATES section of the announcement.

Applications will not be considered valid until all electronic application components, hardcopy original signatures, and mail-in items are received by the OPHS Office of Grants Management according to the deadlines specified above. Application submissions that do not adhere to the due date requirements will be considered late and will be deemed ineligible.

Applicants are encouraged to initiate electronic applications early in the application development process, and to submit early on the due date or before. This will aid in addressing any problems with submissions prior to the application deadline.

Electronic Submissions Via the Grants.gov Website Portal

The Grants.gov Website Portal provides organizations with the ability to submit applications for OPHS grant opportunities. Organizations must successfully complete the necessary registration processes in order to submit an application. Information about this system is available on the Grants.gov Web site, *http://www.grants.gov.*

In addition to electronically submitted materials, applicants may be required to submit hard copy signatures for certain program related forms, or original materials as required by the announcement. It is imperative that the applicant review both the grant announcement, as well as the

application guidance provided within the Grants.gov application package, to determine such requirements. Any required hard copy materials, or documents that require a signature, must be submitted separately via mail to the OPHS Office of Grants Management, and, if required, must contain the original signature of an individual authorized to act for the applicant agency and the obligations imposed by the terms and conditions of the grant award.

Electronic applications submitted via the Grants.gov Website Portal must contain all completed online forms required by the application kit, the Program Narrative, Budget Narrative and any appendices or exhibits. All required mail-in items must received by the due date requirements specified above. Mail-In items may only include publications, resumes, or organizational documentation.

Upon completion of a successful electronic application submission via the Grants.gov Website Portal, the applicant will be provided with a confirmation page from Grants.gov indicating the date and time (Eastern Time) of the electronic application submission, as well as the Grants.gov Receipt Number. It is critical that the applicant print and retain this confirmation for their records, as well as a copy of the entire application package.

All applications submitted via the Grants.gov Website Portal will be validated by Grants.gov. Any applications deemed ''Invalid'' by the Grants.gov Website Portal will not be transferred to the OPHS eGrants system, and OPHS has no responsibility for any application that is not validated and transferred to OPHS from the Grants.gov Website Portal. Grants.gov will notify the applicant regarding the application validation status. Once the application is successfully validated by the Grants.gov Website Portal, applicants should immediately mail all required hard copy materials to the OPHS Office of Grants Management to be received by the deadlines specified above. It is critical that the applicant clearly identify the Organization name and Grants.gov Application Receipt Number on all hard copy materials.

Once the application is validated by Grants.gov, it will be electronically transferred to the OPHS eGrants system for processing. Upon receipt of both the electronic application from the Grants.gov Website Portal, and the required hardcopy mail-in items, applicants will receive notification via mail from the OPHS Office of Grants Management confirming the receipt of the application submitted using the Grants.gov Website Portal.

Applicants should contact Grants.gov regarding any questions or concerns regarding the electronic application process conducted through the Grants.gov Website Portal.

Electronic Submissions Via the OPHS eGrants System

The OPHS electronic grants management system, eGrants, provides for applications to be submitted electronically. Information about this system is available on the OPHS eGrants Web site, *https://egrants.osophs.dhhs.gov,* or may be requested from the OPHS Office of Grants Management at (240) 453–8822.

When submitting applications via the OPHS eGrants system, applicants are required to submit a hard copy of the application face page (Standard Form 424) with the original signature of an individual authorized to act for the applicant agency and assume the obligations imposed by the terms and conditions of the grant award. If required, applicants will also need to submit a hard copy of the Standard Form LLL and/or certain Program related forms (e.g., Program Certifications) with the original signature of an individual authorized to act for the applicant agency.

Electronic applications submitted via the OPHS eGrants system must contain all completed online forms required by the application kit, the Program Narrative, Budget Narrative and any appendices or exhibits. The applicant may identify specific mail-in items to be sent to the Office of Grants Management separate from the electronic submission; however these mail-in items must be entered on the eGrants Application Checklist at the time of electronic submission, and must be received by the due date requirements specified above. Mail-In items may only include publications, resumes, or organizational documentation.

Upon completion of a successful electronic application submission, the OPHS eGrants system will provide the applicant with a confirmation page indicating the date and time (Eastern Time) of the electronic application submission. This confirmation page will also provide a listing of all items that constitute the final application submission including all electronic application components, required hardcopy original signatures, and mail-in items, as well as the mailing address of the OPHS Office of Grants Management where all required hard copy materials must be submitted.

As items are received by the OPHS Office of Grants Management, the electronic application status will be updated to reflect the receipt of mail-in items. It is recommended that the applicant monitor the status of their application in the OPHS eGrants system to ensure that all signatures and mail-in items are received.

Mailed or Hand-Delivered Hard Copy Applications

Applicants who submit applications in hard copy (via mail or hand-delivered) are required to submit an original and two copies of the application. The original application must be signed by an individual authorized to act for the applicant agency or organization and to assume for the organization the obligations imposed by the terms and conditions of the grant award.

Mailed or hand-delivered applications will be considered as meeting the deadline if they are received by the OPHS Office of Grant Management on or before 5 p.m. Eastern Time on the deadline date specified in the **DATES** section of the announcement. The application deadline date requirement specified in this announcement supersedes the instructions in the OPHS–1. Applications that do not meet the deadline will be returned to the applicant unread.

4. Intergovernmental Review

Executive Order 12372 does not apply.

5. Funding Restrictions

Grant funds may be used to cover costs of:

Personnel.
Consultants.
Contract Services.
Equipment and supplies.
Training.
Travel, including attendance at national and regional MRC meetings.
Other grant-related costs

Grants funds may not be used for:

Building alterations or renovations.
Construction.
Fund raising activities.
Political education and lobbying.
Research studies involving human subjects.
Reimbursement of pre-award costs.

6. Other Submission Requirements

None.

V. Application Review Information

1. Criteria

The technical review of the applications will consider the following

four factors, listed in descending order of weight:

Factor 1: Program Plan (35%)

Sufficient details provided to clearly indicate the proposed means for conducting the work.

Specific activities and strategies planned to achieve each objective are described.

Methods, procedures and sequencing of planned approaches are logical and appropriate.

Anticipated problem areas are discussed and potential solutions are recommended.

Description of the proposed project staff, including resumes and job descriptions for key staff, qualifications and responsibilities of each staff member, and percent of time each will commit to the project is provided.

Proposed staff members are qualified and level of effort is appropriate.

Proposed project organizational structure and reporting channels/lines of authority are rational and appropriate.

Factor 2: Background (25%)

The organization's understanding of the need, purpose and requirements of the project are clearly and fully demonstrated.

Relevant organizational experience is described.

Outcomes of past projects and activities with local community-based organizations (particularly in the areas of capacity-building, strengthening public health infrastructure and improving public health preparedness) indicate a clear potential for successful completion of project objectives.

The applicant demonstrates a clear understanding of the mission of OSG and the responsibilities of Emergency Support Function #8 under the National Response Plan.

Factor 3: Evaluation Plan (20%)

Proposed data collection plan, analysis methods and reporting procedures are appropriate.

Plans to assess and document progress towards achieving objectives and intended outcomes are clear. Process, outcome, and impact measures are suitable.

Process measures will show progress toward achieving projected results.

Outcome measures will show accomplishment of planned activities.

Impact measures will demonstrate achievement of the objectives.

Factor 4: Objectives (20%)

Objectives are realistic and have merit.

Objectives are stated in measurable terms.

Objectives are relevant to the project, and in line with MRC program goals.

Objectives are attainable in the stated time frames.

2. Review and Selection Process

OSG will review applications for completeness. An incomplete application or an application that is non-responsive to the eligibility criteria will not advance through the review process. HHS will notify applicants if their applications did not meet submission requirements.

An objective review panel, which could include both Federal employees and non-Federal members, will evaluate complete and responsive applications according to the criteria listed in the ''V.1 Criteria'' section above. The objective review process will follow the policy requirements as stated in the Grants Policy Directives (GPDs) 2.04. Information pertaining to the GPDs can be found at *http://www.hhs.gov/grantsnet/roadmap/index.html.*

VI. Award Administration Information

1. Award Notices

The successful applicant will receive a Notice of Award (NoA). The NoA shall be the only binding, authorizing document between the recipient and HHS. An authorized Grants Management Officer will sign the NoA, and mail it to the recipient fiscal officer identified in the application.

2. Administrative and National Policy Requirements

The successful applicant must comply with the administrative requirements outlined in 45 CFR part 74 and part 92 as appropriate.

3. Reporting

The applicant will submit an original, plus one hard copy, as well as an electronic copy of: (1) Quarterly progress reports (using the Federal fiscal quarters); (2) an annual Financial Status Report (FSR) SF–269; and (3) a final Progress and Financial Status Report in the format established by the OSG, in accordance with provisions of the general regulations which apply under ''Monitoring and Reporting Program Performance,'' 45 CFR parts 74 and 92.

The quarterly progress reports shall provide a detailed summary of major achievements, problems encountered, and actions taken to overcome them. The purpose of the progress reports is to provide accurate and timely project information to MRC program managers and to respond to Congressional, Departmental, and public requests for information about the program. The report for the fourth fiscal quarter (for the period July 1—September 30)) will serve as the annual progress report and must describe all project activities for the entire fiscal year.

The second fiscal quarter progress report (for the period January 1—March 31) will serve as the non-competing continuation application. This report must include the budget request for the next grant year, with appropriate justification, and be submitted using Form OPHS–1.

The applicant will be informed of the progress report due dates. Instructions, report formats and due dates will be provided prior to required submission. The Annual Financial Status Report is due no later than 90 days after the close of each budget period. The final Progress and Financial Status Report are due 90 days after the end of the project period.

The applicant must mail the reports to the Grants Management Office listed in the ''Agency Contacts'' section of this announcement. An electronic copy of the report should be sent to the MRC program office contact.

VII. Agency Contact(s)

For program assistance, contact: CDR Robert J. Tosatto, Medical Reserve Corps Program, Office of the Surgeon General, Department of Health and Human Services, 5600 Fishers Lane, Room 18C–14, Rockville, MD 20857. Telephone: 301–443–4951. E-mail: *MRCcontact@hhs.gov.*

For financial, grants management, or budget assistance, contact: DeWayne Wynn, Grants Management Specialist, Office of Grants Management, Office of Public Health and Science, Department of Health and Human Services, 1101 Wootton Parkway, Suite 550, Rockville, MD 20857. Telephone: (240) 453–8822. E-mail: *Dewayne.Wynn@hhs.gov.*

VIII. Other Information

1. The Surgeon General's Priorities for Public Health

Surgeon General Richard H. Carmona has outlined his priorities for the health of individuals, and the nation as a whole. His goals are to increase disease prevention, eliminate health disparities, and strengthen public health preparedness. Woven through each of these priorities is the effort to improve health literacy.

Increase Disease Prevention. The Surgeon General encourages health care professionals to educate the public on how to prevent diseases and injuries. With seven out of ten Americans dying each year of a preventable chronic

disease, it is imperative that we address such problems as obesity, HIV/AIDS, tobacco use, birth defects, injury and low physical activity.

Eliminate Health Disparities. Having grown up facing the difficulties of health disparities, eliminating them is of great personal importance to the Surgeon General. His goal is to rid minority communities of the greater burden of death and disease from illnesses such as breast cancer, prostate cancer, and others.

Strengthen Public Health Preparedness. Americans count on a strong public health system capable of meeting any emergency. OSG is investing resources to prevent, mitigate and respond to all-hazards emergencies.

Improve Health Literacy. Improving health literacy is important so that all Americans may access, understand and use health-related information and services to make good health decisions.

(To learn more about the public health priorities of the Surgeon General, please visit *http://www.surgeongeneral.gov*.)

2. MRC/ESAR–VHP Integration

MRC and the Emergency System for Advance Registration of Volunteer Health Professionals (ESAR–VHP) each represent key national initiatives of HHS to improve the nation's ability to enhance public health preparedness.

The ESAR–VHP Program is housed within the HHS Health Resources and Services Administration (HRSA). It is designed to standardize State efforts to develop programs and systems necessary to register, credential, and activate volunteer health professionals in an emergency. Volunteer health professionals in this program will primarily be expected to augment hospital and/or other medical facility staff to support a surge in anticipated health care needs for patients and victims during, and immediately following, an emergency.

There are significant advantages to integrating the MRC and ESAR–VHP Programs. Generally, integration will minimize duplication of effort, address response gaps, and promote long-term savings. For example, joint recruiting and training efforts will assure a common understanding of each other's program goals, state-level credentialing can be expanded to cover MRC volunteers, and common notification and deployment technologies will enable significant cost savings.

The MRC/ESAR–VHP Integration Project's primary goal will be to publish guidance for local MRC leaders and state ESAR–VHP coordinators. It should include a description of what is expected to occur and how the groups are expected to respond, as well as the individual, MRC, and ESAR–VHP Program roles and responsibilities.

Dated: June 6, 2006.

Richard H. Carmona,

Surgeon General.

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Announcement of Availability of Funds for Cooperative Agreement to the Fundación México-Estados Unidos para la Ciencia, A.C. (FUMEC) (United States-Mexico Foundation for Science) to Support Mexican Outreach Offices

AGENCY: Office of Global Health Affairs, Office of the Secretary, HHS.

Announcement Type: Cooperative Agreement—Fiscal Year (FY) 2006 Initial Announcement. Single Source.

Catalog of Federal Domestic Assistance: 93.018.

DATES: Application Availability: June 12, 2006. Applications are due by 5 p.m. Eastern Time on July 12, 2006.

SUMMARY: The Office of Global Health Affairs (OGHA) announces up to $600,000 in FY 2006 funds is available for a cooperative agreement to the *Fundación México-Estados Unidos para la Ciencia, A. C.* (FUMEC) (United States-Mexico Foundation for Science) to support the implementation, management, and administration of U.S.-Mexico Border Health Commission (USMBHC) programs and activities at the Mexican Outreach Offices. This initiative will support the development, administration, and evaluation of programs in specified health areas, including training for health personnel, development, and dissemination of educational materials and workshops, research, community outreach, health promotion, and improvement of information technology to enhance program support. HHS/OGHA will approve the budget period to be one year and the project period for up to a five-year period for a total of $600,000 (including indirect costs). Funding for the cooperative agreement is contingent upon the availability of funds.

I. Funding Opportunity Description

Under the authority of Section 4 of the U.S.-Mexico Border Health Commission Act (the Act), Public law 103–400, the Office of Global Health Affairs (OGHA) announces the intent to allocate Fiscal Year (FY) 2006 funds for a cooperative agreement to the *Fundación México-Estados Unidos para la Ciencia, A. C.* (FUMEC) (United States—Mexico Foundation for Science), who will work through the Mexican Outreach Offices of the U.S.-Mexico Border Health Commission, to strengthen the binational public health projects and programs along the U.S.-Mexico border. The cooperative agreement will address activities related to the following topic areas: (1) Substance Abuse, (2) HIV/AIDS, (3) Chronic Diseases, (4) *Vete Sano Regresa Sano* (Go Healthy, Come Back Healthy), (5) Injury Prevention, (6) Diabetes, (7) Family Planning, (8) Domestic Violence, (9) Cancer, (10) Teen Pregnancy Prevention, (11) Oral Health, (12) Rabies, (13) Communicable Diseases, (14) Tuberculosis, and (15) Epidemiological Monitoring.

This assistance is geared to support current, on-going, and proposed public health initiatives in this border region that support the goals and objectives of the U.S.-Mexico Border Health Commission to strengthen access to health care, disease prevention, and public health along the Mexican side of the U.S-Mexico border.

Background: More than 800,000 people crisscross legally everyday, not counting the thousands who find illegal ways to enter the United States. The economic burden on the United States and Mexico is staggering. Much of the border is poor and health resources are scarce. This rapid population growth is putting further pressure on an already inadequate medical care infrastructure, which further decreases access to health care. The border is impoverished and has a double burden of disease to bear. Like many emerging nations, it struggles with serious chronic diseases such as respiratory and gastrointestinal ailments. The large and diverse migrant population increases the incidence of communicable diseases such as HIV/AIDS and tuberculosis, as well as chronic illnesses such as diabetes, certain cancers, and hypertension. In addition, the problems and concerns affecting the border region have broad repercussions for both nations. Travelers, migrants and immigrants, who are crossing the border every day, are taking their health problems with them to other parts of the United States and Mexico.

Although both nations cooperate in specific health areas, until the establishment of a high-level binational commission, the border region lacked a sustainable process for addressing and improving the health of its population.

The U.S.-Mexico Border Health Commission (USMBHC), in collaboration with the U.S. Department of Health and Human Services, works toward creating awareness about the