|  |
| --- |
| **IMPORTANT DATES: (For fiscal year 19-20): July 1, 2019 – June 30, 2020**  Application Cut-Off Date: Spring Period – Feb 1, 2020 to April 1, 2020  Project Completion Date: June 16, 2020 |

**GENERAL POLICY AND CRITERIA**

All requests for funding from the Southeast Regional Trauma Advisory Council will be submitted using this standardized application form. Projects requesting funding must meet the following criteria:

* Support overall trauma objectives (i.e. Injury Prevention, Trauma Education, Performance Improvement, etc.)
* Consistent with SERTAC mission, vision, and values

Additional factors that will be considered favorably include:

* Have attended 50% of General Meeting in previous 12 months
* Use of additional or shared resources and/or funding to reduce costs or increase benefit
* Ability to demonstrate sustainability or long-term benefit of the project

Other criteria may apply, depending on the original source of funds managed by SERTAC.

**SUMMARY OF REQUEST PROCESS**

1. Complete a “Request for Funding – Application Form” (Attachments A-D) to apply for funding from the Southeast Regional Trauma Advisory Council.
2. Submit completed application to SERTAC Coordinator
3. All requests will be reviewed by a SERTAC Executive Council
   1. Applicants may be asked to provide additional information on their request
   2. Applicants may be asked to present their request in person to the Executive Council
4. A decision letter will be sent to the applicant when the request has been either approved or denied
   1. A signed award letter from SERTAC indicates approval of the request and that funds have been budgeted in the amount requested on the application
   2. No purchases should be made until after the award letter date
5. After an approved project is completed, the organization will need to submit a Project Reimbursement Request Form (Attachment E) in order to receive payment of awarded funds.

**APPLICATION COMPONENTS:**

1. **Project Request Summary Form (Attachment A)**
   1. Provide a summary of the project to be funded, including the overall purpose and scope and key elements and/or activities
   2. Provide a summary description of how the project will enhance or maintain the trauma system in Southeast Wisconsin
   3. List anticipated start and end dates for the project
   4. Provide point-of-contact information
   5. Provide information on other non-SERTAC funding/contributors to the project, if applicable
2. **Project Narrative and Cost Estimate Form (Attachment B)**
   1. Use any or all sections needed to capture the estimated cost of the project (see below)
   2. One or more elements may be proposed up to the full requested award amount
   3. Provide a detailed project narrative for each proposed element
   4. Provide a cost breakdown for each proposed element, including an explanation of the appropriate calculations, formulas, and/or unit costs used to determine the line item
   5. Include cost quotes and other appropriate supporting documentation whenever possible (required for any line item expense over $5,000)
      1. If a purchase is greater than $5,000 from one vendor, either:
         1. Provide two competitive quotes for the product or service OR
         2. Letter from the vendor stating they are a sole source provider of product/service
   6. There are four sections to theProject Narrative and Cost Estimate Form:
      1. Exercise, Training, or Educational Sessions
         1. Includes exercises, training/educational courses, and conferences
         2. Travel costs for instructors, moderators, and other necessary staff to conduct a session may be included
            1. Lodging

Request hotel government rates whenever possible (SERTAC can provide a tax-exempt letter upon request)

If government rates are not accepted, reasonable rates for the area will be honored

* + - * 1. Reasonable meal costs can be included, up to the maximum U.S. General Services Administration (GSA) per diem schedule amount for each individual (www.gsa.gov/perdiem)
        2. Mileage can be included at the standard GSA mileage rate. Include a mileage estimate between destinations using commercially-available mapping software.
        3. Include the locations of the session, lodging, and origin point for travel
      1. Travel costs for attendees should not be included in the funding request
    1. Consumable Supplies
       1. Includes materials or other supplies that cannot be reused
    2. Equipment
       1. Includes durable equipment
       2. Provide details in project narrative on how equipment is to be used, maintained, and sustained
       3. Provide an itemized list of equipment to be purchased, along with unit cost
       4. Please highlight any single unit equipment cost greater than $5,000
    3. Service
       1. Includes personnel costs, consultants, contractors, software, or program providing a needed function or capability

1. **Terms and Conditions for Equipment /Capital Assets Form (Attachment C)**
   1. Provide a signed Terms and Conditions for Equipment/Capital Assets form if funds will be used to purchase any tangible or intangible asset or equipment that have initial estimated useful life beyond two years and an initial cost greater than $5,000. These terms and conditions have been developed to assist sub awardees in establishing proper procedures for obtaining effective internal control and record maintenance for capitalized assets purchased with SERTAC funds.
   2. Review the text of the terms and conditions form with your financial or purchasing department.
   3. The form should be signed by an individual authorized to officially represent the organization. Please provide the name and title of the signatory.
2. **Project Reimbursement Request Form (Attachment D)**
   1. Organizations need to submit a “Project Reimbursement Request Form” with all invoices, receipts, and other documentation that indicate the completion of the project elements. Purchase orders and quotes will not be accepted.
   2. The organization requesting reimbursement should obtain an invoice number from its accounting department and insert this number below the “Date” on the form. This number should not be the same as the vendor invoice number(s) you are sending with the request. It should be a unique invoice number the organization’s accounting department will recognize to apply funding received in the form of a check.
   3. DUNS and NIP numbers are required for hospitals, community health centers, or tribal clinics. Other organizations should include them if they have them.
   4. The entire reimbursement request (completed request form plus vendor invoices and/or receipts) should be sent to the SERTAC Coordinator (via scan/email, if possible).
   5. All vendor invoices and receipts should be dated between January 31, 2020 and June 23, 2020.
   6. The SERTAC fiscal agent will mail a check addressed to the organization and will include on the check as an identifier the “Requesting Invoice Number” from the form.
   7. Reimbursement checks will be mailed within 30 days of receiving the completed reimbursement form or the applicable grant funding from the funding source, whichever is later.

**ADDITIONAL INFORMATION**

SERTAC and its awardees will also obey any additional restrictions on use of funding that has been awarded to SERTAC from other private or public sources. All expenditures from federal funding sources must comply with federal guidelines, including 45 CFR Parts 74 and 92 and OMB Circular A-133 Audit Guidelines.

**Attachment A**

**Project Request Summary Form**

|  |  |  |
| --- | --- | --- |
| Date Submitted: | | |
| Project Title: | | |
| Requesting Organization: | | |
| Briefly describe the purpose and scope of the project, key elements, or activities: | | |
| Briefly describe how project will benefit your members and enhance regional trauma preparedness and response: | | |
| Project Start Date: | | Estimated Completion Date: |
|  | | |
| Contact Information for Request | | |
| Name: | | |
| Address: | | |
|  | Phone: | Email: |

**Attachment A**

**Project Request Summary Form (cont.)**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| What is the **amount of funding being requested from SERTAC**? | | | **$** | |
| What is the estimated total cost of this project? | | | **$** | |
| Will non-SERTAC funding sources be applied to this project? Yes / No | | | | |
|  | **If yes:**  (If additional space needed, create additional rows and fill in information, or provide on another sheet.) | | | |
| Source: | |  | | |
| Amount contributed: | | $ | | |
| Contact: | | Name: | | Phone: |
|  | | Email: | | |
|  | |  | | |
| Source: | |  | | |
| Amount contributed: | | $ | | |
| Contact: | | Name: | | Phone: |
|  | | Email: | | |

**Supporting Documents Attached:**

|  |  |
| --- | --- |
| Project Narrative and Cost Estimate (Attachment B) | Yes (must be included with all requests) |
| Terms and Conditions Form (Attachment C) | Yes or N/A (delete incorrect response) |

**Submit to**:

|  |
| --- |
| Note: This form and all supporting documents may be submitted electronically in “pdf” format. Originals will be required for SERTAC files prior to the completion of the project. |
| Southeast Regional Trauma Advisory Council  c/o Anick & Associates  11933 W. Burleigh St.  Wauwatosa, WI 53222  Ingrid Gowdy  Telephone: 414-774-0300  Email:  [ingridg@anickassociates.com](mailto:ingridg@anickassociates.com) |

**Attachment A**

**Project Request Summary Form (cont.)**

**For SERTAC Executive Council use only**:

|  |  |
| --- | --- |
| Date Received: |  |
| Date Committee Review Completed |  |
| Committee Recommendation |  |
|  |  |
| SERTAC Executive Council: | **Approved**: \_\_\_\_\_\_\_ **Denied**: \_\_\_\_\_\_\_\_\_ |
| Chair Signature: |  |
| Reason Denied: | |
| Date Award Notice Sent: |  |

**Attachment B**

**Project Narrative and Cost Estimate Form**

NOTES: Complete one narrative/estimate for each individual vendor or supplier. Use the section(s) that fit the project.

**Project Narrative:**

|  |
| --- |
| Provide a detailed description of the project – use additional pages as needed: |

**Attachment B**

**Project Narrative and Cost Estimate Form (cont.)**

**General Instructions:**

Attach any supporting documentation as appropriate (including quotes/cost estimates from vendors or consultants, explanatory materials, or other information). You may add additional pages/sheets as needed for all elements requested.

**Exercise, Training, Educational Sessions**:

|  |  |  |
| --- | --- | --- |
| Exercise/Course/  Session Title: |  | |
| List primary  educational objectives: |  | |
|  | | |
| Course Expenses | Course Fee per Person: |  |
| Materials Cost per Person: |  |
| Estimated # of Participants: |  |
| Total Estimated Course Expenses:  (Fee Per Person + Materials Per Person) x Estimated # Participants | |  |
|  | | |
| Instructor/  Moderator  Travel Expenses | Lodging per Person: |  |
| Meals per Person: |  |
| Estimated # of Instructors: |  |
| Total Estimated Instructor Expenses:  (Lodging Per Person + Meals Per Person) x Estimated # Instructors | |  |
|  | | |
| **Total Estimated Cost of Session**: | |  |

**Attachment B**

**Project Narrative and Cost Estimate Form (cont.)**

**Consumable Supplies**:

|  |  |  |  |
| --- | --- | --- | --- |
| Vendor Name: | | | |
| Item Description | Quantity | Unit Cost | Subtotal  (Unit Cost x Quantity) |
|  |  |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Vendor Name: | | | |
| Item Description | Quantity | Unit Cost | Subtotal |
|  |  |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Vendor Name: | | | |
| Item Description | Quantity | Unit Cost | Subtotal |
|  |  |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Vendor Name: | | | |
| Item Description | Quantity | Unit Cost | Subtotal |
|  |  |  |  |

|  |  |
| --- | --- |
| **Total Estimated Cost of Supplies:** |  |

**Attachment B**

**Project Narrative and Cost Estimate Form (cont.)**

**Equipment**:

|  |  |  |  |
| --- | --- | --- | --- |
| Vendor Name: | | | |
| Item Description | Quantity | Unit Cost | Subtotal  (Unit Cost x Quantity) |
|  |  |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Vendor Name: | | | |
| Item Description | Quantity | Unit Cost | Subtotal |
|  |  |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Vendor Name: | | | |
| Item Description | Quantity | Unit Cost | Subtotal |
|  |  |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Vendor Name: | | | |
| Item Description | Quantity | Unit Cost | Subtotal |
|  |  |  |  |

|  |  |
| --- | --- |
| **Total Estimated Cost of Equipment:** |  |

**Attachment B**

**Project Narrative and Cost Estimate Form (cont.)**

**Service**:

|  |  |
| --- | --- |
| Vendor Name: | |
| Describe the scope of the contract/service provided: | |
| Estimated Cost of the Service: |  |

|  |  |
| --- | --- |
| Vendor Name: | |
| Describe the scope of the contract/service provided: | |
| Estimated Cost of the Service: |  |

|  |  |
| --- | --- |
| **Total Estimated Cost of Services:** |  |

**Attachment C**

**Terms and Conditions for Equipment/Capital Assets Form**

Only one form required per application if at least one project or element fits the definition below.

These terms and conditions have been developed to assist sub awardees in establishing proper procedures for obtaining effective internal control and record maintenance for capitalized assets purchased with federal grant funds. The agency must be able to account for all property, whether sold or traded, in compliance with the terms and conditions stipulated in the HHS Grant Policy Statement and OMB A-110: Subpart C: Property Standards.

**Definition**:  Tangible or intangible assets or equipment used in agency operations that have initial estimated useful lives beyond two or more years and an initial cost (inclusive of ancillary charges) of at least $5,000.

**Disposition:** Procedures for Surplus Property and Equipment Disposal and OMB Circular A-110: Subpart C: Equipment. Sub-awardees must obtain approval prior to the sale of or use of the assets for trade-in and prior to transferring asset(s) to other federally sponsored programs. Contact the SERTAC coordinator or SERTAC Executive Council prior to disposing or transferring assets.

**Asset / Inventory Records**: The agency must maintain records to verify the existence and current utilization of all SERTAC funded assets for all periods in which the asset is in use and to account for all assets sold or traded-in, in compliance with the grant agreement and OMB Circular A-110: Subpart C: Equipment.

Records shall be retained in compliance with OMB Circular A-110: Subpart C: Retention Access Requirements for Records and at a minimum of the state’s retention period of current fiscal year plus 4 years.

The sub-awardee must ensure that asset records contain the following information: asset description, serial and model number, acquisition date and cost, depreciation method and useful life (for fixed assets), asset location, condition, and disposal date and revenue generated from said disposal, in compliance with OMB Circular A-110: Subpart C: Equipment.

Assets are to be capitalized according to OMB Circular A-122: Attachment B: Equipment and other Capital Expenditures and the agency’s capitalization policy. The agency shall conduct an annual physical review of the capitalized assets and document asset locations and condition as of the end of the agency fiscal year.

**Attachment C**

**Terms and Conditions for Equipment/Capital Assets Form (cont.)**

We, the undersigned, have read, understand, and will comply with the terms and conditions for capital equipment/assets.

|  |  |
| --- | --- |
| **Name of Agency:** |  |
| **City:** |  |

|  |  |
| --- | --- |
| **Signature of Authorized**  **Agency Representative:** |  |
| **Name:** |  |
| **Title:** |  |
| **Date:** |  |

**Attachment D**

**Project Reimbursement Request Form**

|  |  |
| --- | --- |
| Date: |  |
| Requesting Organization Invoice Number: |  |

The reimbursement check will reference this “Requesting Organization Invoice Number.” Therefore, provide a unique number recognizable to your accounting department.

If available:

|  |  |  |  |
| --- | --- | --- | --- |
| DUNS Number: |  | NIP Number: |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Organization Name: |  | | |
| Mailing Address:  (for reimbursement check) |  | | |
| Contact Name: |  | Contact Phone: |  |

|  |  |  |
| --- | --- | --- |
| Item Description & Vender Information | Vendor  Invoice Date | Actual Cost |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
| Total Reimbursement Amount Requested:  (not to exceed amount of original approved amount) | |  |

Add additional rows/pages as needed for all project elements.

Include with this form any receipts, invoices, and other supporting documentation necessary to verify project completion.