

**State of Nevada Department of Health and Human Services
Director's Office
Fund for a Resilient Nevada**

In response to:

Notice of Funding Opportunity (NOFO)

Final Submission Date and Time:

April 7, 2023, at 5:00 p.m. PDT

Our application is respectfully submitted as follows:

Company Name:	Click or tap here to enter text.
Primary Business Address:	Click or tap here to enter text.
Mailing Address: (If different)	Click or tap here to enter text.
Phone:	Click or tap here to enter text.
Executive Director/CEO:	Click or tap here to enter text.
Primary Contact for Proposal:	Click or tap here to enter text.
Primary Contact Email Address:	Click or tap here to enter text.

As a duly authorized representative, I hereby certify that I have read, understand, and agree to all terms and conditions contained within this request for applications and that information included in our organization's application hereby submitted is accurate and complete.

Signed:

Date: Click or tap to enter a date.

Print Name: Click or tap here to enter text.

Title: Click or tap here to enter text.

This form is required to be completed in its entirety. **All fields are mandatory.** If not appropriate or applicable, place N/A. Any failure to respond to any question, may result in disqualification. Do not add or delete from this Application Form. **Font type is to be Arial 11 pt.** Word limitations are considered maximum word counts and Applicants may choose to write fewer words.

A. ORGANIZATION TYPE. Define the primary applicant’s organization type as registered with the State of Nevada Secretary of State Office. *Note: Different funding sources have limits on type of organizations that may receive funding.* If unsure, refer to your business license. **You must check one.**

- Public Agency 501(c)(3) Nonprofit Private Higher Education Tribal
 Other [Click or tap here to enter text.](#)

B. GEOGRAPHIC AREA OF SERVICE

PROVIDE PRIMARY LOCATION OF AREAS WHERE SERVICES WILL INCLUDE. FOR EXAMPLE, WASHOE COUNTY, STATEWIDE OR BY ZIP CODE. SELECT ONLY ONE AND DESCRIBE IN BOX ADJACENT.

<input type="checkbox"/> CITY, OR ZIP CODE	Click or tap here to enter text.
<input type="checkbox"/> COUNTY	Click or tap here to enter text.
<input type="checkbox"/> REGION	Click or tap here to enter text.
<input type="checkbox"/> STATEWIDE	Click or tap here to enter text.

C. APPLICANT ORGANIZATION

ALL SECTIONS OF THE APPLICANT ORGANIZATION ARE MANDATORY AND N/A IS NOT ACCEPTABLE. IF APPLICANTS DO NOT PROVIDE A FEDERAL TAX IDENTIFICATION NUMBER AND A DUNS/UEI NUMBER, YOU WILL BE DISQUALIFIED.

ORGANIZATION NAME	Click or tap here to enter text.	
MAILING ADDRESS	Click or tap here to enter text.	
PHYSICAL ADDRESS	Click or tap here to enter text.	
CITY	Click or tap here to enter text.	NV
ZIP (9-DIGIT ZIP REQUIRED)	Click or tap here to enter text.	
FEDERAL TAX ID #	Click or tap here to enter text.	
DUNS/UEI NUMBER	Click or tap here to enter text.	

D. PROGRAM POINT OF CONTACT

PROGRAM CONTACT IS INDIVIDUAL WHO WILL BE RESPONSIBLE FOR ACTIVITIES OF THE GRANT.

NAME	Click or tap here to enter text.	
TITLE	Click or tap here to enter text.	
PHONE	Click or tap here to enter text.	
E-MAIL	Click or tap here to enter text.	
SAME MAILING ADDRESS AS SECTION C? <input type="checkbox"/> YES <input type="checkbox"/> NO, USE BELOW ADDRESS INFORMATION		
ADDRESS	Click or tap here to enter text.	
CITY	Click or tap here to enter text.	NV
ZIP (9-DIGIT ZIP REQUIRED)	Click or tap here to enter text.	

E. FISCAL OFFICER

FISCAL CONTACT IS INDIVIDUAL RESPONSIBLE FOR THE BUDGET AND REIMBURSEMENT REQUESTS.

NAME	Click or tap here to enter text.	
TITLE	Click or tap here to enter text.	
PHONE	Click or tap here to enter text.	
EMAIL	Click or tap here to enter text.	
SAME MAILING ADDRESS AS SECTION B? <input type="checkbox"/> YES <input type="checkbox"/> NO, USE BELOW ADDRESS INFORMATION		
ADDRESS	Click or tap here to enter text.	
CITY	Click or tap here to enter text.	NV
ZIP (9-DIGIT ZIP REQUIRED)	Click or tap here to enter text.	

F. KEY PERSONNEL (ADD ROWS IF REQUIRED)

KEY PERSONNEL ARE DIRECTLY RESPONSIBLE FOR PROJECT DELIVERABLES. Key personnel are employees, consultants, subcontractors, or volunteers who have the required qualifications and professional licenses to provide proposed services. The Project Manager is a required.		
NAME	TITLE	LICENSED?
Click or tap here to enter text.	Project Manager (Mandatory Field) If licensed, License Type: License Number:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Click or tap here to enter text.	Click or tap here to enter text.	<input type="checkbox"/> Yes <input type="checkbox"/> No
Click or tap here to enter text.	Click or tap here to enter text.	<input type="checkbox"/> Yes <input type="checkbox"/> No
Click or tap here to enter text.	Click or tap here to enter text.	<input type="checkbox"/> Yes <input type="checkbox"/> No

G. THIRD PARTY (E.G. MEDICAID) PAYER IDENTIFICATION

A RESPONSE OF YES MEANS YOU ARE CURRENTLY ENROLLED AS A PROVIDER AND NOT THAT YOU ARE IN THE PROCESS.	
Are you currently a registered provider with the Division of Health Care Finance and Policy (DHCFP) – Nevada Medicaid?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Are you currently registered as a provider with Health Plan of Nevada?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Are you currently registered as a provider with United Health Care?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Are you currently registered as a provider with Blue Cross/Blue Shield Anthem?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Are you currently registered as a provider with Silver Summit?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Please identify any other third-party payors billed (e.g., insurance companies) your organization is registered with as a provider type for billing purposes. Click or tap here to enter text.	

Current provider types (PT) for third-party payors:	
PT 11 Hospital, Inpatient	<input type="checkbox"/> Yes <input type="checkbox"/> No
PT 12 Hospital, Outpatient	<input type="checkbox"/> Yes <input type="checkbox"/> No
PT 13 Psychiatric Hospital	<input type="checkbox"/> Yes <input type="checkbox"/> No
PT 14 Behavioral Health Outpatient	<input type="checkbox"/> Yes <input type="checkbox"/> No
PT 17 Specialty Clinic (e.g. CCBHC, FQHC)	<input type="checkbox"/> Yes <input type="checkbox"/> No
PT 20 Physician	<input type="checkbox"/> Yes <input type="checkbox"/> No
PT 26 Psychologist	<input type="checkbox"/> Yes <input type="checkbox"/> No
PT 32 Community Paramedicine	<input type="checkbox"/> Yes <input type="checkbox"/> No
PT 47 Indian Health Programs and Tribal Clinics	<input type="checkbox"/> Yes <input type="checkbox"/> No
PT 54 Targeted Case Management	<input type="checkbox"/> Yes <input type="checkbox"/> No
PT 60 School Based	<input type="checkbox"/> Yes <input type="checkbox"/> No
PT 63 Residential Treatment Center (RTC)	<input type="checkbox"/> Yes <input type="checkbox"/> No
PT 82 Behavioral Health Rehabilitative Treatment	<input type="checkbox"/> Yes <input type="checkbox"/> No
Other, Please Define: Click or tap here to enter text.	

H. CERTIFICATION OF PROVIDER

ANSWERS ARE SPECIFIC TO THE ORGANIZATION CERTIFICATION AT THE TIME OF THE SUBMITTAL AND NOT ANY TEAM MEMBER CERTIFICATIONS.	
Are you JCAHO (Joint Commission) Certified?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Are you SAPTA Certified under Nevada Revised Statute (NRS) 458, and Nevada Administrative Code (NAC) 458 <i>and</i> do you have a minimum of two (2) years providing substance use disorder treatment?	<input type="checkbox"/> Yes <input type="checkbox"/> No
OR, are you able to provide memorandums of understanding (MOU)'s with community partners who will provide treatment and are able to provide proof of SAPTA certification in good standing?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Please identify any additional certifications your organization (not individuals) hold: Click or tap here to enter text.	

I. CURRENT FUNDING (FEDERAL, STATE, AND PRIVATE FUNDING). NOTE: FAILURE TO PROVIDE ALL FUNDING MAY RESULT IN DISQUALIFICATION. PRIVATE DONATIONS MAY BE IDENTIFIED IN ONE-LINE.

FEDERAL, STATE AND PRIVATE FUNDING. PRIVATE FUNDING MAY BE IDENTIFIED AS TOTAL. ANY FEDERAL OR STATE FUNDS MUST BE DETAILED OUT. ADD ROWS AS REQUIRED. THIS INCLUDES ALL FEDERAL OR STATE GRANTS. STATE GRANTS ARE NOT PRIVATE FUNDING.			
Funding	Type	Project Period End Date	Current or Previous Amount Awarded (\$)

<i>Example: State Opioid Response Grant</i>	<i>Grant</i>	<i>September 2023</i>	<i>\$100,000</i>
Click or tap here to enter text.			
Click or tap here to enter text.			
Click or tap here to enter text.			
Click or tap here to enter text.			
Click or tap here to enter text.			
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Click or tap here to enter text.			
Click or tap here to enter text.			
Click or tap here to enter text.			

J. CAPACITY AND SUSTAINABILITY

Define what you have done to increase sustainability efforts within the last three years (i.e. Medicaid billable, increased other forms of funding, e.g.) to reduce your reliance on federal or state grant funding. Do not exceed 200 words.

Click or tap here to enter text.

K. TARGET POPULATION (SELECT ONLY ONE).

- (A) Adults
- (Y) Youth/Adolescents
- (B) Both, must demonstrate capacity and capability in application

L. PRIORITY AREA (Note – Applicants may not check more than one priority area). Applicants may submit more than one application. Checking more than one priority area may result in disqualification. The priority service areas must match your population of focus in K.

- TARGET 1:** INCREASE THE AVAILABILITY OF EVIDENCE-BASED TREATMENT
- TARGET 2:** EXPANSION OF ADOLESCENT AND TRANSITIONAL AGED YOUTH TREATMENT OPTIONS ACROSS ALL ASAM LEVELS OF CARE FOR OPIOID USE DISORDER (OUD) WITH CO-OCCURRING DISORDER (COD) INTEGRATION
- TARGET 3:** INCREASE ACCESS TO EVIDENCE-BASED TREATMENT FOR TRIBAL ENTITIES
- TARGET 4:** INCREASE AVAILABILITY AND ACCESS TO MEDICATIONS FOR OPIOID USE DISORDER (OUD)
- TARGET 5:** INCREASE TREATMENT FOR NEONATAL ABSTINENCE SYNDROME (NAS)/PRE & POSTPARTUM SERVICES
- TARGET 6:** PROVIDE OPIOID PREVENTION AND TREATMENT CONSISTENTLY ACROSS CRIMINAL JUSTICE AND PUBLIC SAFETY SYSTEM

M. PROJECT ABSTRACT

The project abstract serves as a succinct description of the proposed project and a description of how the funds will be used. The abstract should be clear, accurate, concise, and without reference to other parts of the application. Abstract should be single spaced, do not exceed 250 words. (Name, Priority Area and Estimated Budget do not count towards the 250 words.)

NAME OF PROJECT: Click or tap here to enter text.

Click or tap here to enter text.

Priority Area

Click or tap here to enter text.

Estimated Budget Year One (Pull from Budget)

Click or tap here to enter text.

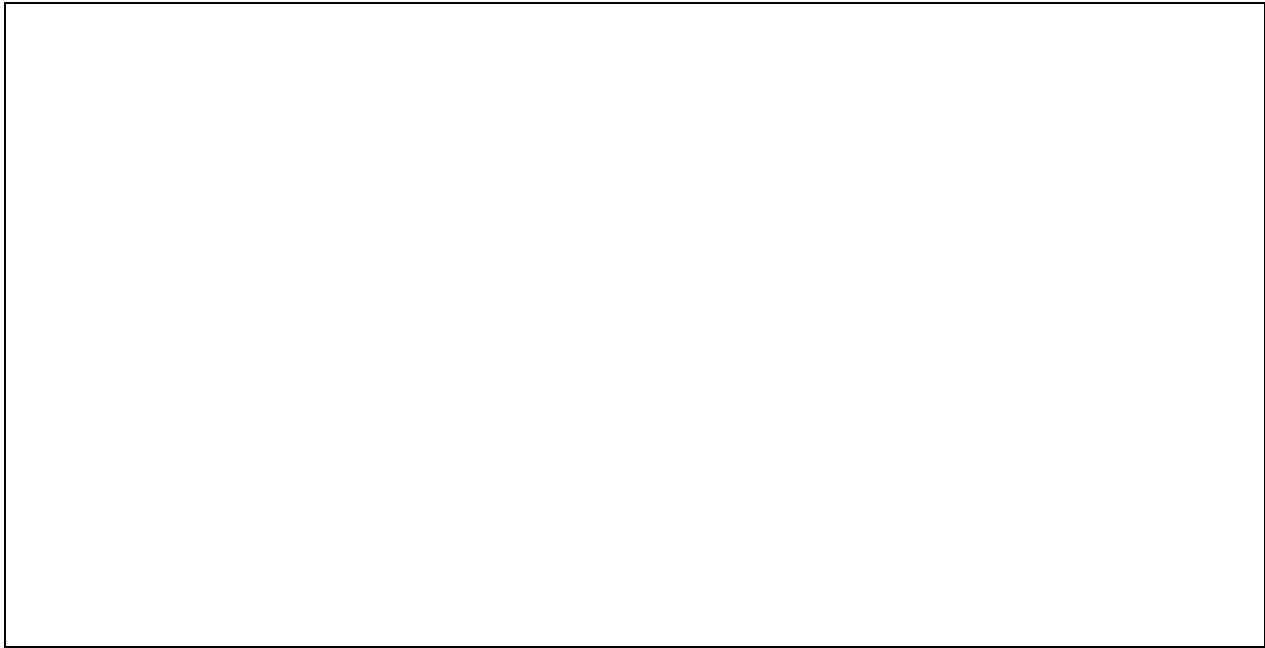
Estimated Budget Year Two (Pull from Budget)

Click or tap here to enter text.

N. ORGANIZATIONAL CAPACITY DESCRIPTION

The Organization Description must include an overview of your organization demonstrating not less than two years of operation, its structure, and relevant experience. Describe organization's qualifications and experiences to implement the proposed project and previous experience related in scope and complexity to the Proposed Project. (Single Spaced, with maximum of 500 words.)

Click or tap here to enter text.



O. PROJECT DESIGN AND IMPLEMENTATION

The Project Design and Implementation should provide a detailed description of the program that is proposed to be funded. The following questions should be answered concisely and completely. Maximum of 1,500 words (single spaced).

1. Describe how the project will address *Target Population*.

Click or tap here to enter text.

2. Describe the program activities and how they relate to the overall objectives, opioid abatement, goals of the project, and how the objectives will be achieved.

Click or tap here to enter text.

3. Describe how many individuals will be served monthly and annually.

Click or tap here to enter text.

4. Describe how the project design and implementation will meet the priority service area targeted.

Click or tap here to enter text.

5. Define the evidence-based practice(s) or promising practice(s) being utilized.

Click or tap here to enter text.

6. Describe how the project meets the requirements for the targeted program.

Click or tap here to enter text.

7. Describe how proposed services meet the requirements of being culturally inclusive and what activities will be done to reach underserved priority populations.

Click or tap here to enter text.

P. CAPABILITIES AND COMPETENCIES

Describe the capabilities of the applicant, the subrecipients, and/or contractors to successfully implement the project. This section should also state the competencies of the staff assigned to the project. Describe the roles, experiences, and tenure of key employees who will be running the day-to-day operations of the project. Maximum of 500 words, single spaced.

Click or tap here to enter text.

Q. DATA COLLECTION

Describe the data and systems that your organization currently utilizes to collect unduplicated client level data, number of services provided, who collects the data, who is responsible for performance measurement and how the data is used to guide and evaluate current program activities. Identify if the organization has an electronic health record system, and what that system is. *(The state will work with the selected organizations to define the requirements for data collections which may include Client Level Data System (CLDS), GPRA, TEDS, or other data collection/systems based on the funding sources.) Maximum of 500 words, single spaced.*

Click or tap here to enter text.

R. SCOPE OF WORK

Complete the form below, provide a description of the services proposed that includes objectives, strategies and how data will be collected to ensure the activity is performed. The State will work with selected providers to detail out the performance measures associated with the scope of work. Do not exceed three pages. Applicant chooses how many goals to complete. Add more lines as needed. (Please note: Certain areas will have specific standards and goals which will be added prior to start of contract)

Describe the primary goal the program wishes to accomplish with this subaward.

Goal 1: Click or tap here to enter text.

Objective	Activities Strategies	How Data Collected/ Documentation
1.	1.	1.
2.	2.	2.

Describe the most important secondary goal the program wishes to accomplish with this subaward.

Goal 2: Click or tap here to enter text.

Objective	Activities Strategies	How Data Collected Documentation
1.	1.	1.
2.	2.	2.

Goal 3: Click or tap here to enter text.

Objective	Activities Strategies	How Data Collected Documentation
1. 2.	1. 2.	1. 2.

Goal 4: Click or tap here to enter text.

Objective	Activities Strategies	How Data Collected Documentation
1. 2.	1. 2.	1. 2.

Add additional Goals as required.

S. Project Manager CV/Resume (One-Page)

Insert a brief resume/biography with highlights of the Program Manager (from Section F), who is responsible for the program deliverables to include education, licensure, and applicable experience for the proposed scope of work. The state reserves the right to request additional resumes or CVs based on program activities. Do not exceed 400 words.

Click or tap here to enter text.

T. Budget Excel Template & Instructions

Budget Template is required to be attached as a separate excel document. The below are instructions to complete the template.

Budget Narrative Template Attached

No Text or Information in this Box. The Excel Document must be attached to the application as a separate document. The template is a separate Excel document located with the NOFO at: [FRN Home \(nv.gov\)](http://FRN Home (nv.gov))

U. GENERAL PROVISIONS OF GRANT ACCEPTANCE OR AWARD

Applicability: This section is applicable to all subrecipients who receive funding from the DHHS under this NOFO solicitation. The subrecipient agrees to abide by and remain in compliance with the following:

1. Litigation settlement and Bankruptcy Agreements
2. One Nevada Agreement
3. NRS 433.712 through 433.744, Administration of Certain Proceeds from Litigation Concerning Opioids
4. CFR 200 -Uniform Requirements, Cost Principles and Audit Requirements for Federal Awards
5. NRS 218G - Legislative Audits
6. NRS 458 - Abuse of Alcohol & Drugs
7. NRS 616 A through D Industrial Insurance
8. GAAP - Generally Accepted Accounting Principles and/or GAGAS - Generally Accepted Government Auditing Standards
9. GSA - General Services Administration for guidelines for travel
10. Grant Instructions and Requirements
11. State Licensure and certification
 - a. The subrecipient is required to be in compliance with all State licensure and/or certification requirements prior and during the grant award.
12. The subrecipient's commercial, general or professional liability insurance shall be on an occurrence basis and shall be at least as broad as ISO 1996 form CG 00 01 (or a substitute form providing equivalent coverage); and shall cover liability arising from premises, operations, independent subgrantees, completed operations, personal injury, products, civil lawsuits, Title VII actions, and liability assumed under an insured contract (including the tort liability of another assumed in a business contract).
13. To the fullest extent permitted by law, subrecipient shall indemnify, hold harmless and defend, not excluding the State's right to participate, the State from and against all liability, claims, actions, damages, losses, and expenses, including, without limitation, reasonable attorneys' fees and costs, arising out of any alleged negligent or willful acts or omissions of subrecipient, its officers, employees, and agents.
14. The subrecipient shall provide proof of workers' compensation insurance as required by Chapters 616A through 616D inclusive Nevada Revised Statutes at the time of their certification.
15. The subrecipient agrees to be a "tobacco, alcohol, and other drug free" environment in which the use of tobacco products, alcohol, and illegal drugs will not be allowed;
16. The subrecipient will report within 24 hours the occurrence of an incident, following DHHS policy, which may cause imminent danger to the health or safety of the clients, participants, staff of the program, or a visitor to the program, per NAC 458.153 3(e).
17. The subrecipient agrees to fully cooperate with all DHHS sponsored studies including, but not limited to, utilization management reviews, program compliance monitoring, reporting requirements, complaint investigations, and evaluation studies.
18. The subrecipient is required maintain a Central Repository for Nevada Records of Criminal History and FBI background checks every 3 to 5 years were conducted on all staff, volunteers, and consultants occupying clinical and supportive roles, if the subgrantee serves minors with funds awarded through this sub-grant.
19. Application to 211. As of October 1, 2017, the Subrecipient is required to submit an application to register with the Nevada 211 system.
20. The subrecipient agrees to a five percent (5%) maximum for administrative expenses.
21. The subrecipient must be enrolled in System Award Management (SAM) as required by the Federal Funding Accountability and Transparency Act.
22. The subrecipient acknowledges that to better address the needs of Nevada, funds

identified in this subgrant may be reallocated if ANY terms of the sub-grant are not met, including failure to meet the scope of work. The DHHS may reallocate funds to other programs to ensure that gaps in service are addressed.

23. The Subrecipient acknowledges that if the scope of work is NOT being met, the Subrecipient will be provided a chance to develop an action plan on how the scope of work will be met and technical assistance will be provided by Department staff or specified sub-contractor. The Subrecipient will have 60 days to improve the scope of work and carry out the approved action plan. If performance has not improved, the Division will provide a written notice identifying the reduction of funds and any other necessary steps.
24. Failure to meet any conditions listed within the subgrant award may result in withholding reimbursement payments, disqualification of future funding, and/or termination of current funding.

Audit Requirements

The following program Audit Requirements are for non-federal entities who do not meet the single audit requirement of 2 CFR Part 200, Subpart F-Audit requirements:

25. For subrecipients of the program who expend less than \$750,000 during the non-federal entity's fiscal year in federal and state awards are required to report all organizational fiscal activities annually in the form of a Year-End Financial Report.
26. For subrecipients of the program who expend \$750,000 or more during the fiscal year in federal and state awards are required to have a Limited Scope Audit conducted for that year. The Limited Scope Audit must be for the same organizational unit and fiscal year that meets the requirements of the Department Audit policy.

Year-End Financial Report

27. The non-federal entity must prepare financial statements that reflect its financial position, results of operations or changes in net assets, and, where appropriate, cash flows for the fiscal year.
28. The non-federal entity financial statements may also include departments, agencies, and other organizational units.
29. Year-End Financial Report must be signed by the CEO or Chairman of the Board.
30. The Year-End Financial Report must identify all organizational revenues and expenditures by funding source and show any balance forward onto the new fiscal year as applicable.
31. The Year-End Financial Report must include a schedule of expenditures of federal and State awards. At a minimum, the schedule must:
 - a. List individual federal and State programs by agency and provide the applicable federal agency name, settlement, judgement, grant, etc.
 - b. Include the name of the pass-through entity (State Program).
 - c. Must identify the CFDA number, if applicable, to the federal awards or other identifying number when the CFDA information is not available.
 - d. Include the total amount provided to the non-federal entity from each federal and State program.
32. The Year-End Financial Report must be submitted to the Department 90 days after fiscal year end at the following address.

Department of Health and Human Services, Director's Office
Attn: Fund for a Resilient Nevada
400 W. King Street, Ste 300
Carson City, NV 89703

Limited Scope Audits

33. The auditor must: a. Perform an audit of the financial statement(s) for the federal program in accordance with GAGAS; b. Obtain an understanding of internal controls and perform tests of internal controls over the federal program consistent with the requirements for a federal program; c. Perform procedures to determine whether the auditee has complied with federal and State statutes, regulations, and the terms and conditions of federal awards that could have a direct and material effect on the federal program consistent with the requirements of federal program; d. Follow up on prior audit findings, perform procedures to assess the reasonableness of the summary schedule of prior audit findings prepared by the auditee in accordance with the requirements of 2 CFR Part 200, §200.511 Audit findings follow-up, and report, as a current year audit finding, when the auditor concludes that the summary schedule of prior audit findings materially misrepresents the status of any prior audit finding; e. And, report any audit findings consistent with the requirements of 2 CFR Part 200, §200.516 Audit findings.
34. The auditor's report(s) may be in the form of either combined or separate reports and may be organized differently from the manner presented in this section.
35. The auditor's report(s) must state that the audit was conducted in accordance with this part and include the following: a. An opinion as to whether the financial statement(s) of the federal program is presented fairly in all material respects in accordance with the stated accounting policies; b. A report on internal control related to the federal program, which must describe the scope of testing of internal control and the results of the tests; c. A report on compliance which includes an opinion as to whether the auditee complied with laws, regulations, and the terms and conditions of the awards which could have a direct and material effect on the program; and d. A schedule of findings and questioned costs for the federal program that includes a summary of the auditor's results relative to the federal program in a format consistent with 2 CFR Part 200, §200.515 Audit reporting, paragraph (d)(1), and findings and questioned costs consistent with the requirements of 2 CFR Part 200, §200.515 Audit reporting, paragraph (d)(3).
36. The Limited Scope Audit Report must be submitted to the Division within the earlier of 30 calendar days after receipt of the auditor's report(s), or nine months after the end of the audit period. If the due date falls on a Saturday, Sunday, or Federal holiday, the reporting package is due the next business day.

The Audit Report must be sent to:

Department of Health and Human Services, Director's Office
Attn: Fund for a Resilient Nevada
400 W. King Street, Ste 300
Carson City, NV 89703

Amendments

37. The Department of Health and Human Services policy is to allow no more than 10% flexibility within the approved Scope of Work budget line items. Notification of such modifications must be communicated in writing to the the Fund for a Resilient Nevada Unit prior to submitting any request for reimbursement for the period in which the modification affects. Notification may be made via e-mail.
38. For any budgetary changes that are in excess of 10% of the total award, an official amendment is required. Requests for such amendments must be made to the Fund for a Resilient Nevada Unit, in writing.

39. Any expenses that are incurred in relation to a budgetary amendment without prior approval are unallowable.
40. Any significant changes to the Scope of Work over the course of the budget period will require an amendment. The assigned program analyst can provide guidance and approve all Scope of Work amendments.
41. The Subrecipient acknowledges that requests to revise the approved subgrant must be made in writing using the appropriate forms and provide sufficient narrative detail to determine justification.
42. Final changes to the approved subgrant that will result in an amendment must be received 60-days prior to the end of the sub -grant period (no later than April 30 for State funded grants and July 31 for federal funded grants). Amendment requests received after the 60-day deadline will be denied.

Remedies for Noncompliance

43. The Division reserves the right to hold reimbursement under this sub-grant until any delinquent requests, forms, reports, and expenditure documentation are submitted to and approved by the Division.

Agreed to:

Signature: _____

Date: [Click here to enter a date.](#)

Printed Name: [Click here to enter text.](#)

Title: [Click here to enter text.](#)

V. FINANCIAL AND INTERNAL CONTROLS QUESTIONNAIRE

ORGANIZATION FINANCIAL INFORMATION (for nonprofit organizations only)

1. According to your organization's most recent audit or balance sheet, are the total current assets greater than the liabilities?

YES NO

2. Is the total amount requested for this FRN Program funding opportunity greater than 50% of your organization's current total annual budget?

YES NO

ACCOUNTING

3. Briefly describe your organization's accounting system and accounting processes, including:

A. Is the accounting system computerized, manual, or a combination of both? If your accounting system is computerized, indicate the name of the financial software.

[Click here to enter text.](#)

B. How are different types of transactions (e.g., cash disbursements, cash receipts, revenues, journal entries) recorded and posted to the general ledger?

[Click here to enter text.](#)

C. Your expenditure reports will be due by the 15th of each month. (If the 15th falls on a Saturday, Sunday, or State of Texas holiday, expenditure reports are due the next business day.) To ensure that you submit expenditure reports timely, please respond to the following:

1) By what date must any Partner Organizations submit reimbursement requests to your agency (e.g., Partner Organizations must submit their reimbursement request, General Ledger report, and supporting documentation to us no later than the 10th of each month)?

[Click here to enter text.](#)

2) By what date do you close the General Ledger (e.g., GL is closed no later than the 10th of each month)?

[Click here to enter text.](#)

D. How are transactions organized, maintained, and summarized in financial reports?

[Click here to enter text.](#)

Answer each of the following questions with either a "YES", "NO", or "NOT APPLICABLE" by checking the respective box.

4. The Fund for a Resilient Nevada has adopted the Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards (2 CFR 200) as the fiscal

and administrative guidelines for this grant program. Is the staff who will be responsible for the financial management of your award familiar with these documents?

YES NO

5. Does your organization have written accounting policies? Do your policies include policies on the procurement of goods/services?

YES NO

6. Does your accounting system identify and segregate:

- Allowable and unallowable costs;
- Direct and indirect expenses;
- Grant costs and non-grant costs; and
- The allocation of indirect costs.

YES NO

7. If your organization has more than one grant contract, does your accounting system have the capability of identifying the receipt and expenditures of program funds and program income separately for each contract?

YES NO NOT APPLICABLE

8. Are individual cost elements in your organization's chart of accounts reconciled to the cost categories in the approved budget?

YES NO

9. Are your accounting records supported by source documentation (invoices, receipts, approvals, receiving reports, canceled checks, etc.) and on file for easy retrieval?

YES NO

GENERAL ADMINISTRATION AND INTERNAL CONTROLS

10. Does your organization have written personnel policies?

YES NO

11. Does your organization have written job descriptions with set salary levels for each employee?

YES NO

12. UGMS requires that any staff paid from State grant funds, to keep a record of time and attendance.

A. For staff funded 100% by the grant, each staff person only needs to certify their time monthly. Both the employee and the employee's supervisor must sign the monthly

certification of time worked.

B. For staff who split their time between the FRN grant and other funding sources, they will need to keep a time record or personnel activity reports or equivalent documentation must meet the following standards:

- 1) They must reflect an after-the-fact distribution of the actual activity of each employee.
- 2) They must account for the total activity, for which each employee is compensated.
- 3) They must be prepared at least monthly and must coincide with one or more pay periods; and
- 4) They must be signed by the employee and the supervisory official having first-hand knowledge of the work performed by the employee.

13. Does your organization maintain time allocated personnel activity reports that meet the above criteria?

YES NO

14. Does your organization maintain personnel activity reports or equivalent documentation that meet the above criteria?

YES NO

15. Are payroll checks prepared after receipt of approved time/attendance records and are payroll checks based on those time/attendance records?

YES NO

16. Are procedures in place to determine the allowability, allocability, and reasonableness of costs?

YES NO

The Organizational Financial Information and Internal Controls Questionnaire must be signed by an authorized person who has completed the form or reviewed the form and can attest to the accuracy of the information provided.

Approved by:

Signature: _____

Date: [Click here to enter a date.](#)

Printed Name: [Click here to enter text.](#)

Title: [Click here to enter text.](#)

W. CERTIFICATION BY AUTHORIZED OFFICIAL

As the authorized official for the applying agency, I certify that the proposed project and activities described in this application meet all requirements of the legislation governing the State Administrative Manual, 2 CFR Chapter 200, Opioid Recoveries Legislation, and the certifications in the Application Instructions; that all the information contained in the application is correct; that the appropriate coordination with affected agencies and organizations, including subcontractors, took place; that this agency agrees to comply with all provisions of the applicable grant program and all other applicable federal and state laws, current or future rules, and regulations. I understand and agree that any award received as a result of this application is subject to the conditions set forth in the Statement of Grant Award. *All Applicants identified for funding must comply with the Grant Instruction and Requirements (GIRS). Link: [Grant Instructions and Requirements revised October 2020 \(nv.gov\)](#) or latest approved version.*

Name (type/print):

Click or tap here to enter text.

Phone

Click or tap here to enter text.

Title

Click or tap here to enter text.

Email

Click or tap here to enter text.

Signature

Date

Click or tap to enter a date.