Continuation Guidance for Cooperative Agreement on Public Health Preparedness and Response for Bioterrorism – Budget Year Five Program Announcement 99051 June 14, 2004

A. INTRODUCTION:

The Centers for Disease Control and Prevention (CDC) announces the availability of fiscal year (FY) 2004 funding for continuation of the cooperative agreement on public health preparedness and response for bioterrorism. Funds are intended to upgrade state and local public health jurisdictions' preparedness for and response to bioterrorism, other outbreaks of infectious disease, and other public health threats and emergencies. This document is provided to assist awardees in developing continuation applications for budget year (BY) five (August 31, 2004 – August 30, 2005) of a project period that began August 31, 1999.

While this guidance contains instructions for CDC awardees, it also includes recipient activities that need to be integrated with those funded by the hospital preparedness cooperative agreement administered by the Health Resources and Services Administration (HRSA). Further, CDC encourages applicants to coordinate activities with current relevant efforts in their jurisdictions or proposed under the various focus areas of this cooperative agreement. Applicants should also coordinate activities within the jurisdiction (i.e., at the state level), between state and local jurisdictions, among local agencies, and with hospitals and major health care entities, jurisdictional Metropolitan Medical Response Systems, and adjacent states.

Applications should demonstrate consensus, approval or concurrence between state and local public health officials for the proposed use of these funds. Bioterrorism events occur locally; response capacity must be assured at both the state and local levels. Due to the variability in financing, organization, and governance of state and local health departments across the United States, there is no single best approach for achieving such consensus; however, documentation must be provided to attest that capacity is to be developed at both the local and state levels. The purpose of such a process is to demonstrate that a significant portion of local public health officials, including those serving a major portion of the state's population, concur with the proposed use of funds. The intent of this provision is to ensure meaningful collaboration between state and local public health officials, while not enabling any one health official to stall the entire statewide process. Local capacity can be built through direct allocation of funds to local levels and through funding of state or sub-state regional activities that directly benefit local communities. Even in those states that operate local health departments, appropriate local capacity development must be ensured. Funding allocations should focus on the benefits to be provided either directly or indirectly to local jurisdictions.

B. DISCUSSION OF BENCHMARKS

CRITICAL BENCHMARKS

Critical Benchmarks are milestones on the road to public health emergency preparedness. HHS therefore places a high priority on their attainment and views awardees' successes or failures in this regard as important indicators of progress. Although, by definition, attaining any particular critical benchmark does not guarantee preparedness, failure to achieve any one of them is a near-certain indicator that the jurisdiction is inadequately prepared.

FY 2002 Critical Benchmarks

As of now (June, 2004), awardees should have achieved the 14 Critical Benchmarks specified in the FY 2002 guidance. To help HHS assess the status of awardees' efforts toward this end, awardees are to complete the accompanying table (Appendix 8) through the Division of State and Local Readiness Management Information System (DSLR MIS) as part of the Cross-Cutting Activities section of the application for FY 2004 funds. Failure to achieve all 14 Critical Benchmarks could result in funding restrictions in the FY 2004 award.

FY 2003 Critical Benchmarks

The Critical Benchmarks specified in the FY 2003 guidance are repeated, with nearly identical language, in the FY 2004 guidance. Information on the progress toward these milestones should be included in the FY 2003 Interim Progress Reports (which awardees already have submitted), the FY 2004 applications, and the FY 2003 Final Reports. HHS expects awardees to have attained these milestones by May 2005. Documentation requirements for reporting evidence of such attainment will be included in the guidance for the FY 2004 Interim Progress Reports.

FY 2003 Cross-Cutting Critical Benchmarks

The FY 2003 guidance included 5 Cross-Cutting Critical Benchmarks – i.e., high-priority milestones that required joint activities under the CDC and HRSA bioterrorism cooperative agreements. As indicated elsewhere in this guidance (Attachment H), HHS expects awardees to attain 4 of the 5 milestones by the end of the FY 2003 budget period (August 30, 2004). Information on the progress toward these milestones should be included in the FY 2003 Interim Progress Reports (which awardees already have submitted), the FY 2004 applications, and the Final Reports for FY 2003. Documentation requirements for reporting evidence of such attainment will be included in the guidance for the FY 2003 Final Reports.

FY 2004 Cross-Cutting Critical Benchmarks

The current guidance (Attachment H) includes two Cross-Cutting Critical Benchmarks. One, Laboratory Data Standard, carries over from the FY 2003 guidance because implementation of this data standard, by its nature, may be an episodic activity over a period of several years. The second benchmark, Preparedness for Pandemic Influenza, is new. Its addition underscores the need to address current vulnerability to the emergence of an influenza strain – whether naturally occurring or terrorist-induced – for which humans have little or no protective immunity and for which an effective vaccine may not be available until the epidemic is far advanced or perhaps never. HHS expects awardees to report their progress toward the two milestones in the FY 2004 Interim Progress Reports and to provide evidence of achievement of the Pandemic Influenza benchmark in the 2004 Final Reports. Documentation requirements for reporting evidence of such attainment will be included in the guidance for the FY 2004 Final Reports.

C. AVAILABILITY OF FUNDS:

Funding Amount*: **Approximately $844 million of fiscal year (FY) 2004*** funds are available to fund BY5 (August 31, 2004 - August 30, 2005) as follows:

$809,956,000	Base funds available for all awardees
$27,000,000	City Readiness funds available to select awardees (see Attachment L)
$5,440,000	Early Warning Infectious Disease Surveillance (EWIDS) funds available to select awardees (see Attachment M)
$7,200,000	Focus Area D (Chemical Laboratories) funds available to select awardees (see Attachment M)

Each state awardee will receive a base amount of $3,915,000, plus an amount equal to its proportional share of the national population as reflected in the U.S. Census estimates for July 1, 2002. The District of Columbia will receive a base amount of $10 million and New York City, Los Angeles County, and Chicago will continue to receive a base amount of $5 million. Due to their demographic characteristics and unique programmatic needs, American Samoa, the U.S. Virgin Islands, Guam, the Northern Mariana Islands, the Marshall Islands, the Federated States of Micronesia and Palau will receive $391,500 per awardee plus a population-based allocation.

Use of Funds: **Budget year five will begin on August 31, 2004 and extend through August 30, 2005.** Awardees must identify their proposed allocation of funding by Focus Area in their submissions for budget period five. However, monies may be re-directed between/among focus areas during the year under the following conditions: 1) Awardees must notify the CDC Grants Office, and 2) copy their CDC Project Officer for all funding re-directions. Prior approval is required for all funding re-directions for sums greater than 25% of the total budget for BY5, or $250,000 (whichever is less).

Cooperative agreement funds under this program may not be used to purchase vehicles or supplant any current state or local expenditures. Supplantation means using Federal funds to replace state or local funds . The Public Health Service Act, Title I, Section 319 (c) specifically states: "SUPPLEMENT NOT SUPPLANT. -- Funds appropriated under this section shall be used to supplement and not supplant other Federal, State, and local public funds provided for activities under this section." Therefore, the law strictly and expressly prohibits supplantation.

Unobligated Funds: ***Please submit interim financial status reports (FSRs) estimating the unobligated balance of funds as of June 30, 2004 with the application.*** Please provide a summary and individual Focus Area FSRs with your continuation application. Include the FSRs with your hardcopy application to CDC's Procurement and Grants Office (PGO). Estimated unobligated funds should also be reported in Section A - Budget Summary of Standard Form (SF) 424A.

Direct Assistance (DA): Subject to the Procurement and Grants Office's review and approval, applicants may allocate a portion of their Bioterrorism Cooperative Agreement budget to Direct Assistance. Direct assistance is a type of assistance that may be provided in lieu of financial assistance (outright funding), when authorized by statute. When authorized, CDC may reduce from the total award the amount that represents direct assistance.

Direct Assistance may consist of:

- The fair market value of any supplies (including vaccines and other preventive agents) or equipment furnished by CDC to the recipient, and
- The amount of the pay, allowances, and travel expenses of any officer or employee of the Federal government when detailed to the recipient, and the amount of any other costs incurred in connection with the individual's detail.
- When direct assistance is in the form of equipment or supplies, CDC generally will use its acquisition process (rather than that of the recipient) to acquire the equipment or supplies.

The vast majority of applicants requesting Direct Assistance will be using this assistance as a vehicle to obligate grant funds to contract services, equipment, and supplies via the federal procurement process or in the form of on-site CDC personnel. Direct Assistance contracts and personnel awards will be made expressly to achieve the goals of the Bioterrorism Cooperative Agreement.

Once the project's budget is approved, the Notice of Grant Award (NGA) issued will reflect the amount awarded as Financial Assistance and an amount awarded as Direct Assistance. Applicants have until September 30, 2004 to obligate their Direct Assistance funds to a contract/task order and/or personnel. As a result of this deadline, all awardees will need to give careful consideration and coordination to ensuring their Direct Assistance allocation is obligated immediately upon release of Bioterrorism Cooperative Agreement funding.

For additional information regarding Direct Assistance, please refer to Appendix 5. If you have any questions or need additional information regarding Direct Assistance for personnel, please contact Glen Koops in the Office of Terrorism Preparedness and Emergency Response at (404) 639-7530 or by email at GAK3@cdc.gov. If you have questions or need additional information regarding Direct Assistance contracts/task orders, please contact Gregory Lanman in the Division of State and Local Readiness at (404) 639-7127 or by email at GHL2@cdc.gov.

D. PROGRAM CONTENT

1. HRSA/CDC Cross-Cutting Activities (Attachment H)

The Department of Health and Human Services (HHS) is funding activities at the state and local levels for public health preparedness through this cooperative agreement and for hospital preparedness through HRSA. To ensure that all preparedness activities are coordinated and integrated at the state and local levels, applicants should address recipient activities that integrate and harmonize efforts funded by both the CDC and HRSA cooperative agreements. The purpose of such integration and coordination is to ensure, to the extent possible, a seamless response to a bioterrorist attack, an outbreak of infectious disease or other public health emergency. Although there are linkages between the activities described in the focus areas and the cross-cutting activities, awardees should respond to the cross-cutting activities in their entirety by consulting the language in Attachment H.

Recipients must coordinate planning and program implementation activities to ensure that state and local health departments, hospitals, and other health care entities are able to mount a collective response featuring seamless interaction of their event-specific capabilities in the following areas:

- Laboratory data standard (Cross-Cutting Critical Benchmark)
- Preparedness for Pandemic Influenza Planning (Cross-Cutting Critical Benchmark)
- Integration of surveillance activities
- Coordination with Indian tribes
- Populations with special needs
- Psychosocial consequences of bioterrorism and other public health emergencies
- Education and training
- Involvement of academic health centers
- Interoperability of IT systems
- Interstate collaboration
- International border states

Several preparedness components such as information technology, training/education, risk communication and public information are fundamental to all emergency preparedness plans and responses. While public health departments play the predominant role in a public health emergency requiring mass distribution of vaccine or antibiotic prophylaxis, hospitals and other health care entities would carry the primary burden in the wake of a mass casualty incident. Integration of efforts must also include coordination of hospital and public health preparedness activities with those of public safety and emergency management agencies, especially with respect to activities funded by the Department of Homeland Security and/or other federal agencies. State awardees should actively support efforts by counties and municipalities to enhance their readiness for public health emergencies, including their capacity to rapidly accommodate state and federal assets such as the Strategic National Stockpile and emergency response teams.

2. Focus Areas for Public Health Preparedness

a. Capacities and Benchmarks: Applicants' public health preparedness activities should

address the *Critical Capacities and Critical Benchmarks*. *Critical Capacities* are the core expertise and infrastructure to enable a public health system to prepare for and respond to bioterrorism, other infectious disease outbreaks, and other public health threats and emergencies. Awardees must ensure that these Critical Capacities are fully addressed in their work plan by responding to the *Recipient Activities* identified in Attachments A-G. *Critical benchmarks* are those recipient activities that should be given priority. Recipient activities not designated as *critical benchmarks* should be undertaken with the understanding that they might take longer than the upcoming budget period to accomplish. In addition, activities associated with *critical benchmarks* that were achieved in previous funding years should be continued in BY 05, as appropriate.

b. Smallpox Preparedness: Recipient activities related to smallpox preparedness are found under the relevant critical capacities in the Focus Area attachments. These smallpox activities relate directly to those already addressed in previous Guidances specific to smallpox efforts. As applicable, awardees should address and respond to these activities in conjunction with other relevant activities. Work plans and funding requests for BY 05 should reference *current* smallpox vaccination preparations related to previous CDC guidance and any planned expansions of their program as current funding levels permit. Smallpox activities can be found throughout the guidance and are listed here for convenience:

Focus Area A:
- Critical Capacity 1, Required Activity 4
- Critical Capacity 2, Required Activity 3
- Critical Capacity 4, Required Activity 7

Focus Area B:
- Critical Capacity 5, Required Activity 10
- Critical Capacity 6, Required Activity 8
- Critical Capacity 7, Required Activities 8 and 9
- Critical Capacity 7, Enhanced Activities 10 and 11

Focus Area C:
- Critical Capacity 8, Required Activity 6
- Critical Capacity 9, Required Activity 8

Focus Area E:
- Critical Capacity 11, Required Activities 4 and 5

Focus Area F:
- Critical Capacity 15, Required Activities 8 and 9

Focus Area G:
- Critical Capacity 16, Required Activities 5-9

c. Enhanced Capacities: Awardees may also consider the *Enhanced Capacities* for each Focus Area. Enhanced Capacities are the additional expertise and infrastructure (i.e., over and

beyond the Critical Capacities) that enable performance above the core level of preparedness. Enhanced Capacities should be addressed only after Critical Capacities have been achieved or are well along in development.

d. Future Directions: CDC intends to transition from *critical capacities* to evidence-based *performance goals* and *measures* in future program announcements, which will assist CDC and awardees in documenting advances in preparedness. Evidence-based performance goals for public health disaster preparedness are currently being vetted with selected awardees for validity and feasibility. Upon receipt of the feedback, the performance goals will be refined, and distributed to awardees as targets for planning in the future. Awardees and CDC will develop evidence that the performance goals have been met over time. CDC and awardees will test the performance goals via routine drills and exercises. As public health system information is collected and analyzed, some performance goals will change. The goal is to use exercises, drills, and real-life situations to identify both strengths and weaknesses in the systems. Draft interim evidence-based performance goals for public health disaster preparedness will be mailed to awardees by August 31, 2004.

e. Workplan: Awardees are asked to review the material submitted to CDC to meet the requirements of the May 2004 semi-annual report and update annual goals or objectives to assist in achieving the *Critical Capacities* and *Enhanced Capacities*. The updated document will become the BY05 workplan from which CDC will monitor your progress throughout the coming year. Activities proposed to achieve each *Critical Capacity* or *Enhanced Capacity* must be tied to the budget narrative and budget justification.

3. Focus Area D – Chemical Laboratories

FY 2004 funds are available for Focus Area D – Lab Capacity for Chemical Agents. The goal is to expand chemical laboratory capacity in all jurisdictions to prepare for and respond to chemical terrorism incidents and other chemical emergencies. This program expansion will allow for full participation of chemical terrorism response laboratories in the Laboratory Response Network (LRN).

The purpose of this focus area is to develop nationwide laboratory capacity that provides rapid and effective analysis of clinical specimens (e.g., blood and urine) for chemical agents likely to be used in terrorism. These laboratory measurements will help guide public health management of a chemical terrorism event by identifying the chemical agent(s) used, the exposed population and the level of exposure. This nationwide capability has three levels of laboratory capacity. Level-One laboratories develop and maintain capacity to collect and transport clinical specimens to other laboratories for analysis for chemical agents. Proper safety precautions as well as chain-of-custody must be maintained. Level-One laboratory capacity is a critical capacity. Awards for Level-One laboratories will be limited to $400,000 per awardee.

Level-Two and Level-Three laboratories are categorized as enhanced capacity. Level-Two laboratories perform chemical agent measurements of **moderate complexity,** including cyanide-based compounds, arsenic, mercury, other heavy metals, and lewisites. Eligibility for Level-Two

requires demonstration of analytical competency in measurement of chemicals in clinical samples. Awards for Level-Two laboratories will be limited to $1,200,000 per awardee. Funding to individual states may vary depending on how many Level-Two methods a state decides to implement in its laboratory.

Level-Three laboratories have Level-Two responsibilities but also perform chemical agent measurements of **high complexity,** including nerve agents, mustards, tricothecene mycotoxins, selected incapacitating agents, and selected toxic industrial chemicals. The five laboratories already funded (California, Michigan, New Mexico, New York, and Virginia) are considered Level-Three laboratories. These States are eligible for up to $1,600,000 per state to maintain Level Three capacities. It is CDC's intent to increase the number of laboratories in Level-Three from five to as many as ten in the future. To be eligible for Level-Three designation, a Level-Two lab must demonstrate analytical competency for all Level-Two chemical agents.

Further detail, including related activities, can be found in Attachment D.

4. CHEMPACK**:** CDC, in collaboration with the Department of Homeland Security, has established a project (CHEMPACK) to place sustainable repositories of nerve agent antidotes in numerous locations throughout the United States, to be immediately accessible for the treatment of affected persons. Under this project, the SNS Program will strategically place the antidotes in locations under controlled and monitored storage conditions and implement strategies to maximize the shelf lives of the antidotes through the Food and Drug Administration's Shelf Life Extension Program. Participation in CHEMPACK is strictly voluntary and restricted to PA 99051 awardees. Recipients of funding through the Cooperative Agreement for Public Health Preparedness and Response for Terrorism may request redirection of current year funds or carried-over, un-obligated prior-year funds to support the costs associated with receiving and managing CHEMPACK materiel. Proposals to implement CHEMPACK activities should be submitted as part of Focus Area A – SNS activities and budget justification. Consultation with CDC / SNS regarding hospital participation in the ChemPack program is encouraged. HRSA funds may be used to upgrade facilities to meet CDC prescribed requirements for storage of the ChemPack caches. Guidance concerning the CHEMPACK program is in Attachment J.

SUBMISSION REQUIREMENTS AND DEADLINE

Continuation applications are due on August 1, 2004. CDC will provide an Internet-based system for submitting continuation applications electronically. This system will enable applicants to complete most required forms electronically, with the exception of Grant forms (see below). Applicants are required to use this system in lieu of paper-based applications. However, one complete hardcopy of the application must be submitted to PGO. Under separate cover, CDC will provide detailed instructions to obtain a digital certificate to access the CDC web portal https://sdn.cdc.gov and use the electronic application system. Any questions or problems concerning use of the Internet-based application should be directed to your project

officer. A list of the project officers is found in Appendix 1: Technical Assistance Contacts.

1. Grant Forms

Forms SF-424, SF-424A, SF-424B and PHS 5161-1 (checklist) must be printed, signed and mailed to the CDC Procurement and Grants Office (PGO). **One complete hardcopy of your application, along with the required forms, must be submitted to PGO**. Programmatic copies must be submitted electronically on the Secure Data Network (SDN) system.

- **All forms will be available from the Secure Data Network (https://sdn.cdc.gov)** In addition, Form PHS 5161-1 is available from the CDC Procurement and Grants office at the following Internet address: http://www.cdc.gov/od/pgo/forminfo.htm.
- Application budget preparation guidance is also available at: http://www.cdc.gov/od/pgo/funding/budgetguide2004.htm

* Forms SF-424 (Cover page) and SF-424B (Assurances) are available from the DSLR MIS application site and the Office of Management and Budget: http://www.whitehouse.gov/omb/grants/grants forms.html

* Form SF-424A (Budget Information) will be generated and pre-populated automatically from the DSLR MIS budget application site. A blank form SF-424A can also be obtained at the following Internet address: http://www.whitehouse.gov/omb/grants/grantsforms.html

Applications must include a projection of the amount of FY2003 funds that will be unobligated at the end of budget period four (i.e., on August 30, 2004) and report this estimate for each focus area on a separate interim FSR form. (See Unobligated Funds, under C. AVAILABILITY OF FUNDS.)

2. Application Narrative and Budget

Applicants should access the electronic application system at the CDC portal https://sdn.cdc.gov/ and follow the online instructions. The application will include a budget submission, an update of the FY 2003 CDC workplan, international border activities (where applicable), and HRSA/CDC cross-cutting activities. Updates to the current workplan will be sufficient.

1. Workplan and Budget Narrative: To streamline the application, review and monitoring process, CDC developed a comprehensive application system that includes budget, activities to meet CDC requirements, international cross-border activities (where applicable), and HRSA/CDC cross-cutting activities. CDC has pre-populated the DSLR management information system (DSLR MIS) with activities meeting CDC requirements from the FY03 workplans and subsequent progress reports. Applicants should 1) access the SDN system to update these activities for this application, and 2) develop and submit their budget

information through the management information system.

2. HRSA/CDC Cross-Cutting Narrative

The DSLR MIS template provides space for responses to cross-cutting benchmarks and activities. The information entered into the MIS for the Cross-cutting benchmarks and activities should be identical for both CDC and HRSA. Thus, one set of responses provided through the MIS will satisfy the requirements of both CDC and HRSA. The responses provided to the Cross-Cutting Benchmarks and Activities will assist the Department of Health and Human Services in assessing the extent and nature of the efforts states are making to develop a cohesive and coherent approach for dealing with bioterrorism and other public health emergencies. These benchmarks and activities will be updated in the MIS as part of regular progress reports. Because the Cross-cutting section is relevant to both public health and hospital preparedness, state health department staff working under the CDC and HRSA cooperative agreements should jointly respond to this section.

3. International Cross-Border Early Warning Infectious Disease Surveillance Initiatives (Selected awardees)

The DSLR MIS template provides space for responses to the International Cross-Border Early Warning Infectious Disease Surveillance (EWIDS) initiatives for eligible applicants. These cross-border issues reflect the broader Departmental goals for cross-border public health security and focus on surveillance of infectious disease outbreaks (both bioterrorist-triggered and naturally occurring) at our borders with Canada and Mexico. These activities will be updated in the MIS as part of regular progress reports.

4. Budget and Budget Justification

The budget should be submitted through the DSLR MIS (https://sdn.cdc.gov/.) Instructions are available on this website to guide jurisdictions through the budget development and submission process. Applicants should use the formats required in the DSLR MIS. Please note that costs associated with the Strategic National Stockpile (SNS) should be documented separately from other costs related to Focus Area A. Note that these costs are separate from those associated with the Cities Readiness Initiative (CRI). Please prepare the budget and budget justification for CRI activities in accord with the instructions in Attachment K. To accommodate this, the electronic budget application permits entry of costs separately for Focus Area A–SNS vs. Focus Area A–Non SNS.

3. Submission

To submit the narrative and budget sections of the application electronically, follow the online instructions. The MIS will notify CDC that the application is ready for review and prevent any further changes to the application by the applicant, pending any recommendations from the project officer. The electronic submission process must be completed by the application deadline (midnight on August 1, 2004 EST).

Note that the budget forms (SF-424A AND SF-424B) must be printed out and mailed along with Form SF-424 and PHS 5161-1 (checklist) with one complete copy of the application to

the CDC Procurement and Grants Office by the submission deadline.

Please mail the Grant and Budget forms to:

Elmira C. Benson, Acting Chief (State and Local Awardees)
Attn: Sharon Robertson
Acquisition and Assistance Branch B
Procurement and Grants Office
Centers for Disease Control and Prevention
2920 Brandywine Road, Room 3000
Atlanta, GA 30341-4146
Telephone: 770-488-2748
Email Address: sqr2@cdc.gov

Rebecca B. O'Kelley, Chief (Territories and Freely Associated States of the Pacific)
Attn: Vincent Falzone
International & Territories Acquisition and Assistance Branch
Procurement and Grants Office
Centers for Disease Control and Prevention
2920 Brandywine Road, Room 3000
Atlanta, GA 30341-4146
Telephone: (770) 488-2785
Email Address: vcf6@cdc.gov

TECHNICAL REPORTING REQUIREMENTS

Progress Report for Budget Period Five - A progress report for activities undertaken in budget period five is due May 1, 2005. This report must be submitted through the DSLR MIS. CDC will provide templates for these reports to assess program outcomes related to activities undertaken in BY 05.

Financial Status Reports – A Financial Status Report (FSR) is due 90 days after the end of the budget period, ending on August 30, 2005. The due date for the FSR is November 30, 2005. Estimated FSRs (through June 30, 2004) are requested with your continuation application (See Unobligated Funds on page 3).

Final Reports – This cooperative agreement will end on August 30, 2005. An original and two copies of the final FSR and final program performance report will be due to the Grants Management Officer named below by November 30, 2005. Programmatic copies should be submitted through the DSLR MIS by November 30, 2005.

Please submit your Reports to:

Elmira C. Benson, Acting Chief (State and Local Awardees)
Attn: Sharon Robertson
Acquisition and Assistance Branch B
Procurement and Grants Office
Centers for Disease Control and Prevention
2920 Brandywine Road, Room 3000
Atlanta, GA 30341-4146
Telephone: 770-488-2748
Email Address: sqr2@cdc.gov

Rebecca B. O'Kelley, Chief (Territories and Freely Associated States of the Pacific)
Attn: Vincent Falzone
International & Territories Acquisition and Assistance Branch
Procurement and Grants Office
Centers for Disease Control and Prevention
2920 Brandywine Road, Room 3000
Atlanta, GA 30341-4146
Telephone: (770) 488-2763
Email Address: vcf6@cdc.gov

Please copy your Project Officer on any electronic submissions.

E. WHERE TO OBTAIN ADDITIONAL INFORMATION

Business management technical assistance may be obtained from:

Sharon Robertson (State and Local Awardees)
Grants Management Specialist
Acquisition and Assistance Branch B
Procurement and Grants Office
Centers for Disease Control and Prevention (CDC)
2920 Brandywine Road, Room 3000
Atlanta, Georgia 30341-4146
Telephone: (770) 488-2748
E-mail address: sqr2@cdc.gov

Vincent Falzone, Grants Management Specialist for Territories
(Territories and Freely Associate States of the Pacific)
International & Territories Acquisition and Assistance Branch
Procurement and Grants Office

Centers for Disease Control and Prevention
2920 Brandywine Road, Room 3000
Atlanta, GA 30341-4146
Telephone: (770) 488-2763
Email Address: vcf6@cdc.gov

Programmatic technical assistance for this request may be obtained from your Project Officer listed on the enclosed contact list (Appendix l).

F. ATTACHMENTS:

A. Focus Area A –Preparedness Planning and Readiness Assessment
B. Focus Area B – Surveillance and Epidemiology Capacity
C. Focus Area C – Laboratory Capacity, Biologic Agents
D. Focus Area D – Laboratory Capacity, Chemical Agents
E. Focus Area E – Health Alert Network/Communications and Information Technology
F. Focus Area F – Risk Communication and Health Information Dissemination
G. Focus Area G – Education and Training
H. FY 2004 Cross-Cutting Activities
I. FY 2004 Cross-Border Early Warning Infectious Disease Surveilance
J. CHEMPACK Program Description
K. Cities Readiness Initiative
L. Cities Readiness Initiative Funding Chart
M. FY 2004 Funding distribution chart

G. APPENDICES:

1. Project Officer Contact List
2. HRSA Contact List
3. NEDSS Contact List
4. Public Health Information Technology Functions and Specifications for Emergency Preparedness and Bioterrorism
5. Direct Assistance Guidance
6. ASTHO-NACCHO Principles of Collaboration Between State and Local Public Health Officials
7. Centers for Public Health Preparedness
8. Critical Benchmark Chart
9. HRSA Bioterrorism Training and Curriculum Development Program