Billing Code: 4163-18-P
DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Disease Control and Prevention
Public Health Emergency Preparedness

Announcement Type: Supplement
Funding Opportunity Number: AA154
Catalog of Federal Domestic Assistance Number: 93.283
Application Deadline: April 8th, 2006

I. Award Description

Authority: This program is authorized under Authority: 42 U.S.C. 247d-3.

Type of Award: Cooperative Agreement

Budget Period Length: Date of Award through August 30, 2006

Throughout the project period, CDC's commitment to continuation of awards will be based on the availability of funds, evidence of satisfactory progress by the recipient (as documented in required reports), and the determination that continued funding is in the best interest of the federal government.

II. Funding Information

Availability of Funds: Approximately $100,000,000 is available to fund 62 States, Cities and Territories for program operations to prepare for and respond to an influenza pandemic. "States, Cities and Territories" are defined as the 50 states, Puerto Rico, the Virgin Islands, the Pacific Island Jurisdictions (American Samoa, Commonwealth of the Northern Mariana Islands, Guam, Republic of the Marshall Islands, Republic of Palau, and the Federated States of Micronesia), and the cities of Chicago, Los Angeles County, New York, and Washington, D.C.
Supplemental funds identified in this guidance may not be used to purchase antivirals.

Additionally, recipients are reminded that any continuation of funding under this cooperative agreement is contingent upon responsiveness to the program guidance, measured progress in meeting the performance measures, and proper stewardship of these congressionally-appropriated funds.

Purpose

This document provides supplemental guidance for recipients of federal funding through the *Public Health Preparedness and Response Cooperative Agreement* for the purpose of further supporting pandemic influenza preparedness and response. This supplemental guidance supports (a) increasing the capacity and capability of state and local public health and medical entities (e.g., primary care, Health Centers, rural health programs, hospitals) to respond to an influenza pandemic and (b) initiating and catalyzing community-wide preparedness efforts through effective development, coordination and testing of State, Territorial, regional, local and tribal public health pandemic plans. The plans should include an outline describing the acquisition, storage, and pre-positioning of antiviral drugs. Congress has appropriated $350,000,000 in one-time emergency supplemental funding for pandemic influenza activities specifically intended to foster the development and exercising of pandemic influenza plans. The funding will be awarded in phases. This guidance applies to the first phase of $100,000,000. Funds may be used to either retain staff or expand staff resources with the understanding that these are one time emergency supplemental funds. New equipment such as personal protective equipment, ventilators, etc. is allowable purchases. Costs associated with Pandemic Influenza Summits conducted prior to the award are allowable expenses.

The remaining $250 million will be allocated to eligible recipients on the basis of performance, (e.g., review of activities and progress by the end of the budget period).

Goals for Pandemic Influenza Preparedness

The Goals are derived from the CDC Preparedness Goals (http://www.cdc.gov/about/goals/goals.htm), and are intended to frame urgent public health system response concepts at all levels for pandemic influenza, and complement the roles of public health agencies in initiating and catalyzing community-wide efforts toward pandemic influenza preparedness. For the purposes of this announcement, "response" is intended to indicate non-routine public health system reaction to limit possible mortality, morbidity, loss of quality of life, or economic damage. The CDC Goals for pandemic influenza are:

PREVENT:

(1) Increase the use and development of interventions known to prevent influenza.

DETECT/REPORT:

(2) Decrease the time needed to classify an influenza outbreak as terrorism or naturally occurring in partnership with other agencies.

(3) Decrease the time needed to detect and report an influenza outbreak with pandemic potential.

(4) Improve the timeliness and accuracy of communications regarding the threat posed by an influenza outbreak with pandemic potential.

INVESTIGATE:

(5) Decrease the time to classify causes, risk factors, and appropriate interventions for those affected by the threat of pandemic influenza.

CONTROL:

(6) Decrease the time needed to provide countermeasures and health guidance to those affected by the threat of pandemic influenza.

RECOVER:

(7) Decrease the time needed to restore health services and environmental safety when an influenza pandemic occurs.

(8) Improve the long-term follow-up provided to those affected by influenza pandemic.

IMPROVE:

(9) Decrease the time needed to implement recommendations from after-action reports following a potential or real influenza pandemic.

Federal pandemic influenza guidance may be found at http://www.pandemicflu.gov, including *The HHS Pandemic Influenza Plan, Part 2: Public Health Guidance for State and Local Partners* at http://www.hhs.gov/pandemicflu/plan/#part2 and the *State and Local Planning Checklist* at http://www.pandemicflu.gov/plan/statelocalchecklist.html. *The State and Local Planning Checklist* is aligned with the CDC Pandemic Influenza Goals and is the basis for the Local/State Pandemic Influenza Self-Assessment Tools contained in Attachment 4(State/Local Self Assessments).

Performance Measures:
At a minimum, CDC will require reporting on the following measures:

All recipients:

- **Number of days following the exercise of the State/Territory-level pandemic influenza preparedness plan required to complete an AAR highlighting needs for corrective action (Target: 60 days). Los Angeles County, New York City, Chicago, and the District of Columbia should exercise and develop an AAR regarding the respective municipal plans.**

State and Territories Only:

- **Number and percentage of municipalities or other communities within the recipient jurisdiction that have developed a written community-wide plan for pandemic influenza preparedness (Target: 80%)**
- **Number and percentage of municipalities or other communities within the recipient jurisdiction that have exercised their pandemic influenza plans and prepared after action reports AARs (Target: 80%)**

II. Recipient Requirements:

In addition to the critical tasks set out below, recipients are expected to comply with the following requirements.

A. Establishment of a Pandemic Influenza Coordinating Committee:

Work to establish a committee or consortium at the state and local levels with whom the grantee is engaged that represents all relevant stakeholders in the jurisdiction (including governmental, public health, healthcare, emergency response, agriculture, animal health education, business, communication, community based, and faith-based sectors, as well as private citizens). This committee will assist the State in articulating strategic priorities and overseeing the development and execution of the jurisdiction's operational pandemic plan to assure that planning is: (1) progressing, (2) integrated and coordinated, and (3) involves all areas/sectors/departments (e.g. transportation, commerce/business, public safety, health, community-based organizations) across the state. If a state or locality already has an existing committee for pandemic influenza planning and preparedness which engages all relevant stakeholders, that committee may be used to meet this requirement.

B. Integration with Other Entities:

Recipients must implement a cohesive planning framework for pandemic influenza preparedness and response activities. This supplemental pandemic influenza funding provides resources to support public health and medical efforts within this overall strategy. Recipients of this supplemental funding should assure collaboration among public health and medical preparedness, influenza, infectious disease, immunization programs and state and local emergency management to maximize the impact of funds and efforts, reduce duplication, and coordinate activities including drills and exercises. Applicants should coordinate activities within their jurisdictions (i.e., at the State level) between State and local jurisdictions, tribes, and military installations; among local agencies; and with hospitals and major health care entities, including tribal and Public Health Service medical and other healthcare facilities; among jurisdictional Metropolitan Medical Response System (MMRS), and adjacent States. If applicable, recipients should coordinate with neighboring provinces, tribal/First Nations indigenous jurisdictions and States across international borders. Recipients should also Ensure that all plans for pandemic influenza response are an integral element of the overall state and local emergency response plans and that they will coordinate effectively with Emergency

Support Function 8, Health and Medical Services, of the National Response Plan and the National Incident Management System.

C. Tribes:

The cooperative agreement requires documentation that describes the process used by the State health department to engage American Indian tribal governments, tribal organizations representing those governments, tribal epidemiologic centers, or Alaska Native Villages and Corporations located within their boundaries in preparedness activities. Recipients of this supplemental funding are required to document the process for providing funding to tribes and engage these entities in pandemic influenza preparedness activities as part of their overall preparedness strategy.

D. Funds to Local Public Health:

1. Due to the pervasive nature of an influenza pandemic, local communities/jurisdictions will not be able to rely on substantial outside mutual aid, mutual support, or federal assistance. The local level is where the effects of the pandemic will be felt and where the response needs to occur. Therefore it is expected that the vast majority of these funds be utilized by the local level. In cases where the state health department serves as the provider of local public health services in areas of the state not covered by a local health department, funds should be dispersed commensurate with that effort.

2. CDC requires documentation with the supplemental application that describes the process used by the State health department is to engage local health departments to reach consensus, approval, or concurrence for the proposed use of supplemental funds. The description should bear evidence that local health department officials have been engaged in the supplemental application process and at least a majority, if not the total, approve or concur with the application itself. The pandemic influenza budget tool (see Attachment 5: Supplemental PanFlu Budget) includes a section in which recipients can describe how consensus was achieved with local health departments as well as list the concurring local health departments.

   In addition, State applicants will be required to provide signed letters of concurrence upon request.

   This evidence may be demonstrated by:
   a) the consensus of a majority of local health officials whose collective jurisdictions encompass a majority of the State's population;
   b) the recommendation of the President of the State Association of County and City Health Officials (SACCHO) if a majority of local health officials whose collective jurisdictions encompass a majority of the State's population agree with the SACCHO's decision; OR

c) any other alternative method agreed to by the State Health Official and a majority of local health officials whose collective jurisdictions encompass a majority of the State's population;
d) State applicants will be required to submit a list of concurring local health departments and a brief description of the process used to engage local health departments to reach consensus, approval, or concurrence for the proposed use of funds. A significant portion of these funds—as determined through a recipient's concurrence process—should be utilities to support activities at the local level.

E. Collaboration across State, Tribal, Military, and International Borders:

Recipients may use supplemental funds to conduct necessary activities in support of cross-jurisdictional planning, coordination, communications, program development, and exercises to enhance pandemic influenza preparedness and response capacity in the United States. In a jurisdiction that shares state, tribal, military installation or international borders, the public health agency may use supplemental funds to jointly participate in pandemic influenza meetings (e.g., city-state-tribal collaboration or city-state-province/state collaboration, etc.); exchange health alert messages; exchange epidemiological data; provide mutual aid; conduct collaborative drills, exercises, and evaluate pandemic influenza scenarios. Recipients may propose relevant activities related to meeting the critical tasks and measures in section III. Proposed activities must be consistent with national laws and regulations of the United States and in harmony with any pre-existing agreements and guidelines.

F. Accountability for Funding:

The recipient must establish a process to track obligations and expenditures of Pandemic Supplemental funds separately from general funds awarded through the *Public Health Preparedness Cooperative Agreement*.

G. Critical Tasks to be Performed During the Budget Year:

1. Conduct a Pandemic Influenza Preparedness Summit to facilitate community-wide planning efforts throughout the recipient jurisdiction. Note that the Summits currently being convened by the respective Governors and the Secretary of the United States Department of Health and Human Services (HHS) satisfy this requirement. If a recipient has already held a summit with HHS, an additional summit is not required. The costs of the summits held prior to the official notice of award for funds can be charged to the supplemental allocation.

2. Exercise the state/territory-level pandemic influenza preparedness plan and prepare an After-Action Report (AAR) highlighting necessary corrective actions. (Los Angeles County, New York City, Chicago and the District of Columbia should

exercise and prepare an AAR regarding their respective municipal-level plans). Note that this information will be pertinent to the performance-based allocation later this year of the $250 million remaining in the emergency supplemental appropriation for state and local pandemic influenza preparedness.

3. Update, as necessary, the assessment submitted with the application. In addition, States and Territories must compile and analyze local-level assessment resulting from the use of the Local Pandemic Influenza Assessment Tool in Attachment 4. Note that this information will be pertinent in receipt of performance-based allocations later this year of the $250 million remaining in the emergency supplemental appropriation for State and Local pandemic influenza preparedness.

4. Initiate and catalyze the development and exercising of pandemic influenza preparedness plans for local communities within the recipient jurisdiction. Public health authorities should enlist representatives of all major sectors of the respective communities to this end. (A single community-wide plan will suffice for Los Angeles County, New York City, Chicago, and the District of Columbia).

5. Determine whether to purchase antiviral drugs in concert with HHS and, if so, report to the CDC Project Officer by July 1, 2006, the number of treatment courses that the recipient wishes to acquire in this manner. Note that most or all of the recipient's purchase will be eligible for a 25% subsidy by HHS.

6. Identify loci throughout the jurisdiction in which the recipient plans to pre-position antiviral drugs if an influenza pandemic were judged imminent – e.g., hospitals, skilled nursing facilities, community health centers, and pharmacies. Note that antiviral drugs will be most effective if used promptly to treat victims of an influenza pandemic and thus need to be pre-positioned at or near healthcare sites at some appropriate time before the onset of the pandemic.

7. Develop a plan for allocating among those pre-positioning loci the recipient's share of the cache of antiviral drugs maintained in the Strategic National Stockpile (SNS). Note that each recipient will be allocated a share of the total of 20 million treatment courses that HHS intends to acquire for the recipients at no cost to them. Also, any particular recipient can acquire additional antiviral drugs from the pertinent vendor(s) in concert with HHS.

   Notes for Antiviral Purchases: HHS will provide further details on a federally negotiated contracting mechanism available for the purchase of antiviral drugs, including a description of the contractual arrangements under which recipients can purchase antiviral drugs which would be eligible for cost sharing with the Federal Government. During the budget year, recipients should address mechanisms for local storage and pre-positioning of antiviral drugs regardless of purchasing mechanism (e.g., federally negotiated contract or direct relationship with vendors).

Federal Responsibilities for the Public Health Emergency Preparedness Supplement

While the supplemental funds are being awarded through the CDC Public Health Emergency Preparedness Cooperative Agreement, it is expected that HRSA will have substantial involvement in the technical assistance and support functions to be provided by the federal government. CDC and HRSA, together, will assist with coordination and collaboration at the local and state levels. HRSA will support CDC in the responsibilities below (see Section I: CDC Responsibilities) and ensure that any efforts carried out under this Supplement are not in conflict with other emergency preparedness efforts.

Antiviral Drug Purchases

HHS is enhancing State and local pandemic influenza preparedness by stockpiling antiviral drug treatment courses for subsequent allocation to States and other eligible entities that receive CDC cooperative agreements for public health emergency preparedness. HHS is in the process of acquiring 20 million treatment courses for this purpose. Most of this cache will be the neuraminidase inhibitor Tamiflu (oseltamivir), which is manufactured by Roche; additionally, a small fraction will be the neuraminidase inhibitor Relenza (zanamivir), which is manufactured by Glaxo Smith Kline (GSK). HHS intends to hold these antiviral drugs in the Strategic National Stockpile (SNS) for release to the States and other entities when an influenza pandemic is judged imminent. HHS will allocate the 20 million treatment courses among the States and other entities in accord with population as shown in the attached table see Attachment 6 (Antivirals).

Another way that HHS is also enhancing State and local pandemic influenza preparedness is by enabling the States and other entities to purchase Tamiflu and Relenza at a 25% subsidy. To this end, HHS intends to negotiate basic agreements with Roche and GSK, respectively, that the States and other entities may use in effecting their purchases. In addition, the current budget allows HHS to subsidize the purchase of 31 million treatment courses in this manner. HHS will allocate this opportunity for subsidized purchases in accord with population as shown in the table below. If any of the States and other entities elects not to use their full share of the subsidized purchase opportunity and others desire to purchase more than their originally allocated share, HHS will redistribute the subsidy funds accordingly.

In subsequent guidance, HHS will provide more details regarding the foreseen basic agreements with the two antiviral drug manufacturers, options for storage of recipient-purchased caches, and options for distributing drugs to and within recipients' jurisdictions in accord with plans the recipients develop as part of this cooperative agreement guidance.

III. CDC Responsibilities: In a cooperative agreement, CDC staff is substantially involved in the program activities above and beyond routine grant monitoring. CDC Activities for this program are as follows:

A. Ensure that pandemic influenza activities that relate to local, state and tribal preparedness are (1) coordinated across (and not discordant with) CDC areas (e.g. infectious diseases, immunization, emergency preparedness), (2) coordinated (and not discordant) with guidance provided by HRSA and other federal agencies.

B. Provide technical assistance for preparedness and pandemic influenza.

- Integration/coordination of federal funding for preparedness
- Subject matter expertise on preparedness activities (e.g., laboratory testing, epidemiology and surveillance, SNS preparedness, information systems and informatics)
- Identification and evaluation of promising practices
- Development of performance goals and standards and self-assessment tools
- Guidance on, and in some cases, the conduct of drills and exercises
-

C. Facilitate inclusion of tribal, military, international, and federal (e.g. Department of Homeland Security (DHS)) activities into national public health preparedness efforts and coordinate the public health preparedness responsibilities as outlined in the National Response Plan (NRP) where CDC is the designated lead agency.
Review updated state pandemic influenza plans, especially as it relates to specific items such as antiviral drug distribution plans.

IV. Eligibility Information: Eligibility is limited to those recipients currently funded through cooperative agreement AA154 and authorized under 42 U.S.C. 247d-3. This includes the 50 states, Puerto Rico, the Virgin Islands, the Pacific Island Territories (American Samoa, Commonwealth of the Northern Mariana Islands and Guam), and the Freely Associated States (Republic of the Marshall Islands, Republic of Palau, and the Federated States of Micronesia), and the cities of Chicago, New York, Los Angeles County, and Washington, D.C.

Cost Sharing or Matching: Matching funds are not required for this program

Unallowable Costs

- No purchase of antiviral drugs is allowed from this supplemental allocation.
- Funds may not be used for research.
- Cooperative agreement funds under this program can not be used to purchase vehicles of any kind.

Supplantation: Cooperative agreement funds can not supplant any current State or local expenditures. The Public Health Service Act, Title I, Section 319C (e) (42 USC 247d-3(e)) 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.

Financial Management Systems Requirements
A state must expend and account for grant funds in accordance with State laws and procedures for expending and accounting for its own funds. 45 CFR Part 92.20.

Grants Subcontracting that Spans Budget Periods: The Procurement and Grants Office (PGO) has provided guidance for contracts let by grantees that span budget periods under grants or cooperative agreements. This guidance may be found at http://pgo.cdc.gov/pgo/webcache/Regulations/GIL_06004_Grant_Contracting_that_Spans_Budget_Periods2.pdf

V. Application Content

Recipients must assure they meet the requirements in Section II, Recipient Requirements. Applications should adhere to the overarching guidance in the 2005/2006 Preparedness Cooperative Agreement and contain the following information:

1. An executive summary (approximately 5 pages) of the recipients' current pandemic influenza preparedness plan.
2. An assessment of state/territory-level pandemic influenza preparedness as determined through the use of the State/Local Influenza Assessment Tools (see Attachment 4). Territories should use the State Assessment Tool. Los Angeles County, New York City, Chicago, and the District of Columbia should use the Local Assessment Tool.
3. The results of a gap analysis indicating the major areas for which additional influenza preparedness efforts within the recipient jurisdiction are necessary.
4. The recipient's proposed approach and associated budget for addressing the most serious gaps in pandemic influenza preparedness along with the critical tasks listed Section III.
5. Data points informing the performance measures (see Section I) if the state/territorial pandemic plan was exercised, and the number and percent of local municipalities with plans, and those who have exercised plans and produced an AAR during this budget year (which started August 31, 2005).

VI. Submission Information

A. Electronic applications using the CDC-provided template are due on April 8th, 2006 11:59 pm EST.

B. Required Forms (The following forms should be submitted to PGO by email with a copy to the appropriate DSLR Project Officer.

- 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 Office of Management and Budget: http://www.whitehouse.gov/omb/grants/grants_forms.html
- Form SF-424A can also be obtained at the following Internet address: http://www.whitehouse.gov/omb/grants/grants_forms.html

- Cover letter signed by Principal Investigator/Project Director of Public Health Preparedness Cooperative Agreement and representative of the business office.
- Detailed Budget and Justification, using the attached Excel budget document Attachment 5 (PanFlu Supplemental Budget).
- Copy of completed State Pandemic Influenza Assessment Tool
- Copies of completed Local and Tribal Pandemic Influenza Assessment Tools and Local Assessment Totals to be provided in time to inform performance-based allocations later this year of the $250 million remaining in the emergency supplemental appropriation for State and Local pandemic influenza preparedness

C. Technical Review: Applications will be reviewed for technical acceptability by the Division of State and Local Readiness and HRSA BHPP Project Officers and other CDC subject matter experts to determine:

- the applicant's current capability to perform the critical tasks
- that the operational plan clearly and adequately addresses the goals, tasks, and measures
- the extent to which the applicant clearly defines an evaluation plan that leads to continuous quality improvement of pandemic influenza response
- the extent to which the applicant presents a detailed budget with a line item justification and any other information to demonstrate that the request for assistance is consistent with the purpose and objectives of the cooperative agreement.

D. Intergovernmental Review of Applications: Applications are subject to Intergovernmental Review of Federal Programs, as governed by Executive Order (EO) 12372. This order sets up a system for State and local governmental review of proposed federal assistance applications. Contact your State single point of contact (SPOC) as early as possible to alert the SPOC to prospective applications, and to receive instructions on your State's process. Click on the following link to get the current SPOC list: http://www.whitehouse.gov/omb/grants/spoc.html

E. Technical Reporting Requirements For Supplemental Funding

Quarterly Progress Reports for the Budget Period must be submitted through the DSLR MIS. CDC will provide templates for these reports to assess program outcomes related to activities undertaken in the Budget Period. In addition, recipients may be required to submit information upon request based on changing threat status or national security priorities. Progress reports for activities undertaken, as well as special topics related to the goals and objectives are due on:

- **July 15, 2006**
- **November 30, 2006**

Financial Status Reports (FSR): Due to separate accounting requirements please submit both a summary and an individual FSR addressing supplemental pandemic influenza activities. An original and two copies must be submitted in hard copy to CDC's PGO and are due on:

- **May 30, 2006** A mid-year estimated FSR.
- **November 30, 2006** A final FSR is due 90 days after the end of the budget period.

Please submit the hard copies of financial status reports (FSRs) to:

VII. Agency Contacts

DSLR Project Officers: see Appendix 3

For general questions, contact:

Sharon Robertson
Grants Management Specialist—Regions 1, 2, 3, 4, 10
Acquisition and Assistance Branch VI
Procurement and Grants Office
Centers for Disease Control and Prevention (CDC)
2920 Brandywine Road
Atlanta, Georgia 30341-4146
Telephone: (770) 488-2748
E-mail address: sqr2@cdc.gov

Angela Webb
Grants Management Specialist—Regions 5, 6, 7, 8, 9
Acquisition and Assistance Branch VI
Procurement and Grants Office
Centers for Disease Control and Prevention (CDC)
2920 Brandywine Road
Atlanta, Georgia 30341-4146
Telephone: (770) 488-2784
E-mail address: aqw6@cdc.gov

VIII. Attachments

Appendix 1. Funding Information
Appendix 2. Direct Assistance
Appendix 3. DSLR Team Leads and Project Officers
Attachment: 4a.* State Self Assessment Tool
Attachment: 4b.* Local Self Assessment Tool
Attachment: 4c.* Local Totals Self Assessment Tool
Attachment: 5 * Budget
Attachment: 6 * Antiviral Purchase List

Dated: MAR 1 4 2006

William P. Nichols, MPA
Director
Procurement and Grants Office
Centers for Disease Control and Prevention

*Sent as an email attachment

Appendix 1: Funding Information

FY 2006 Pandemic Influenza State and Local Funding - Phase 1
Distribution Chart

State/Jurisdiction	Phase 1 Allocation
Alabama	$1,595,205
Alaska	$657,647
Arizona	$1,856,742
Arkansas	$1,163,333
California	$6,723,207
LA County	$2,900,529
Colorado	$1,605,882
Connecticut	$1,347,950
Delaware	$698,960
District of Columbia	$635,601
Florida	$4,633,819
Georgia	$2,609,920
Hawaii	$803,669
Idaho	$832,432
Illinois	$2,878,268
Chicago	$1,197,706
Indiana	$2,007,596
Iowa	$1,215,422
Kansas	$1,162,607
Kentucky	$1,501,451
Louisiana	$1,592,758
Maine	$818,369
Maryland	$1,840,470
Massachusetts	$2,061,287
Michigan	$2,951,805
Minnesota	$1,731,493
Mississippi	$1,200,982
Missouri	$1,890,782
Montana	$723,275
Nebraska	$922,515
Nevada	$1,045,254
New Hampshire	$813,384
New Jersey	$2,601,641
New Mexico	$956,824
New York	$3,205,759
New York City	$2,466,271
North Carolina	$2,547,844
North Dakota	$654,029

Ohio	$3,281,387
Oklahoma	$1,352,695
Oregon	$1,366,765
Pennsylvania	$3,508,291
Rhode Island	$761,679
South Carolina	$1,508,881
South Dakota	$686,008
Tennessee	$1,921,423
Texas	$5,875,044
Utah	$1,071,983
Vermont	$650,611
Virginia	$2,291,072
Washington	$1,990,994
West Virginia	$940,502
Wisconsin	$1,831,224
Wyoming	$622,102
Total	$97,713,349
Commonwealth	
Puerto Rico	$1,443,014
Territory	
American Samoa	$114,066
Guam	$139,782
Northern Marianas Islands	$118,513
Virgin Islands (US)	$126,461
Fed States of Micronesia	$126,298
Marshall Islands	$113,722
Palau	$104,795
Commonwealth and Territory Totals	$2,286,651
Grand Total	**$100,000,000**

Appendix 2: Direct Assistance

I. Direct Assistance

Recipients of the pandemic influenza supplemental funds may apply for direct assistance in the form of Information Technology goods or services.

Direct Assistance
Direct Assistance is a financial assistance mechanism, authorized by statute, where by goods or services are provided to recipients in lieu of cash. Direct assistance generally involves the assignment of Federal personnel, the provision of equipment, or the use of federally negotiated contracts. **Applicants must discuss all requests for direct assistance with the Division of State and Local Readiness project officer prior to submitting an application.**

Funding awarded through direct assistance is part of the total award, not an addition to the award. Direct assistance funds MUST be used in the federal Fiscal Year (FY) in which they are appropriated.

Requests for equipment to be purchased through direct assistance:

Direct Assistance (Contracts and Task Orders):

a. To obligate Direct Assistance funds in an amount of less than $100,000, each applicant must submit a Performance-based Statement of Work for each contract or task order supported by Direct Assistance Funding.

b. To obligate Direct Assistance funds in an amount greater than $100,000, but less than $500,000, each applicant must submit the following items for each contract or task order supported by Direct Assistance funding:

Performance-based Statement of Work: The Division of State and Local Readiness maintains a variety of Statement of work templates available to any applicant upon request. Although performance-based Statements of work are tailored to the specifics of each project, it should contain these common elements:

- Background - general, non-technical terms and explains why the acquisition is required; its relationship to past, current, or future projects; summary of statutory and applicable program authorities and regulations;

- Project Objective – a succinct Statement of the purpose of the acquisition; outlining expected results; and anticipated benefits.

- Scope of Work – an overall, non-technical description of the work to be performed; expands upon project objectives, while avoiding going into all of the details required. Identifies and summarizes various phases of the projects; define

limits in terms of specific objectives, time, special provisions, or limitations. The Scope of Work must be consistent with the detailed requirements.

- Detailed Technical Requirements – Clearly and precisely describe the work in terms of **what** is to be the required output rather than either **how** the work will be accomplished or the number of hours to be provided. Provide requirements that do not limit a contractor to providing a specific product or service, rather the contractor is provided with the objectives to be accomplished, the end goal, or the desired achievement, including all pertinent information needed for a contractor or vendor to submit a proposal. As the contractor is, being hired based upon their expertise and ability to perform, the performance-oriented requirements Statement of work places maximum responsibility for performance on the contractor. Identify any budgetary, environmental, or other constraints. Clearly and firmly define and the criteria for acceptance for all end supplies or deliverables associated with the contract.

- Reporting Schedule – Specify how the contractor shows that it has fulfilled it obligations. Clearly identify the performance-based criteria to be used by the Government for acceptance. Define the mechanism by which the contractor can demonstrate progress and compliance with the requirements, and present any problems it may have encountered. The preparation and submission of technical and financial progress reports on a timely basis reflect on a contractor's efforts to certify satisfactory progress. Specific requirements to submit periodic financial and technical progress reports, to include format and templates will be provided by the Division of State and Local Readiness.

- Special Consideration – Include all and any information that does not fit into one of the other sections of the Statement of work.

- References – Provide a detailed list and description of any studies, reports, and other data referred to elsewhere in the Statement of work.

- **Independent Government Cost Estimate:** The independent government cost estimate is the government's estimate of the costs associated with a particular contract project. The cost estimate determines the amount of money that should be set aside for funding the project and the cost estimate serves as a standard to which the offeror's costs or price proposals will be compared when the offeror's proposal is evaluated. The cost estimate includes direct costs (i.e., labor, material, travel, per diem, printing, consultants, etc.) and indirect costs (i.e., fringe benefits, overhead, and general and administrative expense rates). For this is the government's assessment of the probable cost of the supplies or services to be acquired and serves as a basis for determining the reasonableness of an offeror's proposed costs and understanding of the Statement of work. The cooperative agreement applicant may request assistance in developing a cost estimate from their project officer in the Division of State and Local Readiness.

- **Quality Assurance Surveillance Plans**: These plans must recognize the responsibility of the contractor to carry out its quality control obligations and must contain measurable inspections and acceptance criteria corresponding to the performance standards contained in the original performance-based Statement of work. This plan must focus on the level of performance required by the performance-based Statement of work, rather than the methodology used by the contractor to achieve that level of performance. The plan may also include:

    - technical progress and financial status reports (already a requirement for all direct assistance projects);
    - site visits to evaluate contract performance against scheduled or reported performance;
    - review of invoices and vouchers to assess reasonableness of costs claimed and relate the total expenditures to the physical progress of the contract, based on monitoring activities (i.e., site visits, progress reports, etc.)

1. Please submit the following documents, electronically, to Gregory Lanman in the Division of State and Local Readiness at GHL2@cdc.gov:
    a. **Contract/Task Order less than $100,000**: Submit a performance-based Statement of work as described and outlined in this document.

    b. **Contract/Task Order greater than $100,000, but less than $500,000**: Submit a performance-based Statement of work; independent cost estimate; and quality assurance surveillance plan as described and outlined in this document.

    c. If you are considering a contract or task order in an amount larger than $500,000; please contact Gregory Lanman in the Division of State and Local Readiness at (404) 639-7127 as soon as possible.

2. Upon receipt of each contract/task order package, the Division of State and Local Readiness will obtain proposals and quotes for the requested services, supplies, or equipment through federal contract vehicles. The grantee will receive the proposals for review and selection according to their technical evaluation factors. Contract/task order awards will be based upon your evaluation criteria and selection decision.
3. The Division of State and Local Readiness will obligate all Direct Assistance funding and will assume an active partnership as part of your Quality Assurance Surveillance Plan. This partnership will include oversight of the contract/task order, monitoring contract/task order expenditures and funding balances, and by coordinated site visits by the Project Officers of the Division of State and Local Readiness.
4. For additional information or if you have any questions, please contact Gregory Lanman in the Division of State and Local Readiness at (404) 639-7127 or by email at GHL2@cdc.gov

Appendix 3: DSLR Team Leads and Project Officers

Division of State and Local Readiness (DSLR), COTPER, CDC

Team Lead - East (Regions I - V)	Stefan Weir	(404) 639-7426	sbw6@cdc.gov
Team Lead - West (Regions VI-X)	Jerilyn Gilbert	(404) 639-7453	jtg6@cdc.gov

DSLR Project Officers Assignments

Region	Projects	Project Officer	Telephone	E-mail
I	Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, Vermont	Zach Harris*	(404) 639-7265	zah5@cdc.gov
II	New York City, New York, New Jersey, Puerto Rico, Virgin Islands	Dorotha Love Hall	(404) 639-7649	dit1@cdc.gov
III	Delaware, Maryland, Pennsylvania, Virginia, West Virginia, District of Columbia	Keesler King	(404) 639-7423	knk8@cdc.gov
IV-A	Alabama	Keesler King*	(404) 639-7423	knk8@cdc.gov
	Florida	Zach Harris*	(404) 639-7265	zah5@cdc.gov
	Georgia	John Scott*	(404) 639-7435	jps5@cdc.gov
	Mississippi	Zach Harris*	(404) 639-7265	zah5@cdc.gov
IV-B	Kentucky, North Carolina, South Carolina, Tennessee	Peg Haering	(404) 639-7401	avd6@cdc.gov
V	Chicago, Illinois, Indiana, Ohio, Michigan, Minnesota, Wisconsin	John Scott	(404) 639-7435	jps5@cdc.gov
VI	Arkansas	Vanda Kelley*	(404) 639-7876	vmm1@cdc.gov
	Louisiana	Trevia Brooks*	(404) 639-7613	tnb9@cdc.gov
	New Mexico	Monica Farmer*	(404) 639-0533	mwf7@cdc.gov
	Oklahoma	Stephanie Dopson*	(404) 639-7441	sld9@cdc.gov
	Texas	James Baker*	(404) 639-7408	awq2@cdc.gov
VII	Iowa, Kansas, Missouri, Nebraska	Trevia Brooks	(404) 639-7613	tnb9@cdc.gov
VIII	Colorado, Montana, North Dakota, South Dakota, Utah, Wyoming	Monica Farmer	(404) 639-0533	mwf7@cdc.gov
IX-A	Arizona, California, Los Angeles, Nevada	Vanda Kelley	(404) 639-7876	vmm1@cdc.gov

IX-B	American Samoa, Commonwealth of Northern Mariana Islands (CNMI), Hawaii, Guam, Marshall Islands, Palau, Federated States of Micronesia	James Baker	(404) 639-7408	awq2@cdc.gov
X	Alaska, Idaho, Oregon, Washington	Stephanie Dopson	(404) 639-7441	sld9@cdc.gov

*Temporary Assignments through February 2006.