Tibotec Therapeutics Request for Applications:
LINCC™ Initiative: Linking In-Need Communities to Care

2010 Request for Applications Instructions

To submit your request for funding, complete the attached application in full and attach 1-2 letters of support from local organizations familiar with your organization's work in this area. Please do not submit any additional documentation as it will not be considered.

Proposals should describe programs that will be implemented no sooner than December 2010.

Once you have completed the application, please submit your application by email:

- Email the completed forms below to: **TTRFGA@its.jnj.com**

If you do not have access to email, you can also fax your application:

- Fax your completed application to: **1 609-730-5640**
- **PLEASE CALL 1-609-730-6179 TO CONFIRM RECEIPT OF YOUR FAX**

All requests for funding must be received by **September 30, 2010.** Applications received after this date will not be considered.

Do not resize the text boxes and please use 11 point font.

Executive Summary:

Please fill out once you have completed the application.

Organization name and location:

Barrier(s) to be addressed:

Target population(s):

Estimated number of participants:

BRIEF program description (3-5 sentences):

Reference Number:
Review by:

LINCC: Linking In-need Communities to Care

Requesting Organization

Details of primary requesting organization (*include organization name, telephone number, mailing address and web site address)*:

Primary contact* (*include name, position/title, email address and telephone number*):
*This individual will receive all correspondence related to the application.

Secondary contacts: (*include name, position/title, email address and telephone number*):

List requesting organization's board of directors, trustees and key staff. Please include affiliations.

Partner Organization (if applicable)*

Details of partner organization* (*include organization name, telephone number, mailing address and web site address)*:

*Partner organization refers to an outside organization providing technical assistance with cultural competence and/or treatment education for the purpose of the proposed program. Partner organization can be a health department.

Primary contact at partner organizations* (*include name, position/title, email address and telephone number*):

List partner organization's board of directors, trustees and key staff. Please include affiliations.

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Application for Funding

Barrier(s) that your program will address (check all that apply)
☐ Fear of medication side effects; lack of understanding of benefits of treatment ☐ Stigma, isolation and fear of disclosure ☐ Lack of information; lack of awareness of resources; low health literacy ☐ Denial; lack of symptoms ☐ Substance use or mental health barriers ☐ Lack of support structure(s) or psychosocial support services

Target population(s) (check all that apply)
☐ Women ☐ Communities of color (specify: _____) ☐ Aging population/HIV over 50 ☐ MSM ☐ Dual- or triple-diagnosed and/or homeless (specify: _____) ☐ HBV or HCV co-infected ☐ Rural community ☐ Urban center (population >1,000,000) ☐ Other: _____

Requested Funding Amount
$

1. Briefly describe the organization's mission and the geographic area and population(s) served (including how many clients per year) (300 words or less).*

*☐ Click here if this information can be found on your organization's website. Please include URL in the box above and note if web site also contains link to most recent annual report.

2. Describe the *specific* unmet educational need(s) or healthcare access gap(s) you will aim to address in your community; provide data if available (300 words or less).

3. **Describe the *specific* population you will be targeting with your program/activities, including the estimated size and demographics (300 words or less).**

4. **Describe the primary requesting organization's previous experience with patient/community education and/or linking HIV positive individuals to health care, whichever is relevant to your proposed program (300 words or less).**

5. Describe any organizational partnerships (ie, working with local health department or other community-based organizations) that will be leveraged to facilitate the success of the proposed initiative (300 words or less).

6. **Describe the proposed program, including goals and objectives, specific activities, scope/reach, and other relevant details. Be sure to explain how HIV-positive individuals will be linked to and/or retained in health care (700 words or less).**

7. **How and when will you measure outcomes related to the proposed program? Describe your organization's capacity to measure outcomes and/or past experience (300 words or less).**

8. **Describe how and why your proposed program will be successful in addressing this significant challenge. If you have outcomes from previous activities, please provide (300 words or less).**

9. Include a detailed time line (eg, list of months and key activities) for development and implementation of the proposed program (300 words or less).

10. If you have or intend to apply for additional sources of funding for the proposed program, please provide the details below (300 words or less).

11. If Tibotec Therapeutics is not able to fund the full amount that you are requesting, how would you change, revise or scale back the proposed program (300 words or less)?

12. Please include a plan for disseminating your findings, sharing best practices/challenges, and/or otherwise sharing key learnings so that other organizations can learn from your experience (300 words or less)?

Please tell us how/where you heard about this request for grant applications:

BUDGET REQUIREMENTS

****Please attach your current year's overall organizational budget to the application****

Please complete the following information:

Estimated program reach	
Total Program Cost	
Amount requested from Tibotec Therapeutics	
Balance Being Requested from Other Sources	

CHECK LIST OF DOCUMENTS TO ACCOMPANY THIS APPLICATION

- ☐ Organization's 501(c) 3 Status Letter
- ☐ SIGNED W-9 Form (Note: This cannot have a PO Box as the sole address)
- ☐ Supplier Account Management Form (SAM) – sections A and C only
- ☐ Letter(s) of Recommendation from supporting organizations
- ☐ Organizations Overall Annual Budget for Current Year

Contribution Verification Form

On behalf of my organization, I verify that:

- ☐ The proposed contribution from Tibotec Therapeutics does not constitute more than 10% of my organization's annual operating budget
- ☐ The proposed contribution from Tibotec Therapeutics will not be used to cover general overhead expenses for either the primary requesting organization or partner organization.
- ☐ The proposed contribution from Tibotec Therapeutics will not affect healthcare providers affiliated with my organization in their activities separate from the organization
- ☐ If the proposed contribution will support patient education, I verify that Tibotec Therapeutics will have no influence over content of the program and that any mention of Tibotec Therapeutics products will be consistent with FDA approved labeling.

Please indicate if your organization has previously received support from Tibotec Therapeutics during the **current 2010 calendar year**:

☐ Yes
☐ No

Organization's Name: _____

Requestor's Name: (Please Print)_____

Title_____

Signature _____

FOR INTERNAL USE ONLY
ID #_____
ID #_____