DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

PORTLAND AREA
INDIAN HEALTH SERVICE
1220 SW 3RD AVENUE, Room 476
PORTLAND, OREGON 97204

MAY 14 2010

Dear Tribal Leader:

I am pleased to announce a new, targeted funding opportunity. The Indian Health Service (IHS) Portland Area is now accepting project proposals to be funded under the Domestic Violence Prevention Initiative (DVPI). Enclosed you will find a "Guidance for Distributing Fiscal Year 2009 and 2010 Funding for the Domestic Violence Prevention Initiative."

As noted in the "Guidance," there are three funding categories. You may submit a separate proposal for each funding category. Your proposals must include:

1. Coordinate services for communities to respond to local domestic violence and/or sexual assault crises;
2. Participate in a nationally coordinated program for focusing specifically on increasing access to domestic violence and/or sexual assault prevention or treatment services for survivors and their families;
3. Provide community-focused responses that enhance evidence-based or practice-based domestic violence and/or sexual assault treatment services or education programming;
4. Provide communities with needed resources to develop their own community-focused programs;
5. Establish baseline data in the local communities;
6. Adequately document the level of need for the community, and;
7. Be scaled at a level that will ensure measureable impact.

In accordance with project guidelines, funding recipients must:

- Demonstrate need for funding
- Develop and submit a three year action plan
- Participate in a national evaluation of this project
- Use a portion of awarded funds to develop or enhance funding recipients' local evaluation capacity
- And, publicize funding recipient's activities in the community.

As you prepare your project proposals, please bear in mind that there are substantial levels of accountability and reporting required. Demonstrable outcomes and output measures were developed in consultation with the National Behavioral Health Technical Advisory Committee (NTAC). In the "Guidance" document at Tab C, Exhibits 2 and 2(a) show the Area allocations for FY09 and FY10 for two of the three funding categories for which Areas will be responsible for funds distribution. These are Domestic Violence Prevention Initiative and Sexual Assault

Project Expansion (Community Developed Models). The third funding category, Sexual Assault Project Expansion (National Program for SANE/SAFE/SART), will be reviewed by the Area, but the funds have been allocated and will be distributed from IHS Headquarters. It is also important to note that these are non-recurring funds and that any future funding decisions will be based on demonstrated use of funds toward the achievement of the outcome considerations and measures. You are encouraged to consider collaboration with other programs, locally and regionally, that may enhance services and maximize funds to meet your community needs in addressing domestic violence and/or sexual assault prevention and treatment.

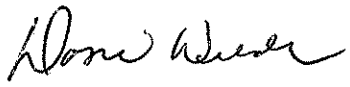
Please note: All project proposals must be received by close of business **Wednesday, June 16, 2010**. Project proposals submitted after this date will not be considered for funding with FY09 and FY10 DVPI funds. Send project proposals to:

Portland Area Indian Health Service
Office of Health Programs
1220 SW Third Ave, Room 476
Portland, OR 97204
Fax: 503-326-2635

As specified at Tab E, Exhibit 4, of the "Guidance" document, proposals received in the Area Office will be pre-screened for eligibility and completeness. The Portland Area will convene a DVPI review committee to determine which proposals will be forwarded to the IHS Director for funding consideration. I am recommending to this committee that total award amounts range between $25,000 and $100,000 per funding category, with the size of grant awards reflective of the number of people and communities served along with demonstrated need. I expect the FY09 and FY10 funds to be distributed on or before August 1, 2010.

Portland Area staff are available to any Tribe or service unit that desires technical assistance in preparing a project proposal. For any questions you may have during the development of your project proposal, please contact LCDR Ann Arnett, L.C.S.W., Portland Area Behavioral Health Consultant, at 503-326-2005, or by email at ann.arnett@ihs.gov.

Sincerely,



Doni Wilder
Director

DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

Indian Health Service
Rockville MD 20852

MAY - 7 2010

TO: Area Directors

FROM: Director

SUBJECT: Guidance for Distributing Fiscal Year 2009 and 2010 Funding for the Domestic Violence Prevention Initiative

I welcome this opportunity to provide Areas guidance for distributing fiscal year (FY) 2009 and 2010 funding to address domestic violence and sexual assault (DV/SA) within American Indian and Alaska Native (AI/AN) communities. Public Law 111-8, the Omnibus Appropriations Act of 2009, provided $7,500,000 for the Domestic Violence Prevention Initiative (DVPI). Congress appropriated an additional $2,500,000 for a total $10,000,000 for FY 2010.

Following are guidelines for selecting funded projects and for distributing these non-recurring funds directly to Tribes and Tribal organizations utilizing Self-Determination contracts and Self-Governance compacts and other funding agreements. These funds will also be used to fund projects awarded to Federally operated programs. Time frames for negotiating awards are at your discretion; however, please complete final allocation decisions no later than 60 days following the date of this memorandum. The IHS expects to distribute Area DVPI funds by May 31, 2010, and to award projects by August 1, 2010.

Thank you for your time and attention to this important matter.

Yvette Roubideaux

Yvette Roubideaux, M.D., M.P.H.

7 Attachments
Tab A – Guidance for Distributing FY 2009 and FY 2010 Domestic Violence Prevention Initiative Funding
Tab B – Exhibit 1: 638 Contract/Compact Amendment
Tab C – Exhibit 2: Table for Distributing FY 2009 DVPI Funds
Tab C – Exhibit 2 (a): Table for Distributing FY 2010 DVPI Funds
Tab D – Exhibit 3: DVPI Proposal Cover Sheet
Tab E – Exhibit 4: Criteria for Evaluating DVPI Proposals
Tab F – Exhibit 5: Notice of Award
Tab G – Exhibit 6: Definitions

Tab A

Guidance for Distributing FY 2009 and FY 2010 Funding for the Domestic Violence Prevention Initiative

Congress appropriated funds for the Indian Health Service (IHS) to implement a nationally coordinated domestic violence prevention initiative (DVPI), providing $7,500,000 in FY 2009 and an additional $2,500,000 for a total $10,000,000 in FY 2010:

> "Domestic violence within the American Indian and Alaska Native (AI/AN) communities continues to be an area of serious concern. Children in these communities have the second highest rate of maltreatment in the country, and one in three AI/AN women will be physically or sexually abused in her lifetime. In order to provide the Indian Health Service (IHS) with additional tools to better address child and family violence in AI/AN communities, the bill includes $7,500,000 to implement a nationally coordinated initiative. With these funds, the IHS is encouraged to further expand its outreach advocacy programs into Native communities; expand the Domestic Violence and Sexual Assault Pilot Project already in operation; and use a portion of the funding for training and the purchase of forensic equipment to support the Sexual Assault Nurse Examiner (SANE) program (Public Law 111-8).

The IHS will disburse DVPI funds within the framework of a demonstration project model. Each Area Director may distribute these non-recurring funds directly to Federally-operated programs and, through agreements authorized by the Indian Self-Determination and Education Assistance Act of 1974, to Area Tribes and Tribal organizations.

Guidelines for DVPI Proposals

According to P.L. 111-8, Area projects selected for funding must include the following:

1. Coordinate services for communities to respond to local domestic violence and/or sexual assault crises;
2. Participate in a nationally coordinated program for focusing specifically on increasing access to domestic violence and/or sexual assault prevention or treatment services for survivors and their families;
3. Provide community-focused responses that enhance evidence-based or practice-based domestic violence and/or sexual assault treatment services or education programming;
4. Provide communities with needed resources to develop their own community-focused programs;
5. Establish baseline data in the local communities;
6. Adequately document the level of need for the community, and;
7. Be scaled at a level that will ensure measureable impact.

Procedures for DVPI Proposals

1. Areas accept project proposals from Tribes, Tribal organizations, and Federally operated programs that focus on domestic violence and/or sexual assault, that include recommended funding for the first and second year of each project, and that indicate the category or categories of funding applied for. Applicants must submit separate proposals for each funding category.

   1) Domestic Violence Prevention Initiative;
   2) Sexual Assault Project Expansion: Community Developed Models
   3) Sexual Assault Project Expansion: National Program for Sexual Assault Nurse Examiner (SANE); Sexual Assault Forensic Examiner (SAFE); and Sexual Assault Response Team (SART)

2. Areas review and score proposals.

3. Areas submit proposals and score sheets to the Division of Behavioral Health (DBH) at the Indian Health Service Headquarters in Rockville, MD.

The DBH will review proposals, submitting those that meet program guidelines to the IHS Director for her approval. Proposals that do not meet program guidelines will be returned to Area offices, which will provide programs an opportunity to address the deficiencies and resubmit proposals for consideration.

Guidelines for Funding Recipients

I. Funding recipients must develop the following types of programs for addressing domestic violence and/or sexual assault:

A. Domestic Violence Prevention Initiative – The DVPI funding will be allocated to all 12 IHS Areas. The funding will be used for the following types of activities in IHS and Tribal programs: outreach, victim advocacy, intervention, policy development, community response teams, and community and school education programs. The programs that receive funding for this portion of the initiative shall implement one of the following models including a) a domestic violence pilot project, which may include activities such as developing Tribal intimate partner violence codes for protection and safety, victim advocacy, community education (e.g., anti-bullying education) and hiring a program coordinator; b) victim advocacy programs that will provide increased access to victim advocacy services in the community; and c) community/collaborative interventions, such as the Duluth Model, which offers tools for communities to coordinate responses to domestic violence with both legal and human services. The Duluth Model provides a method for communities to coordinate their responses and develop interventions with the primary goal of protecting victims of ongoing abuse.

B. Sexual Assault Project Expansion (Community Developed Models) – The Sexual Assault Project Expansion Community Developed Models funding will be allocated to all 12 IHS Areas. The Community Developed Models of collaboration and intervention may include case management, behavioral health services, victim advocacy, and community collaborations. The funding may also be used for the management of SANE, SAFE, and SART activities that may include the involvement of community health aides, community health representatives, licensed practical nurses, and other non-medical community members.

C. Sexual Assault Project Expansion (National Program for SANE/SAFE/SART) – The SANE/SAFE/SART program will **NOT** be allocated to all 12 IHS Areas. However; programs will submit proposals to the Area for review and scoring. This funding will be competed nationally and targeted to Tribal and IHS hospitals and clinics that provide 24 hours a day/7 days a week emergency care. The maximum funding amount for this category is $250,000. For programs submitting proposals in this category, the funding shall address the severe lack of access to sexual assault forensic examinations in hospitals and clinics. The funding may be used for the purchase of forensic equipment and may include case coordination, victim advocacy, and coordination of SANE, SAFE, and SART activities. The program must develop and implement or improve services that are available to help victims of sexual assault through the creation of a SANE/SAFE program by training medical personnel on how to properly conduct sexual assault forensic exams. The programs must develop a SART for a community response to incidents of rape or sexual assault. Program activities related to the training needs of the SART can be included to sustain the SANE/SAFE/SART program at the health facility.

II. Funding recipients must demonstrate need for funding. The funding shall target high risk communities and should be targeted to IHS and Tribal programs that can demonstrate the greatest need for these services in their communities. Funded programs shall be able to implement and evaluate these services so that IHS can be accountable to Congress for these funds.

III. Funding recipients must develop and submit a three-year action plan to the Area Offices. There are three major categories of funding. The action plan shall state the funding category the program will address. Selected programs will receive annual funding for up to three years starting in FY 2010. Fiscal year 2009 appropriations will fund a selected program's first year (August 1, 2010 – July 30, 2011). Funding for the program's second year (August 1, 2011 - July 30, 2012) will utilize FY 2010 appropriations. The third year (August 1, 2012 - July 30, 2013) is subject to appropriations and contingent on first year outcomes. Appropriated funds beyond FY 2011 are subject to discussion and decision pending review.

The primary intent of a funding recipient's action plan is to illustrate how the program will enhance community access to, or support community delivery of, evidence-based or practice-based domestic violence and/or sexual assault prevention or treatment services. Funding recipients must document how their domestic violence and/or sexual assault prevention or

treatment activities will be implemented. The action plan should describe the project implementation process.

This process for planning and implementing a community-wide domestic violence and/or sexual assault prevention or treatment program may be guided by a community action organization, a collaboration, or a group of partners. If such partnerships or collaborations already exist, the action plan should describe how the partnership intends to expand its scope to include implementation of the domestic violence and/or sexual assault prevention or treatment program.

IV. Funding recipients must participate in a national evaluation of this project. Each funding recipient shall coordinate with Ms. Michelle Begay, Public Health Advisor in Division of Behavioral Health, to develop a local process for measuring outcome indicators. The national outcome measures for this initiative are pending review and approval from the Office of Management and Budget (OMB). The funding recipient must also report on applicable Government Performance and Results Act (GPRA) measures and national outcome indicators.

V. Funding recipients must use a portion of awarded funds to develop or enhance the funding recipient's local evaluation capacity. Each funding recipient shall employ an information management system that is compatible with the Resource and Patient Management System (RPMS), the RPMS Behavioral Health module, or the IHS Electronic Health Record. If the funding recipient is unable to use RPMS as an information management system, the funding recipient must demonstrate within the project proposal how the recipient will satisfy data collection requirements.

VI. Funding recipients must publicize program activities in the community, informing them about program goals and objectives. The action plan should establish a timeline for sharing progress with the community.

Tab B

EXHIBIT 1

Amendment to the [Tribe]'s FY 2010 Indian Self-Determination and Education Assistance Act Funding Agreement to transfer funds appropriated pursuant to Public Law 111-8 to Support a National Domestic Violence Prevention Initiative.

Public Law 111-8, the Omnibus Appropriations Act of 2009, provided $7,500,000 for the Domestic Violence Prevention Initiative (DVPI). For FY 2010, Congress provided an additional $2,500,000 for a total of $10,000,000 in the program. The purpose of the initiative is to support a national effort by the IHS to address domestic violence and sexual assault (DV/SA) within American Indian and Alaska Native (AI/AN) communities. The IHS Director has decided to fund one-time, non-recurring demonstration projects intended to expand community-level access to effective Tribal domestic violence and sexual assault prevention programming. The IHS Director solicited proposals from Tribes and as a result of that solicitation, has elected to fund the [Tribe]'s proposal. The parties to this Amendment are the [Tribe] and the IHS. Pursuant to this Amendment, the IHS and the [Tribe] agree that the total amount due under this Amendment is $_____.

These funds, hereinafter referred to as DVPI funds, are distributed to the [Tribe] through a modification to an existing Indian Self-Determination and Education Assistance Act (ISDEAA) Compact or Contract and respective Funding Agreement (FA) or Annual Funding Agreement (AFA) for programs, services, functions and activities (PSFAs).

However, notwithstanding any provision in the [Tribe]'s Compact or Contract and FA or AFA, the following terms and conditions shall apply to the use of these funds. By signing this Amendment, both parties agree:

1. The DVPI funds in the FA/AFA are part of a non-recurring, one-time allocation, and the Tribe acknowledges that:
   a. No contract support cost (CSC) funding is associated with the DVPI funds, and nothing in the FA/AFA or the associated compact/contract creates a promise on the part of the IHS to pay the [Tribe] CSC funding in connection with the DVPI funds.
   b. The Tribe still wishes to contract for the DVPI funds and can conduct the DVPI-funded project or activity, despite the absence of CSC funding.
   c. The IHS will include the CSC need associated with the DVPI funds in the annual CSC Shortfall Report to Congress.

2. The [Tribe] has submitted a proposal (attached to this amendment), including a scope of work and three-year action plan conforming with the requirements set forth by the IHS in [IDENTIFY GUIDANCE DOCUMENT]. Funding provided under this amendment is non-recurring and is intended to fund the first year (August 1, 2010 - July 30, 2011) of the three-year action plan. Funding for the second year (August 1, 2011 - July 30, 2012) and third year (August 1, 2012 - July 30, 2013) of the Tribe's action plan is subject to availability of funds and future evaluation. Nothing in this Amendment construes a right on behalf of the Tribe to any funding for its proposal beyond the funds awarded in this

amendment. The proposal and this amendment constitute the complete agreement between the parties with respect to the use of these DVPI funds.

3. DVPI funds must be expended for the specific purpose outlined in this agreement and the attached proposal. The [Tribe] may not re-budget, redesign, reallocate, or reprogram DVPI funds without written authorization from the IHS.

4. With regard to these DVPI funds, in the event of a conflict between this amendment, the [Tribe]'s Compact, Contract, FA or AFA, or a provision in the ISDEAA, the parties agree that this amendment controls.

Both parties understand that the terms and conditions in this Amendment apply only to these DVPI funds and in no way alter or modify the [Tribe]'s Compact or Contract with respect to other funds.

Signed:

_____
Tribe

_____
Indian Health Service

Dated: The _____ day of _____, _____

Tab C

EXHIBIT 2

Table for Distributing FY 2009 DVPI Funds (Year One)

	SUMMARY – DVPI Proposed FY 2009 Allocations		
AREAS	Sexual Assault Projects Expansion Community Developed Models	Domestic Violence Prevention Initiative	TOTALS
Aberdeen	$ 140,000	$ 232,000	**$ 372,000**
Alaska	$ 199,000	$ 328,000	**$ 527,000**
Albuquerque	$ 83,000	$ 138,000	**$ 221,000**
Bemidji	$ 81,000	$ 135,000	**$ 216,000**
Billings	$ 76,000	$ 125,000	**$ 201,000**
California	$ 58,000	$ 96,000	**$ 154,000**
Nashville	$ 35,000	$ 58,000	**$ 93,000**
Navajo	$ 229,000	$ 379,000	**$ 608,000**
Oklahoma	$ 209,000	$ 347,000	**$ 556,000**
Phoenix	$ 143,000	$ 237,000	**$ 380,000**
Portland	$ 87,000	$ 145,000	**$ 232,000**
Tucson	$ 26,000	$ 40,000	**$ 66,000**
Area Allocation Totals:	**$ 1,366,000**	**$ 2,260,000**	**$ 3,626,000**
Urban Set-Aside	$ 262,000	$ 262,000	**$ 524,000**
Sexual Assault Projects Expansion National Program			**$ 2,400,000**
National Management of DVPI			**$ 950,000**
TOTAL	**$ 1,628,000**	**$ 2,522,000**	**$ 7,500,000**

Tab C

EXHIBIT 2a

Tables for Distributing FY 2010 DVPI Funds (Year Two)

	SUMMARY – DVPI Proposed FY 2010 Allocations		
AREAS	Sexual Assault Projects Expansion Community Developed Models	Domestic Violence Prevention Initiative	TOTALS
Aberdeen	$ 203,000	$ 330,000	**$ 533,000**
Alaska	$ 290,000	$ 469,000	**$ 759,000**
Albuquerque	$ 120,000	$ 195,000	**$ 315,000**
Bemidji	$ 118,000	$ 192,000	**$ 310,000**
Billings	$ 110,000	$ 178,000	**$ 288,000**
California	$ 85,000	$ 138,000	**$ 223,000**
Nashville	$ 52,000	$ 84,000	**$ 136,000**
Navajo	$ 333,000	$ 540,000	**$ 873,000**
Oklahoma	$ 303,000	$ 494,000	**$ 797,000**
Phoenix	$ 209,000	$ 339,000	**$ 548,000**
Portland	$ 127,000	$ 207,000	**$ 334,000**
Tucson	$ 37,000	$ 57,000	**$ 94,000**
Area Allocation Totals:	**$ 1,987,000**	**$ 3,223,000**	**$ 5,210,000**
Urban Set-Aside	$ 262,000	$ 262,000	**$ 524,000**
Sexual Assault Projects Expansion National Program			**$ 3,316,000**
National Management of DVPI			**$ 950,000**
TOTAL	**$ 2,249,000**	**$ 3,485,000**	**$ 10,000,000**

Tab D

EXHIBIT 3

DVPI Proposal Cover Sheet

PROJECT/PROGRAM NAME:	
SUBMITTED BY:	*(please identify if Federal/Tribal)* _____**Federal** _____**Tribal**
PROJECT CONTACT: Project Coordinator/Director Name: Organization Name: Address: City, State, Zip code: Phone number: Fax number: Email:	
LOCAL EVALUATOR: Evaluator Name: Organization Name: Address: City, State, Zip code: Phone number: Fax number: Email:	
DATA COLLECTION METHOD: *(i.e., RPMS, Accucare, etc.)*	
PROPOSAL TYPE: *(please identify proposal type)*	
_____**Domestic Violence Prevention Initiative** _____**Sexual Assault Project Expansion - Community Developed Models** _____**Sexual Assault Project Expansion - SANE/SAFE/SART**	
ABSTRACT: *(Briefly outline what your program is proposing to do. Attach additional page as needed and do not exceed 1 page.)*	

Tab E

EXHIBIT 4

Criteria for Evaluating DVPI Proposals

A separate proposal must be submitted in each of the funding categories to be considered for funding in that category. The three funding categories are: 1) Domestic Violence Prevention Initiative; 2) Sexual Assault Project Expansion (Community Developed Models), and; 3) Sexual Assault Project Expansion (National Program for Sexual Assault Nurse Examiner (SANE), Sexual Assault Forensic Examiner (SAFE), and Sexual Assault Response Team (SART)). Proposals for each category shall address Parts A – D. For programs applying for the Sexual Assault Project Expansion (National Program for SANE/SAFE/SART), the proposal shall address Parts A – E.

Applicants must address all program requirements and provide all required documentation. Each application will be pre-screened by the Area Office for eligibility and completeness as outlined in the Area Guidance. Incomplete applications and applications that are non-responsive to the eligibility criteria will not be referred to the IHS Division of Behavioral Health (DBH) for further review. If clarification is needed, applicants will be notified by DBH to resubmit and clarify components of the application to meet review criteria. Points will be assigned to each evaluation criteria by reviewers adding up to a total of 100 points. Points are assigned as follows:

Part A: Project Information (25 points) (Not to exceed 5 pages): Score:

Section 1: Statement of Need (13 points)

- Provide an adequate baseline picture of the community. (8 points)
  - Community assessment to include patient survey and findings (for example, use of the Delphi Instrument For Hospital-based Domestic Violence Programs or other such assessment tool).
- Identify your target population. (5 points)
  - Provide a good description and justification for focusing on the identified target population.

Section 2: Organizational Capacity (12 points)

- Adequately describe the project staffing and position descriptions for those who will participate in the project, showing their qualifications, tasks/roles, experience and training, and time commitment. (4 points)
- Describe the applicant organization and partnerships/collaboratives ability and experience in successful domestic violence or sexual assault prevention or treatment program management capability. (4 points)
- A description of the community infrastructure addressing domestic violence or sexual assault prevention or treatment. (4 points)

Part B: Project Planning/Evaluation (55 points) (Not to exceed 12 pages): Score: _____

Section 1: Project Plan (30 points)

- Comprehensively describe the purpose, goals, objectives, and activities of the proposed three (3) year program to be implemented [Note: Program should utilize community-focused models that promote evidence-based or practiced-based domestic violence or sexual assault prevention, treatment, educational and/or community awareness programming and provide communities with needed resources to develop community-focused programs with a preference toward coordinated programming that maximizes service delivery]. (5 points)
- Provide a timeline of activities (chart or graph) showing key activities, milestones, and responsible staff. (4 points)
- Describe how the program will provide violence outreach services through use of victim advocates [Note: Victim advocates must have completed victim advocacy training]. (4 points)
- Describe how the program will respond to urgent and emergent requests for victim advocacy. (4 points)
- Comprehensively describe and identify potential problem areas or barriers and propose solutions for domestic violence or sexual assault prevention or treatment. (4 points)
- Demonstrate how the programs will develop/maintain/increase collaborative efforts with community partners. (3 points)
- Describe the process by which the development of a community-based outreach and education component will occur within the overall program. (3 points)
- Describe sustainability and how the program plans to continue this project and activities beyond the three years of funding for this initiative. (3 points)

Section 2: Project Evaluation (25 points)

- List milestones and describe how they relate to the identified key activities included in your timeline. (3 points)
- Describe how your program can establish baseline data and information related to domestic violence or sexual assault in the local community. (5 points)
- Describe how your program's data collection and storage capacity can support surveillance. (3 points)
- Describe your local evaluation process in detail. (2 points)
- State a willingness to collaborate and submit data into the DVPI local and national evaluation process. (3 points)
- Demonstrate evidence of commitment to secure a qualified local evaluator/data collection/entry employee. (3 points)
- State a willingness to participate in a nationally coordinated program focusing on increasing access to domestic violence or sexual assault-related activities. (3 points)
- State a willingness to attend quarterly DVPI conference calls. (3 points)

Part C: Program Report (18 points) (Not to exceed 5 pages): Score:

Section 1: Describe program's prior accomplishment(s) (9 points)

- Describe the program's prior history of implementing successful domestic violence or sexual assault services and/or other SANE/SAFE/SART programs. (5 points)
- Describe any key objectives that helped the program achieve these accomplishments. (4 points)

Section 2: Describe program's prior successful activities (9 points)

- Describe what activities have been successful for the program in addressing this area of need and/or other such "new" initiatives. (5 points)
- Describe any key objectives that helped the program accomplish these activities. (4 points)

Part D: Budget (2 points) (Not to exceed 3 pages): Score:

Budget Narrative/Justification: This narrative must describe the budget requested and match the scope of work described in the project narrative.

- The budget is reasonable and within established limits. (0.5 point)
- The budget calculations are clearly identified and accurate. (0.5 point)
- The budget does not include costs that support activities that would compromise victim safety. (0.5 point)
- The budget costs are reflective of the goals and objectives of the project. (0.5 point)

Part E: Sexual Assault Project Expansion (National Program for SANE/SAFE/SART) (No points assigned and no page limit):

Did the Program applying for this funding category address all requirements below?
YES_____ NO_____

SANE/SAFE/SART Requirements: Programs shall address the following areas:

- Meet the criteria of "a fully operational 24/7 IHS or Tribal hospital or clinic that provides 24/7 emergency care."
- Demonstrate a coordinated, multi-disciplinary approach to sexual assault with an active Sexual Assault Response Team (SART) including representatives from community health care, behavioral health, law enforcement (Tribal, State, Federal) and any community sexual assault advocacy programs.
- Provide a timeline demonstrating the applicant's approach to ensuring training and maintaining competency of individuals authorized to conduct SAFE.
- Clearly describe a three-year plan for SAFE/SANE/SART program activities and objectives, training, and community-based outreach throughout the project period.
- Provide a budget justification and narrative on the purchase of SAFE equipment.

SCORE ASSIGNED BY AREA OFFICE FOR PROPOSAL ____ OF POSSIBLE 100

Tab F

EXHIBIT 5

Notice of Award:
This Notice of Award (NOA) between the Indian Health Service (IHS) Headquarters (HQ), Division of Behavioral Health (DBH) and _____, acknowledges the acceptance of the _____ proposal for inclusion in the Domestic Violence Prevention Initiative (DVPI). This NOA provides further information for participation in the DVPI.

Award Office:
IHS/HQ/DBH

Budget Period:
August 1, 2010 - July 30, 2011 (Year One)
August 1, 2011 - July 30, 2012 (Year Two)
August 1, 2012 - July 30, 2013 (Year Three)

Project Period:
August 1, 2010 – July 30, 2013

Program Contact Information:
Project Contact: _____
Project Name: _____
Organization/Agency Name: _____
Address: _____
_____
_____
Telephone: ( ) _____
Fax: ( ) _____
Email Address: _____

Area Office Contact Information:
Area Office Contact: _____
Telephone: ( ) _____
Fax: ( ) _____
Email Address: _____

Programmatic Involvement:

The IHS responsibilities will include:

- Provide information on requirements for the DVPI project to the awarded entities;
- Identify, share information, and provide training on DVPI-related topics;
- Promote collaboration between DVPI awardees through conference calls and meetings;
- Promote collaboration between DVPI awardees and Federal, State, national, and local

community agency partners working in the areas of domestic violence and/or sexual assault prevention, and;
- Provide technical assistance to the awardee in data collection and evaluation.

The DVPI awardees' responsibilities will include:

- Participate in quarterly DVPI conference calls to share information such as progress, successes, and challenges of the program;
- Provide IHS verification of the establishment of the local evaluation processes;
- Provide IHS information regarding the implementation of the awardees' local data collection activities, including all applicable DVPI outcome measures;
- Submit semi-annual and annual progress reports, financial reports, and data reports;
- Publicize activities in their communities, and;
- Actively participate in a national evaluation process.

Semi-Annual Narrative, Financial (Standard Form 269), and Data Reporting Date:
Due March 1 (Report Period is August 1 – January 31)

Annual Narrative, Financial (Standard Form 269), and Data Reporting Date:
Due August 31 (Report Period is August 1 – July 31)

Narrative Reporting Format:
The semi-annual and annual narrative reports shall include, but are not limited to, a brief description of the following for each program function or activity involved. Please be clear and concise.

Section I – Status of Program:
- List the specific program goals and objectives.
- Describe the activities related to the specific program goals and objectives that have occurred during the project reporting period.
- Describe how your project is utilizing the required local evaluator/data collection/entry employee. If local evaluator/data collection/entry employee has not yet been identified, describe what is being done to obtain one.
- Describe what the program is doing to address sustainability.

Section II – Changes to Project:
- Explain any variation from original proposal (changes to program such as goals, personnel, work plan, etc.).

Section III – Data/Outcomes:
- List the outcome measures.
- Discuss the status and progress of each of the outcome measures.
- Describe what method is being used to collect the data.

Section IV – Collaboration:

- Provide a description of internal and external collaboration and new resources secured.
- Describe how the information collected and complied will be disseminated to the community.

Section V – Technical Assistance:

- List any training or technical assistance you have received for this project.

Section VI – Problems or Delays:

- Describe any barriers, problems, or delays that you have had in the reporting period.
- Provide what actions or plans you have to overcome the barriers, problems, or delays.

Section VII – Budget:

- List funds allocated for this project during this reporting period.
- Submit narrative of the funds expended.
- Provide a justification for large unexpended amounts.

DVPI Project Officer:
The IHS DBH DVPI Project Officer, assigned with responsibility for technical and programmatic questions for the awardee is:

Michelle Begay, DVPI Project Officer
Division of Behavioral Health
Office of Clinical and Preventive Services
Indian Health Service
801 Thompson Avenue, Suite 300
Rockville, Maryland 20852
Telephone: (301) 443-2038
Fax: (301) 443-7623
Email address: michelle.begay2@ihs.gov

Administrator/Health Director: _____
(Please Print Name)

_____ Date: _____
(Signature)

Area Office Program Official: _____
(Please Print Name)

_____ Date: _____
(Signature)

Tab G

EXHIBIT 6

DEFINITIONS

Intimate Partner Violence[1] (IPV) - Actual or threatened physical, sexual, psychological, or stalking violence by current or former intimate partners (whether of the same or opposite sex).

Domestic Violence[2] (DV) - A pattern of physically and emotionally coercive and violent behaviors that may include physical injury, psychological abuse, sexual coercion and assault, progressive social isolation, stalking, deprivations, intimidation, and threats. These behaviors are perpetrated by someone who is, was, or wishes to be involved in an intimate or dating relationship with an adult or adolescent, and are aimed at establishing control by one partner over another.

Sexual Assault[2] (SA) - Consists of a wide range of conduct that may include pressured or coerced sex, sex by manipulation or threat, physically forced sex (rape), or sexual assault accompanied by physical violence. Victims may be coerced or forced to perform a kind of sex they do not want (e.g., sex with third parties, physically painful sex, sexual activity they find offensive, verbal degradation during sex, viewing sexually violent material) or at a time they want it (e.g., when exhausted, when ill, in front of children, after a physical assault, or when asleep). These behaviors may happen in many situations—by a married partner, or boyfriend, on a date, by a friend or an acquaintance, by a stranger or by a family member such as a parent, sibling, or a grandparent.

Examiner[3] - The term refers to the health care provider conducting the sexual assault medical forensic examination. The examiner is also referred to in this document as the "sexual assault forensic examiner," "sexual assault examiner," and "forensic examiner." Many communities refer to their sexual assault examiners by more specific acronyms based upon the discipline of practitioners and/or specialized education and clinical experiences.

Sexual assault medical forensic examination[3] - The sexual assault medical forensic exam is an examination of a sexual assault patient by a health care provider, ideally one who has specialized education and clinical experience in the collection of forensic evidence and treatment of these patients. The forensic component includes gathering information from the patient for the medical forensic history, an examination, documentation of biological and physical findings, collection of evidence from the patient, and follow-up as needed to document additional evidence. The medical component includes coordinating treatment of injuries, providing care for sexually transmitted infections, assessing pregnancy risk and discussing treatment options, including reproductive health services, and providing instructions and referrals for follow-up medical care. This exam is referred to as the "forensic medical examination" under the Violence Against Women Act (VAWA).

Sexual assault response team (SART)[3] - A SART is a multidisciplinary team that provides

---

[1] Centers for Disease Control
[2] Family Violence Prevention Fund
[3] Department of Justice, A National Protocol for Sexual Assault Medical Forensic Examinations 2004

specialized immediate response to victims of recent sexual assault. The team typically includes health care personnel, law enforcement representatives, victim advocates, prosecutors (usually available on-call to consult with first responders, although some may be more actively involved at this stage), and forensic lab personnel (typically available to consult with examiners, law enforcement, or prosecutors, but not actively involved at this stage). However, SART components vary by community. A sexual assault victim is someone who has been sexually assaulted. A victim can be a female or male; either adult or adolescent. There may be instances where individuals, such as unconscious persons or persons with cognitive disabilities, do not actually disclose that they have been assaulted, but others suspect that this may be this case and may be lawfully able to seek help for them. The term "survivor" is used when referring to victims who are involved in long-term healing or have healed from sexual assault. It is important to note that the DVPI addresses a multidisciplinary response, the term "victim" is not used in a strictly criminal justice context. The use of "victim" simply acknowledges that persons who disclose they have been sexually assaulted should have access to certain services and interventions designed to help them be safe, recover, and seek justice. The term "patient" is also used when discussing the role of medical providers.

Victim service provider/advocate[3] - A victim service provider/sexual assault victim advocate (also referred to as "victim advocate" and "advocate") may offer victims and their significant others a range of services during the exam process. These services may include support, crisis intervention, information and referrals, and advocacy to ensure that victim's interests are represented, their wishes respected, and their rights upheld. In addition, advocates and other victim service providers may provide follow-up services, such as support groups, counseling, accompaniment to related appointments, and legal advocacy to help meet the needs of victims, their families, and friends. A number of agencies may offer some or all of the services described above, including community-based sexual assault victim advocacy programs, criminal justice system victim-witness offices, patient advocate programs at health care facilities, campus or military victim service programs, Tribal social services, adult protective services, and others. Where they exist, community-based sexual assault victim advocacy programs are typically best positioned to provide these specific services. Community-based advocacy programs may use paid and/or volunteer advocates to provide services 24 hours a day, every day of the year. It is important to know that information victims share with government-based service providers usually becomes part of the criminal justice record, while community-based advocates typically can provide some level of confidential communication for victims. In addition, community-based advocates commonly receive education specific to the medical forensic exam process and sexual assault issues in general.

Victim-centered[3] - A "victim-centered" approach recognizes that sexual assault victims are central participants in the medical forensic exam process, and they deserve timely, compassionate, respectful, and appropriate care. Victims have the right to be well informed in order to make their own decisions about participation in all components of the exam process. Responders need to do all that is possible to explain possible options, the consequences of choosing one option over another, and available resources.

Vulnerable adults[3] - This term is used to refer to adult individuals with impaired and/or reduced mental capacity who have difficulty or cannot comprehend events that occurred or will occur (e.g., the assault itself or initial response by professionals), questions they will be asked during the exam, or the exam process itself. Exam sites should have internal policies based on jurisdictional statutes governing consent for treatment for and evidence collection from such patients.

Coordinated community response[3] - This term refers to immediate and longer term community response to sexual assault that is coordinated among involved responders. The idea is that while each responder provides services and/or interventions according to agency-specific policies, they also work with responders from other agencies and disciplines to ensure that they coordinate responses. The desired result is a collective response to victims and offenders that is appropriate, streamlined, and as comprehensive as possible. Coordinated community response to sexual assault is a concept that developed out of a need to reduce the historically fragmented approach to these cases and the negative impact of fragmentation on victim well-being, offender accountability, and prevention of future assault.

Involved Parties and Relationships between Them

Source: Saltzman LE, Fanslow JL, McMahon PM, Shelley GA. *Intimate Partner Violence Surveillance: Uniform definitions and recommended data Elements*, Version 1.0. Atlanta (GA): National Center for Injury Prevention and Control, Centers for Disease Control and Prevention; 1999.

Victim - Person who is the target of violence or abuse.

Perpetrator - Person who inflicts the violence or abuse or causes the violence or abuse to be inflicted on the victim.

Intimate Partners - Includes the following:

- current spouses (including common-law spouses)
- current non-marital partners
- dating partners, including first date (heterosexual or same-sex)
- boyfriends/girlfriends (heterosexual or same-sex)
- former marital partners
- divorced spouses
- former common-law spouses
- separated spouses
- former non-marital partners
- former dates (heterosexual or same-sex)
- former boyfriends/girlfriends (heterosexual or same-sex)

Intimate partners may be cohabiting, but need not be. The relationship need not involve sexual activities. If the victim and the perpetrator have a child in common but no current relationship, then by definition they fit in the category of former marital partners or former non-marital partners. States differ as to what constitutes a common-law marriage. Users of the "Recommended Data Elements" will need to know what qualifies as a common-law marriage in their state.

Violence and Associated Terms

Violence is divided into four categories:

- Physical Violence
- Sexual Violence
- Threat of Physical or Sexual Violence
- Psychological/Emotional Abuse (including coercive tactics) when there has also been prior physical or sexual violence, or prior threat of physical or sexual violence.

Physical Violence - The intentional use of physical force with the potential for causing death, disability, injury, or harm. Physical violence includes, but is not limited to: scratching, pushing, shoving, throwing, grabbing, biting, choking, shaking, poking, hair pulling, slapping, punching, hitting, burning, use of a weapon (gun, knife, or other object), and use of restraints or one's body, size, or strength against another person. Physical violence also includes coercing other people to commit any of the above acts.

Sex Act (or Sexual Act) - Contact between the penis and the vulva or the penis and the anus involving penetration, however slight; contact between the mouth and the penis, vulva, or anus; or penetration of the anal or genital opening of another person by a hand, fingers, or other object.

Abusive Sexual Contact - Intentional touching directly, or through the clothing, of the genitalia, anus, groin, breast, inner thigh, or buttocks of any person against his or her will, or of any person who is unable to understand the nature or condition of the act, to decline participation, or to communicate unwillingness to be touched (e.g., because of illness, disability, or the influence of alcohol or other drugs, or due to intimidation or pressure).

Sexual Violence - Sexual violence is divided into three categories:

- Use of physical force to compel a person to engage in a sexual act against his or her will, whether or not the act is completed.
- An attempted or completed sex act involving a person who is unable to understand the nature or condition of the act, to decline participation, or to communicate unwillingness to engage in the sexual act (e.g., because of illness, disability, or the influence of alcohol or other drugs, or due to intimidation or pressure).
- Abusive sexual contact.

Threat of Physical or Sexual Violence - The use of words, gestures, or weapons to communicate the intent to cause death, disability, injury, or physical harm. Also the use of words, gestures, or weapons to communicate the intent to compel a person to engage in sex acts or abusive sexual contact when the person is either unwilling or unable to consent. Examples: "I'll kill you"; "I'll beat you up if you don't have sex with me"; brandishing a weapon; firing a gun into the air; making hand gestures; reaching toward a person's breasts or genitalia.

Psychological/Emotional Abuse - Trauma to the victim caused by acts, threats of acts, or coercive tactics, such as those on the following list. This list is not exhaustive. Other behaviors may be considered emotionally abusive if they are perceived as such by the victim. Some of the behaviors on the list may not be perceived as psychologically or emotionally abusive by all victims. Operationalization of data elements related to psychological/emotional abuse will need to incorporate victim perception or a proxy for it. Although any psychological/emotional abuse can be measured by the IPV surveillance system, the expert panel recommended that it only be considered a type of violence when there has also been prior physical or sexual violence, or the prior threat of physical or sexual violence.* Thus by this criterion, the number of women experiencing acts, threats of acts, or coercive tactics that constitute psychological/emotional abuse may be greater than the number of women experiencing psychological/emotional abuse that can also be considered psychological/emotional violence. Psychological/emotional abuse can include, but is not limited to:

- Humiliating the victim
- Controlling what the victim can and cannot do
- Withholding information from the victim
- Getting annoyed if the victim disagrees
- Deliberately doing something to make the victim feel diminished (e.g., less smart)
- Deliberately doing something that makes the victim feel embarrassed
- Using money that is the victim's
- Taking advantage of the victim
- Disregarding what the victim wants
- Isolating the victim from friends or family
- Prohibiting access to transportation or telephone
- Getting the victim to engage in illegal activities
- Using the victim's children to control victim's behavior (e.g., custody of children)
- Smashing objects or destroying property
- Denying the victim access to money or other basic resources
- Disclosing information that would tarnish the victim's reputation

Violent Episode - A single act or series of acts of violence that are perceived to be connected to each other and that may persist over a period of minutes, hours, or days. A violent episode may involve single or multiple types of violence (e.g., physical violence, sexual violence, and threat of physical or sexual violence, psychological/emotional abuse).

Most Recent Violent Episode Perpetrated by Any Intimate Partner - For victims who have had only one violent intimate partner, the most recent violent episode perpetrated by that intimate partner; for victims who have had more than one violent intimate partner, the violent episode perpetrated most recently, by whichever one of those violent partners committed it. Thus, the most recent violent episode perpetrated by any intimate partner may have been perpetrated by someone other than the victim's current intimate partner. For example, if a woman has been victimized by both her ex-husband and her current boyfriend, questions about the most recent violent episode would refer to the episode involving whichever intimate partner victimized her most recently, not necessarily the one with whom she is currently in a relationship.

*At the March 1996 meeting of the 12-member expert panel, participants discussed the importance of capturing these behaviors as one component of IPV. They also recognized that psychological/emotional abuse encompasses a range of behavior that, while repugnant, might not universally be considered violent. The panel made the decision to classify psychological/ emotional abuse as a type of violence only when it occurs in the context of prior physical or sexual violence, or the prior threat of physical or sexual violence. The panel suggested that "prior" be operationalized as "within the past 12 months."

Pattern of Violence - The way that violence is distributed over time in terms of frequency, severity, or type of violent episode (i.e., physical violence, sexual violence, threat of physical or sexual violence, psychological/emotional abuse).

Terms Associated with the Consequences of Violence

Physical Injury - Any physical damage occurring to the body resulting from exposure to thermal, mechanical, electrical, or chemical energy interacting with the body in amounts or rates that exceed the threshold of physiological tolerance, or from the absence of such essentials as oxygen or heat.

Disability - Impairment resulting in some restriction or lack of ability to perform an action or activity in the manner or within the range considered normal.

Psychological Consequences - Consequences involving the mental health or emotional well-being of the victim.

Medical Health Care - Treatment by a physician or other health care professional related to the physical health of the victim.

Mental Health Care - Includes individual or group care by a psychiatrist, psychologist, social worker, or other counselor related to the mental health of the victim. It may involve inpatient or outpatient treatment. Mental health care excludes substance abuse treatment. It also excludes pastoral counseling, unless specifically related to the mental health of the victim.

Substance Abuse Treatment - Treatment related to alcohol or other drug use by the victim.