

**OHIO DEPARTMENT OF HEALTH (ODH)  
CHOOSE LIFE FUND SFY15  
DISTRIBUTION APPLICATION**

**Interested Organizations:** *This application is due by June 1, 2015. Use this form to apply for SFY 16 Choose Life Funds available for your county and for funds that may be available for contiguous counties. It is important that you completely fill in the requested information and include all other required documentation. An application will only be considered when all required documents and information has been provided by the deadline.*

**I. ODH and Organization Information.**

<b>“Organization”</b>	
Federal Tax ID Number	
Street Address	
City, State Zip code	
County of Location Providing Services <i>(One Application Per Location)</i>	
Address where ODH should Direct Payment	
<b>Contiguous Counties of Service</b> <i>This location serves women from the following counties:</i>	
Name of Person and Title completing application	
Area Code/Phone Number	
Email	

**II. By submitting this Application to ODH, Organization agrees to adhere to the statutory requirements for activities and use of funds as outlined in Ohio Revised Code (RC) 3701.65 and rules under Ohio Administrative Code (OAC) 3701-74-01, and I certify that the Organization:**

- A. Is eligible to receive Choose Life funds as described in RC 3701.65 and OAC 3701-74-01;
- B. Is a private, nonprofit organization;
- C. Is committed to counseling pregnant women about the option of adoption;
- D. Provides services within the state of Ohio to pregnant women who are planning to place their children for adoption, including counseling and meeting the material needs of the women;
- E. Does not charge pregnant women for any services received;
- F. Is not involved or associated with any abortion activities, including counseling for or referrals to abortion clinics, providing medical abortion-related procedures, or pro-abortion advertising;
- G. Does not discriminate in its provision of any service on the basis of race, religion, color, marital status, national origin, handicap, gender or age; and

**III. Contiguous Counties of Service.** If Organization is applying for Choose Life funds that may be available in contiguous counties then Organization certifies that it provides services to pregnant women residing in those counties that are listed as “Contiguous Counties of Service,” in Section I. Organization will be considered for distribution of Choose Life funds from the above-listed contiguous counties if there are no eligible organizations located within those counties.

**IV. By June 1, 2015, if *Organization received funds for state fiscal year 2015*** (July 1, 2013-June 30, 2015), then Organization must submit the following with this Application:

A. One (1) of the following three (3) forms of reporting for state fiscal year 2015 (“Acceptable Form of Reporting”), which will be incorporated into the terms of this Application:

1. An Audited Financial Statement. This audited financial statement is required if Organization traditionally has an audited financial statement that is available at the time of application. The audited financial statement must be prepared by an independent Certified Public Accountant (CPA). The CPA should be familiar with acceptable standards. Either statements must verify that the Choose Life funds were used as follows:

- a) *Not more than sixty percent (60%) of the funds were used for the material needs of pregnant women who are planning to place their children for adoption or for the infants awaiting placement with adoptive parents, including clothing, housing, medical care, food, utilities, and transportation;*
- b) *Not more than forty percent (40%) of the funds were used for counseling, training, or advertising;*
- c) *None of the funds were used for administrative expenses, legal expenses, or capital expenditures; or*

2. Notarized Financial Statement Form. This form of reporting may be used if Organization does not traditionally have an audited financial statement and to have one would create a hardship. The statement must verify that the Choose Life Funds were used as follows:

- a) *Not more than sixty percent (60%) of the funds were used for the material needs of pregnant women who are planning to place their children for adoption or for the infants awaiting placement with adoptive parents, including clothing, housing, medical care, food, utilities, and transportation;*
- b) *Not more than forty percent (40%) of the funds were used for counseling, training, or advertising;*
- c) *None of the funds were used for administrative expenses, legal expenses, or capital expenditures; or,*

3. Expenditure Tracking Form. This form of reporting may be used if Organization does not traditionally have an audited financial statement and a financial statement is not available at the time of application. This form may be found on the ODH website or available upon request; *and,*

B. As well as a new Vendor Information Form (if Organization has moved).

**V. By June 1, 2015, new applicants** must submit the following:

- A. One (1) original, signed W-9 form per organization. If your organization has multiple locations, please choose the location where you would prefer a check to be mailed; and
- B. Completed Vendor Information Form; and,
- C. Completed Direct Deposit Form (*optional*).

**VI. By June 1, 2016, all Organizations** shall submit to ODH one of the three forms of reporting from Section III, above, verifying compliance with the rules regarding the use of funds received during state fiscal year 2016 (July 1, 2015–June 30, 2016).

By my signature, I certify that I have the authority to act on behalf of the above-named Organization and that the information provided in this Application is true and accurate to my knowledge and belief. Further, by my signature, I acknowledge that I understand and Organization agrees that in accepting Choose Life Funds, Organization must comply with the terms and conditions of RC 3701.65 as set forth in this Application for the state fiscal year of 2016 or risk the forfeiture of and be obliged to return said Choose Life Funds in the event Organization does conduct itself in the manner prescribed above.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Person Completing Application

\_\_\_\_\_  
[Print Name & Title]

**Application to be submitted to:**

Dyane Gogan Turner MPH, RD/LD, IBCLC  
Ohio Department of Health  
Bureau of Maternal and Child Health  
246 North High Street, 6<sup>th</sup> floor, Columbus, OH 43215  
614.644.6560  
[Dyane.Goganturner@odh.ohio.gov](mailto:Dyane.Goganturner@odh.ohio.gov)