

## PROJECT PROPOSAL FORM

**INSTRUCTIONS**

1. Before proposing a project, please review the Community Health Improvement Grants program fact sheet ([www.dignityhealth.org/communitygrants](http://www.dignityhealth.org/communitygrants)) and most recent Community Health Needs Assessment and Implementation Strategy ([www.dignityhealth.org/about-us/community-health/community-health-programs-and-reports/community-health-needs-assessments](http://www.dignityhealth.org/about-us/community-health/community-health-programs-and-reports/community-health-needs-assessments)) of the Dignity Health hospital to which you are applying.
2. Prospective applicants are encouraged to contact the Grant Representative to inquire about specific funding priorities. Proposals must address one or more significant health needs in the hospital's Community Health Needs Assessment and Implementation Strategy.
3. Complete the Project Proposal Form on the following pages with thorough but concise responses.
4. E-mail the completed form with requested attachments to your local Grant Representative by the due date on the hospital's Community Health Improvement Grants program fact sheet.

**Hospital Name:** Mark Twain Medical Center**City:** San Andreas**Grant Representative:** Nicki R. Stevens**E-mail:** [nicki.stevens@dignityhealth.org](mailto:nicki.stevens@dignityhealth.org)**PROJECT NAME and GRANT REQUEST****Project Name:** [Click here to enter text.](#)**Grant Request:** \$ [Click here to enter text.](#)**LEAD APPLICANT ORGANIZATION****Organization Name:** [Click here to enter text.](#)**Tax ID Number:** [Click here to enter text.](#)**Web Address:** [Click here to enter text.](#)**Mailing Address:** [Click here to enter text.](#)**Contact Person and Job Title:** [Click here to enter text.](#)**Phone Number:** [Click here to enter text.](#)**E-mail:** [Click here to enter text.](#)**Organization Mission** (*up to three sentences*): [Click here to enter text.](#)

## LEAD and PARTNER ORGANIZATIONS

List the lead applicant and partner organizations and their principal functions and services.<sup>1</sup>  
*A minimum of three organizations in total is required. (Do not include a Dignity Health hospital on this list.)*

1. **Lead applicant organization name** (*required*): Click here to enter text.

What does the organization do? What are its principal functions and services? (Two sentence maximum.)  
Click here to enter text.

2. **Partner organization** (*required*): Click here to enter text.

Web Address: Click here to enter text.

Mailing Address: Click here to enter text.

Contact Name: Click here to enter text.

E-Mail: Click here to enter text.

What does the organization do? What are its principal functions and services? (Two sentence maximum.)  
Click here to enter text.

3. **Partner organization** (*required*): Click here to enter text.

Web Address: Click here to enter text.

Mailing Address: Click here to enter text.

Contact Name: Click here to enter text.

E-Mail: Click here to enter text.

What does the organization do? What are its principal functions and services? (Two sentence maximum.)  
Click here to enter text.

4. **Partner organization** (*optional*): Click here to enter text.

Web Address: Click here to enter text.

Mailing Address: Click here to enter text.

Contact Name: Click here to enter text.

E-Mail: Click here to enter text.

What does the organization do? What are its principal functions and services? (Two sentence maximum.)  
Click here to enter text.

5. **Partner organization** (*optional*): Click here to enter text.

Web Address: Click here to enter text.

Mailing Address: Click here to enter text.

Contact Name: Click here to enter text.

E-Mail: Click here to enter text.

What does the organization do? What are its principal functions and services? (Two sentence maximum.)  
Click here to enter text.

## PROJECT DESCRIPTION<sup>2</sup>

**A) Describe the project’s principal activities and services.** Include the frequency/duration of activities and services, and the resources, people and skills that will be used to deliver these services:

[Click here to enter text.](#)

**B1) Describe how the partner organizations will work collaboratively – including their distinct, complementary and substantive roles** – in delivering project activities and services:

[Click here to enter text.](#)

**B2) Have all listed partner organizations confirmed their participation in this grant proposal?**

Yes     No    If “No,” please explain: [Click here to enter text.](#)

**C) Briefly describe the population to be served** (e.g., ages, race/ethnicity, other key characteristics) and list the principal cities, towns and/or ZIP codes served:

[Click here to enter text.](#)

**D) Explain how this project is a response to one or more significant health needs** in the hospital’s Community Health Needs Assessment and Implementation Strategy:

[Click here to enter text.](#)

**E) Describe how this project will work with the Dignity Health hospital** in the local community:

[Click here to enter text.](#)

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<sup>1</sup> This is a brief description of each organization’s principal functions and services, not a description of proposed grant project activities. For example: “Middletown Community Support Center provides counseling, health education and basic needs services to youth and senior members of the greater Middletown community.”

<sup>2</sup> The maximum length for the Project Description section is two pages. Please be thorough but concise.

## PROJECT ACTIVITIES AND MEASURABLE GOALS

<b>Project Name:</b> <a href="#">Click here to enter text.</a>
<b>Project Description Summary (75 words max.):</b> <a href="#">Click here to enter text.</a>
<b>Significant Health Need(s) Being Addressed:</b> <a href="#">Click here to enter text.</a>

<b>Principal Project Activities and Services</b> <small>(based on Project Description)</small>	<b>Applicant Organization(s) Directly Involved</b>	<b>Activity <u>Output</u> Goals</b> <small>(e.g., units of service to be delivered, numbers of people to be served)</small>	<b>Activity <u>Outcome</u> Goals</b> <small>(measurable improvements from a specific <b>activity</b> in the condition of people served, such as health status, access to care, behaviors, knowledge)</small>	<b>Project <u>Outcome</u> Goals</b> <small>(measurable improvements from the <b>overall project</b> in the condition of people served, such as health status, access to care, behaviors, knowledge)</small>
<a href="#">Click here to enter text.</a>	<a href="#">Click here to enter text.</a>	<a href="#">Click here to enter text.</a>	<a href="#">Click here to enter text.</a>	<a href="#">Click here to enter text.</a>
<a href="#">Click here to enter text.</a>	<a href="#">Click here to enter text.</a>	<a href="#">Click here to enter text.</a>	<a href="#">Click here to enter text.</a>	<a href="#">Click here to enter text.</a>
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### Community Health Principles

The Community Health Improvement Grants program considers five principles to help guide funding decisions. Check the appropriate box or boxes to identify which principle(s) this project fulfills:

- Focus on disproportionate unmet health-related needs
- Emphasize primary prevention and address underlying causes of health problems
- Contribute to a seamless continuum of care
- Build community capacity
- Demonstrate collaboration

### Service to Dignity Health Patients and Use of Protected Health Information

Indicate whether the project will serve Dignity Health patients **and** involve applicant organizations' use of Protected Health Information (PHI), including patient demographic data (e.g., name, address, birthdate). Successful applicants whose projects involve PHI must comply with Health Insurance Portability and Accountability Act (HIPAA) provisions. Dignity Health will provide direction and assistance as needed.

- Yes, project will involve use of Protected Health Information of Dignity Health patients
- No, project will not involve use of Protected Health Information of Dignity Health patients
- Unsure at this time whether project will involve use of Protected Health Information

### Recent Dignity Health Grant Recipients

Have any of the applicant organizations received a Dignity Health grant in the past three years (2020, 2021, or 2022)? *(This is for information only. Recent grant recipients are eligible to apply.)*

- Yes     No    If yes, which organization(s) and year(s): [Click here to enter text.](#)

### Fiscal Agent and Lead Organization Information

Are you using a fiscal agent other than the lead applicant organization?     Yes     No

**If yes, provide organization name, mailing address, e-mail, phone number, and Tax ID number:**

[Click here to enter text.](#)

Submit each of the following for the lead applicant organization and, if applicable, the fiscal agent:

- IRS determination letter of 501(c)3 status, with Tax Identification Number
- IRS Form W-9, with organization's current address
- Board of Directors List and Affiliations

## PROJECT BUDGET AND NARRATIVE

Please provide project budget information. In the table below, the columns are to specify the portion of total requested grant funds that will be for the lead applicant organization (#1), and distributed to partner organizations as applicable to perform specific activities and services.

### 2023 Grant Project Budget

(A) Dignity Health Grant Request:                   \$ [Click here to enter text.](#)

(B) Project Funding from Other Sources:       \$ [Click here to enter text.](#)

(C) Total Project Budget (A+B):                   \$ [Click here to enter text.](#)

Would you be able to implement this project with partial funding?    Yes    No

	Allocation of “(A) Dignity Health Community Grant Request” among Lead Applicant (#1) and Partner Organizations (#2 to #5)					Totals by Personnel and Non- Personnel
	#1: <a href="#">Click here to enter text.</a>	#2: <a href="#">Click here to enter text.</a>	#3: <a href="#">Click here to enter text.</a>	#4: <a href="#">Click here to enter text.</a>	#5: <a href="#">Click here to enter text.</a>	
<b>Salaries and Personnel</b>	\$	\$	\$	\$	\$	\$
<b>Non-Personnel</b>	\$	\$	\$	\$	\$	\$
<b>Totals by Organization</b>	\$	\$	\$	\$	\$	\$

Provide an explanation of personnel and non-personnel dollar amounts in the budget for each organization, and describe how the budgeted amounts support the project’s activities and goals.

**Salaries and Personnel** (number and type of staff, approximate full time equivalents, roles):

[Click here to enter text.](#)

**Non-Personnel** (equipment, printing, supplies, rent, travel, etc.):

[Click here to enter text.](#)

## PROJECT BUDGET AND NARRATIVE

### Other Funding Sources

If you entered a dollar amount for “(B) Project Funding from Other Sources” in the budget section above, identify up to the five largest of these in the table below. (Leave blank if none):

Funding Organization	Recipient Organization	Activity Funded	Amount
Click here to enter text.	Click here to enter text.	Click here to enter text.	\$ Click here to enter text.
Click here to enter text.	Click here to enter text.	Click here to enter text.	\$ Click here to enter text.
Click here to enter text.	Click here to enter text.	Click here to enter text.	\$ Click here to enter text.
Click here to enter text.	Click here to enter text.	Click here to enter text.	\$ Click here to enter text.
Click here to enter text.	Click here to enter text.	Click here to enter text.	\$ Click here to enter text.

### Sustainability

Describe how project will be sustained through organizational and financial commitments over the next three years:

Click here to enter text.