2023 GET HEALTHY SAN MATEO COUNTY

COMMUNITY IMPLEMENTATION FUNDING

APPLICATION

**APPLICATION OVERVIEW**

Name of Applicant Organization:

Applicant Employer Identification Number (EIN)/Federal Tax ID#:

Applicant SAM.gov Identification Number:

Total Annual Funding Requested (anticipated annual funding allocation is up to $70,000 for each Project area):

Project Proposal (Check **one**, a separate application is required for each Project):

Project A: Civic Empowerment (Project Title:      )

Project B: Community Collaboration for Children’s Success (Project Title:      )

Project C: Community Health Worker Collaboration (Project Title:      )

Project D: Resident Engagement Collaborative Model(Project Title:      )

Project E: Restorative Justice Practices in School Settings(Project Title:      )

Target Population(s)/Area(s) (Check all that apply):

|  |  |  |  |
| --- | --- | --- | --- |
|  | American Indian/Alaskan Native |  | Coast Area |
|  | Asian |  | Central County |
|  | Black/African American |  | North County |
|  | Hispanic/Latinx |  | South County |
|  | Native Hawaiian/Pacific Islander |  | Other (Describe below): |
|  | Low-income Communities |  |  |
|  | Older Adults |
|  | Youth (indicate age range:      ) |
|  | General Population |

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| --- | --- | --- | --- | --- |
| **Contact Information:** | | | | |
| **Primary Contact** | | | | |
| Name: |  | | | |
| Title: |  | | | |
| Address: |  | | City: |  |
| State: |  | Zip code: | |  |
| Email: |  | Phone number: | |  |
| Signature: The signatory Certifies authorization to sign on behalf of the applicant and commits to honoring the goal, scope, requirements, and details of the project.  Printed Name of Person with Signing Authority: | | | | |
|  | | | | |
| Title: |  | | | |

**SUMMARY OF RELEVANT EXPERIENCE**

Overview of Similar and/or Current Projects: Describe past (within 10 years) and current experience providing services related to those requested in this proposal. Please limit the response to no more than three examples.

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| --- | --- | --- | --- | --- |
| **Description of Service (including years providing service)** | **Target Population/Area(s) Services are Provided** | **Current Annual Funding Amount**  (Indicate N/A if not currently providing this service) | **Current Funding Source**  (Indicate N/A if not currently providing this service) | **End of Funding** (indicate N/A if currently funded or unknown funding end date) |
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| **PROJECT INFORMATION** |
| **Project Summary** (Summarize the proposed project and specifically state how the project advances health equity, and as appropriate, include data to support need for the project): |
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| **Project Justification** (Describe primary purpose of the project and goal(s), including why this project is innovative and why it is likely to be successful. As appropriate, reference best practices or successes from a similar project. If this a proposed expansion of a current project, explicitly state how the project will be expanded with this funding.): |
|  |
| **Summary of Current Staffing** (Please indicate current staffing capacity, including total FTEs, titles, and brief job descriptions): |
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| **Summary of Collaborations** (Please indicate organizations you are collaborating with that will support the work in this proposal, and the nature of your work together, including planned subcontract or MOU): |
|  |
| **Evaluation Plan** (Describe plan to track and report project challenges and successes): |
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| **Anticipated Outcome** (Describe no more than three expected outcomes of the project. Outcomes are impacts or changes for individuals, groups, or populations as a result of program activities. See [Outcomes and Assessment Methods for Policy and System Change Efforts](https://www.gethealthysmc.org/sites/main/files/file-attachments/assessment_methods.pdf) for examples of outcomes. |
|  |

**PROJECT WORKPLAN**

Complete the Project Workplan for each year. Provide a description of no more than five (5) activities, anticipated reach (which can include anticipated number of people served, meetings held, materials developed, items distributed, etc.), assessment method for each activity (see [Outcomes and Assessment Methods for Policy and System Change Efforts](https://www.gethealthysmc.org/sites/main/files/file-attachments/assessment_methods.pdf) for examples of assessment methods), and anticipated completion date.

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| **Activity Description (Year one)** | | **Reach** | **Assessment Method** | **Completed by Date** |
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| **Activity Description (Year two)** | | **Reach** | **Assessment Method** | **Completed by Date** |
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**BUDGET WORKSHEET**

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| Use the worksheet to propose the requested year one budget amount. You do not have to prepare a budget for year two for this proposal. If proposed project requires a consultant or a subcontract, include information in non-personnel line and specifically indicate details in the description.  **Personnel Expenses** (only include proposed staffing for the project, no need to include in-kind staffing) | | | | |
| **Staff Title** | **% FTE** | **Amount** | **Role/Responsibility Description** | |
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| **Benefits Amount** |  |  |  | |
| **Staffing Subtotal (Personnel + Benefits)** |  |  |  | |
| **Non-Personnel Expenses** (e.g., scholarships, stipends, translation, outreach materials, project supplies (including COVID prevention supplies) etc.) | | | | |
| **Line Item** | | **Amount** | **Description** | |
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| **Non-Personnel Subtotal** | |  |  | |
| **Indirect Expenses** (not more than 12%) | |  |  | |
| **Total Annual Amount Requested** | |  |  | |
| **Considering all the funding your agency has for this Project, what percentage of project funding will GHSMC support?** | | | |  |