

HealthComp Foundation Responsive Grant Application

Applicant Instructions

Please remember that your application is read by staff and Foundation directors. With this in mind, please:

Use complete sentences

Refrain from using ampersands, abbreviations, acronyms or unnecessary capitalization of words

Completely answer all questions

Please contact staff at 216-621-2901 if you have any questions.

Eligibility

Is your organization classified as a 501(c)(3) or a governmental entity?*

Choices

Yes

No (Ineligible - do not complete application)

Does your request fit with the Foundation's grantmaking focus area? The Foundation is interested in supporting programs that address social determinants of health through the creation of social and physical environments that promote good health for all. Does your request fit with this focus area?*

Choices

Yes

No (Ineligible - do not complete application)

If your organization is a hospital system, does the project/program you are proposing involve a collaboration/partnership with a community organization?*

Choices

N/A (My organization is not a hospital system)

Yes

No (Ineligible - do not complete application)

If your organization is a hospital system, does your project budget include matching funds to be contributed by your organization?*

Choices

N/A (My Organization is not a hospital system)

Yes

No (Ineligible - do not complete application)

Is your request for program or project support? The Foundation does not provide funding for capital campaigns, endowments, scholarships or general operating support.

Choices

Yes

No (Ineligible - do not complete application)

Is your organization based in Northeast Ohio? Grants are limited to tax-exempt, nonprofit organizations based within Northeast Ohio that provide programs that benefit the residents of Northeast Ohio communities.*

Choices

Yes

No (Ineligible – do not complete application)

If your organization is based in Northeast Ohio, please indicate the county/counties in which residents will benefit from your proposed programming. *

Choices

- Ashland
- Ashtabula
- Cuyahoga
- Geauga
- Lake
- Lorain
- Medina
- Portage
- Summit
- Other (please specify below)

If you checked "other" for the previous question, please list the county/counties in which residents will benefit from your proposed programming. * *Character Limit: 50*

Organization Background

Organization Information*

State the mission and provide a brief history of the organization, including the year it was founded and how it has evolved since it was founded. *Character Limit: 1050*

Staff Information*

In a brief paragraph, describe your staff, including how many staff members you have in each of these categories: full-time, part-time, interns and volunteers. *Character Limit: 350*

Programs and Services*

Without repeating the information in the Organization Information field above, list the organization's programs. Include a brief description and the number of clients served by each program during the last fiscal year. *Character Limit: 1050*

Board/Staff Demographic Information

Board Member Demographics

Please provide the following percentages for your Board of Directors.

Board Members - Race/Ethnicity

Enter whole numbers only (no fractions or decimals) and do not enter a % sign with the number. If an answer is unknown or not applicable, please enter 0. **Your total must equal 100%.**

% of Total: African-American*

% of Total: Asian/Pacific Islander*

% of Total: Caucasian*

% of Total: Hispanic/Latino*

% of Total: Native American*

% of Total: Multiple Races/Ethnicities*

% of Total: Categorized as Other*

Board Members - Gender

Enter whole numbers only (no fractions or decimals) and do not enter a % sign with the number. If an answer is unknown or not applicable, please enter 0. **Your total must equal 100%.**

- % of Total: Female*
- % of Total: Male*
- % of Total: Transgender
- % of Total Gender Nonconforming
- % of Total: Categorized as Other

Staff Member Demographics

Please provide the following percentages for your organization's staff:

Staff - Race/Ethnicity

Enter whole numbers only (no fractions or decimals) and do not enter a % sign with the number. If an answer is unknown or not applicable, please enter 0. **Your total must equal 100%.**

- % of Total: African-American*
- % of Total: Asian/Pacific Islander*
- % of Total: Caucasian*
- % of Total: Hispanic/Latino*
- % of Total: Native American*
- % of Total: Multiple Races/Ethnicities*
- % of Total: Categorized as Other*

Staff - Gender

Enter whole numbers only (no fractions or decimals) and do not enter a % sign with the number. If an answer is unknown or not applicable, please enter 0. **Your total must equal 100%.**

- % of Total: Female*
- % of Total: Male*
- % of Total: Transgender
- % of Total: Gender Nonconforming
- % of Total: Categorized as Other

Client Demographic Information

Fiscal Year for Data (start date)*

Fiscal Year for Data (end date)*

Total Number of Clients Served*

List the total number of clients served **by the organization** during the fiscal year entered above. Enter a whole number, not a range.

Clients Served - Race/Ethnicity

Enter whole numbers only (no fractions or decimals) and do not enter a % sign with the number. If an answer is unknown or not applicable, please enter 0. **Your total must equal 100%.**

- % of Total Served: African American*
- % of Total Served: Asian/Pacific Islander*
- % of Total Served: Caucasian*
- % of Total Served: Hispanic/Latino*
- % of Total Served: Native American*
- % of Total Served: Multiple Races/Ethnicities*
- % of Total Served: Categorized as Other*

Clients Served - Gender

Enter whole numbers only (no fractions or decimals) and do not enter a % sign with the number. If an answer is unknown or not applicable, please enter 0. **Your total must equal 100%.**

% of Total Served: Female*

% of Total Served: Male*

% of Total Served: Transgender

% of Total Served: Gender Nonconforming

% of Total Served: Categorized as Other

% of Low-Income Clients Served*

If you collect income information about your clients, give the percentage of clients served that are below 200% of the federal poverty level based on Health and Human Services Poverty Guidelines. If your organization does not collect this information, enter N/A here.

Demographic Information Collection Method*

Describe the methods used to collect demographic information. If your organization does not collect this information, enter N/A here. *Character Limit: 500*

Description of Clients Served*

Provide any other detailed information not reflected in the numbers above about the population you serve. *Character Limit: 1050*

Request Information

Project/Program Title*

Please briefly describe your project/program in 10 words or fewer. You will have the opportunity to describe your project below. Examples: to launch a new community garden; to increase access to lead screening services; for case management services for homeless families; for workforce training for low-skilled individuals. *Character Limit: 175*

Amount Requested*

Project/Program Information

The Foundation supports programs that improve the quality of life for individuals in poverty. In particular, the Foundation seeks to address social determinants of health through the creation of social and physical environments (systems and structures) that promote good health for all. Social determinants of health are the conditions that affect health risks and outcomes in the places where people in poverty live, learn, work, and play. The Henry J. Kaiser Family Foundation has identified six categories of social determinants of health:

Community and social context (social integration, support systems, community engagement, discrimination and stress)

Economic stability (employment, income, expenses, debt, medical bills and support

Education (literacy, language, early childhood education, vocational training and higher education)

Food (hunger, access to healthy options)

Health care system (health coverage, provider availability, provider linguistic and cultural humility, and quality of care)

Neighborhood and physical environment (housing, transportation, safety, parks, playgrounds, walkability and zip code/geography)

Social Determinants of Health*

Please indicate the **primary** social determinant of health your project addresses. Choose only one.

Choices

Community and social context
Economic stability
Education
Food
Health care system
Neighborhood and physical environment

Project/Program Description*

Summarize the overall program/project to be funded by this request. Please provide a short and clear statement about what you propose to do with funds from the HealthComp Foundation and who will be served. Please describe how your program/project serves individuals in poverty and how it addresses the social determinant of health you identified as primary. This should be a summary. You will give more detailed information about outcomes and activities below. *Character Limit: 1500*

Health Equity Focus*

Health equity is achieved when every person has the opportunity to attain his or her full health potential and no one is disadvantaged from achieving this potential because of social position or other socially determined circumstances (source: CDC). Health inequities are systematic differences in the health status of different population groups (source: World Health Organization). If your program/project aims to advance health equity, please describe how. If advancing health equity is not a primary aim of this project, please enter N/A. *Character Limit: 1050*

Representation in Project Planning/Implementation*

Are any persons affected by the social determinant(s) of health you seek to address involved in the planning or implementation of the program/project? if so, in what capacity? If not, please enter N/A. *Character Limit: 500*

Description of Population Served*

Describe the population served by the program. If your program seeks to advance health equity or reduce health disparities, be explicit about naming/describing the population impacted by your work. *Character Limit: 700*

Fiscal year for which funds are being requested - Start Date*

Fiscal year for which funds are being requested - End Date*

Number served by program/project - fiscal year for which funds are being requested*

How many individuals will be directly served by this program/project in the fiscal year for which funds are being requested? Whole numbers only.

Number served by program/project - previous fiscal year*

How many individuals were served by this program/project in the previous fiscal year? Whole numbers only. Please enter "New" if this is a new program/project.

Goals and Objectives

Short-Term Program/Project Outcomes

List the 3 most significant outcomes that will be achieved by your program/project within 12 months. Short-term outcomes should be specific, measurable and achievable within the time frame. Examples: 25% of patients with diabetes will have decreased hemoglobin A1C levels; 80% of program participants

will be placed in jobs with family-sustaining wages; 100% of clients will have access to healthy, nutritious food; 90% of students will demonstrate one year's growth in reading skills. Note: If a grant is awarded, you will be reporting on the Short-Term Program/Project Outcomes you list below.

Short-term outcome 1* *Character Limit: 525*

Short-term outcome 2 *Character Limit: 525*

Short-term outcome 3 *Character Limit: 525*

Inputs, Activities and Outputs*

How will your organization achieve the short-term outcomes listed above? Please be specific and include: (1) inputs (who will perform the work and what other resources will be used; examples: consultants, community partners, in-kind contributions); (2) activities to be undertaken (services provided or work to be performed); (3) outputs (numbers to be served); (4) location(s); (5) timeframe; and (6) frequency and/or intensity of programming, as applicable. *Character Limit: 2500*

Evaluation Plan*

Describe your plan for measuring the degree to which you achieve the short-term program/project outcomes you listed above. How will you know whether you achieved the desired impacts? What measurement tools will you use? Who is responsible for evaluation? *Character Limit: 1000*

Desired Long-Term Outcomes

Describe what results should follow from the initial, short-term outcomes beyond the period of the grant. Long-term outcomes may be expressed as desired changes in results, behavior, policies, practices and/or conditions. Long-term outcomes are aspirational in nature and may be difficult to measure. Examples: all children will live in lead-safe housing; hunger will be eradicated; all students will graduate from high school; no child will die before his/her first birthday; all patients will have access to needed prescription medication. Please list up to 3 long-term outcomes

Desired Long-Term Outcome 1* *Character Limit: 525*

Desired Long-Term Outcome 2 *Character Limit: 525*

Desired Long-Term Outcome 3 *Character Limit: 525*

Partnerships/Collaborations

Please describe any partnerships/collaborations that are directly involved with the proposed program/project. If your organization is a hospital system, please describe the community organization(s) you are collaborating with on this effort, why the partner(s) were selected and what role your partner(s) will play. (If not applicable, please indicate.) *Character Limit: 1000*

Attachments

All attachments must be PDFs.

Cover Letter*

Signed cover letter from both Executive Director AND Board Chair

File Size Limit: 1 MiB

Program/Project Budget*

The budget must include all expenses for the program/project and all pending and committed sources of income. Please specify which funding has been secured and which is pending. If the request is for a specific component of a program, please include the entire program budget and not just what is

requested in the application. Also specify what is requested from the HealthComp Foundation.
Document must be one page in length only, in portrait/vertical orientation. File Size Limit: 2 MB

Board-Approved Operating Budget*

Board-approved operating budgets showing actual income and expenses for the last complete fiscal year and projected for the current fiscal year. *File Size Limit: 5 MiB*

Board of Trustees List*

Please include organizational affiliations. *File Size Limit: 2 MiB*

Audited Financial Statements*

Most recent audited financial statement, including management letter (or Form 990 tax return, ONLY if the organization is not required to perform an audit). *File Size Limit: 8 MiB*

Collaboration Letter/Letter of Support

If the proposal involves a partnership with one or more entities, a letter of support from the partner entities should be included. *File Size Limit: 2 MiB*

Collaboration Letter/Letter of Support

Please include any additional letter of support if applicable. *File Size Limit: 2 MiB*

**Indicates a required field*