Fallbrook Regional
HEALTH DISTRICT

COMMUNITY HEALTH CONTRACTS

APPLICATION FORMS

FOR

CHC YEAR 2017 - 2018

FALLBROOK REGIONAL HEALTH DISTRICT
138 SOUTH BRANDON ROAD
FALLBROOK, CA 92028

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AMOUNT REQUESTED: _____

FALLBROOK REGIONALHEALTH DISTRICT

GRANT YEAR 2017-2018 **CHC APPLICATION**

SECTION A. Cover and Introductory pages

1. **ORGANIZATION** AGENCY DIRECTOR PHYSICAL ADDRESS MAIL ADDRESS TELEPHONE FAX EMAIL ADDRESS WEBSITE AGENCY IN SERVICE TO THIS COMMUNITY	_____YEARS
2. **TITLE OF PROGRAM**	
3. **CHC PROGRAM COORDINATOR** TELEPHONE EMAIL ADDRESS How do/will you staff program?	____PAID ____VOLUNTEER ____Combination of Paid & Volunteer
4. **PERSON** RESPONSIBLE FOR SUBMISSION OF **CHC REPORTS** TELEPHONE EMAIL ADDRESS	
5. **APPLICATION PREPARER** TELEPHONE EMAIL ADDRESS	
6. **CATEGORY** IMPORTANT: Refer to Instruction Manual CHC Guideline 6 and to Section D5 in FORMS.	PREVENTION/EDUCATION _____% TREATMENT _____% ANCILLARY _____%

7. **TARGET POPULATION** Include: • Age range, gender, socio-economic grouping and rationale for selection of this population • Projected number of residents of community that will benefit from this program • Is this population served by other similar programs? • If so, is another necessary and why?	
8. **TOTAL AMOUNT OF FUNDING NECESSARY FOR THIS PROGRAM** **AMOUNT OF FUNDING REQUESTED OF FHD** Are there other funding sources available? If yes, describe. Attach additional sheets if needed.	Required for program:__$_____ Requested of FRHD: __$_____ Other sources:
9. **BRIEF DESCRIPTION OF THE PROGRAM** • 9a. is this a new or existing program? • 9b. Does this program collaborate with any programs of other Organizations that serve this community? • 9c. If Yes: Who? If No: Why not?	9a. ___ New ___ Existing 9b. ___ No ___ Yes 9c.

10. **TAX EXEMPT STATUS** • **10a. Is your Organization 501c(3) Tax exempt ?** • **10b. Is a Form 990 required of your Organization?**	10a. _____YES. Refer to GUIDELINES 4 Applicant Eligibility. _____ NO. Explain. 10b. _____NO. _____YES. – Attach a copy of Page 6 of your most recent submission to Section H
11. **CHC FUNDS PREVIOUSLY AWARDED TO YOUR ORGANIZATION** 11a. Describe – Amounts and source – Last 3 years (Do not include FHD grants) 11b. Have any grant funds awarded to your organization ever been withdrawn, reduced or discontinued? If yes, explain.	
12. **LIST OTHER FUNDING SOURCES THAT HAVE BEEN APPROACHED BY YOUR ORGANIZATION IN THE PAST 3 YEARS.** Include Name, Date, Amount requested. Declined or Pending Include Fund Raisers conducted by yourself or other organization(s) where proceeds have been designated to your organization as beneficiary of funds raised. (Do not include FRHD grants)	
13. **13a. Provide your Organization's Mission Statement and describe how this program supports it.**	

13b. Does your program support the Mission-Vision-Values of the FallbrookRegional Health District? See attached	
14. **I (we) certify that all information presented in or attached to this Application is complete and accurate.**	Signature _____ Print name and Title _____ Date _____ Signature _____ Print name and Title _____ Date _____

SECTIONS B and C

NOTE:

- Sections B and C are NOT defined on an FRHD form. You must create each Section.
- These Sections must be typewritten or computer-generated, single-sided, 8-1/2x11" white paper. Text may be single or double-spaced, but no smaller than 10-point type, with one-inch margins on all sides. Each page must be numbered and there is a limit of 4-6 pages for these Sections.
- In Section C label each sub-section requested.

SECTION B STATEMENT OF PROBLEM / NEEDS ASSESSMENT

B1. Discuss the need for the proposed service or program within the District. Demonstrate that it is not a duplication of existing services. (Include quantitative and qualitative data supporting/documenting the health needs.)

B2. Describe potential outcomes if this service or program were not available to the intended target population.

SECTION C AGENCY CAPABILITY

C1. Briefly describe your organization's history and accomplishments.

C2. Describe your experience in the provision of services to the target population identified in your Grant Application Section A.

C3. What are the current activities and/or programs offered by your organization? An agency brochure may be attached.

C4. List and describe collaborative linkages with other organizations that enhance your ability to provide services.

C5. Answer the following questions: Is the proposed program a new service that the agency will provide? Is this an established program that will be continued, expanded or modified to serve District residents?

C6. Describe your plan for maintenance/continuation of the proposed program beyond the 2017-2018 fiscal year.

Fallbrook Regional HEALTH DISTRICT

Serving Bonsall, De Luz, Fallbrook, Rainbow

MISSION

Promoting health for the people of the District

VISION

Reducing the impact of identified major health issues in our District

Strategic Initiatives 2017-18

- Pre-Diabetes & Diabetes
- Hypertension
- Heart Disease
- Behavioral Health

VALUES

Dedication
Efficiency
Integrity
Objectivity
Prudence
Respect
Transparency

FALLBROOK HEALTH DISTRICT
A Tax Supported Public Agency Serving Northern San Diego County

Revised by Fallbrook Healthcare District Board of Directors on December 14, 2016.

SECTION D PROJECT/PROGRAM DESCRIPTION

D1.	Proposed Services/Program
D2.	Project site(s)
D3.	Estimated number of District residents to be served; include targeted age range.
D4.	Impact of program on population served and on the community.

D5. Determine which of the following three Categories your program(s) present. Fully support your determination by describing how your program(s) meet the criteria as presented. Assign the percentage of program within the Category. There may be more than one Category – Each must be fully supported. Total must equal 100%.

- **PREVENTION/EDUCATION**
  Equipment, supplies and/or training for care providers and/or clients related to maintaining good health practices to prevent or control disease and/or prevent injury.

- **TREATMENT**
  Direct provision of care in medical, dental, vision, mental health or therapy services.

- **ANCILLARY**
  Products or services that do not provide direct treatment, prevention or education but otherwise support the District's mission to provide access to healthcare.

PREVENTION/EDUCATION	TREATMENT	ANCILLARY	TOTAL
_____%	_____%	_____%	_____%

SECTION E. GOALS/PROGRAM WORK PLAN PAGE OF .

ORGANIZATION NAME: _____ CATEGORY: _____

TITLE OF PROGRAM: _____ PREPARED BY: _____

BRIEF DESCRIPTION OF PROPOSED PROJECT: ***No more than 3 sentences.***

GOAL

OBJECTIVE (S):

NOTE: *IT IS LIKELY THAT YOUR PROGRAM HAS TIMELINES AND COSTS THAT OCCUR AT VARIOUS TIMES THROUGHOUT THE YEAR. PROVIDE BRIEF DESCRIPTION OF PROJECTED OUTCOMES WITHIN THE TIMELINE MONTHS DEFINED. IF IT IS AN ON-GOING/CONTINUOUS PROJECT, DESCRIBE HOW YOU WILL MEASURE PROGRESS TOWARDS ACHIEVEMENT OF GOAL AT INTERVALS THROUGHOUT THE YEAR.*

TIMELINE	PROJECTED OUTCOME(S) IN MEASURABLE TERMS	PROJECTED COST(S):
JULY – SEPT 2017		
OCT – DEC 2017		

	SECTION E. GOALS/PROGRAM WORK PLAN ORGANIZATION: _____	**PAGE OF .**
JAN – MAR 2018		
APR – JUNE 2018		
DESCRIBE THE DESIRED OUTCOMES OF YOUR PROJECT AS WELL AS THE OUTCOMES YOU WILL BE EVALUATING		

SECTION F. PROJECT BUDGET FORM

ORGANIZATION NAME: **DATE:**

PREPARED BY: **PHONE:**

NOTE:

X+Y+Z must equal W for every line item. Example:

W	X	Y	Z
$ 500.00	$ 250.00	$ 175.00	$ 75.00
PROJECT COST	APPLYING ORGANIZATION	OTHER RESOURCES	FHD

Applying Organization funds plus Other Resource funds plus FRHD grant funds = Meeting the Project's Cost

1) EXPENSES

YOU MAY CHANGE THE EXPENSE ITEMS LISTED TO INDICATE YOUR AREAS OF EXPENSE. EXAMPLES LISTED MAY NOT APPLY TO YOUR PROJECT.

A	PERSONNEL EXPENSES	PROJECT COST	APPLYING ORGANIZATION	OTHER RESOURCES	REQUESTED FROM FHD
A1	*Payroll Taxes & Benefits*				
A2	*Consultant Fees*				
A3	*Salary (list position)*				
A4	*Salary (list position)*				
	TOTAL PERSONNEL EXPENSE	-	-	-	-

B	OTHER EXPENSE	PROJECT COST	APPLYING ORGANIZATION	OTHER RESOURCES	REQUESTED FROM FHD
B1	*Communications (phones, internet etc)*				
B2	*Postage*				
B3	*Office Supplies*				
B4	*Equipment*				
B5	*Printing/Duplicating*				
B6	*Program/Project Supplies*				
B7	*Travel/Mileage*				
B8	*Professional Services*				
B9	*Rent & Utilities*				
B10	*Insurance*				
B11					
B12					
	TOTAL OTHER EXPENSE	-	-	-	-

		W	X	Y	Z	
C	**TOTAL ALL EXPENSES**	PROJECT COST*	APPLYING ORGANIZATION	OTHER RESOURCES	REQUESTED FROM FHD	FRHD %
	SUM OF TOTAL PERSONNEL EXPENSE PLUS TOTAL OTHER EXPENSE	$ -	$ -	$ -	$ -	#DIV/0!

2) FUNDING RESOURCES

D	FUNDS FOR PROJECT		
D1	APPLYING ORGANIZATION	X	-
D2	OTHER RESOURCES	Y	-
D3	REQUESTED FROM FHD	Z	-
	TOTAL ALL FUNDING SOURCES	W	$ -

NOTE: THIS AMOUNT SHOULD BE EQUAL TO YOUR PROJECT COST.

3) % OF AGENCY BUDGET

E	*CALCULATE % of Total Agency budget that this Project represents.*	AGENCY BUDGET**	$ -	#DIV/0!
			PROJECT COST	% of AGENCY BUDGET
	Example:	*AGENCY budget = $100,000.*	*Project COST = $10,000.*	*% of AGENCY budget = 10%*

* Project Cost must be specific to the project for which funding is being sought.

** Agency budget is your agency's entire budget for the year. Fill in the amount.

SECTION G. PROJECT NARRATIVE FORM

DATE: _____ PAGE _____ OF _____

Prepared by: _____

INSTRUCTIONS:

1 List each Line Item from your PROJECT BUDGET FORM (Section F) where an expense is indicated.
2 Provide a brief narrative description of each budget line item to be funded by the proposed CHC.
3 Indicate which Goal/Work Plan the expense supports. (Section E)
4 Include names of other Project Funding Sources and amount provided
5 Include time-line (dates) of anticipated major expenditures. (Example: Cost of Event scheduled for March 15 or Insurance premium due August 30th)
6 Make additional copies of form as needed.

ORGANIZATION NAME:

BRIEF NARRATIVE DESCRIPTION	LINE ITEM	GOAL NUMBER	OTHER FUNDING SOURCES	TIME LINE

SECTION G. PROJECT NARRATIVE FORM DATE: _____ PAGE _____ OF _____

Prepared by: _____

ORGANIZATION NAME:

BRIEF NARRATIVE DESCRIPTION	LINE ITEM	GOAL NUMBER	OTHER FUNDING SOURCES	TIME LINE

SECTION H ATTACHMENTS

SECTION I RIGHTS RESERVED TO THE BOARD OF DIRECTORS

The Fallbrook Regional District Board of Directors reserves the right to decline or accept application(s) upon fair consideration in accord with grant guidelines established and provided to all applicants. On applications accepted and approved, the Board reserves the right to determine the amount of funding to be awarded .

The Board reserves the right to adjust category designation in accord with its' established criteria. In addition the Board reserves the right to seek additional information as necessary to make their funding determinations. This shall be by request for clarification in written form. Requests shall be presented to the applicant by the District Administrator and must be returned to the District office in a timely manner. Site visits and/or interviews may also be scheduled in the application review process.

PREPARED BY: _____

DATE: _____

CONTACT TELEPHONE: _____

EMAIL: _____