**Howard County Health Department**

**Health Disparities Grant**

**Category 2**

**Name of Organization:**

**Mailing Address of Organization:**

**Amount of Funds Requested:**

**Zip Codes Areas Proposed (21044, 21045, 20794, 20763, 20723):**

**Contact Information:**

*Application Preparer*

Name:

Phone:

Email:

*Project Contact*

Name:

Phone:

Email:

*Fiscal Contact*

Name:

Phone:

Email:

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**Health Disparities Grant**

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Please address the following by section in narrative response.

1. Proposal Narrative
2. Organization Background: Tell us about your organization’s mission and who your organization primarily serves. Describe your organization’s experience in providing services and engaging with identified communities. List any partners you work with in the identified communities. (250-word limit)
3. Statement of Need: Why do you feel this project is needed in Howard County? Share any data to support this need in the identified communities. (250-word limit)
4. Description of Project: Tell us how you propose to implement this project. Please describe your strategies for supporting completion of CHW certification training and practicum and making payments to staff and supporting technology needs. (250-word limit)
5. Evaluation: Describe how you will track your progress and measure your success. (250-word limit)
6. Organizational Capacity: Describe your organizational capacity, including organizational structure, fiscal systems and policies, and relevant experience to successfully implement the proposed activities. (250-word limit)

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1. **Action Plan**

Complete the action plan table using the guide below.

|  |  |  |
| --- | --- | --- |
| Grant Objective: Support CHWs in [zip codes] | | |
| Activity | Expected Outcomes | Timeframe |
| List each proposed activity in its own row. Examples:   * Assign Staff to Coordinate Efforts * Purchase Computer Tablets | Describe the expected outcome.  Examples:   * # of Community Health Workers Completing Certification * Stipends Paid * % of CHWs Attending Monthly Meetings * # Computer Tablets Distributed | Define the timeframe for the specified activity.   * Start Date * End Date or Ongoing until June 30, 2023 |

|  |  |  |
| --- | --- | --- |
| Grant Objective: | | |
| Activity | Expected Outcomes | Timeframe |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

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1. **Budget Narrative**

Provide a brief budget narrative complementing the line-item budget. Please note that indirect costs cannot exceed 5% of direct costs.

|  |  |  |  |
| --- | --- | --- | --- |
| Line Item | Budget Item | Funding Requested | Budget Narrative & Justification (Explanation of Spending Request) |
| 1 | Stipends ($300 per Month per CHW) |  |  |
| 2 | Internet Data Plans for Mobile Tablets |  |  |
| 3 | Travel Expenses |  |  |
| 4 | Staff Salaries |  |  |
| 5 | Other (Please specify) |  |  |
|  | TOTAL COST | $ |  |

I hereby declare that the information submitted in this proposal is accurate and correct to the best of my knowledge. If the application is approved, I will be responsible for keeping necessary records and completing narrative and budget reports by due dates. I understand that I or a representative of my organization must attend all scheduled grantee meetings during this active grant period and be prepared to update on the progress of the project while in attendance at these meetings.

**Grant Application Deadline: August 31, 2022**

All applications must be submitted electronically via e-mail attachment to [cvicks@howardcountymd.gov](mailto:cvicks@howardcountymd.gov). In your email’s subject line, please reference your organization name and “FY23 Health Disparities Grant.” *Please do not send hard copies.*