**COMMUNITY BENEFIT FUNDING REQUEST**

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| ***THE PROVIDENCE MISSION***  ***As People of Providence, we reveal God’s love for all, especially the poor and vulnerable, through our compassionate service.***  ***Our Core Values are: Respect, Compassion, Justice, Excellence, and Stewardship.***  \*All requests must be in agreement with our Mission and Core Values to be considered for funding. |

Please type all information on this form and attach additional pages as needed. Any questions left unanswered may result in a denial of request.

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| **Section (1): Contact Information** | |
| Contact Person: Click here to enter text. | Title: Click here to enter text. |
| Phone: Click here to enter text. | Email: Click here to enter text. |
| **Section (2): About Your Organization** | |
| Organization Name: Click here to enter text. | 501c3 Tax ID Number: Click here to enter text. |
| Address (include City and Zip code): Click here to enter text. | Geographic Service Area: Click here to enter text. |
| **Section (3): About Your Project** | |
| **Project Title:** Click here to enter text. | **Total Funding Requested (please provide a detailed program budget as an attachment):** Click here to enter text. |
| **List other partners in this project:** Click here to enter text. | **Other funding resources requested and status:** Click here to enter text. |
| Briefly describe (in 100 words or less) the project you are seeking to fund. What are you trying to do, and why is it important?  Click here to enter text. | |
| What evidence do you have that this is an issue or concern for the people you are serving? (Provide any data you have that justifies the problem, describes access and service gaps, # of people affected, etc.)  Click here to enter text. | |

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| **Section (4): Population Accountability for Results** | | | |
| **The following is a list of the Population Health Improvement Goals selected by Providence. For the Spokane Goals, critical needs and important strategies have also been identified.**  **Which of the following is the primary county of operation and the one critical need/strategy will your project address?** | | | |
| **Spokane County** | | **Stevens County** | |
| **Mental health**  Substance abuse both causes mental illness and is a result of mental illness.  Access to services for dementia patients and the isolation associated.  Adverse childhood experiences.  Child abuse and child welfare.  Access to care including medication, treatment, both inpatient and outpatient.  **Dental**  Access issues with not enough providers who take low income patients, as well as costs and resources available.  Education around prevention needed.  By addressing substance abuse we can address some of the dental issues.  Often there is a mental health component to the dental issues.  Better nutrition will help with better dental outcomes.  **Diabetes**  Healthy weights can lead to better prevention efforts.  Costs are a barrier around healthy foods, supplies, equipment and medication.  Treatment is an issue along with medication management.  **Immunizations**  Education to the health benefits of immunizations  Access in rural and low income neighborhoods  **Stable housing**  Stability of the family and home to aid in physical, mental and emotional health and healing | | **Early childhood support**   Minimize adverse childhood experiences and break the cycle that continues by not addressing these experiences  o Parenting skills  o Whole family care   Emphasize the importance of education and early childhood learning.   Increase the acceptance and knowledge around breastfeeding and lactation.   Decrease the rates of maternal smoking.  **Basic food/nutrition**   Create more access to fresh fruits and vegetables through both availability and costs.   Education on how to prepare healthy food and the importance of nutrition.   Increase diabetes education.  **Behavioral health**   Increase access to mental health and substance abuse services.   Address the rates of child abuse that stem from mental health and substance abuse issues.  **Access to care**   Increase the available workforce and interest in the health care sector.   Address the issues around infrastructure that prevent rural communities having access to various modes of care:  o Emergency transport service  o Connectivity (broadband)   Increase the access to specialty care. | |
| **Section (5): Performance Accountability for Results** | | | |
| Who is the customer(s) of this project and funding? (Who will receive the service and/or benefit from the activities being funded)? Click here to enter text. | | | |
| Please briefly describe these results.  Click here to enter text. | | | |
| **What evidence or rationale do you have that supports why you think your project will lead to the results? (**Is their documented information that supports this as a solution to the identified problem? Literature? Research? Is this an evidence-based, promising or innovative practice?  Click here to enter text. | | | |
| Describe your implementation plan. What key actions and milestones have you planned out and when will these be accomplished? | | | |
| **Key Milestone** | | | **Due Date** |
| Click here to enter text. | | | Click here to enter a date. |
| Click here to enter text. | | | Click here to enter a date. |
| Click here to enter text. | | | Click here to enter a date. |
| **What measures will you use to monitor and report on your performance?**  (You must have at least one measure in each category. You will be required to provide this data at the conclusion of the funding cycle. ) | | | |
| **Category 1: How much did you do? (Ex. # of telephone calls made)**  Click here to enter text.  Click here to enter text. | **Category 2: How well did you do it? (Ex. #/% phone calls answered by the 2nd ring)**  Click here to enter text.  Click here to enter text. | | |
| **Category 3: How is your customer better off? (Refer to the anticipated changes identified above). (Ex. # indicating improved skill after completion of program, % believe the service helped them, #/% behavior change due to program)**  Click here to enter text.  Click here to enter text.  Click here to enter text. | | | |
| **What is the plan for sustaining this program long term?** | | | |

* Please provide a detailed budget with how the funds will be spent in the Program/Project Budget template.
* Please provide any data on the program you are seeking funding for the prior 12 months in the attached performance evaluation template. If this is a new program, what are your projected outcomes from above?

**Program/Project Budget**

Instructions: Provide the budget for the specific program described in the application. Itemized expenses in each category. Please round all numbers to the nearest whole dollar. All in-kind revenue

|  |  |  |  |
| --- | --- | --- | --- |
| **Revenue** | | **Expenses** | |
| **Fees and Services** | | **Personnel** | |
|  | $ | Full – Time | $ |
|  | $ | Part - Time | $ |
| **Fundraising Events, Product Sales, Other Revenue** | | **Outside Fees & Services (Consultant fees, etc.)** | |
|  | $ |  | $ |
|  | $ |  | $ |
|  | $ |  | $ |
| **Support - Committed** | | **Equipment and Supplies** | |
|  | $ |  | $ |
|  | $ |  | $ |
|  | $ |  | $ |
|  | $ |  | $ |
| **Support - Pending** | | **Travel** | |
|  | $ |  | $ |
|  | $ |  | $ |
|  | $ |  | $ |
|  | $ |  | $ |
| **Support - Denied** | | **Marketing & Promotions** | |
|  | $ |  | $ |
|  | $ |  | $ |
|  | $ |  | $ |
|  | $ |  | $ |
| **Other Areas of Revenue** | | **Other Expenses** | |
|  | $ |  | $ |
|  | $ |  | $ |
|  | $ |  | $ |
|  | $ |  | $ |
| **In-Kind Support\*** | | **In-Kind Expenses\*** | |
|  | $ |  | $ |
|  | $ |  | $ |
|  | $ |  | $ |
|  | $ |  | $ |
| **TOTAL ANTICIPATED REVENUE** | **$** | **TOTAL PROGRAM BUDGET** | $ |

* \*All in-kind revenue must be offset in the Expenses column as in-kind expense.

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**\*\*\*Due September 30th for next year funding consideration**

**Incomplete applications will not be considered.**

**Application packet checklist:**

* + **Application**
  + **Program Budget: i.e. How will these funds be used?**
  + **Previous program evaluation/New program projected impact**

**Some recipients may be requested to provide a mid-year evaluation.**

**Return this request to:**

**By Email: \*Preferred Method in Word Document**

[**Sara.Clements-Sampson@Providence.org**](mailto:Sara.Clements-Sampson@Providence.org)

Please address any questions to:

Sara Clements-Sampson, Community Benefits Manager

[sara.clements-sampson@providence.org](mailto:sara.clements-sampson@providence.org)

(509) 474-2423