Reset Form

MOMS HELPLINE
PRENATAL CARE REFERRAL NETWORK GRANT
PLANNING GRANT APPLICATION
State Form 9900404 (2-26)
INDIANA DEPARTMENT OF HEALTH

MOMS HELPLINE

Primary Information	
Organization Legal Name	
Organization Address (Remit-to address)	
Organization Contact Name & Title	
Contact Email	
Additional Contract Contacts	
Signatory Name	
Signatory Title	
Signatory Email	
Signatory **Textable** Phone Number	
Tax ID/EIN	
IDOA Bidder ID (if known/applicable)	
Vendor Number	
Total dollar amount requested	

1. What counties do you expect to include in your plan?

2. Please describe the current prenatal care landscape in your service area. Please include any current initiatives, collaborations, or other relevant context.

3. What experience does your organization (or group of organizations) have with providing prenatal care? Please include geographic area and populations served.

4. What is your capacity to provide prenatal care? How many patients is your organization able to see? How often do you turn patients away because of capacity issues?

5. When you review the expectations Moms Helpline has laid out for participants in the prenatal care referral network, does your organization (or group of organizations) already have in place any components that meet these expectations? Please describe.

6. When you review the expectations Moms Helpline has laid out for participants in the prenatal care referral network, what gaps would your organization (or group of organizations) need to address in order to meet these expectations? (If you do not yet know what gaps you have, please state that.)

7. What challenges do you expect to face as you build your plan to meet the expectations? How do you plan to overcome these challenges?

8. Please describe how you will use these funds to develop a plan to meet the expectations. (Note: The use of funds in this description should match the budget spreadsheet you submit.)