**Grant Application**

**2024 Funding Period:**

**\_\_\_\_\_\_\_\_\_\_\_, 2024 – \_\_\_\_\_\_\_\_\_\_\_, 2024**

Organization Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Street Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City/State: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Project Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Amount Requested: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Total Project Budget: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Applicant/Contact Person: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Title: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ E-mail Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Governor Eric J. Holcomb established the Governor's Public Health Commission in August 2021 and charged it with examining the strengths and weaknesses of Indiana's public health system and making recommendations for improvements.

The commission's report released in July 2022 focuses on six workstreams: governance, infrastructure, and services; funding; workforce; data and information integration; emergency preparedness; and childhood and adolescent health.

The goal is to ensure that every Hoosier has access to the core public health services that allow them to achieve their optimal health and well-being.

Programs, initiatives, and strategies funded by the Miami County Health Department (MCHD), in conjunction with the Indiana Department of Health (IDOH), are to address one of the seven main core services not currently provided, or in need of additional support, by the Miami County Health Department for the benefit of Miami County residents. In addition, each funded project is to reach one or more intended core services as outlined in the Local Health Department (LHD) Core Services Committee Recommendations for LHD Core Services.

**Please check the applicable core service & corresponding sub-service, then detail steps you will be addressing in this grant proposal.**

**CORE SERVICES**

**Core Service #1: Tobacco and Vaping Prevention and Cessation**

* Promotion of tobacco and addictive nicotine prevention and cessation programs and services
* Development of a local tobacco control coalition

**Core Service #2: Chronic Disease Prevention & Reduction**

* Address screening and/or referral for chronic diseases such as (but not limited to) obesity, diabetes, hypertension, and cancer.

**Core Service #3: Trauma & Injury Prevention**

* Coordination of harm reduction for substance use, such as (but not limited to) naloxone distribution, peer recovery and rehabilitation services, and/or trauma and injury prevention initiatives.

**Core Service #4: Student Health**

* Working with MCHD to implement school wellness policies, including a comprehensive strategy to address substance use in schools.
* Partnering with schools to promote whole child health, including physical, mental and student health and wellbeing.
* Supporting schools in performing health screenings, such as vision, hearing and oral health.
* Collaboration and enhancement of current vaccination efforts to ensure childhood vaccine requirements and seasonal vaccine needs are addressed.
* Development and collaboration with school and community partners to help support school needs.

**Core Service #5: Child & Adult Immunizations**

* Offer vaccines to all individuals, including vaccines that are publicly and

privately funded, so that anyone has access to vaccines at low or no cost to the patient. Offering after hours or weekend clinics is preferred.

**PROJECT OVERVIEW**

**Please use additional sheets if necessary.**

This project is (please check): \_\_\_\_\_New \_\_\_\_\_Existing

If existing, please list all other current funding sources and amounts here:

Number of individuals to be served: \_\_\_\_\_\_\_\_\_\_ Male/Female/Both? \_\_\_\_\_\_\_\_\_

Primary age of individuals to be served:

\_\_\_\_\_Children (<18 yrs) \_\_\_\_\_Young Adults 18-25 \_\_\_\_\_Adults 26-55

\_\_\_\_\_Older Adults 55+

Describe your proposed project. What is it that you plan to do? How will you accomplish it? Who will oversee the project? Please provide details on your proposed project.

Is there a similar program currently available/accessible by Miami County residents?

\_\_\_\_\_\_ Yes \_\_\_\_\_\_ No

If yes, please explain how your project will differ from these sources.

How will this project collaborate with other services and/or resources to ensure a quality project and avoid duplication?

How will your proposed project assist the MCHD in ensuring Core Services are provided?

Describe the expected outcome(s). In other words, what do you expect will happen as a result of this project? Think of what happens to the participant/receiver of your services (outcomes), NOT the parts of your project, i.e., workshops, sessions, etc., (outputs).

How will you measure your expected outcome(s)? How will you know if this project is successful? What specific tools will you use to measure your project’s impact on the participants? Surveys (pre and post), public records such as DUIs, arrest records, observations, etc., are samples of how outcomes can be measured.

Can your project be accomplished if only partial funding is available?

\_\_\_\_\_ Yes \_\_\_\_\_ No.

If yes, please explain:

**ORGANIZATION**

Mission Statement:

Describe your organization:

Describe your organization’s prior history, if any, in providing similar services or related work in the Core Public Health Services area(s) proposed:

Describe your organization’s use of evidence-based programming, if any, in the Core Public Health Services area(s) proposed:

**BUDGET SUMMARY**

**Please be specific or attach a detailed/itemized description of your budget for the proposed project.**

Contact person for budget if different than applicant (name/email/phone): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |
| --- | --- | --- | --- |
| EXPENSES | HFI FUNDING | OTHER FUNDING | TOTAL BUDGET |
| Personnel |  |  |  |
| Travel |  |  |  |
| Supplies (type, quantity/costs, etc.,) |  |  |  |
| Equipment |  |  |  |
| Contractual |  |  |  |
| Other |  |  |  |
| Total Funding |  |  |  |

Please include any fundraising efforts you are doing:

**AGREEMENT**

I, the undersigned as the responsible party, do understand that I (my agency) will be contacted by the Miami County Health Department on or before July 5, 2024, or as determined by the state, regarding the outcome of this proposal. I further understand that this original application must be submitted no later than 06/15/24 by 4:00 p.m. for funding consideration. I further understand that funding is contingent upon the following requirements:

* Written reports are due quarterly on September 30th, and December 30th
* All invoices must be turned in to MCHD with quarterly reports.
* MCHD and the applying organization will take care to ensure that local, state, and federal privacy laws are strictly followed, and will only disclose protected health information without a patient’s consent when the information is used for coordination of care or treatment, payment, and healthcare operations activities, or as law allows.
* The population to be served will be residents of Miami County. Serving residents outside of Miami County must get prior approval of the MCHD.
* At least 50% of MCHD board meetings must be attended by the applicant or a representative of the applying organization.
* Recognize the MCHD as a program sponsor in all media releases and printed materials utilized.

I further understand that all monies received are to be used as indicated on this application and any remaining monies received but not used are to be returned to the MCHD.

This grant may be terminated by either party upon notice, in writing, delivered upon the other party 30 days prior to the effective date of termination.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Printed Name

Please email completed application to:

Morgan Townsend, Project Coordinator

[mtownsend@miamicountyin.gov](mailto:mtownsend@miamicountyin.gov)