



**Community Wellness Application  
Mid-Year 2023-2024 Funding Requests  
March – September 2024**

Organization Details:

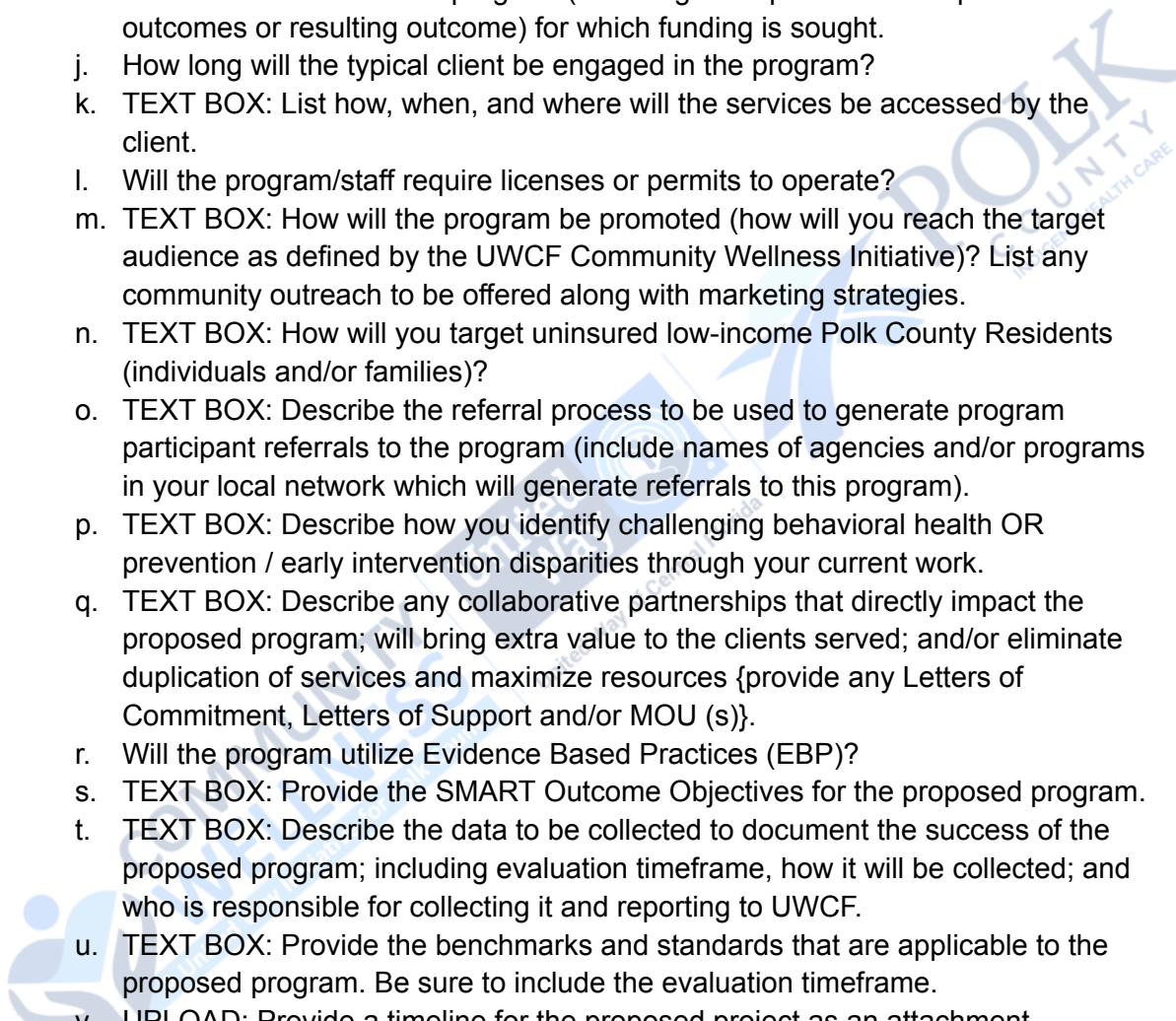
1. Application Agency Name
2. Agency Executive Director and Email
3. Contact Phone Number
4. Primary Agency Contact for this RFP
5. 501(c)(3) IRS Determination Letter - for upload later
6. Federal Tax ID or EIN
7. DUNS Number
8. Business License Number
9. Proposed Program Name
10. A. Program Type
  - a. Program/Service Type
  - b. Expansion of Existing Program/Service
  - c. Existing Program/Service which has lost or will lose funding of current successful program/service
- B. Proposal is for: One-time Program/Service or 7 month Program (3/24-9/24)
- C. Has program received past Community Wellness grant funding or other funding?
- D. Does your program plan to apply for additional funds for this program?

Program & Budget Details

*(Each "Text Box" response is limited to a maximum of 300 words. "Upload" indicates a File Upload field.)*

11. Program & Budget Details
  - a. Funding Category: Prevention/Early Intervention or Behavioral Health
  - b. Funding Amount Requested
  - c. Amount of Total Program Budget
  - d. Who your program serves: All Polk Zip Codes or Specific Polk Zip Codes
  - e. TEXT BOX: Briefly tell us about your Agency's overall background and history, and the different programs you provide.
  - f. TEXT BOX: Please provide a 25-word summary description of the program.
  - g. TEXT BOX: Describe your organization's experience and strengths relevant to your proposed program.

**\*Not for Distribution\***

- 
- h. TEXT BOX: Describe the problem being addressed by your proposal, documenting the need for services with current local data/statistics (cite your reference).
  - i. TEXT BOX: Describe the program (including an explanation of improved health outcomes or resulting outcome) for which funding is sought.
  - j. How long will the typical client be engaged in the program?
  - k. TEXT BOX: List how, when, and where will the services be accessed by the client.
  - l. Will the program/staff require licenses or permits to operate?
  - m. TEXT BOX: How will the program be promoted (how will you reach the target audience as defined by the UWCF Community Wellness Initiative)? List any community outreach to be offered along with marketing strategies.
  - n. TEXT BOX: How will you target uninsured low-income Polk County Residents (individuals and/or families)?
  - o. TEXT BOX: Describe the referral process to be used to generate program participant referrals to the program (include names of agencies and/or programs in your local network which will generate referrals to this program).
  - p. TEXT BOX: Describe how you identify challenging behavioral health OR prevention / early intervention disparities through your current work.
  - q. TEXT BOX: Describe any collaborative partnerships that directly impact the proposed program; will bring extra value to the clients served; and/or eliminate duplication of services and maximize resources {provide any Letters of Commitment, Letters of Support and/or MOU (s)}.
  - r. Will the program utilize Evidence Based Practices (EBP)?
  - s. TEXT BOX: Provide the SMART Outcome Objectives for the proposed program.
  - t. TEXT BOX: Describe the data to be collected to document the success of the proposed program; including evaluation timeframe, how it will be collected; and who is responsible for collecting it and reporting to UWCF.
  - u. TEXT BOX: Provide the benchmarks and standards that are applicable to the proposed program. Be sure to include the evaluation timeframe.
  - v. UPLOAD: Provide a timeline for the proposed project as an attachment.

#### Program & Budget Details

- 12. Service Focus: Clinic Treatment or Non-Clinical
- 13. People Served
  - a. Total number of people to be served each year
  - b. What is the minimum number of clients proposed to be served by this program and still considered successful within the 12-month period?
- 14. Number of people to be enrolled (if an existing program).
- 15. Address where program will be administered
- 16. Address of on-site availability to records for audit (if different from program address)

## Required Documents

17. UPLOAD: Proposed Program Budget
18. UPLOAD: Proposed Personnel Detail Budget
19. UPLOAD: Proposed Fee for Service Schedule
20. UPLOAD: 501(c)(3) Determination Letter

## Required Financials

21. UPLOAD: Financial Statement (Signed by CFO or Board Treasurer)
22. UPLOAD: Income Statement & Statement of Cash Flows
23. UPLOAD: Certificate of Commercial Liability Insurance
24. UPLOAD: Form 990 (Most Recent)
25. UPLOAD: Audit Report (Most Recent)
26. UPLOAD: W-9

## Additional Documentation & Questions

27. UPLOAD: Expansion of program/services: Provide successful data of current program to expand. Additionally, provide data analysis of current program to expand under client eligibility criteria under UWCF Community Wellness (Ref., Polk County resident, FPL less than or equal to 200% and no health coverage).
28. UPLOAD: Continuation of a program that will end due to complete loss of funding: Provide the success of program must be empirically demonstrated. Please also provide an explanation of what the funding was and why it was lost.
29. Is your agency working with or planning to work with any other agencies on this Program? If yes, UPLOAD: Signed Letters of Commitment, Letters of Support and/or MOU from that agency's Director or other authorized representative.