**APPLICATION CHECKLIST:**

**Legal Name of Applicant: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

#### This checklist is provided to ensure that the application is complete, proper signatures are included, and that the required attachments are included. Provide each document in the format indicated and attach this checklist to the submitted proposal. All documents are required unless listed as “OPTIONAL” or “If Needed”.

####

|  |  |  |  |
| --- | --- | --- | --- |
| **#** | **Application Elements** | **Electronic format** | **Attached?** |
| 1 | Application: Completed, signed, and dated | Word/PDF | [ ]  |
| 2 | Complete project budget and cost calculation | Excel | [ ]  |
| 9 | [OPTIONAL] Brief (<1 page) organizational history, including recent projects | PDF | [ ]  |
| 14 | [If Needed] Conflict of Interest Policy (include who must read/sign the policy) | PDF | [ ]  |
| 16 | [If Needed] MOU/MOAs reflecting existing community partnerships that fulfill part or all of the services requested.  | PDF | [ ]  |

**Leadership Signature**:

We encourage you to submit your proposal using the application that follows. However, audio, and visual proposals that answer application questions will be accepted via the Wake County emails listed. Be aware that the number of words allowed each answer is limited. Be clear and concise. Additional certifications and policies may be required if funding is awarded.

**Incomplete applications and applications received after the deadline will not be reviewed. Wake County reserves the right to reject all proposals that do not meet these standards. If you are having trouble completing the application, please reach out to the HealthLit4Wake team for any assistance.**

*To the best of my knowledge and belief, all data and narratives in this application are true, current, and complete. The governing board has authorized the application.*

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

Executive Director (*Please print or type*)

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

Executive Director Signature Date

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

Board Chair/Additional Leadership (*Please print or type*)

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

Board Chair/ Additional Leadership Signature Date

**Application requirements**

**Some sections of this application limit the number of words allowed in the response to encourage concise, clear, specific responses. Only the number of words indicated will be read when reviewed.**

## SECTION 1: Applicant Information

|  |  |
| --- | --- |
| Legal Name of Organization |       |
| Street Address (include city and Zip Code) |       |
| Mailing Address (if different from above) |       |
| Project Mailing Address (if different from above) |       |
| Phone Number |       |
| Federal Tax ID (required) |       |
| DUNS Number (required) |       |
| Email and/or Website |       |

**Program Contact Person**

|  |  |
| --- | --- |
| Name |       |
| Title |       |
| Phone Number |       |
| Email Address |       |

**Program**

|  |  |
| --- | --- |
| Project(s) to be funded |  |

**Funding Requested**

|  |  |
| --- | --- |
| Total Amount of Funds Requested |       |
| Estimated Total Program Budget  |       |
| Percent of Total Program Budget to be funded through this grant |       |

**Check if organization is a . . .**

|  |  |
| --- | --- |
| Minority-owned or –controlled (at least 51%) Business Enterprise (MBE) | **[ ]**  |
| Women-owned or –controlled (at least 51%) Business Enterprise (WBE) | **[ ]**  |
| Health equity, social justice, or community-based-organization (CBO) | **[ ]**  |

## SECTION 2: Organizational Overview and Mission Statement

1. **Organizational Overview**

Provide an overview of your organization: the work the organization does and the population it serves; number of years in business; number of years as 501c3; and the number of years implementing the project you seek funding for. ***BE BRIEF: no more than 500 words***

|  |
| --- |
|       |

1. **Mission Statement**

Include your organization’s formal Mission Statement.

|  |
| --- |
|       |

## SECTION 3: Service Assessment

**Increasing Health Literacy Regarding COVID-19 and Promoting Health Equity for Marginalized Populations:**

Definition**:** Agency provides opportunities for members identifying with marginalized communities to receive culturally sensitive and linguistically appropriate messaging regarding COVID-19 health information. Some of the work that your Agency may provide include hosting COVID-19 vaccination events, pushing social media and marketing efforts, conducting listening sessions, and any other work that connects vaccine hesitant populations with COVID-19 resources.

1. Does your agency currently provide this service in totality as it is defined above? Yes [ ]  No[ ]
	1. If YES, please describe: *BE BRIEF: no more than 300 words*

|  |
| --- |
|       |

* 1. If NO, continue to question 2.
1. Is this service supplemented through an ***established*** partnership with an external agency? Yes [ ]  No[ ]
	1. If YES, please provide a copy of or description of the contract, MOU, or MOA with the external agency describing the nature of the partnership AND Include a summary narrative of this partnership. **BE BRIEF*: no more than 300 words.***

|  |
| --- |
|       |

* 1. If NO, continue to question 3.
1. Are you requesting funding for this service? Yes [ ]  No[ ]

|  |
| --- |
|       |

* 1. If YES, include funds requested for this service on the project budget and describe your plan to implement or expand this service. **BE BRIEF*: no more than 300 words.***
	2. If your funding request includes the addition of one or more Full-Time or Part-Time Employee, please list 3-5 high-level job functions and percentage of time dedicated to each function:

|  |  |
| --- | --- |
| **Job Functions** | **% of Time** |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |

1. Will this service be supplemented through an ***intended*** partnership with an external agency? Yes [ ]  No[ ]
* If YES, please provide a copy of or description of the contract, MOU, or MOA with the external agency describing the nature of the partnership AND Include a summary narrative of this partnership. **BE BRIEF*: no more than 300 words***

|  |
| --- |
|       |

## SECTION 4: Project Activities and Objectives

Describe the community you are hoping to reach with this grant funding. ***BE BRIEF: no more than 300 words***

|  |
| --- |
|       |

Describe your plan to engage with the people you are serving. ***BE BRIEF: no more than 300 words***

|  |
| --- |
|       |

How will your agency collaborate with persons with lived experiences? ***BE BRIEF: no more than 300 words***

|  |
| --- |
|       |

## SECTION 5: Current Data Collection Practices

How will your agency measure the impact of your work during this project? ***BE BRIEF: no more than 300 words***

|  |
| --- |
|       |

Please provide a staff point of contact for your organizations data analysis/evaluation. Include Staff First Name, Last Name, Title, Email, and Work Phone Number.

|  |
| --- |
|       |

## SECTION 6: Technical Assistance Needs

* Please describe any technical assistance needed to fully implement your project. ***BE BRIEF: no more than 300 words***

|  |
| --- |
|       |

## SECTION 7: Additional Questions or Concerns?

* Please list any additional questions or concerns. ***BE BRIEF: no more than 300 words***

|  |
| --- |
|       |