



Dakota Medical Foundation is dedicated to measurably improving health and access to health care services.

GRANT APPLICATION CHECKLIST

1-08

DIRECTIONS:

•An original application form must be completed with an original signature and include the attachments listed below.

•In addition, fifteen (15) copies of the grant application without the attachments listed below must be submitted with the original application.

•Please use this checklist to insure that you have provided the supportive materials required for the original application copy. If you cannot provide these documents, attach a written explanation for their unavailability.

- WE HAVE REGISTERED OUR ORGANIZATION ON IMPACT FOUNDATION'S GIVEBACK WEBSITE AND CREATED AN ORGANIZATIONAL SNAPSHOT. (THIS IS A REQUIREMENT; see attached sheet for instructions and contact information.)**
- A photocopy of the Internal Revenue Service letter determining the applicant organization to be a non-profit, tax exempt organization under IRS Code 501(c)(3) or a letter stating the organization is governmental (federal, state, county or town). Not acceptable are the following: the Secretary of State's certificate as a non-profit corporation, the Employer's Tax Identification number, the organization's tax-exempt number or the application to the IRS for 501(c)(3) status.
•If you have submitted an IRS determination letter as part of a previous application to Dakota Medical Foundation (the Foundation) within the past three years and your IRS status has not changed, you do not need to include your IRS determination letter; please initial here if previously submitted and still valid: _____.
- A statement or letter indicating that the grant request is endorsed by the governing board. (This could be an excerpt from the minutes of an official meeting or a letter from a senior officer of the organization quoting the action taken.)
- A list of the applicant's governing board members (and their titles, company names, addresses and phone numbers if available).
- A total project budget (if the grant request is for less than 100% of the project budget).
- A current fiscal year or calendar year organizational budget. (This is the overall budget for the organization and should not be confused with the project budget.)
•If you have submitted your most recent organizational budget and financial statement as part of a previous application to the Foundation, you do not need to include those items; please initial here if previously submitted: _____.
- The organization's most recent audited financial statement.
- Application must be signed by an officer of your organization. (Unsigned application forms will be returned.)

Submit your application to: Dakota Medical Foundation (DMF)
4152 30th Avenue South, Suite 102
Fargo, ND 58104-8403
701-271-0263 phone 866-451-9249 toll free
701-271-0408 fax

GRANT APPLICATION

A. Organization Information

1. **Organization's name, address, phone, fax number and website address:**

2. **Contact person's name, title, phone number and e-mail address:**

3. **Non-profit tax-exempt status: The Foundation awards grants to organizations in the following 501(c)(3) subsections. Please check the subsection that is applicable to your organization (refer to your IRS determination letter):**

_____ 170(b)(1)(a)(i) . Church

_____ 170(b)(1)(a)(ii) . School

_____ 170(b)(1)(a)(iii) . Hospital or medical research organization

_____ 170(b)(1)(a)(iv) . Organization which operates for benefit of college or university and is owned or operated by a governmental unit

_____ 170(b)(1)(a)(v) . Governmental unit

_____ 170(b)(1)(a)(vi) . Organization which receives a substantial part of its support from a governmental unit or the general public

_____ 509(a)(2) . Organization that normally receives no more than one-third of its support from gross investment income and unrelated business income and at the same time more than one-third of its support from contributions, fees and gross receipts related to exempt purposes

_____ 509(a)(3) . Organizations operated solely for the benefit of and in conjunction with organizations described in the previous seven items

4. **Year organization was formed and its mission, vision, and, if available, values and guiding principles.**

5. **Organization's major activities and past significant accomplishments:**

6. **Number of employees: _____ Full-time _____ Part-time**

7. **Approximate number of clients served yearly: _____**

8. Yearly revenue (last FY): \$ _____

Yearly expenses (last FY): \$ _____

THE FOLLOWING QUESTIONS, 9-14, ADDRESS ORGANIZATIONAL EFFECTIVENESS.

DMF is committed to strengthening health-related non-profit organizations in our region to facilitate the delivery of effective and efficient health improvement programs. If your organization identifies an area of need in any of the following questions (9-14), please feel free to contact the Foundation to inquire about applying for an organizational effectiveness grant to address those needs.

9. Please identify and list sources of revenue (e.g. earned income, grants, donors, special events, etc.) that are equal to or greater than 10% of your total revenues. Provide the percent of total revenue that each represents.

10. Does your organization have a feasible contingency plan for dealing with the sudden withdrawal of a major funding source?

11. Does your board annually evaluate your CEO/executive director?

12. Does your organization have a multi-year plan?

13. Does your organization have a fundraising plan with goals and measurable objectives?

14. Describe how you evaluate your organization and its programs to measure success and outcomes.

B. General Project Information

(You may attach supplemental pages to answer these questions.)

1. Project title:

2. Briefly list the project's goal(s).

3. Briefly summarize the project and the health need it seeks to address. Please include objective evidence (data, statistics, etc.) of the clear and compelling need for the proposed project.
4. Project's service area, target population and number of persons to be served.

C. Specific Project Information

1. Describe your organization's understanding, experience and expertise as it relates to the proposed project.
2. List the qualifications and responsibilities of key project personnel, including staff and volunteers who will be working with the target population (name them if they have already been identified and include job descriptions/resumes, if available). Also identify whether project staff are existing staff or staff to be hired for this project. (If new staff, include job descriptions, if available.)
3. List existing community resources you will utilize (i.e., facilities, people, partnerships).
4. Name other organizations doing similar or related work in your geographic area and describe how your project differs from, contributes to, or complements these activities.

D. Project Activities and Outcomes/Results Measurement

**** Preference will be given to organizations and proposals that demonstrate a commitment to ongoing performance measurement. See Appendix A and utilize the sample format if it meets your needs.**

1. Briefly describe the major project activities that will be completed to achieve the project goal(s) and data that will show that the activities were completed (*brochures, curriculum, sign-in sheets, receipts, payroll records, etc.*).
2. Specifically, how will you measure the project's outcomes/results? (*How will you know the health of the target population improved as a result of your project?*)

E. Financial/Budget Information

Please complete the attached project budget form, Appendix B, for the amount being requested from Dakota Medical Foundation.

1. Total amount requested from DMF:

\$ _____ over ___ one ___ two ___ three year(s)

If you are requesting a multi-year grant, please indicate the amount requested for each year:

Year One: \$ _____ Year Two: \$ _____ Year Three: \$ _____

The amount requested from DMF represents _____% of the total project budget amount of \$ _____. *(Please attach a total project budget.)*

2. Please outline a proposed grant payment schedule according to your project's cash flow needs. *(Dakota Medical Foundation prefers to schedule payment dates throughout the grant period, i.e. monthly, quarterly, or bi-annually versus annually.)*

3. Expected date project or expenditure of funds will begin: _____

Expected date project will end or funds will be fully expended: _____

4. If Dakota Medical Foundation invests in your project, please describe how DMF's grant award would be expended.

5. Name other currently committed and/or potential sources of project funding and the dollar amounts.

6. Will your institution bill for any services in connection with the project? If so, please describe and list revenue and expenditure of revenue in your project budget.

7. Briefly describe how you will ensure that the expenditures associated with the project budget are reasonable and cost-effective. *(If applicable, please include bids for goods and services.)*

8. If applicable, project's funding sources over the past three years:

9. If the grant award is less than the requested amount, would a lesser amount be acceptable?

10. Is there a deadline after which grant funds would not be accepted? If yes, please indicate date and reason.

F. PROJECT SUSTAINABILITY

1. If applicable, provide a detailed plan (including a timeline) to sustain this project when Dakota Medical Foundation's investment is expended. *Preference will be given to projects that demonstrate a solid sustainability plan.*

G. CONFLICTS OF INTEREST

I acknowledge that the Foundation must be informed about *any* potential conflicts of interest Grantee, Grantee's related persons, any individual, and/or anyone acting on grantee's behalf in any capacity may have with the Foundation and any of the Foundation's officers, directors and staff, including without limitation, any opportunities that Grantee and/or Grantee's related persons or any individual may have to direct the use of the Foundation's funds directly or indirectly to any of Grantee's related persons or their immediate family members, any individual, or any organization in which Grantee or Grantee's related persons may have a financial interest or position of control.

To the best of your knowledge, are you aware of any actual or potential conflicts of interest with Dakota Medical Foundation's staff, board and/or committee members?

H. OTHER

We have attempted to ask questions that will provide us with enough information to adequately review your proposal. However, please use this space to provide any additional project information you wish to be considered.

We are committed to developing helpful relationships with our grant applicants. Accordingly, please feel free to contact Deb Watne by phone at 701-356-2654 (toll free #: 866-451-9249) or via e-mail at debwatne@dakmed.org at any time throughout the application process.

SIGNATURE: _____

PRINT NAME: _____

TITLE: _____

DATE: _____

APPENDIX A
DAKOTA MEDICAL FOUNDATION
OUTCOMES/RESULTS PLAN
GRID TEMPLATE

A. PROJECT GOAL(S):
 (If you have multiple project goals, use the same template format for each goal.)

B. OVERALL OUTCOME/RESULTS MEASUREMENT:

1. How will you determine your project's success in achieving the health improvement goal?
2. Identify the data collection tools you will use to measure/verify whether health improvement has occurred:
3. Person(s) responsible for overall project outcomes/evaluation (include phone number):

C. PROJECT ACTIVITIES	DATA TO BE COLLECTED	PERSON(S) RESPONSIBLE FOR ACTIVITY COMPLETION/PHONE NUMBER	TARGET COMPLETION DATE
Activity #1			
Activity #2			
Activity #3			
Activity #4			

**DAKOTA MEDICAL FOUNDATION
OUTCOMES/RESULTS PLAN
GRID FORMAT - EXAMPLE**

A. PROJECT GOAL(S):

(If you have multiple project goals, use the same template format for each goal.)

(STATE HOW THE HEALTH STATUS OF THE PEOPLE SERVED BY YOUR PROJECT WILL BE IMPROVED; WHAT WILL CHANGE?)

Trained staff will provide immediate emergency medical services to cardiac arrest victims and, as a result, cardiac victim survival rates will increase.

B. OVERALL OUTCOME/RESULTS MEASUREMENT:

1. How will you determine your project's success in achieving the health improvement goal?

- a. **Appropriate number of staff trained.**
- b. **Equipment usage occurrences and incident outcomes.**

**MAY INCLUDE: Short Term Indicators: Change in knowledge, skills or attitudes that results in improved health.
Interim indicators: Change in behavior that results in improved health.
Long-term indicators: Change in health condition or status.**

2. Identify the data collection tools you will use to measure/verify whether health improvement has occurred:

- a. **Incident reports.**

MAY INCLUDE:

- COMPARISONS:** Compare what happens to the participants in your project to another group of people or to the previous health status of your participants.
- PRE/POST ANALYSIS (SURVEYS/QUESTIONNAIRES):** Person's health status before and after project.
- BENCHMARKS:** Compare local data to similar regional, state or national data.
- OBSERVE AND RECORD BEHAVIORS**
- REVIEW OF CLIENT RECORDS**

3. Person(s) responsible for overall project outcomes/evaluation (include phone number):

Jane Doe, 555-1212

PROJECT ACTIVITIES List the activities that need to be completed in order to achieve the project goal(s).	DATA TO BE COLLECTED List data source(s) you will provide to verify that the activities occurred; ex.: copy of curriculum used to teach a class, sign-in sheets, publicity flyers, invoices, bids, etc.	PERSON RESPONSIBLE FOR ACTIVITY COMPLETION	TARGET COMPLETION DATE
Activity #1: -Research purchase of defibrillator equipment; purchase appropriate equipment at the best price possible; place defibrillator at facility.	Two bids from competitive companies, invoice copy, identification of placement location.	Jane Doe, 555-1212	March 31, 2002
Activity #2: -Hire qualified person to train equipment users.	Job description, resume, contract, payroll information.	Jane Doe	May 30, 2002
Activity #3: -Research purchase of training manuals; purchase appropriate materials at the best price possible.	Two price quotes from competitive companies, invoice copy.	Jane Doe	June 15, 2002
Activity #4: -Schedule user training sessions for at least two staff persons from each department; carry out training sessions.	Training session flyers/schedule, sign-in sheets, copies of training certificates, roster of trained users per department.	Trainer (to be hired)	July 15, 2002
Activity #5: -Develop incident report form to collect data regarding defibrillator usage occurrences and incident outcomes.	Copy of incident report form.	Trainer (to be hired)	July 15, 2002
Activity #6: -Compile data from incident reports; evaluate project's health impact for final grant report.	Copies of incident reports.	Jane Doe and Trainer (to be hired)	December 31, 2002

APPENDIX B

PROJECT BUDGET FOR DAKOTA MEDICAL FOUNDATION GRANT REQUEST

ORGANIZATION NAME: _____

PROJECT TITLE: _____

(You may type on this form or reproduce it on your computer.)

BUDGET CATEGORIES*	PROJECTED EXPENDITURES YEAR ONE	PROJECTED EXPENDITURES YEAR TWO (if applicable)	PROJECTED EXPENDITURES YEAR THREE (if applicable)	SUBTOTAL OF EACH LINE ITEM
<u>TOTAL AMOUNT:</u>	YEAR ONE \$	YEAR TWO \$	YEAR THREE \$	TOTAL AMOUNT OF GRANT REQUEST \$

Break down individual line items under each budget category, i.e. equipment, salary/benefits, supplies, etc.

Example: 1 part-time RN: 1,040 hours, per year @ \$20 per hour = \$20,800

Benefits for above position (10%): \$2,080