Statewide Health Improvement Partnership (SHIP) 2021-2022
Health Care Project Application

The following questions will be asked on the SHIP online application form. Utilize this document to draft your answers and copy/paste into the online format. The online format does not allow partial applications to be saved so please allow enough time to complete the entire application and submit at that time. *Designates required questions

Organization Name*

Contact Name: First, Last*

Title

Address, City State Zip*

Phone number*

Email*

Business Agent (if different than primary contact)

Address, phone, and email

Provide a short overview of your organization, as it relates to the project. * (Maximum characters: 700)

Provide a short overview of your project including how you will address policy, systems, and/or environment change. * (Maximum characters: 2,500) See guideline documents for definitions and examples.

Approximately how many individuals will this project impact? *

Will this initiative be implemented at multiple locations in Washington County? If yes, please list locations: *

Health Equity

We strive to create opportunities for everyone to be healthy, taking into consideration the needs of different groups. We are looking for partners who will help us achieve this goal.

Please describe how this project will address health equity: (Maximum characters: 1000)

Will your project focus on addressing health inequities within any of the following populations? *

- [ ] Older adults
- [ ] People living in congregate care facilities
- [ ] People diagnosed with Hypertension or Diabetes
- [ ] People who smoke or vape
- [ ] Black, Indigenous and People of Color (BIPOC)
- [ ] People with low incomes
- [ ] People with disabilities
- [ ] None of the above
- [ ] Other:

Please describe how you plan to engage with the populations selected above?
(Maximum characters: 1000)

How is your organization committed to sustaining this project beyond SHIP funding? * (Maximum characters: 750)

How will you document your progress toward project goals? Will this project fulfill any of your Community Health Needs Assessment goals? SHIP evaluation staff are available to work with you to refine the evaluation approach, if needed. * (Maximum characters: 1000)

What is your total budget request? * Health Care dollar limit = $20,000

Please list at least four proposed activities, the budget for each activity, and at least one expected outcome for each activity. You may include up to six activities. Refer to guideline documents for sample language. *

Proposed Activities	Budget	Expected Outcomes

The SHIP grant requires each project to provide an in-kind contribution that is at least 10% of the total grant request. How does your organization plan to meet this requirement? Please include all in-kind contributions (ex: staff time, supplies, equipment), including dollar amounts. *

I submit this partner project application with Living Healthy Washington County (LHWC) and the Statewide Health Improvement Partnership on behalf of the organization listed above. My organization will provide a 10 percent match of the total funding amount being requested. As the organizational representative, I agree my project lead will fully participate in the assessment, implementation, and evaluation process, including but not limited to submitting reports and invoices on time and information as requested. Additionally, the project lead will follow all guidelines for use of funds.

Signature: