

Q1

Greetings,

We invite your organization to participate in the grant process with Beacon Community Impact (BCI). By completing this survey, you are officially submitting a Request for Proposal (RFP) application for program funding and/or technical assistance. It is our hope to work collaboratively in addressing identified health needs in our community, and in doing so ensure a positive impact.

Applications must be completed and submitted no later than **January 28th at 4:00 PM EST**

Please Note - You may click on the documents noted in the header to find a copy of

1. RFP Overview
2. RFP Survey (as a Word Document- including the survey sections)
3. CHNA Implementation Strategy & Metrics
4. Frequently Asked Questions
5. Budget Template

The survey is only a guide for addressing the required sections; it does not represent the RFP in its entirety. Please read the RFP found on our website for full instructions.

I’m happy to answer questions should you have them.

Kimberly Green Reeves | Director  
Beacon Health System

Community Impact

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Email: kgreenreeves@beaconhealthsystem.org

BeaconHealthSystem.org

Q2 **Organization Admin**

Q3 **Organization** Name

Q4 **Program** Name

Q5 **Contact** Information  
Please provide the designated point(s) of contact for BCI's *Health Equity and Outcomes Team* to reach out to within your organization (name, title, email, phone number) for any questions specific to the completion of this report.

* First Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Last Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Title \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Email Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Phone (Mobile) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Phone (Office) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Q6 **Not-for-Profit Tax Identification Number**  
 *(W-9 must be attached before request can be given consideration.)*

Q7 **Organization Address**

* Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Address 2 (i.e.Suite #) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* State \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Zipcode \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Phone Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Q8 **Organization Website**

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

Q9 **Request**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | **FINANCIAL SUPPORT** | | | **TECHNICAL ASSISTANCE** | |
|  | Implementation | Capacity Building | None | Yes | No |
| **Request TYPE** |  |  |  |  |  |

Q10 **If you are requesting Financial Support,** what amount are you requesting for the 2022 grant cycle?

* $1 - $10,000
* $10,001 - $39,999
* $40,000+

Q11 **Counties** where services will be provided

* Elkhart
* Marshall
* St Joseph

Q12 **Proposal Snapshot**

Q13 **Organizational Summary** – Provide a brief history of the organization and capability. Include experiences and major accomplishments implementing the same or similar projects as those proposed in this application.

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Q14 **Describe** what your program/service is trying to accomplish in one sentence.

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Q15 **Proposed service and activities** – Provide a detailed description of the service or activities to be completed. Include quantitative estimates related to the activities by quarter.

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

Q16 **Anticipated outcomes and data collection plan** – Clearly define what outcome/impact the program/service will create in the population served and how data related to these outcomes will be collected. These should include the specific metrics if applicable (refer to the full list of metrics in the CHNA Strategy Implementation & Metrics document attached in survey header)

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

Q17 **Outline a plan** for how the program/service activities will be sustained at the conclusion of this funding. In addition, identify how the proposed program/service has characteristics that can lead to being replicated in other settings.

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

Q18 **Estimate number** of unique people served by county

Elkhart : \_\_\_\_\_\_\_

Marshall : \_\_\_\_\_\_\_

St Joseph : \_\_\_\_\_\_\_

Total : \_\_\_\_\_\_\_\_

Q19 **Administrative Details**

Q20 If you are selected to receive funding for **CAPACITY BUILDING** you will be expected to complete the following **requirements**. Please indicate if you can meet these requirements

|  |  |  |
| --- | --- | --- |
|  | **Yes** | **NO** |
| Attend BCI Partner Orientation in February |  |  |
| Participate in at least one Partner Workshop hosted by the BCI Health Equity & Outcomes Team |  |  |
| Work with Health Equity & Outcomes Team to develop work plan for funding period (Jan-Dec) |  |  |
| Submit 1 progress report made on the established work plan (June) |  |  |
| Submit Final Report (December) |  |  |
| Sign funding contract |  |  |

Q21 If you are selected to receive funding for **IMPLEMENTATION** you will be expected to complete the following **requirements**. Please indicate if you can meet these requirements

|  |  |  |
| --- | --- | --- |
|  | **Yes** | **NO** |
| Attend BCI Partner Orientation in February |  |  |
| Participate in at least one Partner Workshop hosted by the BCI Health Equity & Outcomes Team |  |  |
| Submit Quarter One report |  |  |
| Submit a Mid-Year report (June) |  |  |
| Submit Quarter Three report |  |  |
| Submit End of Year report (December) |  |  |
| Sign funding contract |  |  |

Q22 If you are selected to receive**TECHNICAL ASSISTANCE**you will be expected to complete the following **requirement**:   Please indicate if you can meet this requirement.

|  |  |  |
| --- | --- | --- |
|  | **Yes** | **NO** |
|  |  |  |
| Attend at least one Partner Workshop hosted by the BCI Health Equity & Outcomes Team |  |  |
| Submit a post engagement feedback survey (immediately after project) |  |  |

Q23 If **Technical Assistance is selected:** What areas are you most interested in Beacon Community Impact providing assistance in:

* Collaboration/Networking
* Data Collection
* Monitoring and Evaluation
* Process Improvement
* Program Design
* Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Q24 If **Technical Assistance is selected:** Provide more details about the type of technical assistance you are requesting below:

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**Q25 Attachments**

Q26 **W-9 Attachment**

Q27   
**Organizational Chart**   
    
 A diagram that shows the structure of an organization and the relationships and relative ranks of its parts and positions/jobs in relation to the program/ project.

Q28 **Budget**  
 A detailed spreadsheet showing application of program funding. (please use *Budget Template* attached in survey header).