

**Community Benefit Grant funds are for February 1, 2024-December 31, 2024**

**Proposals must be emailed by Friday December 15, 2023**

Emerson Health is committed to collaborating with our community partners to improve the health status of all those it serves, address root causes of health disparities, and educate the community in prevention and self-care strategies. To this end, we have created the Emerson Health Community Benefit Grant, which will provide a total of $50,000 to fund initiatives to improve community health needs from non-profit organizations and/or public entities.

Eligible groups include, but are not limited to, service providers, health and community-based organizations and coalitions, municipalities, schools, and communities of faith. Awards of up to $5,000 will be awarded to selected agencies serving communities within the designated service area (see Appendix A); project must address a [Community Health Needs Assessment (CHNA) 2021](https://www.emersonhospital.org/community-programs/community-needs-assessment) priority focus area. Funding is not eligible for fundraising efforts or events. **Previous Community Benefit Grant recipients are eligible to apply for a NEW project only.**

The review committee will take all requests into consideration and will award applicants based on need and alignment with priorities.

**IMPORTANT DATES**

* **December 15, 2023— Proposals must be emailed to CommunityBenefits@emersonhosop.org**
* **January 19, 2024**— Awards announced
* **February 1, 2024** — Project start up, and recipients awarded
* **December 31, 2024** — Final report due with summary report and evaluation

**ELIGIBILITY**

* Applicant must serve people in one or more of the Emerson Health communities (Appendix A).
* Applicant must be a tax-exempt 501(c)(3) under the IRS code or a public entity. If applicant is not a 501(c)(3), they must have a Fiscal Agent who is a 501(c)(3) or partner with an agency with an IRS designation as a 501(c)(3), a Section 170, or other IRS non-profit designation.
* Project must address at least one of Emerson Health’s priority focus area
* Collaboration among two or more partners is highly encouraged (not a requirement).
* Funding is not eligible for fundraising efforts or fundraising events.
* **Previous Community Benefit Grant recipients are eligible to apply for a NEW project only.**

**APPLICATION COMPONENT CHECKLIST**

Completed Cover Page questionnaire (2 Pages)

Completed project narrative with responses to all parts of questions 1 and 2.

Completed budget

W-9 Documentation

Signed Award Agreement

**Contact for questions or additional information:**

[CommunityBenefits@emersonhosp.org](mailto:CommunityBenefits@emersonhosp.org)

**EMERSON HEALTH COMMUNITY BENEFIT GRANT APPLICATION COVER PAGE**

*Please do not make any edits to the form and do not bold your answers*

**Submission Date:**

**Project Title:**

**Lead Agency/Organization:**

**Contact Person:**

**Street Address:**

**City:**

**State:**

**Zip:**

**Phone:**

**Email:**

**Website:**

**Collaborative Partners:**

**Amount of Funding Requested: $**

*If your organization has a fiscal agent other than the applicant named above, please complete the following:*

**Name of Fiscal Sponsor:**

**Name of Fiscal Contact Person:**

**Address:**

**City:**

**State:**

**Zip:**

**Phone:**

**Email:**

**What communities will be involved in / impacted by your project? *Highlight or bold your answers***

|  |  |
| --- | --- |
| Acton | Lexington |
| Ayer | Lincoln |
| Bedford | Littleton |
| Berlin | Lunenberg |
| Bolton | Maynard |
| Boxborough | Pepperell |
| Carlisle | Shirley |
| Chelmsford | Stow |
| Concord | Sudbury |
| Groton | Townsend |
| Harvard | Wayland |
| Hudson | Westford |
| Lancaster |  |

**Anticipated number of people that will be impacted by your project?**

**Which of the following health priorities does your project address (you can check more than one)? *Highlight or bold your answers***

Emerson Health Priority Focus Areas

* **Mental Health** *(Preference given to efforts reducing mental health stigma)*
* **Aging Population***(Preference given to efforts providing education to older adults around use of technology)*
* **Economic Insecurity** *(Preference given to projects that catalyze opportunity for underserved populations)*
  + **Food security**
  + **Housing**
  + **Financial stability**

**PROPOSAL NARRATIVE**

***Please create a word document to complete narrative answers and limit your responses to questions 1 and 2 to four pages. Responses must be single spaced using 12-point Calibri or Times New Roman font with one-inch margins.***

1. **Project Introduction**
2. What is the mission of your organization?
3. Provide a clear description of your project. Explain how you will address the specific health priority/priorities identified above.
4. Present data to document the identified need.
5. How is project informed by best practices/evidence based?
6. Outline anticipated collaboration with other agencies, organizations, or entities. Describe the specific role and responsibility of all identified collaborating partners.
7. Describe the target population and those that will benefit from your project. Be sure to include the age range, language, gender and race within the description

1. **Goals and Project Measurement**
2. Use the format/table below to describe your project goals, repeat format if needed (For tips on goals see Appendix C)

**Goals:**

|  |  |
| --- | --- |
| **Strategies/Initiatives**  What will you do? | **Outcome Indicators**  How will you know if this activity was completed? (ex. How many people will you reach? How often? |
|  |  |
|  |  |
|  |  |

***\*If you have more than 1 goal, repeat above format***

1. Describe evaluation strategies and/or tools you will use to measure outcomes and achievement of project goals.

1. **Budget** 
   1. Complete an itemized budget for your proposed project. Include **line item costs** and a brief description of each. Include **justification** for each line item. **Justification is limited to two pages and should not include program details not already described elsewhere in your proposal.** Accuracy will be considered. Please check your math.

Budget Form

Itemize all expenses and summarize all revenue and in-kind support for the project.

*SEE APPENDIX D FOR SAMPLE*

|  |  |  |  |
| --- | --- | --- | --- |
| **Line Item** | Amount requested in application | **IN-KIND and OTHER SOURCES of funding**  (Source and Amount)  **In-kind designates donated goods or services.** | **TOTAL PROJECT COSTS** |
| **Staff**  (Indicate number of hours to be applied to this project and hourly rate.) |  |  |  |
| **Contract Services**  (hourly rate, number of hours.) |  |  |  |
| **Supplies/Equipment** |  |  |  |
| **Other Expenses** |  |  |  |
| **TOTAL** |  |  |  |

**JUSTIFICATION**

The budget justification must explain the relevant details of each line item.

**Justification should not include program details that are not identified elsewhere in your proposal.**

If needed, the budget justification may use **up to two (2)** additional pages.

*SEE APPENDIX E FOR SAMPLE*

### Emerson Health Community Benefit Award Agreement

If we receive a Community Benefit Grant, we agree to the following:

* Regular communication with Emerson Health throughout the duration of the award period.
* To submit a Summary Report (template to be provided) and evaluation of outcomes to the Emerson Health Community Benefits Manager by January 31, 2023
* To include an Emerson Health logo and the following statement in all funded project descriptions, products, and related publicity:

***This project is funded through the Emerson Health Community Benefits Grant Program.***

Lead Agency: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Project Title: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Authorized Signatory: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_