I. ORGANIZATION INFORMATION

Name and Title of Contact Person*
Character Limit: 250

Contact Email*
Character Limit: 50

Contact Person's Telephone Number*
Character Limit: 10

Primary Organization Name
Character Limit: 250

EIN
Character Limit: 250

Name of Executive Director/CEO*
Character Limit: 100

Executive Director/CEO Email*
Character Limit: 254

Executive Director/CEO Phone Number*
Character Limit: 10

If Your Organization is a Subsidiary, Please List the Parent Organization
Character Limit: 250

Fiscally Sponsored*
Please list the organization if being Fiscally Sponsored and explain why you require a fiscal sponsor. Upload the fiscal agreement verifying your Fiscally Sponsored relationship.

Please put n/a if this does not apply.
Character Limit: 2000 | File Size Limit: 1 MB
Organization Website*  
*Character Limit: 2000

Organization Geographic Area(s) Served (Please List)*  
For example: Statewide, New Castle County, Kent County, or Sussex County.  
*Character Limit: 500

Mission Statement or Brief Organization Overview (A few sentences)  
*Character Limit: 1000

How Many Years Has the Organization Been in Operation?*  
*Character Limit: 3

Organizational Experience*  
Explain the organization's experience in administering the work outlined in this proposal and/or support for why you will be successful.  
*Character Limit: 5000

II. SMALL GRANT PROGRAM/PROJECT DETAILS

BluePrints Priority Areas*  
Choose ONE BluePrints focus area your application most fully aligns with:

- **Healthcare Access** (e.g.: preventative care, disease specific, health literacy, research, etc.)  
- **Economic Stability for families and individuals** (e.g.: financial resources strains, food insecurity, housing stability, etc.)  
- **Social and Community Context** (e.g.: mental health, physical activities, social connections, etc.)  
- **Neighborhood and Built Environment** (e.g.: safety, transportation, environmental health, infrastructure, etc.)  
- **Health Workforce** (e.g.: training, upskilling, further education, provider practice improvements, etc.)

Choose:
- Healthcare Access  
- Economic Stability for families and individuals  
- Social and Community Context  
- Neighborhood and Built Environment  
- Health Workforce

Program/Project Name*  
*Character Limit: 100
Program/Project Executive Summary*
This summary should clearly and concisely explain WHO is being served, WHAT the program or project is, WHY the program or project is needed, HOW it will be executed and the anticipated impact. This will be the summary that the BluePrints Advisory Council and Highmark Board will see.

*Character Limit: 1200

Program/Project Need*
Please explain why this program/project is needed and the problem being addressed. Examples of information to share include but are not limited to:

- How the need or issue is identified, i.e. through community surveys, regional data collection, etc.
- Why a new program is needed or why an existing project required this support.
- Who else is addressing this need or problem?

*Character Limit: 2000

Proposed Timeline*
Provide a high-level timeline to execute the program/project. If awarded, use of funding should begin within 3 months of receiving the funds and generally be expended within 12 months.

*Character Limit: 1000

Who does the proposal aim to benefit?*
Select all that apply as relevant to this application and its proposed health outcomes.

Choices
General Population
Specific Gender or Gender Identity
Specific Ethnicity or Race
LGBTQA
Differently Abled
Veterans/Military
Infant & Youths, 0-15 Years
Young Adults, 15-24 Years
Aging Adults, 55+
Other

Specific Gender/Identity/Ethnicity/Race or Other
If you picked Specific Gender or Gender Identity, Specific Ethnicity or Race or Other above, please provide that information.

*Character Limit: 250

How many individuals and/or defined groups to be served?*
For example, 500 cancer survivor patients and their families.

*Character Limit: 250
**Target Population Income Limits**
If relevant to this application, identify the income limits of the target population.

**Please note: Per HUD FY 2021 Income Limits:**
Median Family (4-person) income for MSA Philadelphia-Camden-Wilmington, PA-NJ-DE-MD is $94,500
Low Income (80%) Median Family Income is $75,600

**Choices**
- Low-Income (<50% of median income)
- Low-Moderate-Income (50%-80% of median income)
- Upper-Income (>80% of median income)
- All of The Above
- Does Not Apply

**Percentages of Each Population Checked**
For example, Low-Income 60%, Low-Moderate Income 20%, Upper Income 20% = 100%. Enter n/a if this does not apply.

*Character Limit: 750*

**Partners/Collaboration**
Who are you partnering or collaborating with - community based organizations, local residents, state agencies, etc.?

Identify those partners and their role in your proposal. Put n/a if not applicable.

*Character Limit: 1000*

**Where geographically will most of the program serve?**
Provide the area(s) below.

**Choices**
- Statewide
- New Castle County
- Kent County
- Sussex County

**Primary Geography Served - Zip Codes**
Please list the 5 primary zip codes served by your organization.
MEASURING SUCCESS

Anticipated Community Impact*
Please provide specific metrics and details on community impact relevant to your program/project. This response could include outputs, outcomes and anticipated impacts. For this application:

Outputs are actions being taken.
Outcomes are the effect of the output.
Impact is the change observed relevant to outcomes.
Please note the examples below are illustrative only and may not apply to your program/project. Your response should be specific to your program/project.

Character Limit: 5000

Example 1 - Addressing a chronic condition influenced by weight:
Output: Decreasing calories consumed through diet and nutrition planning
Outcome: The observed weight
Impact: Weight loss contributes to chronic condition improvement as measured by heart rate, blood pressure, etc.

Example 2 - Ensuring vision health of youth
Output: Providing eye exams to children
Outcome: # of children who benefit from eye exams and screenings
Impact: Improvement in children's eye health as measured by # of children who received eye glasses and/or referrals for supplemental vision care

Example 3 - Improving mental health for a specific population
Output: Providing access to mental health services, such as talk therapy
Outcome: # of individuals participating
Impact: Improvement in mental health as measured by patient surveying; decrease in risky behaviors, etc.

Example 4 - Recruiting healthcare workers to a specific region
Output: Creating a residency program
Outcome: # of doctors trained
Impact: Improved access to care as measured by # of residencies completed; # of new patients seen, etc.
**Measuring Success**
Explain what progress or success would look like and how it will be achieved, tracked and measured. At the end of the grant year, the DCF will request a written end of year report. Please provide 3-5 ways your organization will measure success.

*Character Limit: 2000*

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**III. FUNDING**

*Program/Project Budget*  
*Character Limit: 20*

*Amount Requested*  
Guidelines are requests should be less than $50,000.  
*Character Limit: 20*

*Substantiate Need (Budget Narrative)*  
Describe the specific uses for BluePrints funds for the program/project. If this is part of a larger or longer-term program/project, specify how BluePrints funds will be used within the phase or portion of the program/project.  
*Character Limit: 1000*

*Other Funding*  
Please include a list of all other funding sources - declined, awarded or pending - specifically for this program/Project, (grants, gifts, in-kind donations, and loans) including the amounts and dates for pending requests.  
*Character Limit: 1000*

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**IV. DIVERSITY, EQUITY & INCLUSION (DEI)**

**DIVERSITY, EQUITY & INCLUSION**

The Delaware Community Foundation would like to collect demographic data on your Board of Directors and the population your organization serves.

Incorporating the values of Diversity, Equity & Inclusion (DEI)
At the DCF, we are committed to building opportunity for all. To be successful, we know that a focus on equity is crucial.
The DCF has made several organizational commitments and now, we'd like to hear from you on how your organization is incorporating DEI values.
For example:
• Do you incorporate the perspectives of the population served in program design and delivery?
• Has your organization hosted cultural sensitivity training staff and/or board of directors?
• Is your organization seeking out cross-cultural experiences that encourage awareness of other cultures or spend a day in the life of the community members you serve?

* Character Limit: 1000

How many serve on your Board of Directors?*
Character Limit: 20

Board of Directors Demographic: Gender Makeup
Please provide an estimate of the gender identity distribution of your board of directors. The total should match the previous question. If the answer is zero (0) for a category, please put 0. Do not leave blank.

<table>
<thead>
<tr>
<th>Gender Makeup</th>
<th></th>
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<tbody>
<tr>
<td>Females-Bd</td>
<td></td>
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<tr>
<td>Males-Bd</td>
<td></td>
</tr>
<tr>
<td>Non-Binary-Bd</td>
<td></td>
</tr>
<tr>
<td>Choose Not to Identify-Bd</td>
<td></td>
</tr>
<tr>
<td>Unknown/Not Tracked-Bd</td>
<td></td>
</tr>
<tr>
<td>Total Number of Board Members</td>
<td></td>
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<tr>
<td>Race/Ethnic Makeup</td>
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<tr>
<td>--------------------------</td>
<td>---</td>
</tr>
<tr>
<td>American Indian/Native Alaskan-Bd</td>
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<tr>
<td>Black/African-American-Bd</td>
<td></td>
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<tr>
<td>Asian American-Bd</td>
<td></td>
</tr>
<tr>
<td>Native Hawaiian/Other Pacific Islander-Bd</td>
<td></td>
</tr>
<tr>
<td>White/Caucasian-Bd</td>
<td></td>
</tr>
<tr>
<td>Hispanic/Latinx-Bd</td>
<td></td>
</tr>
<tr>
<td>Other/Mixed Race-Bd</td>
<td></td>
</tr>
<tr>
<td>Total Number of Board Members</td>
<td></td>
</tr>
</tbody>
</table>

**Population Served Demographic: Gender Makeup**

Please provide an estimate of the gender makeup distribution of the population you serve. These entries are in % and should total 100% at the bottom. If the answer is zero (0) for a category, please put 0. Do not leave blank.

<table>
<thead>
<tr>
<th>Gender Makeup</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Female-Pop</td>
<td></td>
</tr>
<tr>
<td>Male-Pop</td>
<td></td>
</tr>
</tbody>
</table>
### Population Served Demographic: Race/Ethnic Makeup

Please provide an estimate of the Race/Ethnic distribution of the population you serve. These entries are in % and should total 100% at the bottom. If the answer is zero (0) for a category, please put 0. Do not leave blank.

<table>
<thead>
<tr>
<th>Race/Ethnic Makeup</th>
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</thead>
<tbody>
<tr>
<td>American Indian/Native Alaskan-Pop</td>
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<tr>
<td>White/Caucasian-Pop</td>
</tr>
<tr>
<td>Hispanic/Latinx-Pop</td>
</tr>
<tr>
<td>Other/Mixed Race-Pop</td>
</tr>
</tbody>
</table>
V. REQUIRED DOCUMENTS

Program/Project Budget*
Please provide budget detail for the program/project for which you are applying, including what expenses are included in this grant request.

File Size Limit: 5 MB

Organization Budget*
Please provide budget detail for the organization. List any current or previous BluePrints funding, including year, proposal name and amount.

File Size Limit: 5 MB

Copy of the Most Recent Audited Financials and IRS Form 990*
Organizations that have only completed one fiscal year, please provide accounting records showing the most recent board-approved financials.

File Size Limit: 10 MB

Board List*
Please upload a list of your organization's board of directors.

File Size Limit: 1 MB

IRS Determination Letter*

File Size Limit: 1 MB

Additional Attachment (Optional)
Please upload a photo or collateral that helps visually support the proposed project. Please include a brief description of the attached photo. Please note that these will be reviewed as part of the evaluation process and may be shared with select DCF fundholders.

File Size Limit: 7 MB

VI. PAYMENT PROCESSING
Grants will be processed through Direct payment via ACH transfer. Please complete the fields below to allow the Delaware Community Foundation to award grants to your organization if awarded.
Authorization of Payment*
I (we) authorize the Delaware Community Foundation to electronically credit my (our) account (and, if necessary, electronically debit my (our) account to correct erroneous credits) as follows:

Choices
Checking Account
Savings Account

Attach Bank Details (Voided Check or Letter from Bank)*
Please attach either a voided check or a letter from the bank verifying your account number. This will allow for accuracy of bank details and for efficient payment processing.

File Size Limit: 6 MB

Signature: Agree and Approval for Payment Processing*
I (we) understand that this authorization will remain in full force and effect until I (we) notify the Delaware Community Foundation in writing that I (we) wish to revoke this authorization. I (we) understand that the Delaware Community Foundation requires at least 5 business days prior notice in order to cancel this authorization.

Character Limit: 50

VII. ACKNOWLEDGEMENT

Signature of Applicant Organization's Executive Director/CEO*
By typing your name below, you confirm application organization does not discriminate in staffing or services on the basis of race, religion, gender, age, disability, national origin or sexual orientation.

Character Limit: 100

Signature of Person Completing Application*
By typing your name below, you confirm application organization does not discriminate in staffing or services on the basis of race, religion, gender, age, disability, national origin or sexual orientation.

Character Limit: 100