

2024 Q3 Highmark BCBSD BluePrints for the Community

Delaware Community Foundation

I. CONTACT/ORGANIZATION INFORMATION

Name and Title of Contact Person*

This should be the best person to contact regarding this application.

Character Limit: 250

Contact Email*

Character Limit: 254

Contact Phone Number*

Character Limit: 15

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: 15

If Your Organization is a Subsidiary, Please List the Parent Organization

If not applicable, please put n/a.

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: 2 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*

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. 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.)

Choices

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 could 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 requires 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
- Differentlyabled
- Veterans/Military
- Infant & Youth, 0-15 years
- Young Adults, 15-24 years
- Aging Adults, 55+
- Other

Specific Gender/Identity/Ethnicity/Race or Other

If you clicked **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.

Zip Code

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 relative to outcomes.

Please note that 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. Throughout the grant year, the DCF will request a written mid-year and end of year report. Please provide 3-5 ways your organization will measure success. At your mid-year and end-of-year report, we will ask for progress toward these objectives.

Character Limit: 2000

III. FUNDING

Program/Project Budget*

Character Limit: 20

Amount Requested*

Maximum Request: \$200,000

Character Limit: 20

Substantiate Need (Budget Narrative)*

Describe the specific uses of 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

IV. DIVERSITY, EQUITY & INCLUSION (DEI)

DIVERSITY, EQUITY & INCLUSION (DEI)*

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, and Inclusion*

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 for 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 Director's Demographic: Gender Makeup

Please provide an estimate of the gender identity distribution of your board of directors. The total should match the number in the previous question. If the answer is zero (0) for a category, please put 0.

Gender Makeup	
Female	
Male	
Non-Binary	
Choose Not to Identify	
Unknown/Not Tracked	
Total Number of Board Members	

Board of Directors: Racial/Ethnic Makeup

Please provide an estimate of the racial/ethnic makeup of your board of directors. These entries should match the total number of board members in the previous question.

Race/Ethnic Makeup	
Black/African-American	
American Indian/Native Alaskan	
Asian American	
Native Hawaiian/Other Pacific Islander	
Hispanic/Latinx	
White/Caucasian	
Other/Mixed Race/Ethnicity	
Total Number of Board Members	

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%. If the answer is zero (0) for a category, please put 0.

Gender Makeup	Percentages of Each Population Checked
Female	
Male	

Non-Binary	
Choose Not to Identify	
Unknown/Not Tracked	
Total (should add up to 100%)	

Population Served Demographic: Race/Ethnic Makeup

Please provide an estimate of the racial/ethnic makeup distribution of the population you serve. These entries are in % and should total 100%. If the answer is zero (0) for a category, please put 0.

Race/Ethnic Makeup	Percentages of Each Population Checked
Black/African-American	
American Indian/Native Alaskan	
Asian American	
Native Hawaiian/Other Pacific Islander	
Hispanic/Latinx	
White/Caucasian	
Other/Mixed Race/Ethnicity	

Total (should add up to 100%)	
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V. REQUIRED DOCUMENTS

Project/Program 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 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 other 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 a 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 process payment 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 Account 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*

By typing your name below:

I (we) understand that this authorization will remain in full force and effect until I (we) notify 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: 100

VII. REQUIRED SIGNATURES

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