

River Falls Area Hospital Foundation REQUEST FOR PROPOSALS: ACCESS TO CARE

WELCOME GRANT SEEKERS!

The River Falls Area Hospital Foundation is pleased to announce its 2010 Request for Proposals for organizations serving the health care needs of our region. The foundation welcomes your grant applications, and we invite you to join us in our efforts to improve the health of our region. Please review these guidelines carefully before submitting your application. **The deadline for applications to this grant cycle is Monday, March 1.**

THE RIVER FALLS AREA HOSPITAL FOUNDATION

The River Falls Area Hospital Foundation, formerly the Kinnickinnic Valley Health and Education Foundation, is a local nonprofit organization established in 1978 to raise funds to support the River Falls Area Hospital and other community health initiatives. Most funds raised by the foundation support the hospital, which in turn works to meet the health needs of the community.

In 2005, the foundation announced the creation of four distinct funds to help guide its work.

- The **Health Care Excellence & Innovation Fund** supports excellence and innovation at River Falls Area Hospital.
- The **Community Wellness Fund** supports projects that improve community health.
- The **Access to Care Fund** supports programs that ensure that all people in our region have access to the health care services they need to get and stay healthy.
- The **Health Careers Scholarship Fund** supports scholarships to non-traditional students pursuing careers in health care.

While most of the foundation's grants are to the hospital, the foundation does, on occasion, also request proposals from external organizations working to improve the health of our region.

In October of 2009, the foundation's Harvest Moon Barn Dance raised more than \$50,000 for the foundation's "Access to Care" fund. These are the funds available for this grant cycle. Grant requests for \$500-\$25,000, from both the hospital and external organizations, will be considered. The grant term will be no more than one year; short-term projects will also be considered.

ELIGIBILITY CRITERIA

Organizations that meet the following criteria are eligible to apply:

- The applicant organization must provide or plan to provide services that improve access to health services for residents of the communities served by the hospital.
- Organizations and proposed projects should demonstrate compatibility with the mission, vision and values of Allina Hospitals & Clinic.
- The applicant organization must have the demonstrated capacity to carry out the program work funded by the grant and to maintain fiscal accountability.

In selecting the programs to be funded, priority will be given to projects that:

- Are collaborative, particularly those in which the River Falls Area Hospital is involved.
- Are working to meet identified community needs, with a particular interest in programs that:
 - o Facilitate enrollment in government-funded insurance programs;
 - o Increase access to mental health services;
 - o Increase access to dental health services; and/or
 - o Provide transportation to those otherwise unable to access health care services.

River Falls Area Hospital Foundation REQUEST FOR PROPOSALS: ACCESS TO CARE

- Do not duplicate existing services.
- Have multiple funding sources.
- Serve the primary geographic service area of the hospital (River Falls, Spring Valley, Ellsworth and the surrounding communities).
- Are evidence-based, using strategies proven to get results.

The River Falls Area Hospital Foundation does not generally make grants to:

- Projects that do not substantially benefit residents of the region served by the hospital.
- Projects unrelated to the mission, vision, values and strategic priorities of the hospital.
- Projects that are primarily commercial in nature.
- Individuals, with the exception of grants through the foundation's scholarship program.

HOW TO APPLY

Please assemble your proposal as follows:

1. cover sheet (found on the last page of this packet)
2. proposal narrative
3. roster of the organization's key volunteers and staff
4. a program budget that includes both expenses and revenue, including other sources of funding

In addition, if you are a 501(c)(3) organization, please include:

5. 501(c)3 determination letter
6. prior year's financial statements
7. current year's organizational budget

These materials can be submitted by email, standard mail, or delivered in person. Late or incomplete applications will not be considered for funding. **The completed application and all additional materials are due by 5:00pm Monday, March 1, 2010.**

PROPOSAL NARRATIVE

Each proposal requires a proposal narrative. Use the following outline as a guide. While you are not required to respond directly to every question, the answers to these questions should be found in your overall narrative. Please limit your narrative to five pages.

I. Organization Information (1 page maximum)

- Organization history, mission and goals.
- Description of organization's current programs or activities
- Organization's relationship with other organizations working with similar missions.
- Number of board members, full-time paid staff, part-time paid staff and volunteers.

II. Purpose of Grant (3 page maximum)

Situation:

- To what need does your program respond?
- How was that need identified? Who was involved in that process?

River Falls Area Hospital Foundation

REQUEST FOR PROPOSALS: ACCESS TO CARE

Response:

- What is your overall goal regarding the situation described above?
- What are your program objectives to reach that goal?
- What are the specific activities for which you seek funding?
- Who will carry out those activities? When will this take place?
- If similar work is already being done in our region, how is your program different?
- Why is your organization uniquely positioned to implement this program?
- If this is an ongoing program, what is your plan for future funding of your work?

If there is research that supports the efficacy of your work – if what you are proposing has been established as a best practice - please include a brief summary of that information in your narrative.

III. Evaluation (1 page maximum)

- Describe your criteria for success. What do you want to happen as a result of your activities? Discuss both outputs and outcomes, both immediate and long-term.
- How will you measure these changes?
- Who will be involved in evaluating this work?
- What will you do with your evaluation results?

SELECTION PROCESS

The foundation reviews and responds to all applications, and may request additional information, particularly regarding projects requesting significant funding. Proposals will be evaluated by the foundation's executive director and a grants review committee for consideration of the merits of the proposed activities versus the funds available. The grants review committee will provide its recommendations to the foundation's board of directors, which makes final decisions to approve or decline requests for grant funding.

Grant Cycle

Announcement Date: Friday, January 15, 2010
Requests Due: Monday, March 1, 2010
Awards Announced: Friday, April 16, 2010

For additional information or to discuss ideas related to this funding opportunity, please contact Heather Logelin, Foundation Director, at (715) 426-4503 or heather.logelin@allina.com.

**River Falls Area Hospital Foundation
REQUEST FOR PROPOSALS: ACCESS TO CARE**

GRANT PROPOSAL COVER SHEET

Organization Information

Name of organization _____ *Legal name, if different* _____

Address _____ *City, State, Zip* _____ *Employer Identification Number (EIN)* _____

Phone _____ *Fax* _____ *Web site* _____

Contact person regarding this proposal _____ *Title* _____ *Phone* _____ *E-mail* _____

Is your organization an IRS 501(c)(3) not-for-profit? Yes No
If no, is your organization a public agency/unit of government? Yes No
If no, do you have a fiscal agent? Yes No

Fiscal agent's name and address _____ *Fiscal agent's EIN number* _____

Proposal Information

Project or Program Name: _____

Please provide a 2-3 sentence summary of your request:

Population served: _____

Geographic area served: _____

Program dates (if applicable): _____ Fiscal year end: _____

Budget

Dollar amount requested: _____ \$ _____

Total program budget: _____ \$ _____

Total annual organization budget (if applicable): _____ \$ _____

Authorization

Name and title of top staff or board chair: _____

Signature and Date: _____