HEFFERNAN MEMORIAL HEALTHCARE DISTRICT
"Working for a Healthy Calexico"

HEFFERNAN MEMORIAL HEALTHCARE DISTRICT GRANT APPLICANT GUIDELINES FISCAL YEAR 2024

Heffernan Memorial Healthcare District's (HMHD) mission statement is "To be the area's leading healthcare organization by being a good steward of its finances, a catalyst for the delivery of new and enhanced healthcare services, a consistent supporter of health and wellness, and a reliable healthcare resource for District residents." In that spirit, HMHD has budgeted $25,000.00 to fund local health initiatives within District boundaries for Fiscal Year 2024 (July 1, 2023 to June 30, 2024). The following guidelines will give prospective grant applicants a comprehensive understanding to HMHD's direction and funding priorities.

Program Funding Criteria:

HMHD grant approval criteria includes alignment with HMHD's Mission and Vision Statements. HMHD will entertain proposals that enhance access to care, promote health, and enhance health awareness.

Population Served

As a public agency, HMHD grant funds must serve only HMHD residents (residents of the City of Calexico area). Maps of the District are available at the offices of the Registrar of Voters, the Local Agency Formation Commission (LAFCO), and at the District office located at 601 Heber Ave., Calexico, CA 92231.

Term of Funding

Grants are valid for a maximum of twelve (12) months. An extension of the grant period requires approval of a grant extension or a separate grant. Organizations are cautioned to conduct their programs and activities with the assumption that the program will end on the scheduled completion date.

Grant applicants that are considered to have a financial strong base on significant levels of private and/or other government funding may be deemed ineligible for consideration of District funding. As part of the grant application, organizations requesting $25,000 or having overall operating budgets of $500,000 or more are required to include such funding sources on the provided "All Budget Sources" form.

A. Applicant Eligibility

To be eligible for consideration, the applicant must meet the following requirements:

1. The agency must be an incorporated nonprofit organization with a tax-exempt status under State Law and the Internal Revenue Code; or be a public/governmental agency, program or institution.
2. The agency must demonstrate the ability to provide proposed services. Greater consideration will be given to agencies with experience in providing health-related services.
3. An agency does not need to be located within the HMHD, but it must demonstrate the ability to make services easily accessible to those residing in HMHD community.

B. Funding Priorities

As indicated in the Grants Policy, allocations will be specifically dedicated toward "High Priority" community needs included in the Health Needs Assessments for the Heffernan Memorial Healthcare District population. Only Grant applications addressing the following high priority needs will be considered:

- Urgent Care Services
- Mental Health and Mental Wellness Services
- Chronic Condition Management (i.e. Hypertension, Cardiovascular Disease, Diabetes, Asthma, Obesity, and Cancer).
- Preventive Care Services
- Healthcare Screening (i.e. HTN, Diabetes, Cancer)

HMHD seeks grant requests that emphasize the following characteristics:

- Efforts to make health care more accessible and affordable, especially to underserved residents, while supplementing "safety net" programs
- Delivery of health-related services to high-risk/special needs populations
- Efforts to address unmet healthcare service needs in the community
- Efforts to increase coordination and collaboration of services
- Organizations that demonstrate a realistic potential to sustain projects on a continuing basis after the expiration of HMHD funding
- The training and education of the future health care workforce

Applicants are encouraged, where appropriate, to include matching funds, in-kind services, client fees, agency partnerships, and/or other funding sources.

C. Ineligible for Funding

HMHD will not fund:

- Activities in direct competition with those provided or contemplated by HMHD, or services adequately provided by entrepreneurial or for-profit enterprises in the private sector
- Endowments
- Expenses related to fundraising or lobbying of public officials
- Organizations intending to "pass-through" or re-grant HMHD funds to other organizations, unless acting as an authorized fiscal agent as indicated in the Grant Policy
- Basic research, defined herein as the pursuit of knowledge without practical program or human applications
- Sectarian purposes
- Political purposes
- Individuals (except for HMHD-established and/or supported healthcare scholarship programs)
- Projects for which adequate funding is available from other resources
- Projects capable of sustaining themselves through fee collection or client donations
- Deficit liquidation proposals and/or bankruptcies
- Indirect costs in support of grant purposes are allowable, but in no case shall exceed four percent (4%) of the grant total
- Replacement funds so that a project's current funding can be shifted to other programs of the applicant

D. Review Process

During the review process of the grant applications, HMHD may require additional information from applicants. This information may include oral or written clarification of a grant request and/or site visits. Final funding decisions will be made by the entire HMHD Board at a regular public meeting. The Board may, at its sole discretion, offer a grant greater or lesser than the requested amount.

Grant Monitoring

In accepting a grant, the recipient agrees to periodic monitoring and/or auditing of the grant program by HMHD District staff members and/or a consultant.

NOTE: Any grant recipient not meeting the monitoring requirements as identified and/or agreed to with District staff and/or consultant, including the timely submittal of programmatic reports, will not be eligible for funding in subsequent years or for the payment of open balances during the current funding cycle. Future years' funding may be, at the HMHD Board's discretion, contingent on a measure of quantifiable and/or qualifiable outcomes resulting from the program, including but not limited to a measure of the positive health impact in the community.

E. Information and Inquiries

Please direct any questions to the Heffernan Memorial Healthcare District at (760) 357-6522 or email to information@heffernanmemorial.org in advance of completing these materials. Aside from general questions and phone calls seeking clarity, Heffernan Memorial Healthcare District Board Members, District manager and staff cannot schedule individual meetings with potential grant applicants outside of the established Grants Committee process. The District may provide technical assistance to grant applicants, upon request, by grant program staff.

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GRANT APPLICATION

The following section contains instructions for completing a grant application. The application and all forms must be typewritten or computer-generated. The narrative pages must be single-sided, 8-1/2" x 11" white paper. Text may be single or double-spaced, but no smaller than 12-point standard type (such as Arial, Times Roman), with one-inch margins on all sides.

Each page must be numbered.

Please limit the response to subsection C (Grant Application Summary) to one (1) page. Limit the responses for subsections D (Agency Capability), E (Problem Statement), and F (Program Services and Performance Plan) to a total of five (5) single spaced pages. Please clearly identify all sections with subheadings or by referencing section numbers.

A. **Cover Page** (Use form attached)

1. **Grant Application Checklist** (Use form attached)

2. **Grant Application Summary**

Please include proposed services, project site(s), target population(s), number of HMHD residents to be served, community needs to be addressed, etc.

B. **Agency Capability (Please Describe Briefly)**

1. Your organization's history and accomplishments.
2. Your experience in the provision of services to the target population identified in your grant application.
3. What are the current activities and/or programs operated by your organization? An agency brochure may be attached.
4. List and describe cooperative and collaborative linkages with other organizations that enhance your ability to provide services.
5. Is the proposed program a new service that the agency will provide? Is this an established program that will be expanded to HMHD residents?

6. Note any organizations or programs in the community that provide similar services, as well as whether you've taken any steps to collaborate with them.

C. Problem Statement / Needs Assessment

If this grant application is being submitted for funding as a "High Priority" (as described above), which will assist in addressing one or more of the identified community health needs, please specifically discuss how the program is proposed to address such needs.

Please discuss the need for the proposed service(s) in the HMHD. Discuss how the service is health-related and not a duplication of existing services. Include quantitative and qualitative data documenting the unmet health needs.

D. Program Services and Performance Plan

1. What are the program goals and how do these goals specifically address the identified health needs (s)?
2. What are measurable objectives related to each goal? List specific outcomes and include timelines.
3. What kind of data will be measured and how will that data be collected?
4. How will the effectiveness of the program be assessed? How is quality controlledand monitored? Be specific.
5. How will the proposed program specifically fulfill the elements of the HMHD mission statement? (See page 2 for Mission Statement).
6. How will participants obtain services? Describe the accessibility of the program site(s).
7. How will your agency generate referrals to the proposed program? How will services be marketed to participants?
8. What is the justification for any proposed equipment (if applicable)?
9. For those proposals that desire to be considered on such a basis, how does the proposal demonstrate a collaboration of like providers of service? (See the Grants Policy for specifics and examples).

E. Budget

Project Budget Form is attached.

All Budget Sources Form is attached.

F. Submission of Grant Application and Attachments

Submit **one (1) signed original** and **seven (7) copies** of the Grant **Application**. Also include the following attachments:

1) Articles of Incorporation*
2) Bylaws*
3) Most recent Audited Financial Statement (if needed under California minimum audit requirements)
4) If not required under #3 above, most recent Reviewed Financial Statement by Independent CPA (contact HMHD about the potential of including related costs in Grant Request).
5) IRS Tax Exemption Letter*
6) Board of Directors List

Mail or Deliver to:

Heffernan Memorial Healthcare District
601 Heber Avenue
Calexico, CA 92231

Deadline to submit: June 21, 2023 at 12:00 p.m.

GRANT APPLICATION COVER PAGE

(For July 1, 2023-June 30, 2024 Submissions)

Legal Name of Organization: _____

Agency Director: _____

Address: _____

Phone (&Extension): _____

E-Mail Address: _____

Website: _____

Proposed Project Title: _____

Agency Contact Person: _____

Phone (&Extension): _____

E-Mail Address: _____

Amount of Funds Requested: _____

Number of Unduplicated HMHD Residents to be Served: _____

Ages of Population to be Served: _____

As described as a High Priority Need, this program will assist in addressing the following (check only if applicable):

- o Urgent Care Services
- o Mental Health and Mental Wellness Services
- o Chronic Condition Management (i.e. Hypertension, Cardiovascular Disease, Diabetes, Asthma, Obesity, and Cancer).
- o Preventive Care Services
- o Healthcare Screening (i.e. HTN, Diabetes, Cancer)

Program Description: **(Use an additional page)**

I (we) certify that all information included in this application is complete and accurate.

Signature of person authorized by agency to sign	Printed name and title	Date
Signature of person authorized by agency to sign	Printed name and title	Date

GRANT APPLICATION CHECKLIST (1 of 2)

Please use this checklist to ensure you have included all items in your grant application and provide the completed checklist with your application.

Check the following only if applicable:

- **This program is proposed to address the following needs (check all of those that apply);**
  - o Urgent Care Services
  - o Mental Health and Mental Wellness Services
  - o Chronic Condition Management (i.e. Hypertension, Cardiovascular Disease, Diabetes, Asthma, Obesity, and Cancer).
  - o Preventive Care Services
  - o Healthcare Screening (i.e. HTN, Diabetes, Cancer)
  - o Meal / Nutrition Services

We have included one (1) original and six (7) copies of the following:

- o Grant Application Cover Page (with signatures)
- o Grant Application Summary
- o Agency Capability Statement
- o Problem Statement/Needs Assessment
- o Program Services and Performance Plan
- o Project Budget Form
- o All Budget Sources Form

We have included one (1) original and seven (7) copies of the following (* Not required of Public Agencies):

- o Articles of Incorporation*
- o Bylaws*
- o Most recent Audited Financial Statement, or:
- o Most recent Reviewed Financial Statement by Independent CPA
- o Copy of IRS Exemption Letter*
- o Board of Directors List
- o This Grant Application Checklist

GRANT APPLICATION CHECKLIST (2 of2)

Please note the following:

- If applicable, we have previously submitted all required grant monitoring reports for any previously awarded Heffernan Healthcare District grant(s).
- We understand that award of this grant request in no way establishes an entitlement for future financial assistance.
- We further understand that past funding does not guarantee funding for this grant request.

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HMHD GRANT PROJECT BUDGET FORM FY 2023-2024

Agency Name: _____

Date: _____

PERSONNEL	**HMHD District Funding $**	**Other Funding Available to Project $**	**Total Project Budget $**	**Notes: Additional information**
Salaries–ListPosition(s)				
1.-				
2.-				
3.-				
4.-				
5.-				
6.-				
PayrollTaxesand Benefits *				
Consultant Fees *				
TOTAL PERSONNEL				

Other Expenses	**HMHD Funding $**	**Other Funding Available to Project $**	**Total Project Budget $**	**Notes: Additional information**
1 - Rent				
2 - Utilities				
3 - Insurance				
Miscellaneous–List				
4 -				
5 -				
6 -				
7 -				
8 -				
9 -				
10 -				
TOTAL OTHER$				

TOTAL GRANT EXPENSES				

*Specify details/information.

HMHD ALL BUDGETSOURCES FORM

Per the adopted Grants Policy, organizations having overall operating budgets of $500,000 or more are required to include such funding sources on the following form.

The following information is necessary to provide the Heffernan Memorial Healthcare District with a better understanding of the applicant and program financial resources. Organizations having overall operating budgets of $500,000 or more are required to complete this form.

Total Organization Budget Current Fiscal Year 2024: $_____

Total Requested Project Budget (if different from Organization Budget): $ _____

List Major Sources of Revenue (Total Organization Budget)	List Project Sources of Funding (This Request)

Source of Funds	$ Amount	Percent of Total %	One-Time Funding?		$ Amount	Percent of Total %	One-Time Funding?
Federal		%				%	
State		%				%	
County*		%				%	
City*		%				%	
Other Govt.		%				%	
Proposed HMHD		%				%	
Fees for Service		%				%	
Nonprofit Orgs.		%				%	
Private Donations		%				%	
Other (list)							
		%				%	
		%				%	
TOTAL		%				%	

Percentage of the Organization's budget spent on administration:

Percentage of the requested Project budget spent on administration:

*** City/County**

If the organization currently receives funding from any Cities or Counties, please list jurisdiction, contract amount and contact information.

Jurisdiction	Level of Funding ($)	Contact Name	Contact Phone