General Grant Application Outline

Contribution Guidelines

In considering contributions, the Delta Dental Foundation evaluates each application on its own merits. It considers the programs in which the organization is engaged, the constituencies it serves, the services it offers, its accountability and its fundraising practices, and the level of local community support it attracts. To make it possible to regularly consider new requests, the Delta Dental Foundation's policy is to avoid making multi-year commitments for contributions to specific organizations. Exceptions may be made when a request states that a contribution will be used over a period of years. However, in no case will a multi-year commitment be made for more than three years.

Although exceptions may be made, in general, the Delta Dental Foundation does not provide grants for building construction or to cover an organization's normal overhead expenses. The Delta Dental Foundation gives primary consideration to supporting meritorious programs or activities for which other sources of funding are unavailable. Contributions are also made to specific projects and programs in elementary, middle, and high schools and at individual colleges and universities. Contributions will only be made to organizations providing programs and projects in Michigan, Indiana, Ohio and/or North Carolina.

To formally apply for a grant, please complete and submit the grant request application at https://ddf.smapply.io/.

The following provides the DDF's complete application questions and requirements for application submission.

Please contact the DDF prior to submitting an application to determine eligibility and for any questions at ddf@deltadentalmi.com.

Application Eligibility

In what state is your organization or program located?

Drop down options (select one): Michigan, Ohio, Indiana, North Carolina

Application

1. **Organization Information**

   Tell us a little bit about your organization.

Organization Name	
Tax ID #	
Tax Status	
Address	
City	
State	
Zip Code	
Phone	

Email	
Website	
County	

2. Is your organization a nonprofit?

Drop down (select one): Yes or No

3. Organization Type:

Select the option that best describes your organization:

- ☐ FQHC (Federally Qualified Health Center)
- ☐ Look-alike
- ☐ Community health department
- ☐ School-based health/dental center
- ☐ Volunteer clinic
- ☐ Other (please explain) _____

4. <u>Organization Primary Contact Information</u>

Pronoun(s)	
First Name	
Last Name	
Suffix	
Title	
Mailing Address	
City	
State	
Zip code	
Phone	
Email	

5. <u>Applicant Contact Information</u>

☐ Same as Primary Contact (check if yes)

6. <u>Applicant Contact Information</u>

Please complete if not the same as primary contact.

Pronoun(s)	
First Name	
Last Name	
Suffix	
Title	
Mailing address	
City	
State	
Zip code	

Phone	
Email	

Project Information

Tell us a little bit about your program.

7. Program Title

Enter the name or title of your organization's program/project.

8. Area(s) of Focus

Select the options that best describes your program. (Check all that apply)

- ☐ Increasing dental access to underserved and high-risk populations
- ☐ Identifying and reducing health disparities related to oral and overall health.
- ☐ Providing educational programming on the importance of oral health and how it relates to overall health
- ☐ Continuing education programs for the dental profession

9. Priority Area(s)

All programs must meet one of the following to qualify for funding. (Check all that apply)

- ☐ Increasing dental access to underserved and high-risk populations
- ☐ Age 1 dental visits
- ☐ Increasing access to care or oral health education for people with disabilities
- ☐ Sealant programs
- ☐ Equipment for safety net clinics
- ☐ Medical/dental/mental health integration
- ☐ Serving populations with barriers to care (LGBTQ, elderly/seniors, veterans, homeless, low-income, etc)
- ☐ Fluoridation programs
- ☐ Early childhood (Head Start, WIC, etc)
- ☐ Identifying and reducing health disparities related to oral and overall health
- ☐ Advocacy
- ☐ Research
- ☐ Providing educational programming on the importance of oral health and how it relates to overall health
- ☐ BRUSH program
- ☐ School programs
- ☐ School-based dental clinic
- ☐ Mobile dental programs
- ☐ Continuing education programs for the dental profession

10. What age group does your program serve?

Select the option that best describes the age group your program.

- ☐ All ages
- ☐ Infants (0-2)
- ☐ Children (up to 18)
- ☐ Adults (over 18)
- ☐ Seniors (65+)

11. What population does your program serve?

Select all that your program focuses on.

- ☐ Individuals with disabilities
- ☐ LGBTQ
- ☐ Seniors
- ☐ Veterans
- ☐ Minorities (African American, Native American, Hispanic, etc.)
- ☐ Low-income / Low-socioeconomic class
- ☐ Homeless
- ☐ Infants/children (includes Head Start, WIC, etc)

12. Race Served

If you have this data available, please indicate the percentage known below.

% Caucasian	
% Black/African American	
% Asian	
% Native American/Alaskan Native	
% Native Hawaiian/Pacific Islander	
% Other	
% Hispanic/Latino	

13. Percent Known Poverty Level

If you have this data available, please indicate the percentage known below.

% Patients at or Below 100% of Federal Poverty Guideline	
% Patients at or Below 200% of Federal Poverty Guideline	

14. Percent Known Insurance Status

If you have this data available, please indicate the percentage known below.

% None/Uninsured Patients	
% Medicaid/CHIP Patients	
% Medicare Patients	

15. Which state(s) does your program serve?

Select the state(s) which your program's funding will impact. (Check all that apply)

- ☐ Indiana
- ☐ Michigan
- ☐ Ohio

☐ North Carolina

16. County or Counties Served

Select all counties, within the respective states, that will be impacted by this funding request.
(Check all that apply)

17. How many people do you anticipate will participate in this program?

Estimate the number of lives your program will reach in all aspects of your organization (medical, dental, behavioral, dental, etc.). (Numeric values only.)

18. How many dental patients do you anticipate will participate in this program?

Estimate the number of dental patients your program will reach. (Numeric values only.)

19. Total Cost of Program

Estimate the total budget need to support your program. (Numeric values only.)

20. Amount Requested

Provide the dollar amount being requested from the DDF. (Numeric values only.)

21. Are you seeking other sponsors or funding?

Select one: Yes or No

If yes, please describe:

List all funding partners (federal, state, local, etc.) and any other funding sources you have secured for this project.

22. Is your organization providing any funding for this program?

Select one: Yes or No

If yes, indicate amount: (Numeric values only.)

23. Program Start Date:

Indicate estimated start date of your program. (MM/DD/YYYY)

24. Program End Date:

Indicate estimated end date of your program. (MM/DD/YYYY) If ongoing, please leave blank.

25. Date the funds are requested: Indicate to date you are requesting funds to be distributed. (MM/DD/YYYY)

26. Provide a brief description of the program for which funds are requested.

Describe your funding request including the purpose and expected overall change your organization expects to see as a result.

27. What is unique about your program and why should DDF fund it?

Describe what distinctively sets your organization apart.

28. **Describe follow-up activities or evaluation processes that are a part of this program.**

    How do you plan to track or measure the effectiveness of your program/organization?

29. **How did you hear about this grant opportunity?**

    Please provide where you heard about DDF and this grant opportunity.

30. **How has your organization been impacted by COVID-19 and what adjustments have been made as a result?**

    What, if any, obstacles has your organization come up against within the last year and what changes has your organization had to make due to those difficulties.

Budget Requirements/Requests

Outline the budget requirements ONLY for the program/project your organization is requesting funding for. Make sure to provide as much detail as possible by separating out the line items appropriately. If you are requesting equipment, please provide a copy of a quote(s) you have received.

File types accepted include: .pdf, .doc, .docx, .xls or .xlsx

Financials

If your organization is a 501(c)(3) organization, we require a copy of the most recent Form 990 or most recent copy of your organization's audited financials.

File types accepted include: .pdf, .doc, .docx, .xls or .xlsx

IRS Documentation

IRS public charity classification, reason for non-private foundation status.

File types accepted include: .pdf, .doc, .docx, .xls or .xlsx

Completed W-9

Please include a completed 2018 W-9 for your organization. The form MUST be a 2018 version of the IRS W-9 form (indicated on the top left of the form).

File types accepted include: .pdf, .doc or .docx

Additional Documentation

This section is reserved for any additional documents, videos, etc. that your organization would like to include with your application to the DDF. (Optional)