



## General Grant Application Outline

### Contribution Guidelines

In considering contributions, the Delta Dental Foundation (DDF) evaluates each application on its own merits, and careful consideration is given to each request. Primary considerations include: programs in which the requesting organization is engaged; the constituencies served; accountability and fundraising practices; level of community engagement; availability of alternative sources of funding; viability of the program; and potential impact on oral health and/or dental science. Grants may also be made to specific projects and programs in schools, prekindergarten through grade 12, as well as universities and colleges.

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 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](mailto: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.

<b>Organization Name</b>	
<b>Tax ID #</b>	
<b>Tax Status</b>	
<b>Address</b>	
<b>City</b>	

<b>State</b>	
<b>Zip Code</b>	
<b>Phone</b>	
<b>Email</b>	
<b>Website</b>	
<b>County</b>	

**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
- Volunteer or safety-net clinic
- Nonprofit
- College or university
- Government

**4. Organization Primary Contact Information**

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

**5. Applicant Contact Information**

- Same as Primary Contact (check if yes)

**6. Applicant Contact Information**

Please complete if not the same as primary contact.

<b>Pronoun(s)</b>	
<b>First Name</b>	
<b>Last Name</b>	
<b>Suffix</b>	
<b>Title</b>	

<b>Mailing address</b>	
<b>City</b>	
<b>State</b>	
<b>Zip code</b>	
<b>Phone</b>	
<b>Email</b>	

### **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. Strategic Aim**

Select the ONE strategic aim that best encompasses your program. (Check only one)

- Access to Care
- Advocacy
- Education
- Workforce Development
- Emerging Initiatives

#### **9. What age group does your program serve?**

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

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

#### **10. What population does your program serve?**

Select your program's PRIMARY population of focus. (check only one)

- People with disabilities
- LGBTQ
- Older adults
- Veterans
- Racial or ethnic groups that have been historically or systemically disadvantaged (African American, Native American, Hispanic, etc.)
- Low-income
- People experiencing homelessness
- Infants/children (includes Head Start, WIC, etc.)
- General Population

**11. What is your secondary population of focus (If any)? (optional)**

Select your program’s secondary population of focus. (check only one, if any)

- People with disabilities
- LGBTQ
- Older adults
- Veterans
- Racial or ethnic groups that have been historically or systemically disadvantaged (African American, Native American, Hispanic, etc.)
- Low-income
- People experiencing homelessness
- Infants/children (includes Head Start, WIC, etc.)
- General population

**12. Race Served**

Please indicate the racial and ethnic breakdown of the population you serve. If you do not measure this, please enter “0” in each field.

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

**13. Known Poverty Level**

Please enter the number of patients served below. If you do not measure this, please enter “0” in each field.

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

**14. Known Insurance Status**

Please enter the number of patients served below. If you do not measure this, please enter “0” in each field.

# 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 does your organization serve annually?**

Estimate the number of people you serve in all aspects of your organization (medical, dental, behavioral, dental, etc.). (Numeric values only.)

**18. How many people will this program serve?**

Estimate the number of people who will participate in the specific program for which you’re requesting funding. (Numeric values only.)

**19. Total Cost of Program**

Estimate the total budget needed 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 the 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 program apart.

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

How do you plan to measure the success of your program?

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

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

### Budget Requirements/Requests

Outline the budget requirements ONLY for the program/project your organization is requesting funding for. **(If you submit your overall budget, we will not be able to process your request.)** 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 any 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)