**SUMMIT ENDOWMENT**

**2023 Healthy people 2030 priority grant**

**level i APPLICATION COVER SHEET**

**PROGRAM/PROJECT SUMMARY**

Organization: Click here to enter text.

Project: Click here to enter text.

Grant period: Click here to enter text.

Amount requested: $ Click here to enter text.

Total project cost: $ Click here to enter text.

Task Force Group: Click here to enter text.

Summary: Click here to enter text.

**CONTACT INFORMATION**

Contact Name & Title: Click here to enter text.

Address: Click here to enter text.

Phone: Click here to enter text.

E-mail: Click here to enter text.

Website: Click here to enter text.

**SIGNATURES**

***This organization is in compliance with all applicable Federal, State, and local regulations, as well as Medicare/Medicaid, and other relevant regulations.***

Signed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Applicant Author Title Date

Signed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Chief Executive Officer Title Date

**SUMMIT ENDOWMENT**

**2023 HEALTHY PEOPLE 2030 PRIORITY GRANT**

**LEVEL I program narrative**

**SPECIFIC NEED/PROBLEM IN THE COMMUNITY**

1. What is the specific need/problem you want to address? What is the evidence of this problem or  
 need? Click here to enter text.

2. Describe the geographic area and the target population, including your current role with this group. Click here to enter text.

**YOUR PROGRAM TO ADDRESS THIS SPECIFIC NEED**

1.List the appropriate (1) Healthy People 2030 objective you will address. Click here to enter text.

2. Provide an overview of your program/project. Click here to enter text.

3.Who and how many people will benefit from your effort (*number and ages of people, their* *geographic location, etc.*)? How, exactly will they benefit? Click here to enter text.

4. What desired outcomes (*positive changes or improvements*) will happen?Click here to enter text.

5. What activities will achieve these desired outcomes? Click here to enter text.

6. What other groups will collaborate with you to achieve the desired outcomes? Click here to enter text.

7. Who will lead and staff your program? Summarize their experience and qualifications. Click here to enter text.

8. What do you foresee as the biggest obstacle(s) to achieving desired outcomes? How will you address these obstacles? Click here to enter text.

9. How will you know/measure if you are succeeding? Click here to enter text.

**FUNDING**

1. How will you obtain the rest of the funds needed? Click here to enter text.

2. How will you sustain your program after Summit Endowment funding ends? Click here to enter text.

3. Complete and attach the budget worksheet and budget narrative.

4. Are you a tax exempt, non-profit 501 (c) (3) organization? Click here to enter text.

5. Provide a copy of your IRS determination letter *(unless you are a department or service of WellSpan Chambersburg Hospital, WellSpan Waynesboro Hospital, or WellSpan Health).*

6. Provide a copy of your most recent IRS Form 990.

7. What is your annual operating budget? Click here to enter text.

**YOUR ORGANIZATION**

1. What is your organization’s mission statement? Click here to enter text.
2. Provide a brief overview of a current or recent program that you have evaluated, including outcome/indicator data (results) to support your efforts. Click here to enter text.

**Questions, or for more information, contact:**

Ann Spottswood

Director of Community Services

WellSpan Health

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