



Sample Grant
Proposal for a
Community Health
Worker Program





Table of Contents

Introduction.....	3
How to Use this Sample Grant Proposal.....	4
Summary of the Sample Grant Proposal.....	5
Introduction/Abstract.....	6
Background/Needs Assessment.....	8
Program Description.....	13
Goals and Objectives.....	15
Methodology.....	18
Work Plan.....	21
Evaluation Plan & Tracking and Monitoring.....	29
Resolution of Challenges.....	33
Program Management and Staffing.....	35
Organizational Information.....	38
Reference List.....	41
Sample Budget.....	42



Introduction

Securing funding is an integral step for any Community Health Worker (CHW) program. One of the most common forms of financing for CHW programs is grant funding. The following sample grant proposal is intended to provide an example of how to create a proposal for a CHW program.



How to Use this Sample Grant Proposal

The following sample grant proposal is an example of a proposal or narrative for a CHW program based on standard sections found in requests for proposals from the federal government. Grant proposals requested by private foundation funders may differ in structure and length. You can use this sample proposal as a model of how to describe community health needs, explain a CHW program, and write objectives.

Keep in mind, this is one example of a proposal, and there are other, equally effective formats and approaches. **It is essential to adapt this sample proposal to fit your community, organization, and the specific requirements of the funding agency.** This includes incorporating local data on your target population and the health problems they face in your community.

For more information or assistance on funding and creating grant proposals for CHW programs, please visit our website at mhpsalud.org, or contact us at info@mhpsalud.org.



Summary of the Sample Grant Proposal

In this sample grant proposal, **[Name of Organization]** requests \$367,925 per year (see attached “**Sample Budget for a Community Health Worker Program**”) to conduct a Community Health Worker (CHW) program for two years. The program will be focused on health promotion, increasing community linkages to health and social services, and providing eligibility pre-screening and enrollment assistance for public benefit programs among low-income, Hispanic residents living in the *colonias* of the lower Rio Grande Valley region in Texas. Four full-time CHWs will be dedicated to the program. They will participate in initial and on-going training, receive individual supervision, and serve their community by carrying out:

- A community health assessment with 200 individuals
- Outreach to 4,200 community members
- Referrals to 700 individuals to health or social services, including follow-up on whether or not services were received
- Pre-screening or assistance with 350 applications for public benefit programs (e.g., Medicare/Medicaid, Children’s Health Insurance Program (CHIP), Supplemental Nutrition Assistance Program (SNAP), and Temporary Assistance for Needy Families (TANF)), including follow-up on whether or not benefits were received; and
- 320 health education sessions in the community

As a result of the program, *colonia* residents will have increased linkages to health and social services and access to greater health information.



Introduction/ Abstract

OVERVIEW

Most funders that require an abstract will give specific requirements for what the abstract should include. If an abstract is not required, most grant proposals will include an introductory section in order to orient the funder to your local situation and your proposed program.

Hispanics are at a higher risk than other ethnic groups for several health conditions, including diabetes and obesity. In the Rio Grande Valley of Texas, where the population is predominantly Hispanic, the region rates lower on several health-related factors than in other parts of the state, including high rates of people diagnosed as overweight, obese, or with a chronic disease. This is compounded by the multiple and complex barriers residents of this area face in accessing health resources and services, such as transportation or linguistic or cultural barriers. To respond to these challenges, **[Name of Organization]** will develop, implement, and evaluate a Community Health Worker (CHW) program in the Rio Grande Valley.

The CHW model is an evidence-based approach that uses community-based health promotion and principles of community organization and empowerment to address health issues and to impact knowledge, attitudes, and behaviors from within underserved communities. The proposed program will focus its efforts on *colonias*, unincorporated rural neighborhoods in the Rio Grande Valley that commonly lack water, sewage, and other municipal services. Individuals from these target communities



will be trained as CHWs and will conduct outreach, connect individuals to health and social services, and provide health education to *colonia* residents. CHWs will record and evaluate follow-up to those referred to local health and social services and will administer pre- and post-tests to measure knowledge gain during the health education sessions.

The overall goal of this program is to increase access to health and social service resources and improve the health knowledge of the low-income, Hispanic population in *colonias* of the Rio Grande Valley of Texas. Four CHWs will be recruited and trained to conduct a community health assessment with 200 individuals; conduct outreach to 4,200 community members; refer 700 individuals to health or social services; provide eligibility pre-screening and enrollment assistance for 350 applications for public benefit programs (e.g., Medicare/Medicaid, Children's Health Insurance Program (CHIP), Supplemental Nutrition Assistance Program (SNAP), and Temporary Assistance for Needy Families (TANF)); and facilitate 320 health education sessions in the community. As a result of the program, *colonia* residents will have increased linkages to health and social services and access to greater health information.

THINGS TO KEEP IN MIND

- *An abstract should be a brief summary of the proposed program. It should be no longer than a page, or roughly 350-400 words.*
- *Include only the most important highlights of your proposal, and be sure to include the goals and objectives.*



Background/ Needs Assessment

OVERVIEW

The “Background/Needs Assessment” section establishes the need for your proposed program and should include information such as the social, geographic, cultural, economic, and other contexts of the problem your program will address. Specific and local data is extremely helpful in establishing both the need for the program and your organization’s knowledge of local conditions.

Target Population

The proposed program will take place in the Rio Grande Valley of Texas. The Valley, as it is known, is located in the southernmost tip of Texas along the U.S.-Mexico border. It includes Cameron, Hidalgo, Starr, and Willacy Counties. The Valley is a culturally and geographically unique region of the United States. The four counties have a combined population that is 91 percent Hispanic, and 74 percent of the population aged 5 and older speak Spanish at home.¹ Though predominantly rural, in recent years, the region has experienced some of the most rapid growth in the nation.²

The program will work specifically with the Hispanic population living in *colonias* in the Rio Grande Valley. *Colonias* are unregulated and unincorporated residential areas that oftentimes lack basic services, such as water, electricity, sewage and garbage removal, and street paving and maintenance. Due to the rural and hard-to-reach nature of the *colonias*, data on the amount of people living in *colonias* is often inconsistent and many individuals may go

1. U.S. Census Bureau, 2009-2013 American Community Survey.
2. Gozner, M. (2012, January 5). McAllen, Texas: Big Turnaround for Hard-Hit City. The Fiscal Times. Retrieved November 2, 2015, from <http://www.thefiscaltimes.com/Articles/2012/01/05/McAllen-Texas-Big-Turnaround-for-Hard-hit-City.aspx#page1>



unaccounted for. The Texas Secretary of State reports that 400,000 Texans live in *colonias* along the U.S.-Mexico border,³ while the Housing Assistance Council (HAC) estimates that 1.6 million individuals reside in these neighborhoods.⁴

Need

Hispanics are a growing minority in the United States. According to the Centers for Disease Control and Prevention, one in six people living in the U.S. is Hispanic, and it is believed that this could become one in four by 2035.⁵ Despite the rapid population growth, Hispanics are more likely to suffer from various preventable health problems than whites. For example, Hispanics are 50% more likely than whites to die from diabetes or chronic liver disease. A primary cause of this disparity is the fact that Hispanics are more likely to go without health care until the need is critical and costly.

Therefore, it is imperative that health programs reach into the community and serve Hispanic residents in their homes, faith communities, work places, and schools.⁶

The Valley is notorious for its socioeconomic and health-related challenges. Valley counties rank among the worst in Texas in terms of behavioral, social, and environmental factors that affect health.⁷ Among the various health concerns in the area, there is “an unprecedented diabetes pandemic.”⁸ The prevalence of the disease has increased by 100 percent in the area as compared to an increase of 56 percent in the state of Texas and 52 percent in the country. It is believed that there are numerous other people who have diabetes that have gone undiagnosed.⁹

3. Texas Secretary of State. (n.d.). Retrieved November 2, 2015, from <http://www.sos.state.tx.us/border/colonias/faqs.shtml>

4. Rivera, D. (n.d.). The Forgotten Americans: A Visual Exploration of Lower Rio Grande Valley Colonias. Michigan Journal of Sustainability.

5. Hispanic Health. (2015, May 5). Retrieved December 3, 2015, from <http://www.cdc.gov/media/dpk/2015/dpk-vs-hispanic-health.html>

6. Pérez-Escamilla, R., Garcia, J. and Song, D. (2010). Health Care Access among Hispanic Immigrants: ¿Alguien Está Escuchando? [Is Anybody Listening?]. NAPA Bulletin, 34: 47–67.

7. “Health factors” include health behaviors clinical care, social and economic factors, and the physical environment.

8. Unidos Contra Diabetes. (2015, April). Common Agenda.

9. Ibid.



The Rio Grande Valley also suffers from high rates of obesity. According the 2015 Common Agenda, half of the region’s residents are obese and three quarters are believed to be overweight or obese.¹⁰ Obesity can lead to other health issues, such as coronary heart disease, high blood pressure, stroke, Type 2 diabetes, and some cancers.¹¹

The following table demonstrates how the four proposed counties rank in various health-related areas as compared to the state of Texas as a whole.¹²

Health Topic	State of Texas	Cameron County	Hidalgo County	Starr County	Willacy County
Poor or fair health	18%	30%	27%	33%	Un-available
Adult obesity	29%	28%	34%	31%	30%
Access to exercise opportunities	84%	77%	60%	29%	30%
Uninsured	25%	36%	39%	34%	29%
Primary care physicians	1,708:1	2,109:1	2,186:1	4,740:1	3,151:1
Preventable hospital stays	63	64	69	110	74
Severe housing problems	18%	25%	28%	20%	20%

As the table above shows, the four proposed counties rank significantly lower than the rest of the state in various areas of health and social determinants of health. Additionally, the region has a high amount of uninsured individuals with an average of 34.5 percent for the four counties as compared to 25 percent for the state of Texas. As is evidenced in the table under Primary Care Physicians (PCPs), there are disparities between the amount of PCPs available and the population of the county. Starr County is a federally-designated Health Professional Shortage Area (HPSA), meaning that there are more residents than available health and mental health professionals can serve, and Cameron

10. Ibid.

11. What Are the Health Risks of Overweight and Obesity? (n.d.). Retrieved December 10, 2015, from <http://www.nhlbi.nih.gov/health/health-topics/topics/obe/risks>

12. Health Rankings. (n.d.). Retrieved December 10, 2015, from <http://www.countyhealthrankings.org/app/texas/2015/compare/snapshot?counties=061%2B215%2B427%2B489>



County is a partial HPSA. A lack of insurance and an insufficiency of physicians compound to make it difficult for area residents to access and use health care.¹³

Contributing to these health challenges, many residents are monolingual Spanish-speakers and/or have recently emigrated from Mexico; therefore, having access to culturally and linguistically appropriate health information and outreach is imperative. Additionally, many residents live in rural areas and transportation is not always available to them. Economic factors also impede the Valley population from accessing health resources and services. The following table examines economic factors and their implications on health in the state of Texas and in the four proposed target counties:¹⁴

Economic Factor	State of Texas	Cameron County	Hidalgo County	Starr County	Willacy County
Unemployment	6.3%	10.1%	10.8%	15.4%	13.8%
Children in poverty	25%	45%	45%	51%	50%
Health care costs	\$11,079	\$11,896	\$12,588	\$12,574	\$12,215
Could not see doctor due to cost	19%	30%	33%	40%	Unavailable

Although unemployment rates are often double the state average in some counties, health care costs are higher in the Valley. These costs are high enough to prevent the population from seeking care in some cases, as is evidenced in the table above.

A variety of factors, including lack of insurance, a shortage of medical professionals, and economic disparities create a health environment in which individuals have reduced access to health care, and, therefore are at greater risk of not seeking preventative care for their health needs.

13. A Community Health Needs Assessment & Implementation Plan. (2013, May 1). Retrieved January 5, 2016, from http://missionrhc.org/uploads/file/2013_mrrmc_community-needs-assessment.pdf

14. Health Rankings. (n.d.). Retrieved December 10, 2015, from <http://www.countyhealthrankings.org/app/texas/2015/compare/snapshot?counties=061%2B215%2B427%2B489>



THINGS TO KEEP IN MIND

- *Include demographic data in this section that truly paints a picture of the service area, the target population, and the problem to be addressed. If available, use census data or data from other governmental or reliable sources.*
- *Whether you are writing a proposal for a brand new program or for more funds for an existing program, your organization may have relevant data from previous assessments or program reports. If available, this information should be included as well.*
- *Other local organizations or offices may have data that could help you illustrate the need in the community. For example, nonprofit hospitals must conduct and publish a community needs assessment, which could contain valuable statistics specific to your target population. Other organizations that might have relevant information might include local government offices, partner agencies, and local coalitions or associations.*
- *While it is important to include demographic data, consider using some qualitative data as well. Use anecdotes or quotes from your organization's own reports, stories that have been published in local news sources, or quotes or information from other local authorities working in some aspect with the same health issue or target population.*



Program Description

OVERVIEW

The “Program Description” section describes the proposed intervention and presents evidence of, or arguments for, its effectiveness in meeting the need established in the “Background/Needs Assessment” section.

In the proposed program, **[Name of Organization]** will implement a Community Health Worker (CHW)-led intervention to successfully increase access to health and social service resources and information of *colonia* residents in the Rio Grande Valley. **[Name of Organization]** will recruit CHWs to promote substantial gains in health and well-being in their communities in two key areas: (1) improved access to health care and social services, and (2) improved communication of health information in the community. CHWs will increase access to care by providing outreach to the *colonias* through general door-to-door contacts and through encounters at health fairs and other community events. Through these interactions, CHWs will understand the program participants’ health challenges and will refer individuals to the appropriate health and social service entities as well as connect them to social benefit programs, such as Medicare/Medicaid, CHIP, SNAP, and TANF. Additionally, CHWs will develop relationships with the health and social service agencies and will serve as a bridge between these providers and community members, which will help foster the community’s access to health and improve the community’s perceptions of health providers. Furthermore, the CHWs will provide culturally and linguistically appropriate health education sessions



in the community. Based on the needs and interests identified by community members, the CHWs will disseminate accurate and relevant health information and promote healthier lifestyles.

The CHW model is one of the most time-tested, effective, and frequently cited community-based approaches to improving health. There have been many documented cases of successful CHW interventions that address diverse health problems with a wide variety of populations, both globally and nationally. The proposed program will utilize CHWs to bridge the gap between *colonia* residents and health and social service resources. CHWs are peer health educators who are trusted members of their community. As a member of the community that they serve, CHWs understand the challenges and barriers that might prevent the target population from accessing health and social services. The trusting relationship CHWs develop with the community combined with their knowledge of the health system and social services allows them to serve as a liaison between these services and the community, facilitate access to services, and improve the quality and cultural competence of service delivery.



THINGS TO KEEP IN MIND

- *In this section, focus on **how** the proposed program addresses the previously described needs, but avoid going into too many implementation details. These details will be described in the “Work Plan” section.*
- *As appropriate, you can include information here on your previous experience with Community Health Worker programs or related experience with the target population. You may be asked to provide more detail on your experience with the CHW model and target population in the “Organizational Information” section as well, so keep any mention of prior work or experience limited.*
- *It is a good idea to describe what other services or initiatives exist in the area and how your program will complement these efforts.*
- *Even if it is not required, including a map of the proposed service area can be helpful.*



Goals and Objectives

OVERVIEW

Different funders use different terminology (“Strategies” rather than “Objectives,” for example), but all funders will want to see evidence that your program has specific, measurable, achievable, and realistic goals and objectives, and that you have established a timeframe in which the objectives will be met.

Goal

To increase access to health care and social services and improve health knowledge among low-income, Hispanic residents of *colonias* in the lower Rio Grande Valley of Texas, **[Name of Organization]** will: develop, implement, and evaluate a community-based, CHW-led health promotion program that will result in increased community linkages to health and social services, pre-screening and application assistance for public benefit programs (e.g., Medicare/Medicaid, CHIP, SNAP, and TANF), and expanded communication of health information in the community served.

Process Objectives

- By **[Date]**, recruit, train, and supervise four individuals from the target population as CHWs. *Each CHW will complete 80 hours of initial training upon hire. On-going training and supervision by the Program Coordinator will be provided throughout the program period to reinforce information, provide support, and address individual and program needs as they arise.*



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- By [Date], design and administer a community health assessment to 200 individuals. Results from the community health assessment will be used to identify the topics for the health education sessions, needs, and existing resources within the community
 - By the end of the program period, complete 4,200 individual encounters and provide information on health and social service resources in the community
 - By the end of the program period, make 700 referrals for community members to health or social services
 - By the end of the program period, pre-screen and/or assist with 350 applications for public benefit programs
 - By the end of the program period, facilitate 320 community health education sessions

Outcome Objectives

- Of those receiving a referral to health or social services, 60 percent will indicate receipt of services.
- Of those who received assistance with applying for public benefit programs (e.g., Medicare/Medicaid, CHIP, SNAP, and TANF), 60 percent will confirm approval for benefits.
- Upon completion of a health education session, and as measured by pre- and post-tests, participants who complete the health education sessions will demonstrate a statistically significant increase in knowledge on the given health topic.



THINGS TO KEEP IN MIND

- *Be sure to utilize the SMART (Specific, Measurable, Attainable, Realistic, and Time-bound) criteria when developing your own goals and objectives and tailor them to the requirements of the specific funder or request for proposals.*
- ***Process objectives** focus on what the program will do to meet its goals and how it will do it. These can include activities, meetings, health education sessions, focus groups, etc. **Outcome objectives** focus on the results of the program. For instance, did the program lead to changes in knowledge, increased medical screenings, or improved health? Having both process and outcome evaluation will give you the strongest results for your program. For more information on goals, objectives, and program evaluation, see [MHP Salud's Evaluation Toolkit](#).*



Methodology

OVERVIEW

The “Methodology” section focuses on why the chosen program methods and activities were selected.

CHWs are carefully chosen community members who promote health in their own communities. As members of minority and underserved populations, they are in a unique position to build on strengths and to address unmet health needs in their communities. CHWs are able to integrate information about health and the healthcare system into the language, culture, and value system of the target population, thus increasing the community’s access to health services. CHWs are ideally suited to:

- Address complex barriers to health services
- Advocate for health care services on behalf of community members
- Provide culturally and linguistically competent services
- Change social norms
- Empower peers to improve health conditions in their communities

CHWs are trained to provide health promotion and education to the target population. They foster relationships with local health centers and other service providers and are able to refer community members to these agencies. Through the relationships they build with community members, CHWs can understand the unique challenges that each individual has regarding his or her access to health and social services and can offer culturally-competent solutions to these obstacles. By investing



in the training, support, and action of CHWs, the program creates a sustainable increase in community capacity that facilitates change from the grassroots.

CHWs often have first-hand experience with the systems that impact health. They are suited to engage community members and to speak sincerely about their own experiences in order to advocate for change and ensure that community members become advocates for their own health. In the U.S., CHWs have succeeded in increasing vulnerable communities' access to health care, including pap smears and mammograms, as well as addressing other health concerns.¹⁵ In addition, CHW programs support the Social Determinants of Health pillar of the “Healthy People 2020” initiative. Since CHWs are embedded members of the community, they have a deeper understanding of the social factors that impact the health of their community, like housing, transportation, income, etc.

In this proposed program, the CHW model will be utilized to empower *colonia* residents to adopt healthy lifestyles. Through community-based, individual behavior change interventions, community members will be encouraged to be advocates of their own health and that of their families. CHWs will be the primary implementers of a community needs assessment, which will identify the primary health needs and gaps among the *colonia* residents. The results of the assessment will be used to inform the topics of health education sessions for the community. Throughout these encounters, as well as through outreach in the community, CHWs will refer clients to the appropriate health or social service provider, depending on the specific need of the individual, and will provide follow-up for all those referred. Additionally, the CHWs will help individuals with pre-screening and applying for public benefit programs.

15. Center for Policy Alternatives. (1997). Community health workers: A leadership brief on preventative health programs. Harrison institute for Public Law at Georgetown University Law Center and the Center for Policy Alternatives; Corkery, E., Palmer, C., Foley, M., Schechter, A., Frisher, L., & Roman, S. (1997). Effect of bicultural community health worker on completion of diabetes education in a Hispanic population. *Diabetes Care*, 20, 254-257; Eng, E., & Young, R. (1992). Lay health advisor as community change agents. *Family Community Health*, 15, 24-40; Meister, J., Warrick, L., Zapién, J., & Wood, A. (1992). Using lay health workers: Case study of a community-based prenatal intervention. *Journal of Community Health*, 17, 37-51; Rosenthal, E. L., Wiggins, N., Brownstein, J. N., Rael, R., Johnson, S., & Koch, E. (1998). The summary of the national community health advisor study. Washington, DC: Harrison Institute for Public Law, Georgetown University Law Center; Witmer, A., Seifer, S., Finocchio, L., Leslie, J., & O’Neil, E. (1995). Community health workers: Integral members of the health care work force. *American Journal of Public Health*, 85, 1055-1058.





THINGS TO KEEP IN MIND

- *In this section, it may be appropriate to include a discussion of any theoretical framework that is being used to guide the development of the program.*
- *Make the case as to why the methodology chosen best responds to the previously described needs.*



Work Plan

OVERVIEW

The “Work Plan” section aims to answer the question “What will be done?” This is your opportunity to go into the details of the program implementation.

The proposed program aims to increase access to health care and social services and promote the adoption of healthy lifestyles among *colonia* residents in the Rio Grande Valley. Trained CHWs will provide community-based, culturally-competent peer support, referrals, and health education. Ultimately, the program will break down stigmas that prevent people from seeking care; identify needs and refer people to health and social services; follow up with people receiving care; and provide culturally-appropriate information and education.

Upon initiation of the program, the Program Director and Program Coordinator will begin the recruitment process for the CHWs. As discussed, CHWs are trusted members of the target population who share similar language, culture, and life experience as those they serve. **[Name of Organization]** proposes to hire four full-time CHWs to carry out the community-based program activities. Once hired, the CHWs will participate in a collaborative, two-week training. This initial training will consist of an internal training which will cover topics such as an organizational orientation, conducting community health assessments, making referrals, pre-screening and applying for public benefit programs (e.g.,



Medicare/Medicaid, CHIP, SNAP, and TANF), and [Name of Organization]'s follow-up process on referrals and applications. In addition to internal training, the CHWs will participate in a core competency-based CHW training facilitated by partner organization MHP Salud. The training will emphasize the acquisition of core skills needed for fulfilling their roles. These core competencies include: the role of the CHW, educating in the community, the impact of culture on health, ethical responsibility and confidentiality, self-care, communication, health literacy, technology, data collection and analysis, among others.

During this same initiation period, the Program Coordinator, with support and guidance from the Program Director, will develop and finalize data collection instruments and tracking tools; prepare or purchase supplies and equipment; and design the community health assessment to be implemented by the CHWs. The community health assessment will gauge the current awareness and knowledge of health and social services among community members and identify areas of need or interest in regards to health education. Furthermore, in consultation with the CHWs, [Name of Organization] will ensure that the assessment instrument will be culturally, linguistically, and reading-level appropriate for the community.

After the initial orientation/training, each CHW will be assigned a target area to concentrate their outreach efforts. During outreach, the CHWs will complete individual encounters along with any necessary referrals for health care or social services, assistance with pre-screening or enrolling in benefits, such as Medicaid/Medicare, CHIP, SNAP, or TANF, or other appropriate forms of assistance. The CHWs will also commence the implementation of the community health assessment. To reach community members, CHWs will use a variety of strategies, such as door-to-door outreach, visits to community centers, and participation in health fairs or other community events. The Program Director and Program Coordinator will oversee these and other strategies, but will rely on the CHWs, who are by nature more deeply embedded in the communities



they serve, to recommend the strategies they think would be most effective at reaching the targeted communities.

Upon completion of the community health assessment, the results will be analyzed collaboratively by the Program Director and Program Coordinator and shared with the CHWs. Working together, the Program Coordinator and CHWs will create a plan to integrate health education sessions into the outreach activities. The health education sessions will be designed to respond to needs and interests identified by the respondents. Sessions will last approximately 45 minutes and take place at a location and time that is convenient for participants. CHWs will explore and define appropriate and accessible meeting sites, such as community centers, parks, nearby schools, churches, or other neighborhood meeting venues.

Community outreach (including individual encounters, referrals to health and social services, and assistance with pre-screening and enrollment for public benefit programs) will continue throughout the program period. Follow-up will also be conducted with individuals who receive referrals or application assistance in order to confirm receipt of services or benefits. Additionally, throughout the program period, the CHWs will receive on-going training and weekly supervision from the Program Coordinator. Supervision time will be dedicated to discussing successes and challenges, evaluating progress towards reaching process and outcome measures, problem-solving, and support.

[Name of Organization] has long-standing relationships with several local health and social service agencies in the area, including the Rio Grande Valley Community Health Center (RGVCHC), a federally-funded health center with clinic sites across the Valley, and the Rio Grande Valley Department of Health and Human Services (RGVDHHS). RGVCHC will serve as a key referral site for health care services, and the RGVDHHS will provide ongoing support as the CHWs assist community members with applications for public benefit programs. The CHWs will also reach out to and foster relationships with local



health and social service organizations in the community to inform them of the program and of potential referrals. Through the cultivation of new and existing relationships and in response to the identified needs and interests from the community health assessment, the CHWs (in consultation with the Program Coordinator) will compile a directory of the local health and social service resources. This directory will be continually updated and assessed throughout the program period and will be referenced during outreach as needed.

The following table outlines the program **goals**, **objectives**, **activities**, and **expected outcomes**:

Goal: To increase access to health care and social services and improve health knowledge among low-income, Hispanic residents of <i>colonias</i> in the lower Rio Grande Valley of Texas.	
<u>Objective</u>	<u>Expected Outcome(s)</u>
1. By [Date] , four CHWs will be recruited, trained, and supervised.	<ul style="list-style-type: none">• Community-based CHWs will serve as a trusted resource for access to health and social services as well as health information.
Activities: a. CHWs will participate in 80 hours of initial training upon hire. In addition to topics such as organizational orientation, making referrals, pre-screening and enrollment assistance for public benefits programs, conducting follow-up, etc., the CHWs will complete a core competency training. b. On-going training and supervision by the Program Coordinator will be provided to reinforce information, provide support, and address individual and program needs as they arise.	
2. By [Date] , design and administer a community health assessment to 200 individuals.	<ul style="list-style-type: none">• Better understanding of the health needs and interests of community members will be achieved• Results from the community assessment will be used to inform the development of community health education sessions.



<u>Activities:</u> a. Program Coordinator will develop a community health assessment to gauge current health and social service needs and interests. b. Each CHW will be assigned a target area and implement the community health assessment with at least 50 individuals.	
3. By the end of the program period, CHWs will reach at least 4,200 individuals through community outreach.	<ul style="list-style-type: none">• CHWs will reach at least 2,000 individuals in year one.• CHWs will reach at least 2,200 individuals in year two.• Total of at least 4,200 individuals will be reached with information on community health and social service resources.
<u>Activities:</u> a. Each week, CHWs will provide door-to-door outreach, visits to community centers, and/or participation in health fairs and other community events. b. CHWs will network with local health and social service agencies to promote the program as well as become more aware of the services agencies provide in the community. c. CHWs will compile a directory of local health and social service agencies to be used as a reference tool while conducting outreach, and will be periodically updated the directory throughout the program period as new contacts are made.	
4. By the end of the program period, CHWs will complete at least 700 referrals to health or social services.	<ul style="list-style-type: none">• CHWs will complete at least 330 referrals in year one.• CHWs will complete at least 370 referrals in year two.• Total of at least 700 referrals to health or social services will be completed.• 60 percent of those receiving a referral to health or social services will indicate receipt of services.
<u>Activities:</u> a. In the course of outreach and through the health education sessions, CHWs will identify community members interested in receiving services for health and social services. b. CHWs will conduct follow-up with those receiving a referral to see if services were received.	



<p>5. By end of the program period, pre-screen and/or assist with at least 350 applications for public benefit programs.</p>	<ul style="list-style-type: none">• CHWs will assist with at least 170 applications in year one.• CHWs will assist with at least 180 applications in year two.• Total of assistance with at least 350 applications for public benefit programs.• 60 percent of those who received assistance in applying for public benefits will confirm approval of benefits.
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Activities:

a. In the course of outreach and through the health education sessions, CHWs will identify community members interested in applying for public benefit programs.

b. CHWs will conduct follow-up with those they assisted with enrollment in public benefit programs to see if the application was approved.

<p>6. By the end of the program period, facilitate at least 320 health education sessions.</p>	<ul style="list-style-type: none">• CHWs will facilitate at least 140 health education sessions in year one.• CHWs will facilitate at least 180 health education sessions in year two.• Total of at least 320 health education sessions in the community.• As measured by pre- and post-tests, 75 percent of participants from each health education session will demonstrate an increase in knowledge on the topic.
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Activities:

a. Focusing on the health needs and interests identified by community members in the community health assessment, the Program Coordinator and CHWs will create health education sessions to address those issues.

b. Program Coordinator will develop pre- and post-tests to capture knowledge change for each health topic.

c. With guidance from the Program Coordinator, CHWs will design health education sessions that are culturally and linguistically appropriate to the target audience.

d. CHWs will secure accessible meeting locations and times for the health education sessions and promote the sessions during outreach, at community centers, and at community events.



A Program Timeline by Quarter of key program activities follows:

Activity	Q1	Q2	Q3	Q4	Q5	Q6	Q7	Q8
Program Coordinator (PC) and Program Director (PD) will work with [Name of Funder] to ensure that the proposed program work plan and budget are approved								
PC, with support from PD, will hire and train four CHWs								
PC and PD will develop data collection instruments								
PC and PD will design community health assessment with input from CHWs								
CHWs will implement community health assessment in target community, including compiling directory of local health and social service agencies								
PC, with support and guidance from the PD, will analyze the results of the community health assessment. Then, together with the CHWs, create a plan for health education sessions addressing the interests and needs identified from the assessment.								
CHWs will conduct outreach and complete individual encounters with community members								
CHWs will foster relationships with local health and social service agencies and compile/continually update a directory of agencies to be used as a reference tool when conducting outreach								
CHWs will connect and refer community members to health and social services								
CHWs will follow up with community members on whether or not referral for services were received								
CHWs will assist with pre-screening and enrollment for public benefit programs								
CHWs will follow up with community members on whether or not application for benefits was approved								
CHWs will conduct health education sessions in the community. Topics will be based on findings from the community health assessment.								
PC and PD will submit bi-annual progress and financial reports to [Name of Funder]								
PC and PD will close the program and submit final report to [Name of Funder] .								





THINGS TO KEEP IN MIND

- *Work Plan tables may sometimes be included as an attachment rather than part of the grant proposal. Additionally, instead of having separate Work Plan and Program Timeline tables, you may combine the information into one table, and even add more details, such as “person(s) responsible,” “outputs/deliverables,” or “impact” for each activity. Be sure to refer to the instructions in the request for proposals for guidance on what information to include.*



Evaluation Plan & Tracking and Monitoring

OVERVIEW

In this section, describe how your organization plans to evaluate, track, and monitor progress towards program goals. Be specific and realistic in the evaluative measures you describe.

[Name of Organization] already has established evaluation processes that are used to measure the efficacy and efficiency of the program service delivery, any level of changes in the participants' behavior, and the program's impact on the community.

The first evaluation will be carried out in the first quarter of the funding period. The community health assessment will be used to better understand the specific needs and interests of the *colonia* residents. The assessment tool will be developed from the framework of previous community health assessments conducted by **[Name of Organization]** for similar purposes with input from the CHWs to ensure the tool is culturally and linguistically appropriate. The data collection period will last approximately four weeks, during which each CHW will use an existing mobile application to collect a minimum of 50 responses. To ensure that the results reflect a variety of perspectives in the community, each CHW will be assigned a specific region in which they will collect responses from individuals that represent different voices from the community. The data from this assessment will be compiled by the Program Coordinator and collaboratively analyzed with the Program Director. The results will inform all aspects of the subsequent program development and implementation, including the development of



health education sessions and a community resource directory.

The program's tracking and monitoring system will serve as a process evaluation method as the continuous stream of data regarding program activities generated through this system will allow management staff to continually evaluate the team's progress towards reaching program goals. Using a mobile application, **[Name of Organization]**'s CHWs will collect and submit data electronically for the program's activities each week. This includes the community health assessment as well as the individual encounters and health education sessions. Individual encounter data includes basic demographic information, services provided, and any required or requested follow-up activities, such as securing an appointment for services or assisting with applications for benefits. Health education session data consists of a sign-in sheet to track attendance. The Program Coordinator will review and analyze submitted data to continually monitor and evaluate the data collection and progress towards reaching program goals and objectives. Quarterly, the Program Coordinator will analyze program data and submit a report to the Program Director, who will share the responsibility for tracking progress towards long-term goals. This system will ensure that there is accountability for the program goals on multiple levels. Emphasis will be given to referrals, application assistance, and pre- and post-tests outcomes as well as addressing any issues that arise during the program implementation. Additionally, regularly-scheduled supervision meetings, staff meetings, and partner meetings will allow all staff to stay updated on progress and collaboratively solve any problems or obstacles.

Feedback on the strengths and areas for improvement for the program will be solicited from multiple perspectives. Although CHW input is actively sought throughout the program, at the end of each program year, the CHWs will have the opportunity to formally reflect on completed activities and provide recommendations to the Program Coordinator. Additionally, the Program Coordinator will annually facilitate surveys, interviews, and/or focus groups with a sample of community members and stakeholders on the impact of the program and how it could be improved. Ultimately, the Program Coordinator



and Program Director will be responsible for assessing suggested changes and implementing any changes prior to the next program year.

Two approaches will be used to measure the proposed outcome objectives. Pre- and post-tests will be used to measure changes in a participants' knowledge before and after a group education session. All pre- and post- tests will be developed by the Program Coordinator and Program Director before being administered, and both pre- and post- tests will be tailored to include questions specific to the topic of the health education session. Participants who receive a referral or assistance applying for public benefit programs will be contacted by the CHW approximately one month after the service was provided to complete a brief follow-up interview. The interview will be approximately five minutes or less, and in most case will be conducted over the phone. When appropriate, the CHW may conduct the interview in person during a home visit.



THINGS TO KEEP IN MIND

- *Some grant funders may ask directly about the sustainability of the program. Evaluation is always an important aspect of sustainability, so make that connection in this section. Even if a funder doesn't specifically request it, strong sustainability plans only strengthen a proposal, so consider including sustainability information in your grant proposal.*
- *Including a logic model can be a helpful way to show the effectiveness of your program, and in some cases may be required by a funder. A **logic model** provides a visual representation of how your program is supposed to work and presents the relationship between the resources you have to implement the program, the activities you plan to carry out, and the changes or results you hope to achieve.¹⁶ If a logic model is required by the funder, they frequently ask that it is included as an attachment. However, if they do not outline specific requirements, it can be embedded in the narrative.*
- *Grant proposals that include an experimental/research aspect or that call for demonstration sites require a more complex evaluation system and place a heavier emphasis on the dissemination of findings. They also usually require the organization to identify an Institutional Review Board (IRB) as well. To make sure your evaluation plan meets all of the requirements, consider breaking this section into sub-sections.*

16. W.K. Kellogg Foundation. (2004). Logic Model Development Guide. Retrieved December 1, 2015, from <http://www.smart-givers.org/uploads/logicmodelguidepdf.pdf>



Resolution of Challenges

OVERVIEW

Not all funders include a “Resolution of Challenges” section. Those that do are looking for at least two things: your organization’s ability to foresee those challenges that can be foreseen, and some sense of your ability to meet unexpected challenges.

One of the primary challenges [Name of Organization] anticipates is a lack of trust from within the *colonias*. A long history of disenfranchisement and marginalization from public agencies combined with a tense political climate surrounding immigration has made many *colonia* residents distrustful of outsiders entering their community. The culturally and linguistically sensitive interventions this program is built around will serve as a method to address this challenge. One of a CHW’s greatest assets is his or her ability to capitalize upon their existing rapport as a member of the community to gain support and investment from the community in any intervention. The CHWs will be a critical tool in not only accessing the residents of *colonias*, but also establishing a trusting, ongoing relationship with the community. This relationship will continue to grow as the community’s specific needs are respected through the creation and continual development of a community-based program using the results of the community health assessment.

In the past, [Name of Organization] has found that participants’ motivation to change their behavior and/or lifestyle has been a challenge as well. The use of CHWs also inherently addresses this issue. Using culturally and linguistically appropriate materials



combined with the support of a trusted community member may provide the necessary motivation that had been previously lacking. However, there may be other obstacles influencing the motivation of participants. As peers, CHWs best understand the obstacles program participants face in making lifestyle changes. They also understand what resources are available to help community members overcome these obstacles, putting them in the best position to problem-solve and address these issues with program participants. Leveraging their unique position, the CHWs can structure health education classes, events, and other program activities to respond directly to the community's specific needs. Additionally, CHWs are expected to follow-up with clients after different encounters, providing them the opportunity to check-in with program participants and provide extra support if there are persistent barriers that need to be addressed.

Another challenge that may present itself is staff turnover, an issue that **[Name of Organization]**, like nearly all organizations, has encountered in the past and has created policies and procedures to remediate. **[Name of Organization]** already employs the management staff that will be assigned to this program. If the proposed program is funded, existing funding sources will continue to pay these staff for the percentage of work dedicated to those programs, and funding from this program will cover only the staff's FTE assigned to this program. **[Name of Organization]** has in place appropriate and efficient recruitment, hiring, and orientation procedures for the CHWs that will be brought on for this program. **[Name of Organization]**'s salary and benefits package, professional development and advancement opportunities, and organizational culture all contribute to making the agency an attractive work environment, contributing to staff retention. Should the partner agencies experience turnover throughout the program period, they will be expected to fill the vacated position within a reasonable amount of time as laid out in **Attachment X: Memorandum of Understanding** with each agency.



Program Management and Staffing

OVERVIEW

The “Program Management and Staffing” section describes the staff and any applicable partnerships that will carry out the proposed program.

This program will be overseen by a Program Director (PD). The PD will be responsible for monitoring the progress of the program, tracking data, and compiling and analyzing data into an annual report. The PD will also participate in the coordination and hiring of the CHWs and the training of the Program Coordinator (PC). Additionally, the PD will conduct regular supervision with the PC to track progress and problem solve any obstacles that have arisen. The PD will act as the primary contact for all partner agencies and will actively meet and collaborate with them.

The PC’s primary responsibility will be to train and manage the CHWs. With support from the PD, will be responsible for hiring the CHWs and coordinating any necessary training. The PC will conduct weekly supervision meetings with the CHWs to provide feedback, monitor progress, and problem-solve any challenges the CHWs have encountered. Outside of scheduled supervision, the PC will respond to any questions or concerns the CHWs have, address any issues as they arise, and identify and provide additional training and professional development opportunities for the CHWs. The other main responsibility of the PC will be to coordinate the logistics for the implementation of the program. The PC will also be responsible for compiling and



analyzing program data to be developed into reports to send to the PD. The PC will also meet and collaborate with partner agencies as needed.

The CHWs will be responsible for implementing the program. Specifically, each CHW will be required to contact 50 individuals for the community health assessment, complete 1,050 individual encounters, make approximately 175 referrals, assist at least 87 individuals with public benefit applications, and conduct 80 health education sessions over the course of two years. The CHWs will also be responsible for using a mobile application to collect data and feedback from participants to report back to the PC. The CHWs will meet with the PC on a weekly basis to report progress and troubleshoot any challenges they are experiencing. At times, the CHWs may be expected to participate in special events, communicate with partners, or present to stakeholders.

Although **[Name of Organization]** will be providing the culturally specific education and health promotion services to the community, **[Name of Organization]** does not have the capacity to process the applications for public benefits or to provide medical or social services. In order to provide these services as seamlessly as possible, **[Name of Organization]** has long-standing partnerships with both the RGVCHC and RGV DHHS. As reflected in the **Attachment X: Memorandum of Understanding**, designated point of contact staff at both of these organizations are prepared to accept and follow-up on referrals from the CHWs. **[Name of Organization]** has collaborated with these organizations on other CHW programs over the past four years. Over the course of this time, a referral system was developed that has been evaluated and revised to ensure that services are being delivered as effectively and efficiently as possible. This time-tested system will be used for the proposed program.

In addition, **[Name of Organization]** will collaborate with MHP Salud, a national nonprofit organization that provides training and technical assistance to health organizations on the CHW model, to provide a core competency-based training for the CHWs during their initial training. See **Attachment X: Letter of Support**.



THINGS TO KEEP IN MIND

- *Many funders ask for the details of the experience of the proposed programming staff. Resumes can usually be included as attachments, but the description of the staff and their experience would typically be included in the narrative section.*
- *For proposals with special populations or for culturally specific services, it is best to include staff who reflect or have experience with the target population.*
- *Some funders may also ask for detailed information about staff that will be involved in the program from partner agencies. If this is required, include this information in the narrative section as well. Instructions on what to include are typically within the request for proposals.*
- *Memorandum of Understanding vs. Letter of Support*
 - » *A **Memorandum of Understanding** (MOU) is also sometimes referred to as a Letter of Agreement (LOA). This is a formal agreement between two organizations outlining the details of a proposed partnership. The MOU will include specific details about what services and/or commodities each organization will contribute to the partnership. If the funder requires collaboration among local organizations, they will most likely require a signature on the MOU from each organization that will participate.*
 - » *Some funders may ask for **Letters of Support** (LOS). An LOS demonstrates that other local organizations support the proposal being submitted. An LOS is not a binding contract or formal agreement between two organizations. It may include details about how the author of the LOS will provide support, but they are usually general commitments. For example, “Healthy Communities of New York will support Manhattan Community Health Workers by assisting them in reaching statewide networks of health care providers.” An LOS is one way to ensure the program will not be duplicating services and that, if granted the funding, the applicant will not encounter push-back from other local organizations. As seen in this sample grant proposal, an LOS can also be used to show that an organization has made arrangements to receiving technical support from a contractor or other organization to expand organizational capacity. This kind of technical assistance or training may be a requirement for some grants, especially those that are experimental.*



Organizational Capacity

OVERVIEW

The “Organizational Capacity” section includes several paragraphs on your organization’s history, accomplishments, organizational strengths, etc.

[Name of Organization] is a nonprofit organization dedicated to developing and implementing community-based, culturally competent health programs. The organization’s mission states: **[Name of Organization]** implements programs to improve health outcomes in the medically underserved communities of the Rio Grande Valley. **[Name of Organization]** carries out direct-service programs that are tailored specifically to meet the needs of the most difficult to reach and underserved populations in our community.

At the core of this mission is embracing the use of the CHWs, one of the most time-tested, effective and frequently cited community-based approaches to improving health. **[Name of Organization]** has 20 years’ experience in developing and adapting CHW programs, which has resulted in the organization’s ability to expertly identify and meet the needs of people who are medically underserved, underinsured and/or hard-to-reach in our service area. **[Name of Organization]** currently implements four direct-service CHW programs, a testament to **[Name of Organization]**’s ability to develop and implement culturally appropriate interventions for the *colonia* residents.

The importance of developing such culturally and



linguistically tailored programs is emphasized by the fact that last year 70 percent of the individuals served by **[Name of Organization]** identified as Hispanic or Latinos. Over 93 percent of this population made less than \$25,000 annually, and over 77 percent were uninsured. By using culturally appropriate interventions like CHW programs, **[Name of Organization]** was able to educate, support, and assist 196 new mothers during and after their pregnancy, successfully assist 1,271 individuals in enrolling for public benefits or health plans, and facilitated diabetes self-management courses with 185 individuals last year.

[Name of Organization] has the fiscal and administrative systems, leadership, and expertise to successfully implement and manage the proposed program, as is demonstrated by **[Name of Organization]**'s track record of success in program implementation, management, and evaluation. Over the past 20 years, **[Name of Organization]** has received and managed multiple state and federal grants, has a stable funding history, and during this time the annual budget has steadily increased to include diverse funding sources. All of these attributes reflect programmatic capability, sustainability, and commitment. Throughout its history, the agency has complied with grants management and reporting requirements and has never had unresolved questions or concerns regarding fiscal or management practices. **[Name of Organization]** undergoes both a Regular and A-133 Audit every year as a standard practice. All of the organization's audits have resulted in unqualified opinions.



THINGS TO KEEP IN MIND

- *The funder may ask for the organization's specific qualifications to work on the proposed program. In this case, include details about past programs that were similar. If past programs have ended, include a brief discussion of why they ended.*
- *Some funders specifically request that the organization's accomplishments and experience are only discussed in this section and not mentioned elsewhere in the proposal. Read the instructions in the request for proposals carefully to see if this is the case. If not, it may be appropriate to briefly mention your organization's past experience in other sections, such as "Methodology," but be sure to save all the details of past accomplishments and organizational history for this section.*



Reference List

In this sample grant proposal, citations for sources were placed in footnotes. Some funders may require a “Reference List” instead, which can appear here or as an attachment. Refer to the instructions in the request for proposals for more details.





Sample Budget for a Community Health Worker Program



This sample budget, based on the “Sample Grant Proposal for a Community Health Worker Program,” can serve as a starting point to give you an idea of the line items and categories of expenses that you will want to consider in planning your program budget. Many, if not all, of the amounts will vary based on your location, organization, etc. A budget justification or narrative may also be required to provide more a more detailed description of the proposed costs. Additionally, different funders may have varying requirements on what can be included in the budget and/or within a specific expense category. Be sure to refer to the grant application instructions for more information on necessary budget documents and guidelines.

	Base Cost	Unit	Total Cost
Personnel			
<i>Include in this section all staff that will work on this project and the amount of full-time equivalent (FTE) that they will dedicate. The personnel listed here should also be included in your proposal. In a budget justification, include the personnel’s key roles in the proposed program.</i>			
Program Coordinator (PC)	\$43,000	1.0 FTE	\$43,000
Program Director (PD)	\$52,000	0.25 FTE	\$13,000
Community Health Workers (CHWs)	\$31,200	4.0 FTE	\$124,800
<i>Total Personnel</i>			\$180,800
Payroll Taxes and Fringe Benefits			
<i>Payroll taxes and benefits may include FICA, unemployment, retirement, Social Security, and worker’s compensation.</i>			
PC (calculated at 31% of salary)	\$43,000	0.31	\$13,330
PD (calculated at 29% of salary)	\$13,000	0.29	\$3,770
CHWs (calculated at 36% of salary)	\$124,800	0.36	\$44,928
<i>Total Payroll Taxes and Fringe Benefits</i>			\$62,028



Supplies			
<i>This section includes items that personnel may need in the office or out in the field, such as photocopies, materials, office supplies, and technology. Larger items that cost over \$5,000 per item should be placed in a category called "Equipment."</i>			
Basic office supplies (calculated at \$1,000 per FTE)	\$1,000	5.25 FTE	\$5,250
Safety supplies for CHWs (first aid kit, uniform, etc.)	\$250	4 CHWs	\$1,000
Technology for CHWs (laptops, cell phones, tech accessories, etc.)	\$800	4 CHWs	\$3,200
Health education materials (manuals, handouts, books, videos, etc.)			\$1,500
Promotional items for program outreach			\$500
<i>Total Supplies</i>			<i>\$11,450</i>
Mileage/Travel			
<i>This section should include local and non-local travel, such as mileage and fuel reimbursement and travel costs, such as airfare, lodging, car rental, per diem, conference fees, and any other costs that may be accrued when traveling.</i>			
PC (150 miles/week x 48 weeks x \$0.52/mile x 1 PC)	\$0.52	7,200	\$3,744
CHWs (200 miles/week x 48 weeks x \$0.52/mile x 4 CHWs)	\$0.52	38,400	\$19,968
<i>Total Mileage/Travel</i>			<i>\$23,712</i>



Other			
<i>This category includes those items that don't fit in the previous ones. Refer to the grant application instructions for items that can or cannot be included in the "other" section. In a budget justification, clearly explain why the items in this category are needed.</i>			
Communications (postage, phone, internet access, etc. calculated at \$1,200 per FTE)	\$1,200	5.25 FTE	\$6,300
Facilities (calculated at \$1,800 per FTE)	\$1,800	5.25 FTE	\$9,450
Evaluation incentives (focus groups, etc.)			\$600
<i>Total Other</i>			\$16,350
SUBTOTAL			\$294,340
Indirect			
<i>Indirect costs are those that contribute to an organization's administrative overhead, or costs required to run the organization. These may include facility fees, some personnel costs, shared equipment costs, among others. Indirect costs are determined by each organization (some may have a negotiated indirect cost rate) and should be added to the total program cost as applicable.</i>			
Calculated at 25% of total expenses	\$294,340	0.25	\$73,585
<i>Total Indirect</i>			\$73,585
TOTAL			\$367,925



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