CEDAR FALLS HEALTH TRUST FUND BOARD
Request for Funding
Application Packet
Fiscal Year 2020/2021

Attached is the application packet as adopted by the Cedar Falls Health Trust Fund Board. If you have any questions regarding the application, please contact Jennifer Rodenbeck, City of Cedar Falls at 268-5108 or Jennifer.Rodenbeck@cedarfalls.com

As with any process, it is vital that all participants adhere to the rules and requirements. Therefore, a checklist has been established to guide you through the process. Another checklist at the conclusion will ensure compliance with the procedure.

____ **Do** use the forms as they are. You may use this hard copy form or request an electronic form by email to Jennifer Rodenbeck or through the City's website. Do not attempt to duplicate forms with your own software or typewriter. Forms may be photocopied.

____ **Do** type the request information. Handwritten forms are not acceptable.

____ **Do** keep page numbers (located on forms upper right hand corner) **in order**.

____ **Do** attach a list of your current Board of Directors (complete with addresses) as an appendix to the application packet.

____ **Do** have your packet in on time. **(October 3, 2019, 4:00 pm**)

____ **Do** sign and date this packet in the space given below.

____ **Do** return this checklist with your application packet.

____ **Do** provide a total of 9 **copies of the application packet**. (1 Original + 8 Copies)

____ **Do** complete a separate application packet for each project.

I certify that I followed the guidelines as listed above and that the agency's Board of Directors has approved the application as presented. I also understand that if our agency changes the purpose of the project included in this application after the application has been selected for funding, that the Cedar Falls Health Trust Fund Board reserves the right to deny the funding of the application.

Signed ____ Date _________________

Organizational
Affiliation ____

Agency
Name ____

Project
Title ____

AGENCY OVERVIEW

Name of Agency: ____________________

Location Address: ____________________

City: ____________________ Zip Code: ____________

Mailing Address: ____________________

City: ____________________ Zip Code: ____________

Name of Executive Director: ____________________ Telephone: ____________

Name of Person Completing Forms: ____________________ Telephone:____________

Fax: ____________

Email: ____________

Location of Satellite Branches

Number of Agency Staff Members	
Full-time	
Part-time	
Seasonal	
Total	

Length of time agency has been in existence. Years: _________ (and/or) Months: __________

Mission of your agency: (Use an additional page if necessary.)____________________

Summarize your agency's primary goals for the upcoming year: (Use an additional page if necessary.)____________________

Please list previous funding that your agency has received from the Cedar Falls Health Trust Fund Board, including year and amount:

PROJECT OVERVIEW

AGENCY: ____

PROJECT TITLE: ____

What is the primary goal of this project?

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I. Describe how this project meets the definition of health related.

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II. **Need, in terms of population served:**

What is the total number of Cedar Falls citizens served by your agency? _____________

What is the total number of Cedar Falls citizens served by this specific project? _______

III. Compatibility with other local or regional plans:

Is the current project/service that you are applying for duplicated or partially duplicated within the Cedar Falls metro area? _________

If yes, please name the organization providing the duplicate service and briefly describe what is unique about your service and why duplication is necessary.________________

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IV. Need: Describe the financial need for this project.

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V. Matching sources:

Please list by percentage the other types of funding, if any, that will be matched with Cedar Falls Health Trust Fund funding to complete your project or program.

Name of Matching Organization	Dollar Amount of Match	% Amount of Match
Cedar Falls Health Trust Fund		
Total	$	100%

VI. Type of project/program:

Describe your project/program as one of the following:

a) Capital Expenditure
b) One-time program startup cost
c) One-time operational cost
d) Ongoing program and/or operational cost
e) Other: ________________________________

VII. Fees for services:

Please describe below the fee structure that will be used by your organization for the project/program that you are applying for. Will the project or program charge a fee for the service to be utilized by Cedar Falls residents? Will the service be free, subsidized, charged on a break-even basis, or provide a profit center for your organization?

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INDIVIDUAL PROJECT BUDGET
(Round to Whole Dollars)
(Page 1 of 2)

BUDGET LINE ITEMS	**Project Budget**
REVENUES (Excluding funds applied from Health Trust):	
1. Non-Governmental Revenues	
2. Governmental Revenues	
3. Miscellaneous Revenues	
4. Client Paid Fees	
TOTAL REVENUE (Sum 1+2+3+4 above)	

EXPENDITURES:	
A. Personnel Costs	
B. Materials and Supplies	
C. Contracted Services	
D. Capital Outlay	
E. Other	
TOTAL EXPENDITURES (Sum A+B+C+D+E above)	
SURPLUS/DEFICIT (Subtract Total Expenditures from Total Revenues)	
AMOUNT REQUESTED FROM THE CEDAR FALLS HEALTH TRUST FUND BOARD	
TOTAL PROJECT SURPLUS/DEFICIT (Subtract amount from Health Trust from Surplus/Deficit)	

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FINAL CHECK LIST

_____ Have you completed all blanks and boxes?

_____ Have you completed an application packet for each project that you are requesting funding for?

_____ Has the box on page 7 titled *Amount requested from the Cedar Falls Health Trust Fund Board* been completed and does that match the amount requested by your agency?

_____ Have you proofread the entire application?

_____ Have you proofread your numbers for accuracy?

_____ Have you kept a photocopy of your completed Cedar Falls Health Trust Fund Board Request for Funding application packet for your records?

_____ Have you provided a total of 9 copies of your application packet?

Mail completed application packets and all attachments/enclosures (including the beginning and final Checklists) to:

Jennifer Rodenbeck
City of Cedar Falls
220 Clay St
Cedar Falls, IA 50613

Applications are due in to the above address by 4:00 pm on October 3, 2019. Please do not email the file, please provide the hard copies.