2024 Health Equity Innovation Award Proposal

Requesting Organization name Organization

Phone Number

Website URL of Organization

Are you also the payee/fiscal agent of this request?

What type of organization is the payee/fiscal agent of this request?

Payee/Fiscal Agent Organization's federal taxpayer ID number

(IRS): Non-profit Organization Status

(IRS): Organization Legal Name

(IRS): Organization Address

(IRS): Organization City

(IRS): Organization State

(IRS): Organization Zip Code

Payee/Fiscal Agent Name

If your organization is a subsidiary, please list the parent organization

Payee/Fiscal Agent Mailing Address (line 1)

Payee/Fiscal Agent Mailing Address (line 2)

Payee/Fiscal Agent City

Payee/Fiscal Agent State

Please provide the county the Payee/Fiscal Agent is based out of:

Payee/Fiscal Agent Zip Code

Please attach your w-9 form

Contact First Name

Contact Last Name

Contact Job Title

Contact Phone Number

Extension # (if applicable)

Contact Email Address

Organization Info

Which of the following best represents the payee/beneficiary organization's primary mission?

Please briefly outline the payee/beneficiary organization’s mission.

Has the payee/beneficiary organization received a donation from any Lifetime Healthcare Companies entity in the past?

Are there any Lifetime Healthcare Companies employees who are on the Board of the payee/beneficiary organization?

Please identify Lifetime Healthcare Companies employees who are on the payee's/beneficiary organization's Board.

Does the payee/beneficiary organization offer health (medical) coverage to its employees?

What is the name of the health (medical) insurance carrier the payee/beneficiary organization uses?

If other, please provide

Does the payee/beneficiary organization offer dental coverage to its employees?

What is the name of the dental insurance carrier does the payee/beneficiary organization uses?

If other, please provide

Are you aware of any current employees of the payee/beneficiary organization serving on the Board of Directors of any Lifetime Healthcare Companies entity?

Please identify current employee(s) of the payee/beneficiary organization who are serving on a Lifetime Healthcare Companies Board of Directors.

Are you aware of any current employees of the payee/beneficiary organization that have an immediate or extended family member serving on the Board of Directors of any Lifetime Healthcare Companies entity?

Please identify the current employee(s) of the payee/beneficiary organization with an immediate or extended family member serving on a Lifetime Healthcare Companies Board of Directors and who the family member is.

Program Info

Please provide the name of the program or event for which you are requesting funding.

Please provide a description of the program/event.

Is there an event, or multiple events, associated with this program/event?

What is the date of the event/program?

Do you have additional event/program dates?

What are your additional event/program dates?

What is the primary focus area for this community investment:

Other primary focus area:

Please select the subcategory for the focus area selected above

What is the amount requested?

What is the total project cost?

Are there other funders for this project?

Please identify other funders and dollars/inkind services committed

If gap in funding exists after potential award (full or partial), please identify if the program may still begin/continue

Is the implementation of the program or event contigent on our funding?

When will this program likely begin?

What is the approximate duration of this program (e.g. 1 month, 1 year, multiple years)?

Please indicate the number of lives that will be directly impacted or will benefit directly from this program/event.

Please describe the way(s) in which you will promote this program/event.

How will we be recognized as a funder of this program/event?

Impact Page

What population does this program primarily serve?

What other population(s) does this program serve?

What specific population will this program/event primarily serve?

Please select all populations this program/event will serve?

Please select the primary county impacted by this program/event.

Please select all counties that are impacted by this program/event.

How does your program reduce health disparities using an innovative approach?

Please select all the ways you will measure success of this program:

Other:

How will this initiative help the people being served to live healthier and more secure lives?

Additional Attachments

Please attach any additional information pertinent to your request (Attachment 1)

Please attach any additional information pertinent to your request (Attachment 2)

Please attach any additional information pertinent to your request (Attachment 3)