Minnesota Department of Health

# American Indian Special Emphasis Grant RFP Exhibit A: Project Description and Work Plan Template

## Applicant contact information

Full Name:

Full Address:

Minnesota Tax ID#:

Unique Entity Identifier (UEI) Name and Number:

Federal Tax ID #:

Authorized Representative Name:

Authorized Representative Phone:

Authorized Representative Email:

Project Manager Name:

Project Manager Title:

Project Manager Phone:

Project Manager Email:

## Project description

Please provide a brief description of the programs or activities you will undertake for the next year using this funding. Add or delete rows or additional pages, as needed, to describe your project:

## Work plan

|  |  |  |  |
| --- | --- | --- | --- |
| **Activity Description** | **Lead and Support Staff** | **Timeline** | **Activity Output** |
| 1. |  |  |  |
| 2. |  |  |  |
| 3. |  |  |  |
| 4. |  |  |  |

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To obtain this information in a different format, call: 651-201-4975.