Minnesota Department of Health

# Attachment A: Healthy Brain Community Grants Application

## Instructions

Review the Healthy Brain Community Grants Request for Proposals (RFP) before completing the application to ensure that the application meets all terms and conditions.

**Please complete all fields in this application (scored and unscored).**

Please submit your complete application by **Tuesday, November 12, 2024, at 11:59 p.m**. Central Time via email to [health.healthybrain@state.mn.us](mailto:health.healthybrain@state.mn.us) with the subject line: *Healthy Brain Community Grant Application – [insert applicant organization name].* Refer to the RFP for additional instructions on how to submit via email.

If you experience problems with the application or need the application in a different format, call 651-201-5400 and leave a message for the "Aging and Healthy Communities Unit".

**Remember, you must submit all documents for the application to be considered complete:**

1. Application Form *(this form)*
2. Budget (Excel template)
3. Due Diligence Review Form (unscored)
4. Applicant Conflict of Interest Disclosure Form (unscored)

## Section A: General Information (Unscored)

### Lead Organization

Lead Organization Name:

Executive Director/Chief Executive Officer:

Address:

Phone:

Email:

Federal Employer ID (EIN):

Minnesota Tax ID:

### Fiscal Agent (if different from lead organization; leave blank if no fiscal agent)

Lead Organization Name:

Executive Director/Chief Executive Officer:

Address:

Phone:

Email:

Federal Employer ID (EIN):

Minnesota Tax ID:

### Project Contact(s)

### Contact #1 (may be the same as person listed above)

Name:

Title:

Phone:

Email:

### Contact #2 (optional)

Name:

Title:

Phone:

Email:

**Project Information**

**Community(s) served (check all that apply):**

* Black or African American communities
* American Indian or Alaska Native communities
* Asian/Pacific Islander/Hmong communities
* Hispanic or Latin communities
* LGBTQIA+
* People with disabilities
* Additional communities not listed, please describe below

Please describe:

**The proposed project is (check all that apply):**

* An existing project
* An expansion project
* A new project

**The proposed project includes a planning period (up to 3 months):**

* No
* Yes
* Length of planning period:

**Geographic area(s) served or impacted by the proposed project (check all that apply):**

* Central Minnesota
* Northeast Minnesota
* Northwest Minnesota
* Southeast Minnesota
* Southwest Minnesota
* Twin Cities metropolitan area

**The proposed project addresses the following areas related to dementia (check all that apply):**

* Risk Reduction
* Early Detection and Diagnosis
* Caregiver Support

### 

**Annual Funding Request**

|  |  |
| --- | --- |
| **Funding Type** | **Annual (1 year) Funding Request** |
| First fiscal year (this should match your budget through September 29, 2026) | $enter amount here |
| Total funding over three-year grant period (budget amount listed above x3) | $enter amount here |

### Signature Instructions

You must download this form to complete the electronic signature field. You may sign using an Adobe Digital Signature or Adobe Fill and Sign.

## Certification

*I certify that the information contained in this application is true and accurate to the best of my knowledge, and that I submit this application on behalf of the lead organization.*

Name:

Signature:

Title:

Date:

## Section B: Application (50 points)

**Section B is scored and required. Please answer all of the questions below. Word limits are in place to give you an estimate of how much content to include for our reviewers.**

### Applicant Profile (5 points)

1. Provide a brief overview of the lead organization, including history, mission, services, and major programming. (Up to 5 points) (200 word max)

### Project Narrative and Community Engagement (20 points)

1. What is your project about? Include 2 to 4 goals, key activities, and the communities you plan to work with. (Up to 10 points) (500 word max)
2. Who will do the work (staff, contractors, partners)? What experience do they have that will help make this project successful? (Up to 5 points.) (200 word max)
3. How will you involve community members to make sure your project is meaningful and inclusive? (Up to 5 points) (200 word max)

### Project Alignment (10 points)

1. How will this funding improve dementia risk reduction, early detection, or caregiver support in the community you plan to work with? (Up to 5 points) (300 word max)
2. How will your project connect to at least one of the strategies in the Minnesota Dementia Strategic Plan (MDSP)? (Up to 5 points) (300 word max)

### Expected Results and Measuring Success (10 points)

1. What outcomes do you hope to achieve? (up to 5 points) (200 word max)
2. How will you know that your project was successful? (Up to 5 points) (200 word max)

## Scoring criteria related to additional attachments:

### Attachment C: Budget (Scored) (5 points)

Please complete the budget template provided. Scoring will be determined by allocation, alignment, and appropriateness.

Healthy Brain Initiative   
Minnesota Department of Health  
PO Box 64882  
St. Paul, MN 55164-0975  
[health.healthybrain@state.mn.us](mailto:health.healthybrain@state.mn.us)

www.health.state.mn.us

10/10/2024

To obtain this information in a different format, contact: [health.healthybrain@state.mn.us](mailto:health.healthybrain@state.mn.us)