



Grant Application

Before you apply...

Applicants must contact the Foundation prior to submitting an application. The Foundation provides technical assistance to applicants to ensure that organizations submit the best possible applications that are competitive for funding. Foundation staff is also available to answer questions that may come up as you complete your application. All prospective applicants should contact Heather Knaplund, (206) 528-2337 or (800) 572-7835 extension 2337 or via email hknaplund@deltadentalwa.com.

Eligibility

To qualify for a Washington Dental Service Foundation grant, your organization must be one of the following (please check the appropriate box):

<input type="checkbox"/>	Public charity with tax-exempt status under section 501(c)(3) of the Internal Revenue Code
<input type="checkbox"/>	Public or governmental entity such as a school or health district
<input type="checkbox"/>	Tribal organization with 7871 tax-exempt status
<input type="checkbox"/>	Tax-exempt dental association

Please submit a written confirmation of the above status, such as a current copy of your organization's U.S. Treasury (IRS) tax determination letter.

Our organization has a physical presence in the state of Washington.

<input type="checkbox"/>	Yes
<input type="checkbox"/>	No

The project for which funds are requested predominantly benefits people living in Washington state.

<input type="checkbox"/>	Yes
<input type="checkbox"/>	No

I. Information About Your Organization

Organization Name	
Street Address	
City, State, ZIP Code	
Phone	
Website (if available)	
Contact Person	
Title	
Work Phone	
Cell Phone	
Fax Number	
E-Mail Address	

A. Brief Summary of your organization (history, mission & services provided; 200 words or less)

B. Background and Service History

Please describe:

- i. the oral health services your organization currently provides (e.g. diagnostic, preventive, restorative, education, outreach, oral surgery, etc.),
- ii. demographic characteristics of the population served by your organization (age, race, gender, socioeconomic status, etc.),
- iii. the number of facilities your organization operates,
- iv. days and hours of operation, and
- v. the geographic area covered by your services.
- vi. What is the historical impact of the oral health services your organization provides?

Performance Category	2010	2009	2008
Number of Users/Patients/Clients, Ages 0-5			
Number of Patient Visits, Ages 0-5			
Number of Users/Patients/Clients, Ages 18 and under			
Number of Patient Visits, Ages 18 and under			
Number of Users/Patients/Clients, Ages 19 to 55			
Number of Patient Visits, Ages 19 to 55			
Number of Users/Patients/Clients, Ages 55 to 64			
Number of Patient Visits, Ages 55 to 64			
Number of Users/Patients/Clients, Ages 65 and over			
Number of Patient Visits, Ages 65 and over			
Number of Users/Patients/Clients, Total			
Number of Patient Visits, Total			

- vii. If your project will serve pregnant women, fill out the historical impact of the oral health services your organization provides.

Performance Category	2010	2009	2008
Number of Users/Patients/Clients, Pregnant Women			
Number of Patient Visits, Pregnant Women			

C. Staffing

What are your current staffing levels (i.e., number of Full-Time Equivalent dentists, hygienists, dental assistants, lab techs, administration, etc.)?

D. Finances

Please attach copies of:

- i. your organization’s three most recent IRS 990 Forms (if applicable);
- ii. your organization’s most recently audited financial statements (If your organization does not have audited financial statements, submit a recent balance sheet (assets and liabilities), along with a statement of income and expenses);
- iii. your organization-wide budget (revenues and expenditures) for the current fiscal year; and
- iv. the current fiscal year budget (revenues and expenditures) for the department, section or unit that will administer the project to be funded by this grant request (if different from the organization-wide budget).

Please also list:

- v. your organization’s current operating and capital reserve levels, and
- vi. the policies upon which those reserve levels are based (*e.g., three months operating reserves*)

E. Grant History

If you have previously received any grants from Washington Dental Service Foundation, please indicate below:

Date	Amount Requested	Amount Allocated	Purpose	Outcomes

II. Grant Request

A. Project Title:

Funding Request: \$_____

- i. Project Summary (200 words or less):
- ii. Detailed Project Description (i.e., objectives, specific activities, partners and their roles):
- iii. Please describe your project timeline below and list significant project milestones and projected dates of accomplishment in the table provided.

Milestones

Milestone	Projected date	Comments
<i>(e.g. equipment purchased, equipment in use, etc.)</i>		

Also, please describe:

- iv. how this project aligns with WDS Foundation’s Grant Making Focus (described in the Grant Guidelines) including how it improves the oral health of young children, pregnant women, and/or seniors,
- v. the demographic characteristics of those who would benefit (age, race, gender, socioeconomic status, etc.),
- vi. the geographic area that would be impacted by this grant,
- vii. how many additional patients or clients would be served and/or how many
- viii. additional dental visits or other oral health services would be provided,
- ix. the anticipated short-term and long-term impact of this project, and
- x. why this project is necessary.

B. Financial Model

Please show your expense and revenue projections for three years or to the point you anticipate a positive balance, whichever is greater.

- i. If your proposal expands direct patient services please complete the service expansion expense and revenue projections template. Our objective in requesting this information is to better understand the potential for sustainability of your expansion.
- ii. If your proposal is a one-time project that does not involve patient services, please submit a project budget.
- iii. Service expansion – expense and revenue projections

SERVICE EXPANSION – EXPENSE AND REVENUE PROJECTIONS				
Expenses	Year 1	Year 2	Year 3	Comments
Operating				
<i>Operating Subtotal</i>				
Capital				

<i>Capital Subtotal</i>				
Total Expenses				
Revenue*				
Total Revenue				
Balance (revenue – expenses)				

iv. Fundraising plan

FUNDRAISING PLAN				
Funding Source	Amount Requested	Amount Committed (or decision date)	Funding period	Other comments
Total				

C. Leadership and Partners

- i. Please list the names and qualifications of key staff responsible for project implementation.
- ii. If this is a collaborative effort, identify each project partner, along with their role and contribution.

D. Sustainability

- i. Explain how this project will be sustained, both operationally and financially, after Washington Dental Service Foundation funds have been expended:

E. Evaluation Plan

- i. Define project success.
- ii. In the table below, please describe the quantifiable indicators which will be used to measure effectiveness and outcomes. An example is provided.

Objective	Metric	Baseline	Target Outcomes
<i>(e.g. Increase patient-visits by young children)</i>	<i>(# patient-visits by children age 0-5)</i>	<i>(2009 1st qtr: 250 2009 yr: 1100)</i>	<i>(2011 1st qtr: 350 2011 yr: 1400)</i>

F. Acknowledgement Plan

- i. Describe how the Washington Dental Service Foundation’s grant will be acknowledged:

Attachments Checklist

	Written confirmation of your organization’s designated status (e.g. current copy of your organization’s U.S. Treasury (IRS) tax determination letter
	Organization’s three most recent IRS 990 Forms (if applicable)
	Organization’s W-9 Form
	Organization’s most recently audited financial statements [If your organization does not have audited financial statements, submit a recent balance sheet (assets and liabilities) along with a statement of income and expenses]
	Organization-wide budget (revenues and expenditures) for the current fiscal year
	Current fiscal year budget (revenues and expenditures) for the department, section or unit that will administer the project to be funded by this grant request (if different from the organization-wide budget)
	If this proposal will be sustained through patient revenue, attach a pro forma
	Organization’s current board members and their affiliations
	Any other information you deem pertinent to your application

Submitting the Application

One original and two copies of your application (with attachments), along with a cover letter signed by the highest-ranking official in your organization, are due at the Washington Dental Service Foundation by March 15th or September 15th. **Faxed, emailed and/or late applications will not be accepted. The entire request should be either single or double sided. Please do not bind or staple your request.** Please address your application to:

Heather Knaplund
Washington Dental Service Foundation
P.O. Box 75983
Seattle, WA 98175-0983

Street Address for UPS or FedEx

Heather Knaplund
Washington Dental Service Foundation
9706 4th Ave NE
Seattle, WA 98115

Expectations of Grantees

Successful applicants are asked to sign a grant agreement and provide status reports and a final grant report documenting progress toward agreed-upon metrics.