## 

## Obesity Initiative: “Matching Funds” Grant Program Application

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| Applicant Information |
| |  |  |  |  | | --- | --- | --- | --- | | Full Name: |  |  |  | |  | Last | First | M.I. | | Address: |  | | | |  | Street Address |  |  | |  |  |  |  | |  | City | State | ZIP Code | | Company Phone: | ( ) | Email: | |  |  |  | | --- | --- | | Coalition Name: |  | |  |  | |
| Grant Overview |
| **Purpose:** To conduct a half-day forum that will engage multi-stakeholders in your market to create pathways forward in addressing the barriers to treating obesity.  **About the “Matching Funds” Grant Program:**   * Provide $5,000 to coalitions who successfully apply to the National Alliance of Healthcare Purchaser Coalitions * Awardees should develop initial program through this round of grant funding, but also seek to develop a sustained, multi-faceted effort on obesity Activities must utilize information gained from the National Alliance Obesity Guidebook   \*\* The focus of this grant is to produce a material impact in the health of our populations through education, policy, population and community health treatment.  ***Grant Proposal Timeline***   |  |  | | --- | --- | | Proposal Submission | November 1st – 21st | | Review Submissions | November 27- 30th | | Announce Awards | December 1st | | Run Program by | Q1 2018 | | Submit Summary Report | Within 30 days of program completion | |
| Complete the following for Submission: |
| Provide a brief summary (up to 400 words) of why this program would be valuable for your members: |
| Indicate at least three key takeaways you want to provide to your members through this program: |
| Can you complete the grant activities by Q1 2018? |
| |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | |  | YES |  | NO |  |  | |  |  |  |  |  |  | |
| How will you secure the matching funds? You may choose more than one option |
| |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | |  | Monetary support from vendors and/or health plans attending the event | |  | Coalition Revenue | |  | |  | Other (needs to be approved) | In-kind support | | | |
| **Indicate the venue where your program will be held:**  **Indicate the date for your half-day program (must be confirmed):**  **Please indicate the names and titles of who you plan to have attend your forum.**  **Physician:**  **Health Plan Representative:**  **Employers:**  **Public Health Representative:**  **Consultants:**  **Advocacy Groups (ex. Stop Obesity Initiative, Diabetes Associations):**  **Others:** Will you highlight a regional Diabetes Prevention Program (DPP) during the forum? |
| |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | |  | Yes |  | No |  | | |  | | | | |   **When submitting application, please attach the following documents. (See samples) – must hyperlink:**   1. **Proposed agenda of half day forum** 2. **Proposed budget** |

### Please return completed forms by November 21st to:

### Margaret Rehayem, [mrehayem@nationalalliancehealth.org](mailto:mrehayem@nationalalliancehealth.org)