##

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

|  |
| --- |
| 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