

**Healthier Wisconsin Partnership Program**

**Capacity Building Component**

**Change Incubator Funding   
Application Form**

Investing in community-based partnerships to overcome challenges and key next steps to increase readiness for and effectiveness in carrying out larger community health improvement initiatives

**Instructions:** Please complete the following application in collaboration with your partnership and submit electronically via email to HWPP at [healthierwisconsin@mcw.edu](mailto:healthierwisconsin@mcw.edu) to be considered for Change Incubator funding.

**Contact Information**

**HWPP Capacity Building Program Officer:**  
Tracy Wilson, MPH  
414-955-4364  
[trwilson@mcw.edu](mailto:trwilson@mcw.edu)

**HWPP General Contact Information:**   
414-955-4350  
[healthierwisconsin@mcw.edu](mailto:healthierwisconsin@mcw.edu)  
<http://www.mcw.edu/Advancing-Healthier-WI-Endowment.htm>

**Change Incubator Funding**

**Contact Information**

**Primary Partner Contact Information** – the primary partner must be an eligible Wisconsin-based, non-profit, IRS tax exempt 501(c)3 or government organization, have an EIN number and have the capacity to serve as the fiscal and contracting agent for the partnership.

**Organization:**        
**Organization Website:**        
**Contact Name:**  **Title:**        
**Email:**       **Phone Number:**        
**Please indicate the type of organization:**

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| --- | --- | --- |
| Non-profit organization (check the applicable type below):  ***Attach a copy of your IRS non-profit verification to this form*.**  health, social service or other community-based organization  faith-based organization  private university or school  other (specify): | **or** | Government organization (check the applicable type below):  state or local government  tribal organization  public university or school  other (specify): |

**Supplanting Attestation:**

1. Would funding from HWPP supplant or replace other funding that you/your organization already has for project purposes as described in this proposal?   
   NO YES – if YES, please describe:
2. Are there any projects that you/your organization have previously taken within the last three (3) years, or that you/your organization are currently doing, that are closely related to the proposed project?   
   NO YES – if YES, please describe:
3. Would the proposed use of funds from HWPP leverage or complement funds you previously or currently receive?  
   NO YES – if YES, please describe:
4. Have you already applied to another funding source for the same or similar project?   
   NO YES – if YES, please describe the project and the date and result of that application or when you expect to receive notification:
5. Please provide any other relevant information:

*By signing this form, you agree to perform responsibilities as described within this submission and understand that HWPP is a cost-reimbursement program. Additionally, by signing this form, your organization attests to its eligibility and represents that the information provided in this submission is accurate, complete and current and the individual signing affirms that s/he has authority to execute this form on behalf of the organization.  By signing, you acknowledge that the MCW Consortium on Public and Community Health is subject to Wisconsin Public Records laws and its records may be subject to release as required by law*. *The organization represents that the funding from the Healthier Wisconsin Partnership Program will not supplant, and acknowledges that this information shall be relied upon by the Medical College of Wisconsin to discharge its legal and regulatory obligations with respect to the subject matter of this form.*

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| **Primary Contact Signature** Printed Name and Date  REQUIRED***Electronic signatures are acceptable****.* | |
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| **Organization Authorized Signature** Printed Name and Date  IF DIFFFERENT FROM ABOVE ***Electronic signatures are acceptable****.* | |

**Project Overview**

**Goal Statement** – include what end product will be developed, by whom and to contribute to what larger health improvement initiative or health impact (please limit to 250 characters)**:**

**Which Change Incubator funding track is your partnership applying for** (please check all that apply)?

**Partnership Development and Action Planning** – support the development and initial infrastructure and action planning of new health-related partnerships, coalitions or networks

**Strategic Planning and Partnership Growth and Sustainability** – support existing partnerships to continue to grow as a group and engage new partners, develop detailed strategic plans to sustain the partnership, and collaboratively engage in community health improvement initiatives

**Communicating your Impact** – support partnerships to strengthen communication skills and form comprehensive communication plans and materials to effectively tell their story, demonstrate their impact, and drive the initiative forward to increase awareness and support for next steps

**What organizations will be participating in the project?** Change Incubator funding applications require a partnership of Wisconsin-based, health related entities that includes representation from diverse organizations and perspectives. Please list all partnering organizations and briefly describe their roles on the proposed Change Incubator project and commitment to the larger community health improvement initiative.

**What end product will result from the investment?**

**Why is Change Incubator Funding needed to achieve the goal stated above?** Please include how the proposed work will fit into the larger community health improvement initiative and why it is necessary to advance that larger effort to the next stages.

**How will the goal be accomplished?** Please include specific activities to be accomplished during the project and how partners will demonstrate their progress and success.

**Timeframe and Budget**

**Project Timeframe** (in months):

**Proposed Project Start Date** (subject to change based on the application process and funding decision):

**HWPP Budget Request** (not to exceed $10,000):

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| --- | --- | --- |
|  | **Amount** (in whole dollars) | **Description of Expenses** |
| **Consultants** individual or entity hired to perform professional, short-term services related to the project |  |  |
| **Supplies** direct project-specific expenses, including, but not limited to, office supplies, printing, telephone or other communication expenses |  |  |
| **Meeting Expenses** including, but not limited to room rental fees, refreshments and other project-specific meeting expenses; entertainment and alcohol are unallowable expenses |  |  |
| **Mileage** reimbursement of project staff for use of personal vehicles; include payment methodology equation |  |  |
| **Travel** project-specific travel expenses, including, but not limited to, hotel stays and air/train/bus fare |  |  |
| **Other**  identify specific expenses |  |  |
| **Total** |  |  |

**In-kind or matching support** – please include any additional funding that will directly support the proposed work as well as funding for next steps and related to the larger community health improvement initiative. Please use the following definitions to determine what types of support to include:

* In-kind support includes services (i.e. personnel time), resources (i.e. mileage, meeting space), and goods (i.e. meeting refreshments) supplied in-kind by the partners in direct support of the AHW project
* Matching funds include funds received for the project prior to or at the time of the AHW award from a source other than AHW that required an institutional match and related to the aims or goals of the AHW project

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| **Description of In-kind/Matching Support**  Include who is providing the support and for what activities | **Amount** (in whole dollars) |
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