Office of Oral Health
FY 2014 Oral Disease & Injury Prevention Program Grant Application

County Name: Baltimore County

Amount of Funding Requested:

Section I: Program Description

A. Project Narrative and Funding Support

1. Please provide a description of your project including partnerships with other organizations that will be participating with you. Indicate the scope of the proposed initiative, and what the funding support will provide.

2. Which of the following program components will apply to your project?

- ☐ Clinical Dental Services for Children
- ☐ Off-Site Component*: Fluoride Treatments
  - ☐ Rinse
  - ☐ Varnish
  - ☐ Toothbrushing (w/Fl. Toothpaste)
- ☐ Clinical Dental Services for Adults
- ☐ Oral Cancer
  - ☐ Screenings
  - ☐ Healthcare Provider Education
  - ☐ Patient Education
- ☐ Water Fluoridation
  - ☐ Well Testing & Equipment
- ☐ Other; Please describe:

** Off-site components include: School-Based/Linked, Head Start, Judy Centers, WIC, or similar programs*

3. What will funding for this project support?

☐ Salaries for Clinical or Program Staff	☐ Dental Equipment
☐ Dental Supplies for Clinic	☐ Water Fluoridation Equipment
☐ Off-Site Dental Supplies	☐ Other; Please describe:

B. Program Target Populations

Children's Programs

4. Does your program have a clinical component for children? ☐ YES ☐ NO. If no, skip to 6.

5a. What is the target population for the children's clinical program?

5b. Please provide a brief (one paragraph) description of your children's clinical program indicating the scope of services you provide.

6. Will your project have off-site components such as school-based/linked, Head Start, Judy Center, WIC or other programs? ☐ YES ☐ NO. If no, skip to 8.

7a. What off-site component(s) will your program include?

Off-Site Component Programs

☐ School-Based/Linked/Mobile	☐ WIC
☐ Head Start	☐ Other; Please describe:
☐ Judy Center	

7b. At how many locations will your off-site program be implemented?

7c. If your program has an off-site component that is school-based, school-linked or mobile, what was the selection rationale for your school locations?

Selection Rationale

- ☐ High percentage of children receiving free or reduced lunch
- ☐ Title I designated school – (# of Title I schools in jurisdiction:)
- ☐ Other (explain):

7d. For your off-site program component(s), what is the age (or grade) of your target population?

8. Will you provide fluoride treatments at these sites? ☐ YES ☐ NO. If no, skip to 12.

9. What kind of fluoride treatments will your off-site program provide?

Type of Fluoride Treatments Proposed

- ☐ Fluoride Rinse
- ☐ Fluoride Varnish
- ☐ Toothbrushing with Fluoridated Toothpaste

Adult Program

10. Does your program have a clinical component for adults? ☐ YES ☐ NO. If no, skip to 12.

11a. What is your adult clinical target population?

11b. Please provide a brief (one paragraph) description of your adult clinical program indication the scope of services you provide.

12. Does your program have an oral cancer component? ☐ YES ☐ NO. If no, skip to Section C.

13. In the box below, please provide a brief (one paragraph) description of the oral cancer component of your program indicating the scope of services you provide.

Section II: Performance Objectives

List your performance objectives, *including your health education activities*, in the space below. You must have at least three (3) performance objectives and they MUST correspond with the required evaluation criteria in Section III below**. (These are the measures to be included with your Budget Package, DHMH 4542, if you are awarded funding.)**

1.

2.

3.

4.

All programs must have an Oral Health Education component. Please indicate the type of oral health education that you intend to implement. Activities can include, but are not limited to classroom education, community education, Children's Dental Health Month activities, etc.

Section III: Evaluation

Below is a list of outcomes that are expected to be reported for each identified project. This information will be reported on an Excel spreadsheet reporting form provided by the Office of Oral Health to be submitted via e-mail to dhmh.ugaoralhealth@maryland.gov. Please review your project's reporting requirements and sign off indicating your acknowledgement. In addition, provide the name and title of the person who will be responsible for submitting this information to the Office of Oral Health on a quarterly basis in Section VI. Please note, only one report should be submitted for the health department during the reporting period.

Please estimate the following annual anticipated reach for your program or select "NOT APPLICABLE" if the data element is not applicable to your program.

Table 1.Children Clinical	ANNUAL ANTICIPATED REACH	NOT APPLICABLE
Number of Patients Seen (children)		☐
Number of Clinical Visits (children)		☐
Number of Children Receiving Emergency Treatment		☐
Number of Children Receiving Health Education		☐
Number of Children Receiving Fluoride Treatments		☐

Specifically for the school-based or school-linked component of your program, estimate the annual anticipated reach for your program.

Table 2.School-Based/School-Linked/Mobile	ANNUAL ANTICIPATED REACH	NOT APPLICABLE
Number of Children Receiving Fluoride Treatment		☐
Number of Children Receiving Health Education		☐

For adult program components of your program, estimate the annual anticipated reach in the following areas.

Table 3.Adult Clinical	ANNUAL ANTCIPATED REACH	NOT APPLICABLE
Number of Patients Seen (adults)		☐
Number of Clinical Visits (adults)		☐
Number of Adults Receiving Emergency Treatment		☐
Number of Adults Receiving Health Education		☐

For oral cancer components of your program, please estimate the annual production in the following areas.

Table 4.Oral Cancer	ANNUAL ANTICIPATED REACH	NOT APPLICABLE
Number of Oral Cancer Screenings		☐
Number of Oral Cancer Referrals for Biopsy		☐
Number of Patients Educated on Oral Cancer		☐
Number of Healthcare Providers Educated on Oral Cancer		☐

Please note: If you are awarded funding for community water fluoridation, you will be required to provide brief status reports on your program on a quarterly basis. This quarterly report will be a short narrative updating the Office of Oral Health on water fluoridation activity and will be reported separately from the Oral Health Activity & State Stat Reporting Form.

I understand if my proposal is funded, I will need to report the above information back to the Office of Oral Health on a quarterly basis via an Excel spreadsheet reporting system that will be e-mailed to dhmh.ugaoralhealth@maryland.gov.

Name:	**Date:**

Section IV: Sustainability Plans

The poor overall economic climate continues to place undo pressure on federal, state and local budgets. For this reason it becomes imperative that each award recipients provides a thorough explanation of their plans to sustain their programs if the Office of Oral Health is unable to continue their funding. **Your response will be used as a selection criterion when reviewing your proposal.** See attached "Helpful Hints Document" for suggestions.

Section V: Budget and Application Submission

Please submit a twelve (12) month budget using the budget form supplied with your application, with supporting justification and documentation as per the usual instructions for the DHMH Unified Grant Award along with this completed application to dhmh.ugaoralhealth@maryland.gov. **NOTE: In your e-mail's subject line, please reference "Your county name and FY 2014 Oral Health Application."** If your proposal is approved, you will be asked in your award letter to **officially** submit your budget electronically, using the DHMH 4542 budget package to dhmh.ugaoralhealth@maryland.gov. Please note that your budget ***should not*** include requests to purchase audio or video equipment or out of state travel to conferences.

Section VI: Contact Information

Please provide the following contact information. This information is used to enter into our reporting system and will be used to generate emails regarding your Oral Health Awards. Therefore it is very important that this information be complete and correct, especially regarding the quarterly reports.

CONTACT POSITION	NAME	PHONE	EMAIL
1. Application Preparer			
2. Quarterly Report Contact			
3. Fiscal Report Contact			
4.			
5.			
6.			