Office of Oral Health
FY 2017 Oral Disease & Injury Prevention Program Grant Application

County Name: _____ Amount of Funding Requested: _____

Section I: Program Description

☐ **Clinical Dental Services for Children**
- ☐ Restorative
- ☐ Preventative
- ☐ Emergency

Describe your target population (such as age ranges, race/ethnicity, income, Medicaid eligibility, Head Start, WIC, etc.).	

Evaluation Measures:		**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 Fluoride Varnish		☐

☐ **Off-Site Component for Children**
- ☐ School-Based/Linked/Mobile
  - ☐ High percentage receiving free/reduced lunch
  - ☐ Title I designated schools: # of Title I schools_____
  - ☐ Other (explain):
- ☐ Early Head Start
- ☐ Head Start
- ☐ Judy Center
- ☐ WIC
- ☐ Other; please describe:

Describe your target population (such as age ranges, race/ethnicity, income, Medicaid eligibility, Head Start, WIC, etc.).	

Evaluation Measures:		**Annual Anticipated Reach**	**Not Applicable**
	Number of Children Receiving Fluoride Varnish		☐
	Number of Children Examined/ Screened		☐
	Number of Children Receiving Oral Health Education		☐

☐ **Clinical Dental Services for Adults**

- ☐ Restorative
- ☐ Preventative
- ☐ Emergency

Describe your target population (such as age ranges, race/ethnicity, income, Medicaid eligibility, Head Start, WIC, etc.).	

Evaluation Measures:		**Annual Anticipated Reach**	**Not Applicable**
	Number of Patients Seen (adults)		☐
	Number of Clinical Visits (adults)		☐
	Number of Adults Receiving Emergency Treatment		☐

Off-Site: Oral Cancer Program– Target Pop:

- ☐ Screenings
- ☐ Healthcare Provider Education
- ☐ Patient Education

Describe your target population (such as age ranges, race/ethnicity, income, Medicaid eligibility, Head Start, WIC, etc.).	

Evaluation Measures:		**Annual Anticipated Reach**	**Not Applicable**
	Number of Oral Cancer Screenings		☐
	Number of Oral Cancer Referrals for Biopsy		☐

Water Fluoridation

- ☐ Well Testing & Equipment

Describe your target population (such as age ranges, race/ethnicity, income, Medicaid eligibility, Head Start, WIC, etc.).	
Evaluation Measures:	**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.

☐ **Other; please describe**:			
Describe your target population (such as age ranges, race/ethnicity, income, Medicaid eligibility, Head Start, WIC, etc.).			
Evaluation Measures:		**Annual Anticipated Reach**	

Oral Health Education Component (**Required**) ☐ Classroom education ☐ Community education ☐ Children's Dental Health Month activities ☐ Other; please describe:			
Describe your target population (such as age ranges, race/ethnicity, income, Medicaid eligibility, Head Start, WIC, etc.).			
Evaluation Measures:		**Annual Anticipated Reach**	
	Total Number of Adults and Children Receiving Health Education	Children: Adults:	

2. 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 specifically what activities funding will support. (Limit: 200 Words)

Section II: Budget and Application Submission

1. What will funding for this project support?

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

Please submit a twelve (12) month budget narrative 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.

Section III: 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. Please make sure that the Office of Oral Health is notified when contact information changes.

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