

Office of Oral Health

FY 2013 Oral Disease & Injury Prevention Program Grant Application

County Name: Allegany

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. In addition, indicate the scope of the proposed initiative.

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

<input type="checkbox"/> Clinical Dental Services for Children	<input type="checkbox"/> Oral Cancer
<input type="checkbox"/> Off-Site Component*: Fluoride Treatments	<input type="checkbox"/> Screenings
<input type="checkbox"/> Rinse	<input type="checkbox"/> Healthcare Provider Education
<input type="checkbox"/> Varnish	<input type="checkbox"/> Patient Education
<input type="checkbox"/> Toothbrushing (w/Fl. Toothpaste)	<input type="checkbox"/> Water Fluoridation
<input type="checkbox"/> Clinical Dental Services for Adults	<input type="checkbox"/> Well Testing & Equipment
	<input type="checkbox"/> 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?

<input type="checkbox"/> Salaries for Clinical or Program Staff	<input type="checkbox"/> Dental Equipment
<input type="checkbox"/> Dental Supplies for Clinic	<input type="checkbox"/> Water Fluoridation Equipment
<input type="checkbox"/> Off-Site Dental Supplies	<input type="checkbox"/> Well Testing & Equipment
	<input type="checkbox"/> 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, 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

<input type="checkbox"/> School-Based/Linked/Mobile	<input type="checkbox"/> WIC
<input type="checkbox"/> Head Start	<input type="checkbox"/> Other; Please describe:
<input type="checkbox"/> 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

<input type="checkbox"/> High percentage of children receiving free or reduced lunch <input type="checkbox"/> Title I designated school – (# of Title I schools in jurisdiction:) <input type="checkbox"/> 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 10.

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

Type of Fluoride Treatments Proposed

<input type="checkbox"/> Fluoride Rinse <input type="checkbox"/> Fluoride Varnish <input type="checkbox"/> Toothbrushing with Fluoridated Toothpaste
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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 indicating 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.

C. 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.

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 II: 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 fhauga-oralhealth@dhmh.state.md.us. 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 V. 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.

<i>Table 1.Children Clinical</i>	ANNUAL ANTICIPATED REACH	NOT APPLICABLE
Number of Patients Seen (children)		<input type="checkbox"/>
Number of Clinical Visits (children)		<input type="checkbox"/>
Number of Children Receiving Emergency Treatment		<input type="checkbox"/>
Number of Children Receiving Health Education		<input type="checkbox"/>
Number of Children Receiving Fluoride Treatments		<input type="checkbox"/>

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

<i>Table 2.School-Based/School Linked/Mobile</i>	ANNUAL ANTICIPATED REACH	NOT APPLICABLE
Number of Children Receiving Fluoride Treatment		<input type="checkbox"/>
Number of Children Receiving Health Education		<input type="checkbox"/>

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

<i>Table 3.Adult Clinical</i>	ANNUAL ANTICIPATED REACH	NOT APPLICABLE
Number of Patients Seen (adults)		<input type="checkbox"/>
Number of Clinical Visits (adults)		<input type="checkbox"/>
Number of Adults Receiving Emergency Treatment		<input type="checkbox"/>
Number of Adults Receiving Health Education		<input type="checkbox"/>

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

Table 4. Oral Cancer

	ANNUAL ANTICIPATED REACH	NOT APPLICABLE
Number of Oral Cancer Screenings		<input type="checkbox"/>
Number of Oral Cancer Referrals for Biopsy		<input type="checkbox"/>
Number of Patients Educated on Oral Cancer		<input type="checkbox"/>
Number of Healthcare Providers Educated on Oral Cancer		<input type="checkbox"/>

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 fhauga-oralhealth@dhmh.state.md.us.

Name:	Date:
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Section III: 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 recipient 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 IV: 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 fhauga-oralhealth@dhmh.state.md.us. **NOTE: In your e-mail's subject line, please reference "Your county name and FY 2013 Oral Health Application."** If your proposal is approved, you will be asked to **officially** submit your budget electronically, using the DHMH 4552 budget package to fhauga-oralhealth@dhmh.state.md.us in your award letter. Please note that your budget *should not* include requests to purchase audio or video equipment or out of state travel to conferences.

Section V: Contact Information

Please provide the following contact information. Also, please note not all of these items will be necessary if your program does not have each of these 5 components or if individuals are serving in more than one capacity.

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