1. **Organization Name**:

2. **Organization Address**:

3. **Name, Email and Telephone of Organization CEO**:

4. **Name, Title, Email and Telephone of Project Director**:

5. **Additional Contact Information**:

6. **Project Title**:

7. **Area of Focus** (check one): Addressing Chronic Disease Prevention and Disease Management

Promoting Maternal and Child Health

Addressing Behavioral Health, including the Opioid Crisis

Providing Dental Care to Support the launch of the new Maryland Medicaid Dental Benefit

8. **Program Jurisdiction**:

9. **Year One / Total CHRC Request**: Year 1 $: Total Request: $

10. **Program Duration (check one):**  One Year  Two Year  Three Year

11. **This program is (check one)**:  A New Program  An Expansion of Existing Services

12**. Has the applicant received CHRC funding in prior years**?  Yes  No

If NO, describe how your organization meets the definition of a “Community Health Resource”:

12A. **Type of Organization**:  Primary Care Provider  Hospital  Non-Profit Community-Based Organization

Local Health Department  Behavioral Health Provider  FQHC  Other (explain)

Links to definition of a Community Health Resource: [Primary Community Health Resource](http://www.dsd.state.md.us/comar/comarhtml/10/10.45.05.02.htm), [Designated Community Health Resource](http://www.dsd.state.md.us/comar/comarhtml/10/10.45.05.04.htm), [Access Community Health Resource](http://www.dsd.state.md.us/comar/comarhtml/10/10.45.05.03.htm) (Note: if applying as an Access Community Health Resource, an MOU with a Primary Care Provider must be submitted with your Letter of Intent).

13. **A description of the applicant organization** (maximum 250 words):

14. **A description of the project including: the services the project will provide, the target population, and the need for the program in this community** (maximum 500 words):

15**. Letter of Intent – Required Documents**:

Audited Financial Statement

Federal Form W9

Sliding Fee Scale (All Applicants)

**Access Services Community Health Resource Eligibility Documents - Required:**

Executed Memorandum of Understanding or similar referral relationship (memorialized) with a Primary Care provider (Access Community Health Resources) that **pre-dates** the Letter of Intent submission and the

Sliding fee scale of the primary care/referral partner.