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.