

HEALTH PARTNERSHIP LETTER OF INTENT

ORGANIZATION INFORMATION

Organization Name or Fiscal Agent, if applicable

Tax ID Organization Type

Address City State Zip Code

Phone Web Address

EXECUTIVE DIRECTOR CONTACT

Prefix First Name Middle Initial Last Name

Title

Office Phone Extension E-mail

PRIMARY CONTACT FOR THIS REQUEST

Same as Executive Director

Prefix First Name Middle Initial Last Name

Title

Office Phone Extension E-mail

PROJECT DESCRIPTION

Project Title

Project Start Date Project End Date

Project Budget Grant Amount Request

Project Reach Please select the Health Trust Funding Strategy that aligns with your project.

INSTRUCTIONS

The Letter of Intent (LOI) should not exceed more than two (2) pages. Please ensure that you provide SMART outcomes.

1. Describe the project goal.
2. Describe the outcomes you expect to achieve during the grant period.
3. What policy, practice, or system is your project seeking to change and why? Explain how your project builds health equity.
4. Describe the target population that will be impacted through this project. If possible, provide the number of people that you anticipate will benefit from the project during the grant period.
5. Are you collaborating with other partners on this project? List the organization(s) and their role(s).