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).