Minnesota Department of Health

# SEAL Minnesota Application: Component A

## Grant Application Cover Sheet

**1. Applicant Organization** (with which grant agreement is to be executed)

**Legal Name:**

**Street, City State Zip:**

**MN Vendor ID:**

**Vendor -Location Code:**

**DUNS Number[[1]](#footnote-1):**

**DUNS Name:**

**2. Contact Person for Grant Project**

**Name/Title:**

**Email Address:**

**Phone:**

**3. Project Organization** (if different than number 1)

**Clinic Name:**

**Street, City State Zip:**

**4. Director of Applicant Organization** (if different from number 2)

**Name/Title:**

**Email Address:**

**Phone:**

**5. Total Requested Amount out of $5,000:**

**I certify that the information contained herein is true and accurate to the best of my knowledge and that I submit this application on behalf of the application organization.**

**Signature of Authorized:**

**Agency Representative:**

**Title:**

**Date:**

## Project Narrative

### Applicant Information (0.5 – 1 page)

*Briefly describe Applicant Organization’s, and, if relevant, Collaborating Community Partner’s:*

* Mission and Goals
* Service Area
* Population Served
* Provided Services
* Collaborating community partners

### Project Proposal (1-2 pages)

*Briefly describe the proposed project. Include:*

* Project Description
  + *School sealant program model*
    - School-based, school-linked, other
    - Types of sealant materials used
    - Workforce employed
    - Innovative practices, if relevant
    - Consent process and rates
    - Other services provided in conjunction with sealants
    - Retention practices and rates
    - Referral mechanism
    - Infection control
* Anticipated outcomes
  + Anticipated number of schools and students served, teeth sealed, children referred, etc.
  + Anticipated number of schools served that will meet 50% Free and Reduced Priced lunch (FRPL) criteria
  + Anticipated geographic areas served, include dental health professional shortage areas (Dental-HPSAs)
  + Other anticipated school-linked settings served
  + Anticipated retention check plans
  + Other anticipated outcomes
* Project Need
  + Use data as relevant to support this section
* Project Feasibility
  + Relevant Experience
  + Community Collaboration
  + Other Supports

### COVID Safety Procedures (0.5 – 1 page)

*Describe infection prevention and control measures utilized during clinics to prevent the spread of COVID-19.*

### Data Acknowledgement (0.5 page maximum)

*Please review the requested data variables, presented in the RFP, and indicate that your organization will be able to report on them. If there are variables your organization cannot or may not be able to collect or report, indicate the variable and reason below.*

## Project Workplan

*Use the following template to submit your workplan. The example in the template is given for your reference only.*

**Overall Project Goal:** Improve the oral health of students in Sample county.

**Project Objective**: 100 students will receive sealants on their secondary molars by June 30th, 2022.

**Expected 1-Year Outcome Measure:**

A minimum of X% increase in the number of eligible schools\* from previous year

A minimum of X number increase in children with dental sealants from previous year

|  |  |  |
| --- | --- | --- |
| **Baseline Measure from Previous Year** | **Data from Past Year** | **Year 1 Target** |
| # of eligible (50% or more FRPL) schools served |  |  |
| # of children served |  |  |
| # of referrals or follow up performed |  |  |
| # of retention checks performed |  |  |
| # of Dental HPSAs served |  |  |
| # of schools continued for services from previous years |  |  |
| # of new schools served |  |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Activity** | **Description** | **Start Date** | **Finish Date** | **Staff Responsible** | **Indicators** |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |

**Anticipated facilitators and barriers:**

**Sealant standardization and data management plan:**

**Retention check plan:**

**Referral and follow up plan:**

**Additional comments:**

## Project Budget

Please use the following form to submit the project budget. The cost items included in the Grant Funds Requested column are those that will be supported by grant funds. The budget should be specific to proposed activities described in the project narrative. *This budget form is not intended to represent the applicant organization's total budget.*

The Budget Form should include justification for each line item to show how budget cost items were calculated. Examples of justification can include:

* Salary: Calculation of anticipated hours by hourly salary
* Supplies/Equipment: Link to item cost, quote, etc.
* Travel: Mileage reimbursement calculations

An example table is included below, but budget may also be provided in narrative format as long as all requested information is included.

| **Budget Item** | **Budget Justification and Calculation** | **Grant Funds Requested** |
| --- | --- | --- |
| 1. (ex: Dental Hygienist Salary) | ex: Hygienist will work at 10 clinics \* 4 hrs = 40 hrs  40 hrs \* $50/hr = 2000) | $2000 |

To obtain this information in a different format, call: 651-201-3538.

Minnesota Department of Health  
Oral Health Program  
625 Robert St. N   
PO Box 64975  
St. Paul, MN 551-1  
651-201-3538  
[prasida.khanal@state.mn.us](mailto:prasida.khanal@state.mn.us)  
[www.health.state.mn.us](http://www.health.state.mn.us/)

1. *If you don’t have a DUNS number, you may apply after the awards are announced. To apply for a DUNS Number visit* [*grants.gov*](https://www.grants.gov/applicants/organization-registration/step-1-obtain-duns-number.html) *or call 1-866-705-5711. There is no charge.* [↑](#footnote-ref-1)