

## Group School Health Mini-Grant Application

Please complete the following application and return it by email, mail, or fax to:

William Biskupiak, Montana School Health Program  
Montana Department of Public Health & Human  
Services Cogswell Building, Suite C-314B, 1400  
Broadway Ave Helena, MT 59620-2951

Phone: 406-444-0995  
Fax: 406-444-7465  
Email: wbiskupiak@mt.gov

Group awards will be given to three or more nurses, asthma/diabetes educators, or school administrators who wish to do a project together instead of applying for an individual grant. Please follow the required group guidelines for the project you select.

### Step 1: Contact Information- Please choose one person as the primary contact for the award.

Name	
Credentials	RN LPN AE-C CDE Other, specify:
E-mail Address	
Work Address	
Phone Number	
County	

Other nurses in group:

Name  RN  LPN  AE-C  CDE Other, specify:  
 Name  RN  LPN  AE-C  CDE Other, specify:  
 Name  RN  LPN  AE-C  CDE Other, specify:  
 Name  RN  LPN  AE-C  CDE Other, specify:

### Step 2: Background Information

1. For which schools or districts do the applicants in your group provide nursing, education, or administrative services?
2. - Approximately how many students does your group provide nursing, education, or administrative services for?
3. - How many hours per week do the members of your group provide nursing, education, or administrative services in the school setting?
4. - Briefly describe how asthma, diabetes or other chronic diseases affect the students in the school for which this project is meant. Include the approximate number of students with know chronic conditions (specific to your project) in your school(s) where your project will be carried out.
5. - How will this grant assist you in providing help to students with asthma, diabetes, or other chronic conditions?

**Step 3: Choose a Project**

Check the box beside the project you will implement.

- School Staff Asthma Training
- School Staff Diabetes Training
- Assess Chronic Disease School Policies and Practices
- Teach a Chronic Disease Self-Management Curriculum
- Student Referrals to the Asthma Home Visiting Program
- Facilitate a Hands Only CPR Training for Students, full CPR Course, or Stop the Bleed Training
- Attend Event: Big Sky Pulmonary Conference/Asthma Educator Course/Diabetes Conference or Training
- Design Your Own Project

A full description of each project can be found on the [dphhs.mt.gov/schoolhealth](http://dphhs.mt.gov/schoolhealth) website. For further clarification about any of the projects, please contact the Montana School Health Program at 406-444-0995.

**Step 4: Letter of Support**

Attach one letter of support from a school administrator on official letterhead to this application. The letter should indicate administrator approval of the project and support of your group’s efforts. No special form is required.

**Part 5: Budget**

For group grantees, the grant provides an award of \$1,000 for two people and \$1,500 for three people. Please indicate below, how you intend to allocate the award money. You may use the money to compensate your group members for their time, purchase supplies and make copies, cover meeting expenses and travel, purchase demonstration tools, or for any other activity that is related to improving chronic disease or emergency response outcomes at your school(s). A sample budget is provided below, but this serves as a recommendation only, as expenses will vary based on the project chosen. You may allocate the money as you see fit.

	Sample Budget	Your Budget
Hourly Wage	\$1000	
Printing/Copying	\$150	
Meeting Expenses	\$100	
Travel	\$50	
Other (supplies, tools, etc.)	\$200	
Total	\$1500	

Please describe "other" expenses:

**Part 6: Check Recipient Information**

Name/Agency \_\_\_\_\_

Complete Address \_\_\_\_\_

**Part 7: W-9 Submission**

If the organization or individual receiving payment has not previously received funding from the Public Health and Safety Division of the Montana Department of Public Health and Human Services, you will be asked to complete a W-9. Upon receiving your application DPHHS will determine if you need to fill out a W-9. If a W-9 is needed, you will receive a form to complete and return. Grants will not be processed if DPHHS does not have a valid taxpayer identification number on file.

**Part 8: Signature**

We certify that the information presented herein is accurate. If we are chosen to receive the award, we will complete the project and return the outcomes report to the Montana School Health Program by May 31, 2019. If we receive the award, we give permission for our names and the news of our award to be released to our school’s administration and board, as well as to the local media.

Primary Contact Signature \_\_\_\_\_ Date: \_\_\_\_\_ -  
 Signature \_\_\_\_\_ Date: \_\_\_\_\_ -  
 Signature \_\_\_\_\_ Date: \_\_\_\_\_ -  
 Signature \_\_\_\_\_ Date: \_\_\_\_\_ -  
 Signature \_\_\_\_\_ Date: \_\_\_\_\_ -

(For e-mail submission, type your names above.)

When you've completed the application, save it and send it to the Montana School Health Program by mail, email, or fax indicated at the beginning of this application. Please remember to send the letter of support with the grant application. If we do not receive these items, we cannot process your application.

Thank you for applying for a school health mini-grant. If you do not hear from us within two weeks of applying for the award, please contact the Montana School Health Program at 406-444-0995.