

## DELTA DENTAL OF ILLINOIS FOUNDATION COMMUNITY BENEFIT GRANT APPLICATION

### ORGANIZATION INFORMATION

Date of Request:

Legal Name of Organization:

Address:

City:  State:  Zip Code:

Phone:  Fax:

Executive Director:

Authorized Contact Person(s) and Title(s):

Mission Of Organization:

Fiscal Year Of Organization:

Is your organization an IRS 501(c)(3) or 501(c)(4) not-for-profit?  Yes  No

*If Yes, please enclose a copy of the 501(c)(3) or 501(c)(4) letter your organization received from the IRS. Please also include the most recent financial statement, an income statement and a balance sheet.*

*If No, you are not eligible.*

### REQUEST INFORMATION

Delta Dental of Illinois Foundation provides funding and goods-in-kind to support five oral health care targets. Please indicate the area(s) addressed by your program or organization and rank your involvement as high (H), medium (M), or low (L) on the line provided next to the target.

Raising awareness of the importance of oral health.

Improving oral health knowledge.

Making oral health care more accessible to the undeserved in Illinois

Making oral health care more affordable to the undeserved in Illinois.

Improving education for oral health professionals.

Funding Request Amount:

Goods-in-kind Request:

Toothbrushes (quantity):  Oral Health Education Brochures (quantity):

Other (specify):

Total Program Budget:

Total Organizational Budget (current year):

## PROGRAM INFORMATION

Delta Dental of Illinois Foundation's mission is to improve the oral health of the residents of Illinois by supporting organizations and programs that provide oral health education and/or access to oral healthcare services to those residents.

How will funding this grant request improve oral health in Illinois, specifically the five target areas listed above? (State briefly. Include any participant qualifications for the program. Additional background may be attached.)

Please describe the program goals and outcome objectives. Include information on how you will measure the impact of your program. Please be specific.

Please describe the geographical area and the location(s) of the communities served by the program.

Please indicate the number of people served by the specific oral healthcare program to which this grant application applies:

Has your organization received funding from Delta Dental of Illinois Foundation previously?  Yes  No

*If Yes, please complete the section Oral Health Grant Evaluation section below.*

## ORAL HEALTH GRANT EVALUATION

Please state the program goals and desired outcomes:

Briefly, describe how you accomplish the goals of the program:

Briefly, state how well the program is working; specifically provide the number of people treated by type of treatment provided, i.e. preventive, diagnostic, restorative, oral surgery, endodontics, periodontics. Please address how you are supporting the five oral health target areas of Delta Dental of Illinois Foundation. (Feel free to provide additional information separately from this form.)

Please describe the geographical area and the communities served by the program as well as the number of people treated.

How do you measure the results and/or impact of this program? Please provide actual metrics and actual results.

What are the most important reasons for your successes and/or shortfalls?

What have you learned from the program that has been (or could be) successfully implemented to other organizations?

How has the support from Delta Dental of Illinois Foundation helped you achieve a desired result(s)?

*You may send additional information, if you wish, along with this evaluation form.*

## COMMUNITY BENEFIT GRANT APPLICATION SIGNATURE

I certify that we are eligible for funding based on the application guidelines. I further certify that I am authorized to sign on behalf of our organization. By signing below, I authorized Delta Dental of Illinois Foundation to use the name of our organization for the purpose of publicizing the grant. This would include the dollar amount of the grant and other details concerning the organization's grant.

Signature: \_\_\_\_\_

Please Print Name: \_\_\_\_\_

Delta Dental of Illinois Foundation may visit your site as part of the evaluation process.  
Interim and/or Final Reports will be required.

You may attach additional information if you wish, along with this application to:

**Delta Dental of Illinois Foundation**  
**Ann Marie Walker - Director of Corporate Communications**  
**111 Shuman Boulevard**  
**Naperville, IL 60563**  
**Fax: 630-983-4139**  
**[awalker@deltadentalil.com](mailto:awalker@deltadentalil.com)**