Gold Coast Health Plan℠
A Public Entity

Integrity • Accountability • Collaboration • Trust • Respect

COMMUNITY HEALTH INVESTMENTS 2026-2027

Pathways to Wellness
Community Grant Program
Application Narrative

I. APPLICANT INFORMATION

Complete your application using the space provided.

Name of Organization: _____ Year Incorporated: _____

Name of Fiscal Agent, if applicable: _____

Tax ID Number (fiscal agent if using such): _____

Street Address (include fiscal agent if not the same): _____

City and State: _____ 9-digit Zip Code: _____ – _____ (Req.)

Name and title of President, Executive Director, or Chief Executive Officer: _____

Phone Number(s): _____

Email Address: _____ Website: _____

Name and title of project contact, if different from above: _____

Phone Number(s): _____

Email Address: _____

Type of Organization:

Select One: ☐ **501(c)(3)**

☐ **Public or government entity**

State Type of Entity: _____

Project Name: _____

Geographic Area(s) Served: _____

Population(s) Served: _____

Organizational Budget: $_____ Project Budget: $_____ GCHP Request: $_____

Does your organization meet ALL the criteria outlined in the request for application? ☐ Yes ☐ No

II. SUMMARY OF REQUEST		
Please note, no funds will be provided for direct medical services. Target populations may overlap into different Populations of Focus categories. Check off **all the Population(s) of Focus you will target or impact**, even if populations overlap. You must select at least one, and may select more than one:		
A	☐	Persons with mental health disorders.*
B	☐	Persons with substance use disorders needs.*
C	☐	Persons with other disabilities.
D	☐	Older Adults.*
E	☐	Persons who are homeless.
F	☐	Low income women.*
G	☐	Young people from traditionally underrepresented backgrounds.
H	☐	Immigrants and families of mixed immigration status.
I	☐	Persons with limited English proficiency.
J	☐	Low-wage workers and their families or dependents.
K	☐	Uninsured children and youth formerly enrolled in Medi-Cal.

** Priority population identified by the Ventura County Community Health Improvement Collaborative Community Health Needs Assessment 2025.*

1. Project Aims / Goals

Describe your overall project aim, including how the project will measurably improve members' access to healthcare services, including meeting new Medi-Cal requirements. This includes work, volunteer and education opportunities and/or access to food and basic needs.

The statements should be well-written and clearly describe what you intend to accomplish in Specific, Measurable, Achievable, Realistic, Timely, Inclusive, and Equitable (SMARTIE) terms.

2. Organizational Background

State your organization's overall mission and goals, and describe the current programs and activities most relevant to the proposed project. Describe your organization's experience and qualifications on the topic of focus selected.

3. Statement of Need and Alignment with GCHP Selected Priorities

Describe the needs, problems, or issues to be addressed through the proposed project. Identify and describe in detail the specific populations of focus that you have selected to target. Explain specifically how the selected population(s) targets GCHP members and your organization's experience and qualifications with the selected population(s) of focus. Provide specific data whenever possible to justify the need. Explain how your proposal is aligned with GCHP's Pathways to Wellness project priorities.

4. Project Design

Explain in detail how you propose to target the particular population(s) of focus, geographic area, and implement the proposed strategies. Indicate why you have selected the proposed strategies. Include examples that show how implementation of the proposed approach will achieve your project aims for Medi-Cal members. Describe how the program will be implemented over the 12-month grant period. Your proposal must be sound and feasible. **Please explain how you will sustain this project after the grant period ends.**

5. Project Data Collection, Benchmarks and Milestones

Describe your project goals, objectives, outcomes, and major milestones. These must be specific, measurable and attainable. What will success look like? Include what data you will collect, by whom, how often, and how the data measures your intended project objectives. (Must be consistent with attached Workplan).

6. Collaborative Partners

Identify any collaborative partnerships that you have already established or that will be established for the successful implementation of the proposed effort. Describe the roles and responsibilities of identified partners and how they will contribute to the proposal.

7. Key Staff and Responsibilities

List key project staff and volunteers and describe their roles and responsibilities. Indicate their level of expertise in addressing the targeted populations.

8. Potential Challenges

Identify any potential challenges that might be encountered while implementing the proposed project.
Describe how your organization will overcome these challenges.

III. BUDGET NARRATIVE
9. Provide a budget narrative justification for all proposed expenses in the project budget. Please note that the grant cannot fund direct medical care nor direct Enhanced Care Management (ECM) care and cannot duplicate or replace other sources of state, federal, local, or GCHP funding.

IV. EVALUATION
10. Describe how you will evaluate the success (measurement strategy) of the proposed project. Describe what measures and metrics will be used to demonstrate that you successfully achieved the project objectives and outcomes (must be consistent with attached Workplan). **Please include at least one outcome measure and one member experience measure in your measurement strategy.**

V. STRATEGIC BENEFIT TO GCHP MEMBERS
11. Please explain how the proposed effort will benefit GCHP members directly. Estimate the number of GCHP members that might benefit from your efforts.

12. Specifically outline any type(s) of public recognition that GCHP will receive if your project is funded that are not already listed in the Acknowledgment checklist (Attachment C).

VI. ORGANIZATIONAL FINANCIAL/LEGAL/LICENSURE

13. Please list any current or previous (within five years) pending material litigation brought against your organization.

14. If your organization is tax-exempt, please list any pending or prior allegations or actions questioning or challenging propriety of tax-exempt status.

VII. AUTHORIZING GRANT AGREEMENT SIGNATOR SIGNATURE

Print Name and Title of Grant Agreement Signatory: _____

Grant Agreement Signatory's Phone Number: _____ Email: _____

Grant Agreement Signatory's Signature: _____ Date: _____

See Request for Applications (RFA) document for submittal guidelines and informational call.