United Way of East Central Iowa

Community Impact Partner Fund

Focus Area: Health

Request for Proposals (RFP)

September, 30 2016

Introduction

United Way has three Community Goals around Education, Financial Stability, and Health to guide our community toward a strong, stable future for everyone. These goals are rooted in an understanding of community conditions and supported by purposeful interventions that include multi-generational foundations and a commitment to equity. They also serve as a roadmap for how our community can offer opportunities for a better life to those who have the fewest assets and the largest obstacles.

Creating positive change in our community takes all of us working together. Solutions begin when we understand why conditions exist and believe we can make our community better. Data combined with a shared vision help make decisions about how change can happen and possible solutions.

A strong, thriving community is important to all of us. United Way measures and evaluates results so partners and donors know their contributions make the greatest impact in changing people's lives and strengthening communities.

The Value of Community

Individuals live in families who, in turn, live in communities. Anyone who wants to create sustainable impact in people's lives must also create impact in the systems, families, and neighborhoods where these individuals live, work, and learn.

This lasting community change is built around knowing where we are, where we want to be, and whether our efforts make a difference. Performance measures and indicators are necessary ingredients for this sustainable change.[1] While individual stories and perceived improvement are a good start, successes must be supported by measurable indicators of changes in order to evaluate how the lives of our community members have changed for the better.

Neighborhoods: Place Matters

When creating change, place matters. High stress, isolated, and under-resourced neighborhoods have a profound impact on outcomes for children and families. In these neighborhoods, data clearly depicts the daily struggles many community members face.

Neighborhoods with higher numbers of single-parent families, higher percentages of rental apartments, increased crime, lower educational levels, and other variables paint a grim picture compared to more affluent neighborhoods. Research from Professor Robert D. Putnam has shown that this disparity continues to grow. "Class segregation across America has been growing for decades," Putnam notes, "so fewer affluent kids live in poor neighborhoods, and fewer poor kids live in rich neighborhoods".[2] Dr. Robert Sampson from Harvard also states that neighborhood differences have lasting impacts on "crime, poverty, child health, public protest, the density of elite networks, civic engagement, teen births, altruism, perceived disorder,

[1] Waner, Ben. (2011) Central Massachusetts Regional Planning Commission, Data That Tells A Story.
[2] R. Putnam. Our Kids: The American Dream in Crisis (New York: Simon & Schuster Press, 2015) 217.

collective efficacy, [and] immigration"[3] among other things. This cyclic nature of neighborhood poverty, where poor neighborhoods with few assets lead to fewer opportunities for its residents, must be interrupted for our citizens to thrive.

Impacts of neighborhood disparities persist throughout life, and are strongest for those in early childhood years and late adolescence.[4] During these phases, individuals from lower-income neighborhoods experience the most profound impacts including identity development, academic achievement, internalizing and externalizing of behaviors, sexual risk, and physical health.[5] If we support change in any of the issues clients experience, we then need to be aware of the environment and neighborhoods that can either improve or diminish these factors.

In addition to the tangible effects of lower-income neighborhoods, social networks are also affected by the environment around clients. More affluent neighborhoods tend to be connected with many more unique relationships through informal interaction. Whether through work or physically living near others, more affluent neighborhoods tend to include more college professors, lawyers, doctors, and other professional individuals, which can create networks for financial success and career opportunities.[6] Likewise, children in lower-income neighborhoods are less likely to have an informal mentor to guide them both academically and professionally.[7]

United Way has an interest in understanding the neighborhoods where lower-income community members live. By helping build assets in these areas, we begin to remove some of the obstacles impacting families in need.

A Multi-Generational Approach

Successful interventions need to address both children and families so they can thrive together and break cycles of generational poverty. The Aspen Institute calls these successful programs two-generation programs and states successful two-generation programs address four components in a family's life: Education, Economic Supports, Social Capital, and Health and Well-being:[8]

- Education focuses on the essential interventions children need in their early lives coupled with education parents receive (both formally and informally). In addition to early childhood supports, there is a strong connection between a mom's education level and positive outcomes for her children – especially regarding the child's school readiness.[9]
- Economic supports are basic needs and asset-building components of a parent's life that allow them to have a safe foundation as they build skills for themselves and their children.

[3] R Sampson. Great American City: Chicago and the Enduring Neighborhood Effect (Chicago: University of Chicago Press, 2012)
[4] V. M. Murray, C Berkel, N.K Gaylord-Hardon, N. Copeland-Linder, M. Nation. "Neighborhood Poverty and Adolescent Development," Journal of Research on Adolescence Volume 21 2011: 21, 114-128.
[5] Ibid.
[6] Putnam, 217.
[7] Ibid.
[8] Ascend at the Aspen Institute "Two-Generation Playbook," 2014.
[9] Child Trends and Center for Health Research. (2004). Early Child Development in Social Context. Data from K. Denton, E. Germino-Hausken, and J. West (project officer). America's Kindergartners, NCES (Washington, DC: U.S. Department of Education. National Center for Education Statistics, 2000) 2000-2070.

- Social capital refers to connections people build in order to navigate the world around them. This could be as simple as a peer support who helps talk through a tough time or as detailed as formal leadership and career coaches who build on parents' strengths and resilience.[10]
- Health and well-being components focus on the building of resilience for children and families in the face of trauma or toxic stress. Physical and mental health have a major impact on a family's ability to thrive and must also be considered in building a two-generation approach.[11]

United Way's community goals incorporate these components and place a priority on multi-generational collaborative strategies that build resilience in children and families.

Adverse Childhood Experiences (ACEs)

Research on Adverse Childhood Experiences (ACEs) states when a child experiences consistent trauma; including situations of abuse, neglect, witnessing violence, or general maltreatment, the brain adapts to these situations by elevating stress hormones (known as cortisol). Long term, stress hormones can alter parts of the brain tied to emotional regulation, visual and spatial memory, language and math proficiency, and other important abilities.[12] There is a relationship between childhood exposure to abuse and household problems and chronic disease in adulthood including cancer, liver disease, skeletal fractures, chronic lung disease, and heart disease. In addition investigators found relationships between early adverse life events and other health problems such as smoking, suicide, depression, obesity, drug use, alcoholism, teen pregnancy, sexual risk behaviors, and sexually transmitted diseases.[13]

As a community, we can change the conversation to focus on resiliency. By shifting the focus to create more compassionate environments that support children regardless of what they experience and building safe, stable, and nurturing relationships, we can break the cycle of toxic stress and promote healthy futures for each child in our community. Protective factors that help reduce adversity and build resilience include:[14] [15]

- Increasing social connections for both parents and children by identifying a network of supportive adults for parents and by establishing positive relationships for children with caring adults in school, family, friends, or neighbors
- Facilitating nurturing home environments and increasing knowledge of parenting and child development through modeling supportive parenting, parenting classes, and parenting support groups
- Assisting parents in recognizing experiences with ACEs through counseling services
- Establishing concrete supports that meet a children's basic needs such as housing, food, clothing, and healthcare

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[10] Ascend at the Aspen Institute. "Two Generations, One Future; Moving Parents and Children Beyond Poverty Together," 2012.
[11] R.F. Anda & V.J. Felitti, "The Adverse Childhood Experiences Study," <http://www.acestudy.org>
[12] M. Teicher, et al., "Neurobiological & Behavioral Consequences of Exposure to Childhood Traumatic Stress," Stress in Health and Disease, ed.BB Arnetz & R Ekman (Upsala, Germany: University of Upsala, 2006).
[13] EG Flaherty, R. Thompson, AJ Litrownik, et al. "Effect of Early Childhood Adversity on Child Health," Archived Journal of Pediatric Adolescent Medicine, 2006. 160(12):1232-1238.
[14] R. Pearl, "Can We Stop a Traumatized Child From Becoming a Traumatized Adult? Forbes Magazine, 16 April 2015: <http://www.forbes.com/sites/robertpearl/2015/04/16/can-we-stop-a-traumatized-child-from-becoming-a-traumatized-adult>
[15] 2016 ACEs Report. 29 August 2016: <http://www.iowaaces360.org/iowa-aces-research.html>

- Expanding on parental resilience by providing tools to reduce stress such as practicing problem solving, peer support opportunities, and mindfulness training
- Training professionals to recognize ACEs in a variety of settings such as physicians, teachers, etc.
- Establish child-focused programs to decrease negative consequences of ACEs, school-based counseling, and adult-led youth groups
- Being responsive to children in order to help them develop self-regulating behaviors

United Way strives to support successful strategies by addressing family strengths through an ACEs lens and focusing on resilience for the whole family throughout their lives.

Trauma-Informed Care

One strategy to build resilience and address or prevent ACEs in our community is by supporting work through a trauma-informed care lens. Substance Abuse and Mental Health Services Administration (SAMHSA) suggests six key principles to help communities work through traumatic situations and focus on healing. These six principles are Safety; Trustworthiness and Transparency; Peer Support; Collaboration and Mutuality; Empowerment; Voice and Choice; and Cultural, Historical, and Gender Issues.

- Safety: Throughout a trauma-informed organization, staff and those they serve feel physically and psychologically safe.
- Trustworthiness and Transparency: An organization's decisions and operations are transparent with the goal of building trust among the staff, clients, and families of clients.
- Peer Support and Mutual Self-Help: Especially in hectic schools, trauma-informed organizations need to have a strong system of peer support between staff so that everyone feels supported to do their best.
- Collaboration and Mutuality: Healing happens in relationships and everyone can play a part. You do not need to be a therapist to be therapeutic.
- Empowerment, Voice, and Choice: Each individual's strengths need to be recognized, built on, and validated in their work. The organization's belief in resilience and in the ability of individuals to heal promotes recovery from trauma in a way that builds on what individuals have to offer instead of responding to perceived deficits.
- Cultural, Historical, and Gender Issues: The organization actively moves past cultural stereotypes and biases (whether it be on race, ethnicity, sexual orientation, age, geography, or anything else), offers gender-responsive services, leverages the healing value of traditional cultural connections, and recognizes and addresses the context of historical trauma as well.[16]

The Need for Equity

True community success cannot be fully achieved without awareness and intentionality in addressing equity in our work. Equity and equality are often used interchangeably, but there is a very important distinction between the two:

[16] "Guiding Principles of Trauma-Informed Care," SAMHSA: Substance Abuse and Mental Health Services Administration, Spring 2014, Volume 2, Number 2. <http://www.samhsa.gov/samhsaNewsLetter/Volume_22_Number_2/trauma_tip/guiding_principles.html>

Equality makes sure everyone has the same thing without any regard to additional barriers. **Equity** ensures everyone has access to all the same opportunities with consideration for barriers.

Across the United States, communities are changing; this is also true for East Central Iowa. Our rural communities are growing older and have decreased access to resources within their communities. Additionally, looking at population trends from 1990–2014, in UWECI's five-county service area, all counties have become more diverse. Linn County alone saw an increase of 192% in the non-Caucasian population from 1990–2014. This is a trend we cannot ignore.

Local disparities

One indicator of potential inequity is to look for disparities in the rate different populations experience barriers or challenges as compared to the general population. A point in time analysis indicated only one of every 24 residents is black, yet one of every three Linn County Jail inmates is black. Although African Americans made up 7.4% of the child population in Linn County, they represented 19% of the victims of abuse.[17]

Disparities for children

Research shows that children from economically disadvantaged families can be up to two years behind in language development.[18] This may be because children of low-income families hear less than ⅓ the amount of words that children of high-income families hear, which equates to a word gap of 30 million words by the time both children reach age four.[19] Low-income children are also not as ready for kindergarten as their higher-income peers. Locally, only 50% of Free Reduced Price Lunch (FRPL) kindergarteners are proficient in early literacy skills compared to 72% of higher-income peers.[20]

Children of color are approximately three and a half times as likely to go into foster care and age out or exit foster care without being adopted. African American and low-income children (accessing free and reduced price lunch) struggle to achieve at the same level as their white, financially stable peers. According to Putnam, the socio-economic status (SES) of families, rather than test scores, is a more important predictor for which eighth graders would graduate from college. Children from low-income households who score well on tests are less likely to get a college degree than children from affluent households who score poorly on tests. This contributes to the continuation of the cycle of poverty within black and low-income parts of our community.[21]

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[17] U.S. Census Bureau; American Community Survey, 2014 American Community Survey 5-Year Estimates, *Tables B01001B & B01001*; (August 2016).

[18] Nicholas Zill and Jerry West, "Entering Kindergarten: A Portrait of American Children When They Begin School: Findings from The Condition of Education 2000," U.S. Department of Education, National Center for Education Statistics. (Washington, DC: U.S. Government Printing Office, 2001) http://nces.ed.gov/pubs2001/2001035.pdf

[19] B Hart and T.R. Risley.(1995). Meaningful Differences in the Everyday Experience of Young American Children (Baltimore, MD: Paul H. Brookes Publishing Company, 1995)

[20] Iowa Department of Education. Basic Educational Data Survey, Address and Enrollment Files, 2009.

[21] R. Putnam. 217.

Disparities in Financial Stability

Families may remain in poverty for generations if not given proper supports and resources to overcome challenges. For a family of three, a household needs to make $50,255 to meet basic needs; however, many in our community do not have stable enough wages to reach this threshold, particularly families of color. A median African American household income is nearly half of what is needed to support a family and median Hispanic families do not fare much better, only making 2/3 of what is needed. 52% of those receiving Supplemental Nutrition Assistance Program (SNAP) benefits are African-American and 38% are Hispanic, yet African Americans and Hispanics only make up 7% of the total Linn County population.

This disparity is also true when looking at housing. Housing cost is one of the main reasons that families may be unstable. In Linn County, renters are more likely to struggle to afford their housing. 38% of renters pay more than one third of their income on housing, compared to homeowners in which 20% struggle to afford their mortgage.

While both renters and homeowners may struggle with affordability, renters are more likely to suffer severe stress from instability due to the lack of a critical asset. In Cedar Rapids the housing cost burden for owners is nearly one in five is compared to nearly one in two for renters. Even though there are real financial risks in homeownership, there continues to be strong association between owning a home and accumulation of wealth. Policies supporting homeownership can alleviate wealth disparities by extending to those who are in a position to succeed as homeowners.[22]

Disparities in Health

Additionally, people who lack health insurance in Iowa include 11% of the Hispanic population and 9% of African Americans. At 6%, Linn County has the second highest rate of uninsured people per county in Iowa. Hispanic men ages 18–34 (16%) have the highest rate of being uninsured for 2015, followed by African American men at 15% and Hispanic women 13%.[23] There is also evidence an increase in mental distress in our communities of color. According to the Centers for Disease Control Quality of Life Survey[24], those at highest risk for frequent mental distress are: Black, Non-Hispanic persons at 16.9%, persons aged 55–64 years at 9.1% and women 8% versus 7.1% overall for the state of Iowa and 12.6% for the nation in 2010.[25]

For women, as income decreases, poor mental health increases. Low-income mothers are twice as likely to experience some form of depression in their lifetime.[26] Depression affects mothers functioning in society and leads to higher rates of adverse experiences (divorce, unemployment, poverty, etc.). In 2010, 19.1% of women in Linn County experienced inadequate social and emotional support.[27] This is especially true for Black and Hispanic women experiencing greater adversity.[28] When a mother has poor mental health it also affects her children. Cognitive and

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[22] Joint Center for Housing Studies- Harvard University, September 2013. http://www.jchs.harvard.edu/sites/jchs.harvard.edu/files/hbtl-06.pdf

[23] http://aspe.hhs.gov/basic-report/2015-plan-selections-county-health-insurance-marketplace

[24] United States. US Government: Centers for Disease Control and Prevention, "Behavioral Risk Factor Surveillance System, Health-Related Quality of Life Survey."

[25] http://apps.nccd.cdc.gov/HRQOL/

[26] J. Knitzer, S. Theberge and K. Johnson, "Reducing Maternal Depression and Its Impact on Young Children: Toward a Responsive Early Childhood Policy Framework," National Center for Children in Poverty, January 2008 http://www.nccp.org/publications/pdf/text_791.pdf

[27] Linn County Public Health, BRFSS, 2010

[28] K. Ertel, J. Rich-Edwards, K. Koenen, "Maternal Depression in the United States: Nationally Representative Rates and Risks.," Journal of Women's Health, 2011. 20(11), 1609–1617.

social-emotional development, behavior, school readiness, and overall health of a child is negatively impacted when their mother experiences poor mental health.[8]

Eradicating poverty and its negative effect on children and families by applying an equity-informed perspective to solutions requires cross sector, collaborative work that focuses on the entire family; if parents aren't doing well, then children will struggle. Equity will improve when we look for and understand the source and the root cause of disparities. Through United Way and funded partners, we can make an impact on many trends to reverse the cycles of poverty and inequity in our community.

Care Coordination and Navigation

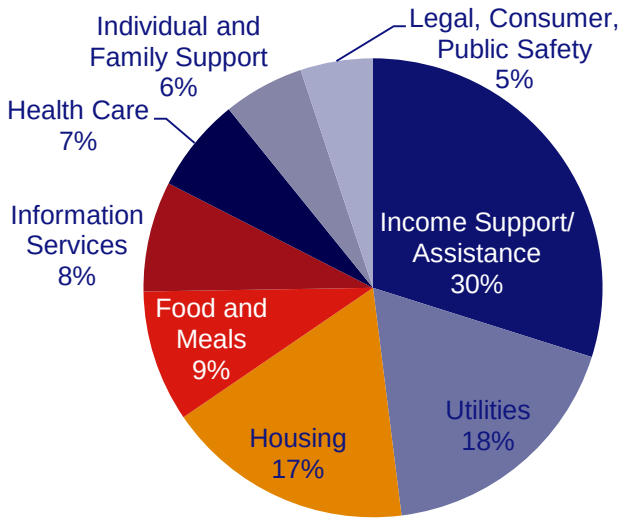
In spite of living in a resource rich area, systems have become increasing complex. People may not know where to go for help with basic necessities like rent, health care, utilities, transportation, food, etc. For some individuals navigating the maze of health and human service resources, having a person, who is an 'expert' in navigating areas of services would alleviate significant stress because they could have help finding the services they need. In discussions with individuals using services, many expressed the need for someone to help with coordination and navigation in agencies. Care coordination and navigation takes a collaborative and cross-sector approach to addressing many barriers clients experience while using services.

The Institute of Medicine (IOM) identifies care coordination as one of 20 national priorities for action because care coordination interventions have the potential to improve both efficiency and quality. A literature review conducted by Stanford-USFC Evidence-based Practice Center found that for the care coordination and navigation interventions reviewed, many experienced positive outcomes for their populations of study.[29]

2-1-1 is an example of a service in our community that is a centralized source of health and human service resources. 2-1-1's goal is to connect people to the right resources at the right time. People who call 2-1-1 work with trained and certified Information and Referral Specialists who assist individuals and families find possible resources to meet their needs. Information about where people call from (i.e., zip code), what they call about, and gaps in services are shared to assist community planning and identifying where we can make the biggest impact.

United Way 2-1-1 also supports effective collaboration. Areas of support for families through 2-1-1 include enrollment in health insurance as well as access to Volunteer Income Tax Assistance (VITA). VITA provides tax preparation services for free and helps families get cash they need to address some of their needs.

[29] K.M. McDonald, et al. "Closing the Quality Gap: A Critical Analysis of Quality Improvement Strategies Volume 1-Series Overview and Methodology," Technical Review June, 2007: Number 9. PsycEXTRA Dataset, 9(7). doi:10.1037/e439892005-001.



In FY 2015, residents of the 39 county service delivery area of 2-1-1 most frequently requested assistance in the areas represented in this chart. The **eight** needs listed account for **87%** of all calls received during this timeframe and encompass many of the basic needs low-income people are looking to address.

What We Have Achieved So Far

Education, Financial Stability, and Health use evidence-based and best practice intermediate outcomes to track our progress toward the Community Goals. Each fiscal year, our funded partners report twice annually (mid-year and year-end) on intermediate outcomes. The data is then aggregated and shared with our volunteers and board through Report Cards. Report cards show progress made in our community through the work of many different agencies. The links below show our Report Cards for fiscal year 2015. Take a look at these to see where you align and how you could help us make more progress in our community.

http://www.uweci.org/wp-content/uploads/2015/10/Education-Report-Card-FINAL2.pdf
http://www.uweci.org/wp-content/uploads/2015/10/Financial-Stability-Report-Card.pdf
http://www.uweci.org/wp-content/uploads/2015/10/Health-Report-Card.pdf

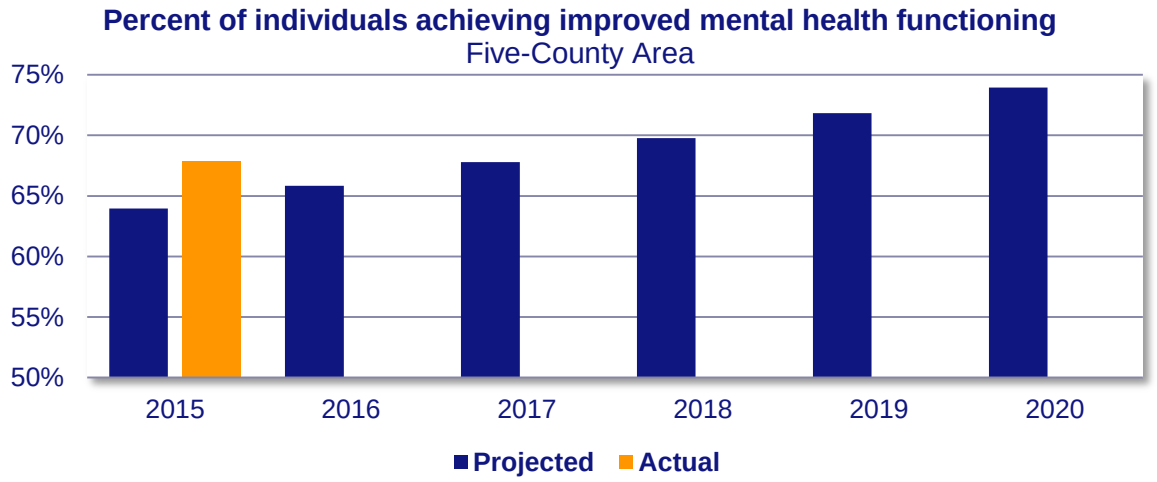
Our goal is to build solutions that create positive social change. We do this by raising awareness, bringing together the right partnerships, and investing in services to strengthen people and our communities. United Way focuses on education, financial stability, and health because they are the essential building blocks for a good quality of life. By addressing the root cause of shared issues in these three focus areas, we can get real results and create lasting, positive solutions.

Health Goal

United Way of East Central Iowa's (UWECI) community health goal is to improve social connectedness and mental health functioning of low-income adults in our five-county area. In order to achieve our goal it is necessary to reduce health barriers and promote well-being, healthy behaviors, and healthy aging across the lifespan. The three focus areas are prevention, reducing adverse experiences, and healthy community living.

Prevention includes activities such as education, screening, and coordinating services and navigation of complex care systems. United Way invests in prevention, mitigation, and treatment of main contributors to Adverse Childhood Experiences (ACEs) for families and children. Prevention helps us better address underlying issues that impact long-term health and improve functioning at home, work, and school. In addition, United Way supports home-based services that increase well-being and independence for older adults and persons living with a disability.

Through various strategies, we assess how individuals will improve social connectedness and/or experience increased levels of functioning at school, work, and/or home. The chart below demonstrates the growth in impact needed between 2015–2020 to achieve the community goal. The target population is individuals with income less than 250% of the federal poverty line (FPL). For a three-person household size, this means making less than$50,400.[i]



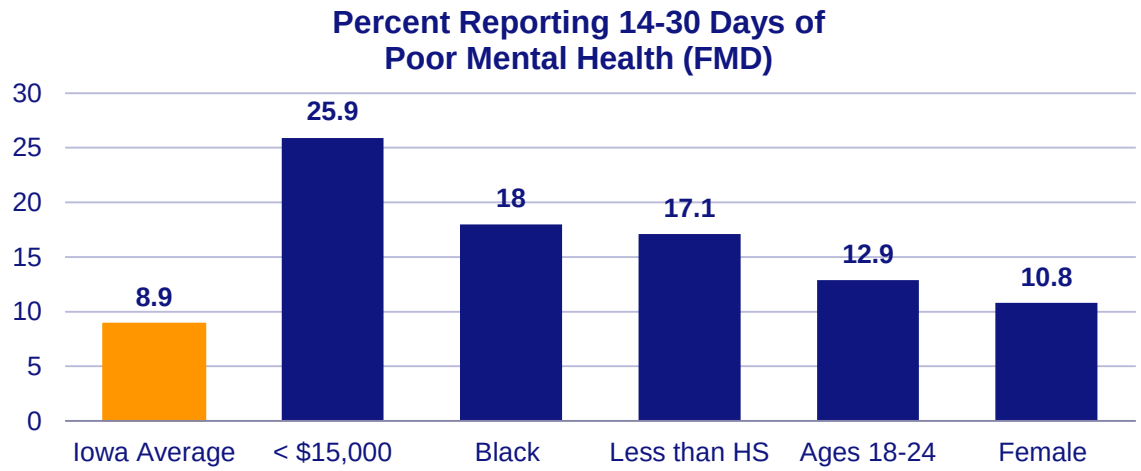
United Way's health goal has evolved throughout the last six years, with increased understanding of what factors determine health. In 2012-2014 there were two distinct health and independence goals. In 2015-2017 health and independence joined as one goal to address birth to end of life in order to collectively measure progress towards improving social connectedness and mental health functioning. The Affordable Care Act addresses some gaps for the uninsured, we continue to address root cause issues and challenges for children, adults, and seniors. United Way uses the Substance Abuse and Mental Health Services Administration (SAMHSA) National Outcome Measures[ii] for mental health and substance abuse to compare progress towards improved social connectedness and mental health functioning.

Current Condition

There are a number of factors that impact mental health functioning, social connectedness, and well-being of individuals in our community. By understanding our current condition and who is at risk we can better leverage resources to address these factors.

According to the Iowa 2014 Centers for Disease Control and Prevention Behavioral Risk Factor Surveillance System (BRFSS) Survey, the percentage of Iowans who report their health as fair to poor condition increases as annual household income decreases. For those responding to the health-related quality of life (HRQOL) question self-reported perception of physical and mental health over time:

- Those reporting fair or poor general health were more likely to have less than a high school education, live in households earning less than $15,000 per year, be African American, and be 75 years and older.
- Those reporting poor physical or mental health that impact daily activities (reporting 14 or more days) increased with older ages, less education, and lower income.
- Populations at highest risk for frequent mental distress (FMD) (those experiencing 14 or more days of poor mental health in the past 30 days) are those with annual household income less than $15,0000, Black-African American/Non-Hispanic, less educated, younger, and female in comparison to Iowa's overall rate of 8.9% reporting poor mental health.[iii]



In addition, renters or individuals with residential instability experience adverse impacts in mental health disparities, lower academic achievement, and increased behavioral problems in children than compared with homeowners. This is true in Cedar Rapids neighborhoods with high housing cost burden in which there are issues of safety, substance abuse, and food insecurity. For adults, stable housing associates with improvement in mental health and a reduction in hospitalizations or days spent in the hospital. This is also true for seniors: those who have greater stability at a residence tend to have less mental health and behavioral health issues.[iv]

Who's at Risk?

Low-Income People of Color

In 2015, Linn County had the second highest rate of uninsured individuals in Iowa at 6% for the general population. In contrast, 11% of the Hispanic population and 9% of African Americans lacked health insurance. Hispanic men ages 18–34 (16%) had the highest rate of being uninsured, followed by African American men at 15% and Hispanic women 13%.[v]

Those experiencing increased days of poor physical health (14–30 days of poor physical health) accounted for 10.1% of the general population in Iowa and 16.6% of African American populations. Overall, those experiencing poor mental health (frequent mental distress) represent 8.9% of Iowans, but 18% of African Americans — more than twice the rate. [vi]

Low-Income Women

One in 16 women in United Way's five-county service area are uninsured and not able to access consistent screenings and preventative services.[vii] Individuals who live below 250% FPL are most likely to have less education, be younger, be under or unemployed, and be uninsured.[viii]

In Linn County, one in four families are single female-headed households.[ix] Additionally, if a woman is a single head of household, there are additional barriers to quality care that also affect her children's health.[x]

In a 2015 United Way 2-1-1 survey, 35% of women responded they were not getting care for an identified medical need. Additionally, 72% of respondents stated they, or someone in their household, had unaddressed mental health needs.

For Linn County residents, 29% reported experiencing one or more days of poor mental health. Among female respondents, mothers are at an increased risk for experiencing poor mental health, with 47.4% experiencing 11 or more days per month. [xi]

Those Struggling with Substance Abuse & Mental Health

Unaddressed mental or emotional problems made physical health conditions worse. Those with depression are more than four times as likely to suffer from a heart attack as those without similar history. Nearly 37% of individuals who abuse alcohol and 53% of individuals who abuse drugs also have at least one serious mental illness. [xii] Those with mental illness may face a loss of income due to unemployment, expenses for social supports and services, and additional issues that impact daily functioning and overall quality of life.

The percentage of youth in Linn County who report using alcohol, tobacco, and illicit drugs is slightly less than that of Iowa as a whole. According to the Iowa Youth Survey, 11% of students in Linn County use illicit drugs, 8% use alcohol, and 4% use tobacco.[xiii] Binge drinking is an issue for both adults and youth in Linn County. Among Iowa adults, 21.4% reported at least one binge episode in the last 30 days; this is lower for Linn County adults at 18%. Eleventh graders

reported 12% engaged in binge drinking within the past 30 days.[xiv]

Alcohol dependency and abuse are major public health problems carrying a large economic cost and placing heavy demands on the healthcare system. In fact, excessive alcohol use is the third leading lifestyle-related cause of death for people in the United States annually. In 2010, the cost of excessive alcohol use in the United States reached $249 billion.[xv] Chronic alcohol use affects every organ and system of the body, and can lead to medical disorders (e.g., fetal alcohol syndrome, liver disease, cardiomyopathy, and pancreatitis). Heavy drinking also increases the risk for certain cancers. Drinking increases the risk of death from automobile crashes as well as recreational and on-the-job injuries. Furthermore, persons who have been drinking more likely commit both homicides and suicides.[xvi]

Those Impacted by Adversity and Trauma

In addition to basic health needs, Adverse Childhood Experiences (ACEs) in the forms of household dysfunction, neglect, and abuse are common across socio-economic and culture/ethnic lines. ACEs are often interrelated and have a significant cumulative impact on public health including mental, physical, and behavioral health throughout the life course. ACEs are traumatic events that can upset a child's sense of safety and well-being.[xvii] Household dysfunction includes having a parent with unaddressed mental health or substance abuse, having an incarcerated household member, witnessing domestic violence, or experiencing parental separation or divorce. Neglect includes emotional or physical neglect influencing a child's ability to have needs met by consistent caregivers. Abuse includes emotional, physical or sexual abuse of a child that impacts their development and creates toxic stress that may prevent children from learning, being socially connected in a healthy way, and can result in long-term health problems and early death as an adult.

Mechanism by Which Adverse Childhood Experiences Influence Health and Well-being Throughout the Lifespan

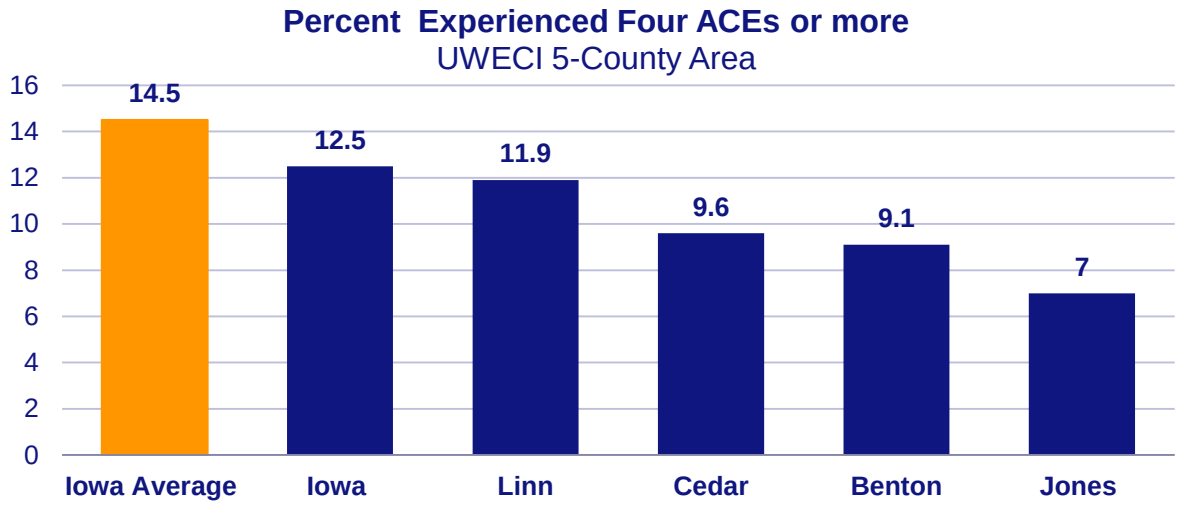
Stress, trauma, and adversity in childhood impact lifelong health and well-being including physical, emotional and mental, financial, and educational outcomes. Trauma can occur at any age from many kinds of events.

According to the 2016 Iowa ACEs report *Beyond ACEs: Building Hope & Resiliency in Iowa*, ACEs are common:

- 56% of adults report at least one ACE
- 14.5% experienced four or more ACEs, indicating a significant level of stress in childhood
- Other than neglect, the most common ACEs reported were childhood emotional abuse (26.8%) and substance abuse in the home (26.1%)

If an individual experiences one type of ACEs, they are more likely to experience additional ACEs. As the number of ACEs increases, so does the likelihood a child experienced neglect. Although adversity can impact anyone, those more likely to report higher ACEs in Iowa are younger (age 18–34), multiracial or African American, and have not graduated from high school.

- A greater share of Iowa adults reporting four or more ACEs live in Iowa's largest cities or smaller regional centers. Respondents reporting four or more aces in our UWECI service area, although less than Iowa's 14.5%, were greater in Iowa and Linn County.

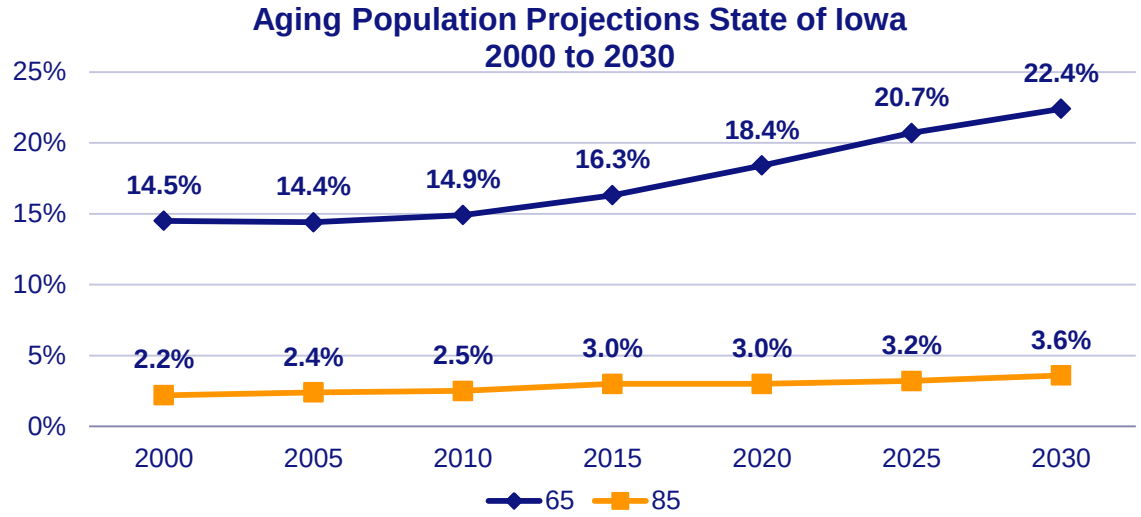


ACEs impact lifelong health and well-being. The more ACEs someone reports, the more likely they are to have a wide range of poor outcomes as adults, and the greater the risk for each particular outcome:

- Those with four or more ACEs compared to those with zero ACEs are:
  - Twice as likely to rate their health as poor or fair
  - 2.5 times as likely to rate their mental health (including stress, depression, and problems with emotions) as not good
  - 2.5 times as likely to report activity limitations because of physical, mental, or emotional problems
  - 2.2 times more likely to have a heart attack
  - 3.3 times more likely to smoke
  - Six times more likely to have depression
- A national study showed that those with four or more ACEs were 2.3 times more likely to report serious financial problems, 2.5 times more likely to have absenteeism, and 3.6 times more likely to have serious job problems than those with zero ACEs.
- Iowa youth experience stress at a level that suggests similar outcomes as Iowa's current adult population.
  - Looking at the Iowa Youth Survey, 16 risk factors were identified including questions related to drinking, drug use, having thoughts of suicide, being bullied, having a happy home, and feeling connected to the community. About 25% of Iowa youth had at least three risk factors and 8% had six-plus risk factors. [xviii]

The Aging Population

Our communities' changing demographics affect lifelong health. Nationally, 10,000 baby boomers will turn 65 years old each day as we approach 2030.[xix] According to the Iowa Department on Aging, in 2012, those older than age 60 represented 20% of the population. Projections show that 22% of Iowans will be 65+ and 3.6% 85+ by 2030, with growth projected at 1–2% per year. It is imperative to find ways to meet needs of older and more frail Iowans.[xx]



In UWECIs' service area, there are more than 43,000 individuals age 65 and older; 68% live in Linn County. [xxi] Many struggle to meet their needs, with as many as 52% of older two-person households having less than $40,000 and living below the 250% Federal Poverty Line. [xxii]

Although there has been some migration from rural to urban communities, many of our seniors still live in rural counties where there are fewer resources and more barriers to accessing proper care, support, and social connections. A positive health routine and active social life can help reduce chronic pain, alleviate depression and sleep problems, improve memory, and increase mobility. Access to appropriate and available care providers that can support seniors in their homes is one of the greatest challenges to those in our rural communities and those living in poverty.

- 93% of Iowans age 50 and older say it is important to be able to stay in their own homes as they age.
- There is a growing need for community-based supports for health and independence that provide lower cost alternatives to long-term facilities for those with low-care needs.[xxiii]

According to the American Association of Retired Persons, seven out of every ten individuals 65+ will need support and assistance to maintain some degree of independence.

- In Iowa, more than 300,000 family and informal caregivers provide these services and supports on an ongoing basis, keeping them out of costly institutions.[xxiv]
- In Iowa, family caregivers provided unpaid care valued at about $3.9 billion annually (2013).[xviiii]

According to Healthy People 2020, caregivers who provide assistance with activities of daily living (whether it is family, community, or service providers) will continue to increase as our aging population increases. Caregivers are at increased risk for negative health consequences, including stress and depression, and need increased supports to preserve their own health. [xxv]

Those Living with Disabilities

In UWECI's service area, one in 15 children (age 0–18); one in seven adults (age 18–64); and one in two seniors (age 65 and older) live with disabilities that impact their quality of life. [xxvi]
To serve individuals with disabilities, we need to ensure they can access resources throughout the community to maintain a higher quality of life.

According to the 2014 Behavioral Risk Factor Surveillance System (BRFSS) survey older people, females, people with less education, and people with lower household incomes reported higher percentages of disability. Of the five demographic areas analyzed, people age 18–24 years reported the lowest percentage (9.1%). Those age 75 years and older reported the highest percentage of disability (42.3%), which is the most rapidly growing group in the population. The second highest reporting group included those with an annual household income less than $15,000 (40.4%). Many people with disabilities are unable to work due to their disability. Additionally, children with a disability account for approximately 5% of the total population of children under age 18.[xxvii]

For both the aging population and those living with disabilities, there will be a greater emphasis on quality of life in the community and access to resources and supports for those needing direct care services, as well as informal and family members providing the care.

What Works

In UWECI's five-county area, the goal is to create conditions for well-being from birth to end of life in both rural and urban communities. With proper coordination and health services across systems, United Way supports efforts that reduce health barriers and promote well-being, healthy behaviors, and healthy aging across the lifespan, especially for those that are at greater risk of health disparities.

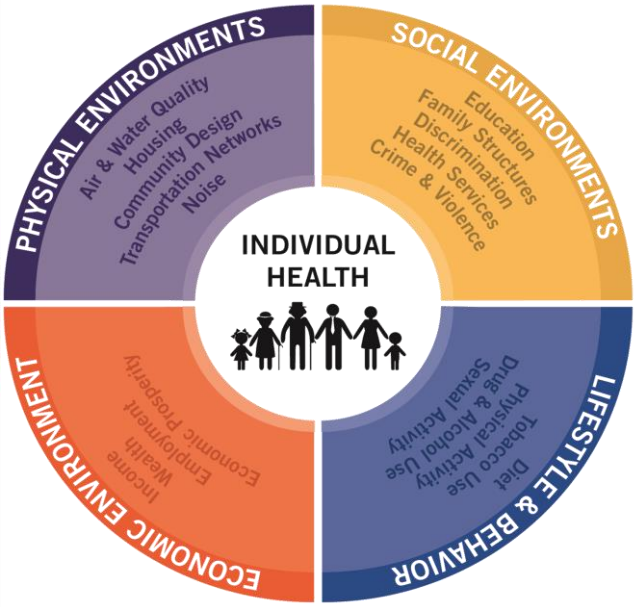
1. Preventative Health

- **Increase protective factors that contribute to long-term health by increasing education, screening, care coordination and reducing health barriers.**

The Centers for Disease Control and Prevention state that preventing disease is key to improving America's health and keeping rising health costs under control. When we invest in prevention, the benefits have multiple impact. Children grow up in communities, homes, and families that nurture their healthy development, and adults become productive and healthy, both inside and outside the workplace. Businesses benefit because a healthier workforce reduces long-term health care costs and increases stability and productivity.

According to the Center for the Study of Social Policy research has confirmed the importance of early childhood experiences in influencing behavior in youth and adults. By strengthening protective factors we can prevent further physical and mental health needs from birth to end of life. Protective factors include parental and youth resilience, social connections, knowledge of parenting and child and youth development, concrete support in times of need, social –emotional and cognitive competence of children and youth. Taken together, protective and promotive factors increase the probability of positive, adaptive and healthy outcomes even in the face of risk and adversity.[xxviii]

According to the Robert Wood Johnson Foundation (RWJF) County Health Rankings research, the conditions we are born, grow, live, learn, work, and age in influence our lifelong health. To improve health outcomes, we need to address adverse conditions that create barriers to good health. Approximately 70% of health outcomes are due to socioeconomic factors that contribute to or detract from healthy individuals and communities and impact length and quality of life. These factors include:



- Social and economic factors (40%): Education, employment, income, family and social support, and community safety
- Healthy behaviors (30%): Tobacco use, diet and exercise, alcohol and drug use, and sexual activity
- Clinical care (20%): Access to care and quality of care
- Physical environment(10%): Housing, transit, air, and water[xxix]

According to the World Health Organization, health is a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity. [xxx] Care coordinators, service providers, community agencies, insurance coverage programs, and local public health agencies attend to the strengths and needs of the people they serve while taking into account their economic, racial, ethnic, gender, and cultural characteristics. Building awareness of the need to address social determinants of health (SDoH) will require integrated, collaborative, and outcome-based strategies for connecting people to the services they need in order to get well and stay well.[xxxi]

Examples of local integration of SDoH in assessment, navigation, and care coordination was piloted with United Way's Women's Leadership Initiative's funded partners: Eastern Iowa Health Center (EIHC) and Area Substance Abuse Council (ASAC) Heart of Iowa residential treatment program for women and their children. At the Heart of Iowa, a Care Coordinator is dedicated to initial assessment of basic needs, resources for women and their children, and eventual transition back into the community. ASAC saw an increase in treatment completion in

comparing FY15 to FY16. During FY16, they were able to measure outcomes of navigation and care coordination around enrolling the women on Medicaid (Title XIX) and primary care providers, coordination of addressing basic needs, and screening and enrollment in eligible benefits (Family Investment Program, Supplemental Nutrition Assistance Program, Women, Infants and Children Supplemental Nutrition Program, etc.). The Care Coordinator was able to connect mothers and children with supports to address mental and emotional health needs, along with the Treatment Counselors addressing substance abuse issues, to improve outcomes in daily functioning.

In addition to mental health needs, there are also basic needs that need to be addressed for under-resourced and overburdened women. Eastern Iowa Health Center (EIHC) serves patients from UWECI's service area. EIHC offers services to patients including preventive health screenings, annual exams, and in-office procedures (e.g., colonoscopies, prenatal care). Additionally, EIHC providers deliver approximately 80% of the babies born to mothers with Medicaid in Cedar Rapids.[xxxii]

In 2015, EIHC served 7,764 patients. Of these patients, 69% had Medicaid coverage, 98% were low-income, and 27% self-identified as a racial/ethnic minority.

- In FY16 (July 1, 2015 through June 30, 2016), EIHC served 4,354 women of whom 28% saw a Medical Social Worker and 77% (954 of the 1,238) received additional screenings for other needs in addition to their reason for coming to the health center.
- On average, the Medical Social Worker provided nine in-office interventions, referrals, and/or education to women. Of the referrals,35% addressed basic needs (food, housing, financial assistance, transportation) that affecting well-being.[xxxiii]

The EIHC Medical Social Worker also supported 37% of women with needs related to emotional and mental health needs.

2. Reducing Adverse Childhood Experiences (ACEs)

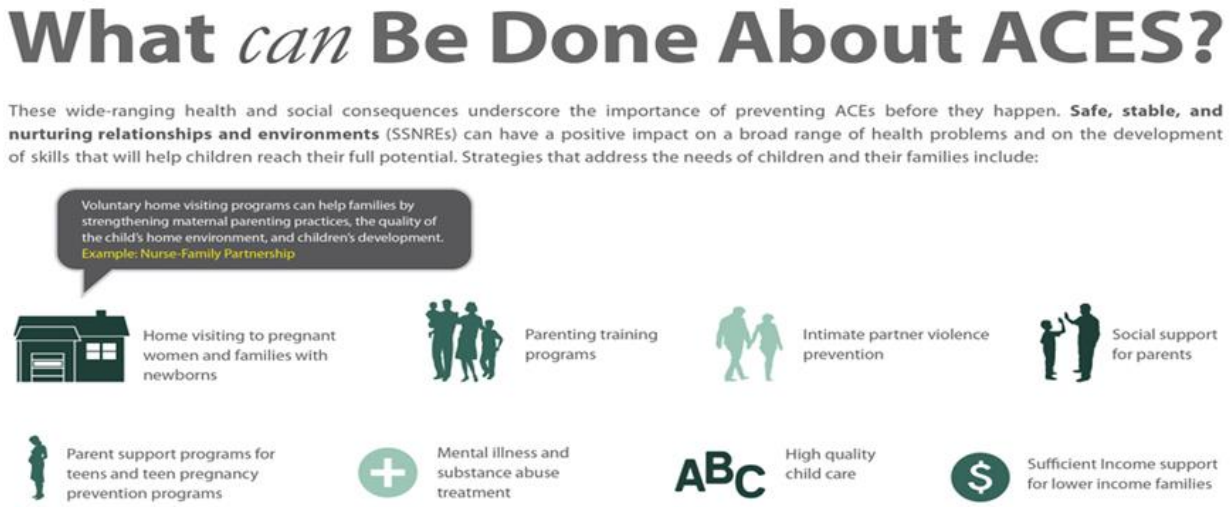
- **Prevent, mitigate and treat main contributors of adverse childhood experiences for families with children to build resiliency.**

According to the Substance Abuse and Mental Health Services Administration's (SAMHSA) concept of a trauma-informed approach, "a program, organization, or system that is trauma-informed":

- Realizes the widespread impact of trauma and understands potential paths for recovery;
- Recognizes the signs and symptoms of trauma in clients, families, staff, and others involved with the system;
- Responds by fully integrating knowledge about trauma into policies, procedures, and practices; and
- Seeks to actively resist re-traumatization.[xxxiv]

SAMHSA suggests six key principles to help communities address traumatic situations and focus on healing: safety; trustworthiness and transparency; peer support; collaboration and mutuality; empowerment; voice and choice; and cultural, historical, and gender issues. [xxxv]

It is a priority to support the healthy growth of families' well-being where they live and work by preventing, mitigating, and treating ACEs that impact long-term health. By assessing the needs of the population being served in order to address underlying issues as well as basic needs it can be accomplished. The Center for Disease Control and Prevention recommends steps to create safe, stable, nurturing relationships and environments in the graphic



3. Community Living

- **Increase family and social supports that improve independence and the ability to live and function within the community**

As both the population of individuals living with disabilities and aging individuals increase, it is vital to focus on community living through access to care, resources, social connections, and well-being across UWECI's five-county service area.

We can improve conditions by supporting home-based services that increase well-being and independence for older adults and persons living with a disability:

- According to *Aging in Place*, 87% of adults age 65+ want to stay in their current home and community as they age. Among people age 50 to 64, 71% of people want to age in place. [xxxvi]
- Under the Americans with Disabilities Act of 1990, states must administer their programs, services, and activities "in the most integrated setting appropriate to the need of the qualified individuals with disabilities."
- Home-based care is more cost effective and often more appropriate for those needing moderate levels of care to maintain community connections and well-being.

Costs of Senior Care per Year State of Iowa 2016 [xxxvii]				
Nursing Home (private room)	**Assisted Living** (private room)	**Adult Day Care** (5 days/ week)	**Home Health Aid** (7 hrs/ week)	**Homemaker Services** (3 hrs/ week)
$68,255	$42,000	$15,600	$8,372	$3,501

Ongoing person-centered care planning that includes caregivers, quality measures of care, and monitoring of health conditions, adequate training and support for formal and informal care providers will be vital to maintain the quality of life for aging populations.

Our Priorities

Health Community Goal: By 2020, improve social connectedness and mental health functioning of low-income adults by 10%.

Guiding Principle: Reduce health barriers and promote well-being, healthy behaviors, and healthy aging across all life stages.

Target Populations: Persons of all ages living in households with an annual income of up to 250% of the Federal Poverty Level (FPL). UWECI seeks to work with strategies serving individuals and families living in Benton, Cedar, Iowa, Jones, and Linn counties.
Priority to the following subpopulations in greatest need:

- Individuals and families who are 250% of the FPL and are uninsured or underinsured
- Individuals with physical, mental, or emotional barriers that limit functioning at home, work, and/or school
- Individuals with disparities in access to quality health and supportive services that improve well-being and independence

Priorities:

1. Focus on preventative health to address factors that contribute to long-term health through education, screening, early detection and reducing health barriers.
2. Reducing Adverse Experiences through prevention, mitigation, and treatment of main contributors of ACEs for families and children to build resiliency.
3. Supporting home-based services that increase well-being and independence for older adults and persons living with disabilities.

Intermediate Outcome 1: PREVENTATIVE HEALTH -Increase factors that contribute to long-term health by increasing education, screening, early detection and reducing health barriers.

Types of activities that will be considered for funding include programs that:

- Provide health education;
- Promote preventative screenings; early intervention;
- Address healthcare barriers;
- Improve navigation and care coordination;
- Promote well-being.

A. <u>Output</u> measurement(s) your strategy will be reporting:

# of unduplicated persons served per intervention type. (required)
# of households served per intervention type. (required)
Others as approved through the letter of intent process(please list):

B. <u>Indicator</u> measurement(s) your strategy will be reporting on (must report on at least one):

(%) with additional services based on screening
(%) referred for severe/urgent care

(%) with increased knowledge of risky behaviors
(%) Others as approved through the letter of intent process (please list):

Intermediate Outcome 2: REDUCING ADVERSE EXPERIENCES – Prevent, mitigate and treat main contributors of adverse childhood experiences for families with children to build resiliency.

Types of activities that will be considered for funding include programs that:

- Reduce levels of crisis and/or trauma;
- Increase social connectedness and/or
- Improve functioning at school, work and/or home.

A. <u>Output</u> measurement(s) your strategy will be reporting:

# of unduplicated persons served per intervention type. (required)
# of households served per intervention type. (required)
Others as approved through the letter of intent process(please list):

B. <u>Indicator</u> measurement(s) your strategy will be reporting on (must report on at least one):

(%) within increased feelings of social connectedness.
(%) with improved functioning at school, work and/or home.
(%) with decreased levels of crisis, depression, anxiety and/or stress.
(%) of persons screening on ACEs, behavioral health problems and/or trauma.
(%) who received services based on follow-up.
(%) who completed treatment with goals met.
(%) Others as approved through the letter of intent process (please list):

Intermediate Outcome 3: COMMUNITY LIVING –Support home-based services that increase well-being and independence for older adults and persons living with disabilities.

Types of activities that will be considered for funding:

- Services that improve/maintain daily functioning and increase family and social supports.

A. <u>Output</u> measurement(s) your strategy will be reporting:

# of unduplicated persons served per intervention type. (required)
# of households served per intervention type. (required)
Others as approved through the letter of intent process(please list):

B. <u>Indicator</u> measurement(s) your strategy will be reporting on (must report on at least one):

(%) with improved/maintained daily functioning.
(%) with increased feelings of social connectedness.

(%) with increased family and social supports.
(%) with increased skills on how to care for a loved one at home.
(%) of caregivers with decreased levels of stress.
(%) reporting increased access to nutritious, low-cost food.
(%) with decreased sense of isolation and loneliness.
(%) with increase knowledge of how to improve/maintain their health and wellness.
(%) Others as approved through the letter of intent process (please list):

QUESTIONS

A. Narrative Questions

Continuation Grant Questions (45 points)

1. What problem area do you intend to address and why is this needed locally?
2. Who are your target clients and how do you reach them? Or Who are you clients and how do you engage them in your services?
3. What is/are the services you will deliver and what result will you achieve?
    a. Describe the service sequence.
    b. In your description it should be clear how the activities relate to the result your organization is working to achieve.
4. What evidence exists or do you have that shows your approach will work to solve your clients' problem or need?
5. Please describe how you determine that participants experience better outcomes by participating in your program, compared to people who are not in your program.
    a. What is the difference that is being made?
    b. Why should we continue to fund this work (Looking specifically at impact and outcomes)?
6. Is there anyone else doing what you are doing?
7. What other organizations help you achieve desired outcomes for clients?
8. What's changed in our environment that's impacted the service and how have you coped with those changes?
9. Please describe any risks you face that may impact your ability to deliver forecasted outcomes/results such as staff turnover, available talent, policy change, or other funder changes. How would you address them?

Enhancement Grant Questions (15 points)

If applying for an Enhancement Grant please answer the nine Continuation Grant Questions and the following three questions.

1. Please describe how you will expand the impact of your program/service. To be considered the enhancement should include one or more of the following: expanded geography, expanded populations, or dramatically expanded services.
2. What changes or trends led to the need for this enhancement?
3. What is your staffing plan to address this shift?

B. Data and Measurement Components

1) Please describe the measurement tool you are using including the source of the tool and the method of choosing this tool. Please also provide any reliability and validity information you have on the measurement you will be using to collect your data.

2) Please clearly describe your methodology for calculating indicator measurements including timing and frequency of measurement.

3) Complete your logic model and include this information.

C. Financial: Budgets and Request Justification

C1. Impact Strategy Budget & Narrative

Impact Strategy Budget Form

Please complete an Impact Strategy Budget Form using the MS Excel form on the UWECI website. UWECI should not be the only source of income reflected on the impact strategy budget. The Impact Strategy Budget should reflect all sources of income and related expenses to implementing the strategy being proposed. Budget figures should coincide with the grant cycle (July 1-June 30 fiscal year). Funding requested from UWECI should not exceed 70% of the total strategy budget.

Do not change any titles to line items in the budget form.

Impact Strategy Budget Narrative

Please use the "Narrative" space in the budget form (Excel spreadsheet) to explain Impact Strategy Budget line items that you feel are needed, including:

- Line item variance greater than $10,000 or greater than 10% between budget years. Please reference the line item(s) and provide an explanation.
- Complete the schedules as appropriate
- Budget deficits of any size require both an explanation and an anticipated resolution
- Describe key financial opportunities and threats that may affect your strategy budget in the next three years.

Please reference the applicable line item number and description for each explanation provided. For example:

Line item 10 - Salaries: The variance is a result of a 1 FTE staff position that was not filled for five months.

C2. Funding Request Justification Form

Please complete a Funding Request Justification Form using the MS Excel form on the UWECI website. This form shall serve as the primary tool to set context for the amount of funding being requested. Agencies may modify the form to suit their need, however all information requested must be addressed. ***If the proposal is requesting funding to support activities that align /with two or more intermediate outcomes, please complete a "Funding Request Justification Form" for each Intermediate Outcome.***

Funding Request Narrative:

Provide additional information that sets context for the funding requested, including but not limited to:

- Provide and explain how it is calculated the agency's general administrative rate (%) applied to service provisions.
- Revenue streams that support this strategy and funding restrictions they may impose.

Glossary of UWECI Terms

Activities – the type of service or what the agency does with its inputs, i.e., resources dedicated to or consumed by the agency, to fulfill its mission (e.g. workshops, counseling, trainings, etc.)

Barriers – related issues effecting the situation of the primary focus area.

Base Data – information gathered at the beginning that is used later to provide a comparison for assessing impact.

Care Coordination – links patients with community resources to facilitate referrals and respond to social service needs. Tracks and supports patients when they obtain both inside and outside services. Communicates with clients and community resources about needs and goal setting.

Community Goal – a broad, systemic community change tied to a United Way focus area of Education, Financial Stability, or Health that cannot be directly measured, but rather evidenced by changes in related indicators, i.e., measures used to illustrate benefits or changes in knowledge, skill, behavior or condition for participants and/or communities.

Cultural Competence – set of congruent behaviors, attitudes, and policies that enable systems, agencies, or professionals to work effectively in cross-cultural situations.

Diversity and Inclusion – diversity is the range of human differences, including but not limited to race, ethnicity, gender, gender identity, sexual orientation, age, social class, physical ability or attributes, religious or ethical values system, national origin, and political beliefs. Inclusion is involvement and empowerment, where the inherent worth and dignity of all people are recognized. An inclusive agency promotes and sustains a sense of belonging; it values and practices respect for the talents, beliefs, backgrounds, and ways of living of its members.

Educational Attainment – refers to the highest level of schooling a person has reached.

Federal Poverty Level – guidelines set by the federal government used to set eligibility criteria for various programs: http://www.akleg.gov/basis/get_documents.asp?session=29&docid=52164

Focus Areas – the three categories of community issues that comprise UWECI's Impact Agenda; Education including, Early Childhood Development and Care, and Positive Youth Development; Financial Stability; and Health which includes Independence. Also referred to as pillars.

Housing Cost Burden – the percentage of household income spent on mortgage or rent. HUD programs consider households spending more than 30 percent of income on either rent or mortgage to be "cost-burdened." Households spending more than 50 percent are considered to be "severely cost-burdened."

Impact Cabinet – a governing body which oversees the Community Solutions Teams, that will determine funding for each Focus Area and discuss overarching issues, strategies and policies.

Indicators – measures used to illustrate benefits or changes in knowledge, skill, behavior or condition for participants and/or communities.

Inputs – resources dedicated to or consumed by the agency; some examples include staff, volunteers, time, money, equipment, etc.

Integration – the process of improving organizational performance by facilitating the continuous alignment of strategies within the ever changing social service environment.

Intermediate Outcome – the change that is desired through funded strategies of UWECI to contribute to the Community Goal's achievement.

Low-income — United Way of East Central Iowa considers persons or households with annual incomes below 250 percent of the federal poverty guidelines to be low-income.

Logic Model – a tool that helps frame a strategy by evaluating data from all key data sources (e.g. inputs, activities, outputs, indicators and intermediate outcomes).

Multi-generational – of or relating to several generations.

Navigation – refers to the assistance offered to patients in finding their way through the complex social service and/or health systems to overcome barriers in accessing quality care and treatment (e.g., arranging financial support, coordinating among providers and setting, arranging for translation services, etc.), and emphasize a patient-centric model. Navigation is the assistance that enables successful Care Coordination

Outputs – the direct products of activities. These are usually measured in terms of the volume of work accomplished and/or participants served. Examples: number of classes taught, number of counseling sessions conducted, hours of service provided.

Self-Sufficient Wage – a calculation of the compensation required to provide for an individual's or family's needs. Please reference Iowa Policy Project's website to access the Cost of Living in Iowa Report.

Socioeconomic Status (SES) – is often measured as a combination of education, income and occupation. Socioeconomic status is commonly conceptualized as the social standing or class of an individual or group.

Solutions Teams – teams of volunteers and lead staff that will work collectively to research best practices, select partners, allocate funds, monitor performance, support community initiatives, build collaboration, understand community systems and create advocacy all under an identified focus area on an ongoing basis.

Strategy – incorporates the activities or services within your agency that support your alignment with an intermediate outcome. This strategy may align with what has been traditionally labeled as a program or group of programs in your agency.

Trauma-Informed – care is a framework that involves understanding, recognizing, and responding to the effects of all types of trauma.

Target Population – the market segment or group you are planning to serve.

Targets – numerical goals for an agency's level of achievement.

Vision – a future ideal state for a community condition, issue or population group.

BUDGET FORM DEFINITIONS

REVENUE

Line #	Line Description	Line Explanation
1	UWECI Community Impact Funding	Amount requested from the CIPF, and the amount current partner agencies received from UWECI for Partner Agency Funding.
2	Other UWECI Funding	Funding received from UWECI for Donor Option
3	Funding from other United Ways	Funding received from a United Way other than UWECI.
4	Contributions & Events	Include all general contributions for which the donor receives no direct private benefit such as any funds restricted by the donor; also include revenue resulting from special events sponsored by an agency for the purpose of fundraising.
5	Foundation Grants	Funding received from private, corporate, community, or family foundations such as the Hall-Perrine Foundation, Greater Cedar Rapids Community Foundation, etc.
6	Government Grants	Funding received from the United States Government, the State City and or County.
7	Program Service Revenue	Include revenues that are received by the agency for personal memberships and fee payments for services furnished by the

		organization.
8	Other Revenue	Include revenue that cannot be itemized in previous line items.
9	TOTAL IMPACT STRATEGY REVENUE	The sum of lines 1-8.

EXPENSES

Line #	Line Description	Line Explanation
10	Salaries	Salaries and wages earned by the agency's or Impact Strategy's regular and temporary employees; does not include fees paid to consultants or contract fees.
11	Benefits and Payroll Taxes	Amounts paid and accrued by an agency under employee benefit plans offered by the agency and payroll taxes.
12	Fees for Services (non-employees)	Professional fees and expenses of professional consultants and practitioners who are not employees of the organization.
13	Advertising/Promotion	All marketing and communication related expenses, including costs for printing, design work, etc.
14	Office expenses	Includes the cost of material, appliances, and other supplies.
15	Occupancy/Utilities	Costs to agency or impact strategy for occupying owned or leased land, buildings and/or offices including telephone, internet and other facilities operations costs
16	Travel/Meetings	All expenses of travel and transportation for agency representatives, also expenses of conducting or attending meetings related to the organizations activities.
17	Assistance to Individual Households	Cost to the agency of specific material assistance or services for a particular client or patient.
18	Dues	Amounts paid for memberships in other organizations that provide benefits and services i.e. membership in a network or association
19	Insurance	All costs of insurance except employee benefits and other payroll related insurance.
20	Other Expenses	Expenses not reportable in other lines.
21	TOTAL AGENCY/ IMPACT STRATEGY EXPENSES	All expenses, direct and indirect, attributable to the agency/impact strategy.
22	Net Excess (Deficit)	The difference between TOTAL REVENUE and TOTAL EXPENSES.

SUBMISSION REQUIREMENTS

Contact Information:

If you have any questions, please contact Leslie Wright at (319) 398-5372 ext. 815 or communitybuilding@uweci.org

Accessing the RFP Forms:

Agencies can find all necessary forms on the UWECI web site: www.uweci.org/2016RFP.

LATE OR INCOMPLETE SUBMISSIONS WILL NOT BE CONSIDERED FOR FUNDING.

UWECI must receive all materials electronically via email submission to communitybuilding@uweci.org by **noon** on **January 13, 2017*.** In order to be considered complete each Funding Proposal should include the following:

Checklist of Items	Submission Method	☑ CHECK
Funding Proposal including: ▪ Cover Page ▪ Narrative ▪ Impact Strategy Budget ▪ Funding Request Justification Form ▪ Program Process Map	☑ Email all documents together as one pdf that may be duplicated	
Logic Model	☑ Email pdf document	
Current roster of organization's Board of Directors with their affiliations	☑ Email pdf document	
Affidavit of Non-Discrimination	☑ Email pdf document	
Counterterrorism Compliance Form	☑ Email pdf document	
Current Partners:	Submit Accountability Review documents on your regular schedule.	
New applicants only:		
1) 501(C)(3) Designation Letter 2) Current Bylaws 3) Audit or Independent Financial Review 4) IRS Form 990 5) Board approved annual budget with accompanying narrative	☑ Email all documents together as one pdf that may be duplicated	

*** The invitation to apply will be sent via email on October 28th, 2016**

[i] Iowa, United States, "Iowa Policy Project Cost of Living 2016." The Iowa Policy Project, <http://www.iowapolicyproject.org/2016Research/160405-COL-map.html>.

[ii] Substance Abuse and Mental Health Services Administration. Behavioral Health Barometer: Iowa, 2014. HHS Publication No. SMA–15–4895IA. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2015.

[iii] Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, Health-Related Quality of Life Survey, Iowa 2014

[iv] Maqbool, Nibihah, Janet Viveiros, and Mindy Ault. "The Impacts of Affordable Housing on Health: A Research Summary." Insight from Housing and Policy Research (2015): National Housing Conference. Center for Housing Policy, Apr. 2015. Web 2 Mar. 2016. http://www2.nhc.org/HSGandHealthLitRev_2015_final.pdf

[v] www.enrollamerica.org- Iowa State Snapshot- Oct. 2015 https://s3.amazonaws.com/assets.enrollamerica.org/wp.../2015/11/IA_snapshot.pdf

[vi] Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, Health-Related Quality of Life Survey, Iowa 2014

[vii] Enrollment Snapshot released by the Department of Health and Human Services (HHS) on June 2, 2015. This includes all new and renewing consumers during the second open enrollment period from November 15, 2015 to February 22, 2015. Additional information can be found at: https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2015-Fact- sheets-items/2015-06-02.html

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