CRISIS INTERVENTION AND PREVENTION SERVICES
2025 REQUEST FOR PROPOSAL (RFP) APPLICATION
Part 1 – Organization Narrative Form

Submit Application to: cddapplications@cityofmadison.com

Deadline: 4:30pm September 22nd, 2025

Official submission date and time will be based on the time stamp from the CDD Applications' inbox. Late applications will not be accepted.

The intent of this RFP application is for applicant organizations to have the opportunity to apply for funding towards programs/services under the umbrella of the Crisis Intervention and Prevention (CIP) Service Area in the Community Resources Unit. There are two priority areas in the CIP RFP: *Crisis Intervention Support Services* & *Prevention Services and Activities,* each of which has two program types. Program types include 24/7 Helpline, Shelter Services, Community-based Individual/Family Support, and Building Community & Stabilization. Organizations can apply for each program type. Please refer to the guidelines for full program type descriptions 1.1.

Priority Areas	Crisis Intervention Support Services	Prevention Services and Activities
Program Types	*24/7 Helpline* – Organizations who provide gender-based violence crisis assistance via phone, text, online, in person, etc. Programs need to focus on youth and adults experiencing domestic violence, sexual assault, intimate partner violence, and/or human trafficking. Organizations are expected to have established policies and protocols for shelter operations, provide ongoing staff training, and promote practices that support staff well-being and self-care.	*Community-Based Individual & Family Support* - Organizations who provide trauma-informed, coordinated support that assists individuals and families in meeting short-term basic needs and access services as they recover and work to improve overall personal and family well-being. These services aim to educate, inform, connect, and assist in system navigation.
	Shelter Services - Organizations must operate an existing shelter that serves individuals or households experiencing domestic violence or, in the case of youth, those without safe housing alternatives. Organizations are expected to have established policies and protocols for shelter operations, provide ongoing staff training, and promote practices that support staff well-being and self-care.	*Building Community & Stabilization* – Organizations who provide community-wide or group-based activities that increase protective factors and reduce the likelihood of crisis, especially for communities disproportionately impacted by poverty and systemic inequity. These services aim to create spaces, educate, inform, and connect individuals to their neighbors and the district they live in.

Responses to this RFP should be complete but succinct. Materials submitted in addition to **Part 1 - Organization Narrative**, **Part 2 - Program Narrative(s)**, and **Part 3 - Budget Workbook** *will **not** be considered in the evaluation of this proposal*.

Do not attempt to unlock/alter this form. The font should be no less than 11 pt.

If you need assistance related to the content of the application or are unclear about how to respond to any questions, please contact CDD staff: Nancy Saíz, Community Development Specialist nsaiz@cityofmadison.com or Yolanda Shelton-Morris, Community Resources Manager yshelton-morris@cityofmadison.com. We are committed to assisting interested organizations in understanding and working through this application and funding process.

If you have any questions or concerns that are related to **technical aspects** of this document, including difficulties with text boxes or auto fill functions, please contact Nancy Saíz, nsaiz@cityofmadison.com.

APPLICANT TYPES

Every organization applying for funding *must submit an organizational history narrative per program* detailing their organization's background, mission, and vision (Questions 1-4 below*).*

Single Applicants

If your organization is applying for multiple programs, each program application must be submitted separately with all the required submission documents (See RFP Guidelines 1.1 Required Information and Content of Proposals).

Joint/Multi-agency Applicants

For those choosing to submit a joint/multi-agency proposal, ***only*** the designated ***'LEAD Agency'*** is required to:

1) Complete and submit responses to questions 5-9 below pertaining to organizational history and mission statement, partnership history, rationale for partner selection, division of roles and responsibilities, anticipated challenges, and any previous collaborations or partnerships.

2) Submit the organizations' history partnership narrative per priority area or program type.

Part 1 - Organization Narrative Form

***Note: Please use the grey text boxes when completing this form**

<table>
<tr><td>Legal Name of Organization:</td><td>Allied Wellness Center</td><td>Total Amount Requested:</td><td>$ 214,925</td></tr>
<tr><td rowspan="2">All program(s) connected to your organization:</td><td colspan="3">Program Name: CHWs: Partners in Health
Amount Requested: $ 109,221
Applicant Type: Single Agency Application
Program Type: Community-Based Individual and Family Support Services
List Program Partner(s) (if applicable): ADMNA, Allied NRT, JFF, Project Respect, PHMDC community nurse</td></tr>
<tr><td colspan="3">Program Name: Community Roots: Growing Allied Health
Amount Requested: $ 70,965
Applicant Type: Single Agency Application
Program Type: Building Community & Stabilization: ADULT & FAMILY
List Program Partner(s) (if applicable): ADMNA, Allied NRT, JFF, JustDane, Project Respect, PHMDC community nurse</td></tr>
</table>

	Program Name: Teens Taking Charge Applicant Type: Single Agency Application Amount Requested: $ 34739		
	Program Type: Building Community & Stabilization: YOUTH List Program Partner(s) (if applicable): ADMNA, JFF, Allied NRT		
	Program Name: Applicant Type: Choose an item. Program Type: Choose an item. List Program Partner(s) (if applicable): Amount Requested: $		
	If you are applying for more than four programs, please contact* Nancy Saíz *nsaiz@cityofmadison.com		
Contact Person for application (Joint Applications - **Lead** Org):	Leslie McAllister	Email: leslie_mcallister@hotmail.com	
Organization Address:	4689 Atticus Way, Madison, WI 53711	Telephone:	608-213-3009
501 (c) 3 Status:	☒ Yes ☐ No	Fiscal Agent *(if no)*	

Single and Lead Agency Qualifications: Complete this section if you are applying as a SINGLE AGENCY or serving as the LEAD AGENCY in a joint/multi-agency application.

1. **Briefly describe your organization's history, core mission, and experience providing services relevant to this proposal.** If applicable, highlight any work related to crisis intervention, prevention, or serving the proposed population. Please keep your response concise (approximately 1–2 paragraphs).

   For over 20 years, the Allied Wellness Center (AWC) has been a cornerstone of support for the Allied Belmar and Dunn's Marsh neighborhood in Madison. The AWC was established in 2004 with the mission of addressing health disparities in marginalized communities, focusing on fostering well-being, resilience, and empowerment. Services provided by Community Health Workers (CHWs) who reflect the diversity and lived experience of the neighborhood aim to reduce barriers to accessing needed health and social services, particularly for families that are economically disadvantaged, communities of color, and immigrant populations. Over two decades, the agency has built a strong network of partnerships with local health and social service providers within and outside of the neighborhood, public agencies, and grassroots organizations, enabling the AWC to serve as an anchor for comprehensive community support.

   Grounded in the Strengthening Families Framework, the AWC's CHWs support and promote individual, family and community well-being through voluntary one-on-one support for individuals/families in their homes,

hosting or supporting family-friendly community building activities in the neighborhood, organizing a variety of health and wellness education programs, and creating opportunities for meaningful cross-cultural dialogue. The CHW staff have also been part of advocacy efforts to promote programs and policies that address those social and structural determinants of health (SDOH) that get in the way of individual, family, and community wellness, like poor quality housing, limited/no access to healthy food, lack of transportation, services that are fragmented and difficult to access, and community violence. Each full-time CHW manages a caseload between 10-15 individuals/families, and together they identify short- and long-term goals that participants and the CHWs work on together. They use a HIPAA-compliant online tool to track client information, services utilization, and program outcomes. In addition to the one-on-one work, CHWs provide health education and information during the weekly food pantry that serves more than 100 households, and they lead or co-lead 2-3 health promotion activities or community events per month.

2. **Describe your organization's experience implementing programming aligned with the Crisis Intervention and Prevention RFP Guidelines.** Please include specific examples relevant to the programs proposed in this application. If applicable, list all the current Crisis Intervention and Prevention programs your organization operates, along with their inception dates.

   In the early 2010s, the AWC board of directors – made up of a majority of Allied community members – developed a vision for the agency to train and hire residents to help improve the health and well-being of their families and neighbors. While that journey has taken a long time, the AWC has been realizing that vision through the hiring and training of CHWs since 2021. The AWC CHW Program is well-aligned with the goals of this RFP to provide needed and coordinated services that aim to increase stability and improve the overall well-being of children, youth, and families in the neighborhood.

   AWC secured funding from the first round of City CIP grants in 2022 to develop and refine the neighborhood-based CHW program model. We have served over 50 residents through tailored, individualized support – some of the activities have included:

   - connecting residents to needed dental care/surgery
   - helping families apply for Head Start
   - connecting uninsured individuals to free/reduced health care
   - helping caregivers access culturally relevant mental health services for themselves and their children
   - accompanying participants to their medical appointments to help them feel less fearful and to better understand and manage their health issues
   - assisting families to successfully apply for available financial assistance for significant medical bills
   - assisting individuals/families to find better housing
   - connecting families to City Building Inspection when their landlord/management company was not responding to maintenance requests, and
   - providing participants some limited needed financial assistance to help them accomplish their health and wellness goals.

The AWC CHW team has actively participated in the provider workgroup of CIP grantees, and through those meetings, they have made connections with other providers that have become valuable resources for referrals for Allied residents and partners in joint projects.

3. **Describe any significant changes or shifts at your agency in the past two years:** This may include changes in leadership, turnover of management positions, strategic planning efforts, or expansion/loss of funding and/or staff. Please describe how these changes may impact your agency's ability to provide the proposed services. If there are no changes to the report, write "No Changes."
   Starting in late 2021, the AWC was fortunate to secure local, state, and federal grants through American Rescue Plan (ARP) dollars, which allowed for program expansion; however, those grant dollars are no longer available. So far, AWC has been able to piecemeal together smaller grants and donations to maintain staffing levels, but that will continue to be a challenge.
   Originally hired in May 2022, with support of the CIP grant and federal CHW funding through federal ARP dollars, the AWC's Program Manager left in April 2024 to pursue other opportunities. With declining funds, the AWC was able to hire a part-time CHW Program Coordinator, who has post-graduate training in health advocacy and deep ties to the Allied neighborhood. She provides direct supervision and on-going support to the CHW team about both their casework and community health and wellness promotion activities, ensuring a positive, productive and accountable work environment. She is also responsible for onboarding and orienting new staff, as well as helping build a healthy, strong team that can work effectively together. She maintains the agency systems for tracking and ensuring completion of all grant expectations. Given her more than five years of experience in the community, the CHW Program Coordinator also plays a vital role in building and maintaining strong collaborative relationships with service providers and other stakeholders in the neighborhood. She also takes the lead on maintaining the agency website: https://alliedwellnesscenter.org.
   The AWC moved to a new office space in the fall of 2024 at the Derby Apartments, with support of the City's Community Facilities Loan (CFL) Program. The new office space is reasonably affordable, more accommodating for staff, and it is more accessible to residents, particularly new residents at the Derby that have filled the caseload of one of the AWC CHWs.
   Recently, the AWC has been able to hire a new CHW to replace a staff member who had a baby and left the organization – at least for the near future. We were able to have a month of overlap with the new employee and the departing CHW, to allow for more successful onboarding and orientation to the work, as well as an opportunity for a warm handoff –supporting intentional relationship-building to happen between the new CHW and individuals/families he will be serving. This new CHW will not only be able to take on her caseload of individuals/families, but also, he will assume some of her administrative and data collection/program reporting duties.
   The AWC has also been able to hire a Community Health Intern from UW this summer, and she has been supporting the individual and programmatic work of the CHWs. She has also developed a monthly blood pressure check and health education program at the Allied Food Pantry, which she co-facilitates with the CHWs.
4. **Describe any anticipated changes or shifts at your agency in the next two years**. Please describe how these changes may impact your agency's ability to provide the proposed services. If there are no changes to the report, write "No Changes."
   No Changes

5. **Describe your organization's required qualifications, education, and training for program staff.**
   Include how your organization supports staff in meeting these requirements and any ongoing professional

development opportunities offered (e.g., trauma-informed care, Adverse Childhood Experiences [ACEs], culturally responsive services, etc.).

All the AWC CHWs are required to complete the 100-hour Milwaukee Area Health Education Center (AHEC) CHW Training Program where participants learn concepts and principles of basic public health care, including health promotion and maintenance, chronic disease prevention, and self-care management at the community level. The virtual training program consists of weekly online coursework with a textbook followed by 6 months of 1:1 coaching after training. After a final presentation, the CHW-in training becomes certified. Our newest CHW is currently enrolled in this course, and we anticipate that he will become a certified CHW by the spring 2026.

Through current and previous grants, CHWs had the opportunity to receive training in a variety of public health/health/mental health, individual/family/community violence prevention, trauma-informed care, and family support topics, including attending statewide and local conferences. With a current grant from the WI Child Abuse and Neglect Prevention Board, the CHW team will be trained in the Strengthening Families/Protective Factors, as well as be able to access training for family support professionals that is available through the UW-Milwaukee Professional Development System on topics like preventing child sexual abuse, child development/brain development, creating cultural connections, and parent leadership. This funding also supports the Program Coordinator with access to extensive supervision training. The CHWs are also supported with ongoing education through a partnership with the UW Department of Family Medicine and Community Health: they meet monthly with a family physician, Dr. Jonas Lee about health-topics and how to support their clients around those topics, and they are working with staff at the Osher Center of Integrative Medicine to adapt training modules of the Whole Health Framework, a model of care that has demonstrated consistent success in improving health and wellness within the U.S. Veterans Affairs system and other health care settings, for individuals from historically marginalized groups.

The AWC staff are encouraged to discuss their individual professional development goals with the CHW Program Coordinator, and together they explore how to best meet those needs. While some of those needs might be met through training that is available through other grants or content covered through our regular meetings with the UW Family Medicine partners, others may require additional agency financial resources.

Joint/Multi-Agency Qualifications: *Fill out if you are **THE LEAD AGENCY** in the Joint/Multi-Agency Application **ONLY***

Program name:

Program type: Choose an item.

List all joint or partner applicants involved in this program and include their website links (for reference to their mission and vision statements)

6. **Provide an overview of your organization's partnership history with the collaborating agency or agencies.** When and how did the partnership(s) begin, and what collaborative initiatives or projects have you worked on together in the past?

7. **Explain the rationale for partnering with the agency or agencies identified in this application.** What unique strengths or resources does each organization contribute, and how do these assets complement one another in achieving the goals of the proposed program?

8. **Describe how roles and responsibilities will be divided between your organization and the collaborating agency or agencies in the proposed program.** How will each partner contribute to program design, implementation, and evaluation?

9. **Outline any anticipated challenges or barriers related to the partnership and describe how you plan to address them collaboratively.**

10. **If applicable, describe any past collaborations your organization has had with agencies providing crisis intervention or prevention services for youth, individuals, or families at risk of or experiencing crisis due to gender-based violence**. What lessons or insights did you gain from those experiences and how will they inform you in your approach to the current partnership?

CRISIS INTERVENTION AND PREVENTION SERVICES
2025 REQUEST FOR PROPOSAL (RFP) APPLICATION
Part 2 - Program Narrative Form

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Program Narrative Form **MUST be completed for EACH PROGRAM** for which you are asking for funds.

JOINT/MULTI-AGENCY APPLICANTS
Only the designated 'LEAD AGENCY' is required to submit the Program Narrative form on behalf of each of the identified partners listed in the application.

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Part 2 - Program Narrative Form

Program Name:	CHWs: Partners in Health	Total Amount Requested for this Program:			$ 109,221
Legal Name of Organization:	Allied Wellness Center	Total amount Requested for Lead/Single Applicant			$ 214925
Legal Name of Partner(s) (Joint/Multi-Agency Applicants only):		Total Amount Requested for Partner 1:			$
		Total Amount Requested for Partner 2:			$
		Total Amount Requested for Partner 3*:			$
Program Contact: Lead Organization Contact	Leslie McAllister	Email:	leslie_mcallister@hotmail.com	Phone:	608-213-3009

Program Type**:** Select **ONE** Program Type for this form.

☐ **Crisis Intervention Support Services: 24/7 Helpline**

☐ **Crisis Intervention Support Services: Shelter Services**

☒ **Prevention Services and Activities: Community-Based Individual/Family Support**

☐ **Prevention Services and Activities: Building Community and Stabilization**

- ☐ **Adults and Families**
- ☐ **Youth ages 12-18 years old**

PLEASE NOTE: Separate applications are required for each distinct/stand-alone program. Programs are considered distinct/stand-alone if the participants, staff and program schedule are separate from other programs, rather than an activity or pull-out group.

1. PROGRAM OVERVIEW

A. Need: What specific need(s) in the City of Madison does this program aim to address? Please cite the data or community input used to support your response.

AWC has a long-standing mission to address racial and ethnic health disparities – with a broad and holistic definition of health - by empowering community residents to take charge of their well-being. It was the vision of resident members of the board in the early 2010s to train and employ residents to lead this work that has guided the agency over the last 10+ years and continues to guide the work today. The AWC mission and the vision of community elders is operationalized through the hiring of CHWs who are trusted members of or have been connected to the neighborhood with a deep understanding of the population they serve. The one-on-one CHW work, as well as health and wellness promotion programming offered, are informed by regular surveys and interviews conducted in the community and from interaction with and feedback from participants in our services.

At the AWC, we understand the critical role that social determinants of health (SDOH) – those conditions that affect health in the places we live, learn, work, pray and develop – play in our lives and in our health. This was made even clearer during the COVID-19 pandemic for low-income, BIPOC communities like Allied. In the initial phases of the pandemic, researchers looked at data from 10 major US cities, and they found that the COVID-19 infection and death rates were substantially higher in areas that were more racially and ethnically diverse and lower incomes. (Adhikari, S., Pantaleo, N.P., Feldman, J., et al, Assessment of Community-level Disparities in Coronavirus Disease 2019 Infections and Deaths in Large Metropolitan Areas, JAMA Network Open Letter, 2020, Volume 3 Number 7). This was not surprising to the AWC staff and board nor the Allied community, and the experience with COVID-19 has reinforced the commitment of the CHWs to start to address SDOH in their work at the individual/family and community levels.

Through the goal-setting process during intake and the first few individual visits, the CHWs track participant needs they identify to be better equipped to address their/their family's health and well-being. The CHW team has noted common challenges

among participants - those SDOH - that are barriers to community health and well-being. Among those currently receiving one-on-one CHW services, the most common challenges reported include: financial stress, poor quality housing, housing insecurity, interpersonal and community violence, social isolation/lack of emotional support, lack of health insurance, and lack of access to health/mental health/dental care.

B. Goal Statement: What is the overarching goal of your program in response to the identified need? How does this goal align with the scope, priorities, and desired outcomes described in the RFP guidelines?

The project aims to address various health and wellness issues prevalent in the Allied community, particularly among minority populations, by focusing on social determinants of health (SDOH). One primary health issue is the disparity in access to culturally relevant healthcare services and resources, which is intricately connected to socioeconomic factors, such as income level, level of educational attainment, and limited or no access to decent quality affordable housing and healthy food. Limited access to high-quality healthcare and culturally and linguistically responsive social services can exacerbate existing health disparities, leading to poorer health outcomes and reduced quality of life among marginalized populations.

We know that residents in neighborhoods like Allied that have been historically marginalized are at risk for poor outcomes in several areas – educational attainment, economic well-being, and overall health, for example. Through social support, resource connection, and system navigation with the support of a trained CHW, the AWC is improving individual, family, and community health and well-being by starting to address those barriers – individual and structural – that get in the way of good health. Through this work, the CHWs are also empowering residents to take charge of their own health and well-being by engaging in health promoting activities and relationships; building connections with their neighbors; learning about available community resources; and becoming more skillful advocates for themselves and their families within health, education and social service systems. This emphasis on addressing SDOH and community empowerment is well-aligned with the prevention focus of the RFP that aims to prioritize services upstream and center community-driven solutions that promote personal, family and community well-being.

C. Program Summary Briefly summarize your proposed program, including the population served, core services or activities, where and how services will be delivered, and key expected outcomes. This should provide a high-level snapshot of the program.

Participants in AWC services live in the Allied Dunn's Marsh community, which includes City of Madison and Fitchburg residents. The staff engage in one-on-one support with a caseload for 1.0 FTE CHW between 10-15 individuals/families at any one point in time. As part of the intake process, CHWs support participants to develop goals for themselves and their families to improve their health and well-being. Those goals may be related to:

- improving physical and mental health (e.g. healthier eating and exercise, education about particular health topics, managing chronic illness, etc.);
- navigating complex health, social services, educational and legal systems;
- enhancing knowledge and skills around parenting;
- accessing needed financial resources; looking for or improving employment opportunities; and
- identifying ways they could feel more connected to their community.

They keep track of those goals, documenting progress toward goals and what happens during the visits in their case notes available on the JotForm platform.

The CHW one-on-one services are typically delivered in the home, but they could also happen at the AWC office or in the community, wherever the participants feel most comfortable. CHWs may also accompany participants to appointments. CHWs may meet with participants monthly, every other week, weekly, or more often if that is necessary to help meet their individual and family goals. A typical caseload includes participants with a mix of meeting frequency. The CHWs use JotForm, an on-line HIPAA compliant system for intake, case notes, and data collection. They receive supervision and on-going support from the CHW Program Coordinator. The CHWs also engage in relevant training opportunities, and they have support from the Program Coordinator to identify and work toward their professional development goals.

With one-on-one CHW support, participants will make progress toward their goals, more confidently navigate systems and access services, more effectively manage demands/stressors of everyday life, feel more prepared to manage their personal and family health and wellness, and feel less isolated in their own community. This in-depth one-on-one work with residents informs the development of health promotion projects with youth and families, as well as identifies residents who could assume leadership roles to promote health in their community.

2. POPULATION SERVED

A. Proposed Participant Population: Describe the intended service population that will be impacted by this program (e.g., location, ages, race/ethnicities, income ranges, English language proficiency, if applicable etc.)

AND how has your org/agency engaged members of this population in designing, informing, developing, implementing the proposed program?

The AWC's service area uses the same boundaries as the Allied Dunn's Marsh Neighborhood Association (ADMNA): West Beltline Highway on the north, Seminole Highway on the east, Chicago Northwestern Railroad on the south, and Verona Road on the west. All residents that live in the service area are eligible for CHW support.

Currently, the AWC has 1.5 FTE CHW that serve the primary Spanish-speaking residents in the neighborhood – 43% of the population in Allied (according to the 2020 census) and anecdotally that percentage has increased since the last census. The AWC and our partners have seen an increase in the number of recent immigrants in the neighborhood, and they speak a variety of languages. In an effort to better support newly arriving residents whose primary language is not English or Spanish, the AWC staff have access to a language line that is also used by the UW Health system.

The current CHW caseload is 34 and 44% are primary Spanish-speakers; 12% are non-native English speakers that also don't speak Spanish. Since moving offices, AWC has experienced a dramatic increase in referrals for one-on-one CHW services, primarily through outreach at the weekly food pantry and the new residents in the Derby Apartments. The CHW team is also connecting pantry users who are not Allied residents to connect with other agencies in their communities that can help connect them to available resources.

The CHW team has completed surveys with residents to inform services – those have been conducted door-to-door and at the weekly food pantry that serves more than 100 households weekly. AWC also gathers feedback from participants to improve services and inform CHW training as well as new programming. CHWs are responsive to their one-on-one clients, providing them with information and connecting them with other community resources that may help them meet their needs. During their bi-monthly training sessions, CHWs bring questions to Dr. Lee about common health issues, disease management or health care system challenges they are seeing with the participants, so that he can tailor their education/discussion sessions to meet the CHWs most immediate needs.

B. 2024 Participant Demographics: If your organization has offered similar or related programming in 2024, please provide available demographic data for participants served. This can include data collected through formal programs, pilot efforts, or community-based work—even if it was not funded by the City. If exact numbers are not available, please provide your best estimates and briefly note how the data was gathered (e.g., intake forms, surveys, observations). If you are a new applicant and do not yet have demographic data, please indicate that below.

Race	# of Participants	% of Total Participants
White/Caucasian	16	57
Black/African American	8	27
Asian	2	7
American Indian/Alaskan Native		
Native Hawaiian/Other Pacific Islander		
Multi-Racial		
Balance/Other	2	7
Total:	28	
Ethnicity		
Hispanic or Latino	14	50
Not Hispanic or Latino	14	50
Total:	28	
Gender		
Man	5	18
Woman	23	82
Non-binary/GenderQueer		
Prefer Not to Say		
Total:	28	

Comments (optional):

C. Language Access, Cultural Relevance: Please describe how the proposed program will serve non-English speaking youth, individuals, and families. Describe how the proposed program builds and sustains adequate access and cultural relevance needs.

AWC prioritizes inclusivity and cultural relevance. Bilingual staff and interpreter services at community events ensure accessibility for immigrant families that are primary Spanish speakers. Program materials are adapted to reflect diverse cultural practices, and events welcome LGBTQIA+ families. Recently, the AWC added the use of a language line – the same one used at UW hospitals and clinics – to more effectively communicate with residents who speak languages other than English or Spanish. Efforts like these foster trust and create a welcoming, supportive environment for all families.

D. Recruitment and Engagement Strategy:

a. **Recruitment & Outreach:**
How does your program plan to recruit and reach members of the identified service population? Please describe any community outreach strategies, partnerships, or referral pathways you will use.
AWC utilizes a multi-faceted outreach strategy to engage families in our services, including door-to-door outreach, connecting with residents during community events, and direct referrals from partner organizations such as JFF, PHMDC and Reach Dane and referrals from program participants. AWC partners with the weekly Allied Food Pantry - CHWs have a presence at the weekly pantry that allows them to share relevant health and wellness information, as well as information about AWC services and community events while residents are waiting for their turn at the pantry. Presence at the weekly pantry provides a pathway for residents to enroll in services as well as an opportunity for CHWs to check in with individuals/families they support. Allied Fresh mobile pantry distributes flyers advertising AWC services and activities to over 240 households they serve. Additionally, being in the Derby Apartments has meant that AWC staff and services are more visible to the new residents – we have experienced increasing participation in one-on-one services from Derby residents.

b. **Addressing Barriers to Participation:**
What specific barriers to participation (e.g., transportation, scheduling, language, trust) might the population face, and how does your program plan to address them?
Ensuring that services are linguistically and culturally relevant: Over the last decade, the Allied neighborhood has experienced a significant shift in demographics, with primary Spanish-speakers from different parts of Central and South America now making up the largest racial/ethnic group in the neighborhood. As AWC has expanded its staff since 2022, the agency has prioritized having bi-lingual, bi-cultural CHWs on the team, which has continued with our most recent hire. In effort to have the most current information about community resources/services that support primary Spanish-speakers, the CHWs participate in LaSup meetings, regularly connect with the DCDHS Office of Immigration Affairs, and have attended conferences/workshops that support their on-going learning about how to best support Latine individuals/families in the neighborhood.

Building Trust and Belonging Across Communities: As Allied Wellness Center (AWC) has expanded its capacity to serve our diverse community—particularly through the addition of bilingual Community Health Workers (CHWs)—we've seen an increase in visibility and utilization of services by our Spanish-speaking residents. While this is a positive development, we also recognize that some African American residents have shared concerns or misconceptions that certain services may not be intended for them. We take this feedback seriously and see it as an important opportunity to strengthen trust and inclusion across all segments of our community. AWC remains fully committed to serving all residents of the Allied Dunn's Marsh neighborhood. In addition to our bilingual CHWs, we proudly have an African American CHW who plays a vital role in outreach, relationship-building, and culturally resonant programming. She provides personalized invitations to her majority Black caseload, encouraging participation in AWC's full range of services and wellness activities. As part of our intentional efforts to increase representation and engagement, she recently co-launched a Black Men's Health and Wellness Group, creating a dedicated space for community connection and health promotion. She is also helping to pilot a Black Women's Group launching in fall 2026. In her ongoing work at the food pantry and local events, she continues to connect personally with African American residents to share information about available one-on-one supports, health programs, and community events. We view this work as essential to our mission: building a wellness-centered community where everyone feels seen, supported, and included

Transportation is a significant barrier for many residents in Allied. Even when families have a car, it is often being used by the parent/caregiver who is working. The AWC addresses this challenge by having CHWs provide home visits or finding a comfortable place in the community that residents can walk to for their visits. Moving to an office more centrally located in Allied has also helped improve resident access to our

services. AWC also supports residents to access services/resources outside of Allied to help them achieve their health and wellness goals – medical, social, legal and other services– through bus tickets/passes, Uber/taxi rides, and gas cards. In addition, last year AWC launched a work group including churches and neighborhood-based service agencies to start to address transportation challenges. The workgroup developed a project to improve access for residents to prepare for and obtain their learner's permit. Since its inception, AWC has enrolled three participants in the Learning to Drive Initiative with volunteer tutors. To date, one of these residents received her learners' permit and has been supported by AWC and Allied Partners funds with behind-the-wheel instruction - she is scheduled to take her driver's test later this fall. In addition to this initiative, CHWs advocated with Madison's Metro Transit to become an approved site in the neighborhood for residents to access low-income reduced-priced bus fares. Prior to this, Allied residents had to go in person to the Metro Transit office across town to sign up for this program. Lack of transportation is a significant barrier to receiving care and accessing needed resources – the Learning to Drive project and increasing access to low-income bus tickets/bus passes by making them available in the neighborhood has started to address this large and complex issue many Allied residents face.

Poor quality housing and housing instability: The neighborhood has seen an increase in rents and diminishing quality of housing in Allied. Dealing with housing crises often gets in the way of residents being able to meet other needs related to their personal and family health and wellness. Recognizing housing challenges facing Allied residents – being able to afford increasing rents, frequently having to move/high mobility, living in overcrowded conditions, concerns about retaliation if one raises concerns about safety issues about their apartments with their landlord (e.g. non-renewal of monthly leases, eviction, etc.), and feeling unsafe with neighbors/guests of neighbors – the CHWs focus a lot of their attention on this issue. They maintain working relationships with agencies that can offer rental assistance and legal support, they are in regular contact with City Building Inspection, and they regularly call attention to these issues with the Allied NRT when seeking solutions to seemingly intractable issues.The information gathered from CHWs in late 2023, helped inform the City Building Inspection Unit's plan to start systematic inspections in Allied that started in late 2024 and continue to the present day. AWC and a couple of other NRT members will be meeting as a group to identify ways to address civil rights violations by landlords. This group will also be meeting with the City Alder to explore social social support and health/mental health services that will be needed with a new affordable housing development in the neighborhood

c. **Enrollment & Engagement Approach:**

Describe how participants will be enrolled and engaged in the program. Include any tools, processes, or approaches you will use that are responsive to the needs and preferences of the population served (e.g., Individual Service Plan (ISP), intake forms, assessment tools, culturally responsive practices).

Participants in one-on-one CHW services can be referred to the AWC through partner organizations in the neighborhood and by neighbors who are receiving services; residents may also self-refer. The AWC uses JotForm – a HIPPA-compliant online platform – for referrals, case notes, and data collection. The AWC JotForm referral form for one-on-one CHW services is available from the programs page of the agency website, so it is easily accessed by referral partners and individuals/families that self-refer.

In addition to the referral form, the AWC has also developed forms in JotForm for intake, on-going case notes, and collection of demographic information.

- During the intake process and for the first couple of visits with the CHW, participants are encouraged to develop short- and long-term health and wellness goals that they'd like to work on with CHW support. This could include connections to other needed resources, increasing one's knowledge about a health/wellness topic or topics related to parenting, learning how to better manage one's medical issue/disease, understanding one's rights and developing skills to more effectively advocate for needed services within health/social/educational/legal systems.
- Together the CHWs and participants make a plan to start to address those goals, with regular check-ins to gauge progress toward achieving goals. These short and long-term goals are recorded in the progress notes and remain part of the client record so that CHWs can easily refer back to the goals as needed.
- The case notes form serves as a tool to document progress toward identified goals, and it provides the CHWs with information that shapes how they tailor their support for each participant from one visit to the next. CHWs are supported in the process by the CHW Program Coordinator through weekly supervision sessions, as well as opportunities to share about cases during staff meetings or education sessions with Dr. Lee.
- In addition to demographic information, the JotForm platform is used to generate feedback forms that are used to inform how CHW services may be improved over time. The feedback forms are also a mechanism for gathering information needed for process and impact outcomes that are needed for grant reporting purposes.

3. PROGRAM LOCATION, DESCRIPTION, AND STRUCTURE

A. Activities: Describe your proposed program activities. Please be sure to specify your program type, i.e. shelter services, workshops, helplines, classes, etc.,).

- CHWs provide one-on-one support to individuals/families in their homes, at the AWC office or other places in the community where they choose
- Meetings may occur monthly, bi-weekly, or weekly – depending on the needs/wishes of the client
- CHWs support participants to create health and wellness goals for themselves/their families that they'd like to work on – usually includes some short-, medium- and long-term goals; as they work together, CHWs regularly check in with participants about their progress on goals and celebrate progress toward meeting and achieving goals
- CHWs assist participants to connect with other needed resources
- CHWs also assist participants with navigating complex health care, social service, education, and legal systems; with this support, participants learn skills to advocate for their needs
- CHWs receive weekly support from the CHW Program Coordinator, which includes review of case notes and thinking through potential actions/steps to take
- The team also meets weekly to check in with one another, share important information about available resources/referral partners, offer mutual support and coordinate efforts.These meetings are essential for planning group-based programming, discussing current community health issues, and exploring potential partnerships with other providers that may offer services that would be of benefit for Allied residents.
- The CHW team also meets twice monthly with Dr. Lee from the UW to discuss health concerns that are coming up for individual clients and residents CHWs meet through group-based activities.

B. Use of Evidence-Based or Promising Practices:

Please identify any evidence-based or evidence-informed models, practices, or curricula used, including sources or documentation of their effectiveness. If your program does not use a formal evidence-based model, describe the rationale for your approach and how it aligns with the goals of crisis intervention and prevention.

Community health workers are a proven health equity strategy, as they often come to the work from communities they serve and have similar experiences as their neighbors. (Landers S, Levinson M. Mounting Evidence of the Effectiveness and Versatility of Community Health Workers. American Journal of Public Health, April 2016) With training and on-going support, CHWs are well-positioned to:

- help others navigate health, education and social service systems
- offer social support to neighbors who may be isolated
- breakdown complex information and recommendations from health-care- providers in terms those they serve understand
- provide health and wellness education and connection to needed resources
- collect valuable information about the needs and assets of the community; and
- advocate for more culturally relevant services and supports from all types of providers.

While the AWC continues to refine our community-based model, all AWC CHWs have performed these functions, with the goal to improve access to services, advance the quality of services and promote health and wellness in a BIPOC and low-income community that has been historically marginalized and oppressed by inequitable systems.

At the Allied Wellness Center (AWC), the CHWs have been recruited from the community - as residents or people who have a history of supporting the neighborhood - or have lived experience in communities like Allied. All the AWC CHWs identify as BIPOC, and two of the CHWs are also able to provide services in both English and Spanish, which is especially important as the neighborhood has a growing population of primary Spanish-speakers. The AWC strives to center the voice of the community in our programming as well as in our governance structure. The work of the CHWs is guided by a health equity approach that addresses the needs and strengths of individuals and communities to help them be healthy, rather than providing everyone with "equal" or the "same" services regardless of their level of need. It also includes acknowledging and addressing historical and structural barriers to good health that have affected some people more than others. The CHWs are actively engaged in community outreach to gather information directly from the community about its needs and strengths and regularly seek community feedback about acceptability and feasibility of proposed programming. When doing one-on-one support work with individuals or families, the CHWs engage their clients as partners in developing goals and mapping out the steps needed to achieve those goals. Their work is tailored to the specific needs and strengths of the individuals and families with whom they are working.

Starting in early 2025, the CHW team began working with staff at the Osher Center of Integrative Medicine at the UW to adapt training for a Whole Health approach, an evidence-informed model of care that has demonstrated consistent success in improving health and wellness within the U.S. Veterans Affairs system and other health care settings. Central to the approach are trained peer-support specialists who have shared experiences with their fellow veterans who implement the "Taking Charge of My Life and Health" curriculum that walks participants through their own "whole health" journey, with a focus on mindful self-reflection, self-care and community building. In a neighborhood setting, AWC's CHWs are being trained to bring those same Whole Health principles and practice to the Allied community through both one-on-one support and group-based health education and community wellness promotion work. This framework and the supporting curriculum that will be used by CHWs in the community is well-aligned with the City's CIP RFP, which aims to promote community-rooted solutions that promote long-term equitable health and well-being for individuals, families and communities.

C. Program/Service Schedule and Location: Please fill out the charts below to describe the schedule for your proposed program or service, including days and hours that services, classes, workshops, or other activities will be operating (if your staff operates during varied hours, please give your best overview of when your staff are interacting with clients).
   a. If your program operates at **multiple locations** with the **same schedule**, please list all locations TOGETHER in **TABLE 1** and include the schedule of operation
   b. If your program operates at **multiple locations** with **different schedules**, use **TABLE 2 in addition** to table 1 to detail each location's unique schedule
   c. If you are submitting a **JOINT/MULTI-AGENCY** application:
      i. Use **TABLE 1**, if the service operates at **multiple locations** with the **same hours** (Please list all locations)
      ii. Use **TABLE 2,** in addition to table 1, if the service is operating at **multiple locations** with **different hours**

Table 1:

PROGRAM LOCATION(s):		
Day of the Week	**Start Time**	**End Time**
Monday	**9:00 AM**	**5:30 PM**
Tuesday	**9:00 AM**	**5:30 PM**
Wednesday	**9:00 AM**	**5:30 PM**
Thursday	**9:00 AM**	**5:30 PM**
Friday	**9:00 AM**	**5:30 PM**
Saturday	Choose an item.	Choose an item.
Sunday	Choose an item.	Choose an item.

If hours are different than those listed, please use rows below drop-down list

Table 2: (Optional/if needed)

PROGRAM LOCATION(s):		
Day of the Week	**Start Time**	**End Time**
Monday	Choose an item.	Choose an item.

Tuesday	Choose an item.	Choose an item.
Wednesday	Choose an item.	Choose an item.
Thursday	Choose an item.	Choose an item.
Friday	Choose an item.	Choose an item.
Saturday	Choose an item.	Choose an item.
Sunday	Choose an item.	Choose an item.

If hours are different than those listed, please use rows below drop-down list

If applicable, please list the third and any subsequent service locations. Include the specific program schedule(s) differences as compared to the programs included in the tables above:
The AWC office serves as the home-base for the CHW team. Because the CHWs have one-on-one clients they support and engage in group-based activities, they may flex their time when an evening or weekend health education or community-building activity/event occurs. CHWs generally attend 2-3 evening or weekend activities per month.

4. ENGAGEMENT COORDINATION AND COLLABORATION

A. Family Engagement: Describe how your program engaged youth, individuals, and families in the development of this proposal, and how they will be involved in the implementation and assessment of the program activities.

While the AWC has not yet had to institute a waiting list for one-on-one CHW support, the team is very close to being at capacity, with the Program Coordinator taking on some individual clients. Referrals from neighborhood service provider partners, from other program participants, and self-referrals have dramatically increased since the move last fall into the office space at the Derby. This speaks to the need for the tailored individual CHW supports to continue – and for the AWC to secure additional funding for expansion.

As reported earlier, the platform AWC uses for referral, intake, and on-going casework, also allows the organization to gather information from participants about their experiences in the program. Participants in one-on-one services are surveyed regularly to gather feedback about the usefulness of services, how effectively the CHWs work to support them in achieving their goals, and the impact of CHW services on their health and well-being.This information is used to support CHW professional development, as well as efforts to engage partners to bring their services to the neighborhood when possible, to limit traditional barriers to service. In addition to information gathering of participants through JotForm, the CHW team has regularly surveyed neighborhood residents to get a better sense of what they would like the AWC to prioritize – both for one-on-one work as well as community-building events and health/wellness promotion activities.

B. Neighborhood/Community Engagement: Describe how your program engaged neighborhood residents or other relevant community stakeholders in the development of this proposal, and how they will be involved in the implementation and assessment of the program activities.

The CHW program at the AWC is the legacy of a grassroots board of active neighborhood residents who recognized it as a strategy more than a decade ago to fulfill the agency's mission to address health inequity by meaningfully engaging the community in the work. The current program's success is based on the strong ties the CHW team has to the neighborhood - they have lived or worked in the neighborhood to develop relationships and a deep understanding of the needs and interests of the community. This feedback from program participants informs CHW practice as well as AWC decision-making, including the decision to re-apply for CIP

funding. The AWC remains committed to continue this practice of engaging the community in shaping our services. This fall the AWC aims to create a resident health and wellness advisory board – that reflects the age and racial/ethnic diversity of the neighborhood – to help staff assess how current programming is meeting intended goals and to guide future health/wellness education and community-building events/activities. As part of the work of the Community Advisory Committee, the AWC intends to host an event for residents in the fall of 2026 to (1) learn about services/activities of the agency and (2) gather their feedback about how to shape one-on-one CHW services and group-based programming for 2027.

In addition to gathering information from program participants, the AWC regularly engages in more general neighborhood surveys - aiming to capture the needs, interests, and good ideas from the broader community - to guide programming, our partnerships, and grant applications. The AWC also collaborates with the other providers and the ADMNA to collectively meet community health/wellness needs, and those partnerships have also informed this proposal. AWC staff regularly attend the monthly ADMNA and Allied NRT meetings, which serves as a valuable forum to gather input about proposed programming and feedback about their perceptions of CHW services and how services could be improved/enhanced and expanded.

C. Collaboration: Please complete the table below and respond to the narrative questions regarding program collaboration with community partners.

Note:

- Single applicants **MUST** list all partners/collaborators below and include a letter of commitment/support from the agency partner highlighting the ways in which the agency will support the program.
- Joint Lead applicants **MUST** include the program partners list, their role & responsibilities, contact person, and attach a Memorandum of Understanding MOU.

Partner Organization	Role & Responsibilities	Contact Person	Signed MOU (Yes/No)?
ADMNA	promote CHW services; make referrals as appropriate	Katy Farrens	yes
JFF	promote CHW services; make referrals as appropriate; team with CHWs to support individuals/families on their caseloads as appropriate	Maureen Murphy	Yes
Allied NRT	promote CHW services; collaborate with the AWC for grou-based activities/events; make referrals as appropriate	Abigail Ryan and Jeremy Nash	Yes
PHMDC community nurse	promote CHW services; make referrals as appropriate; support CHW with educational materials	Rose Fredrickson	No
Project Respect	promote CHW services; make referrals as appropriate; assist CHWs to connect participants to mental health and substance abuse services	Jan Miyasaki	Yes

List any additional partners, their role & responsibilities, contract person and MOU information (if applicable):

How do these partnerships enhance this proposal?

These partners, along with current program participants, are key referral sources for CHW one-on-one services. Both the JFF social worker and the PHMDC public health nurse may also team with the CHW staff to support individuals and families together as appropriate. Project Respect is a long-term partner with the AWC, and they have agreed to refer their participants to one-on-one CHW services and assist CHWs to connect participants to mental health and substance use services as needed.

What are the decision-making agreements with each partner?
These are letters of agreement

D. Resource Linkage and Coordination: What resources are provided to youth, individuals, and families participants by your proposed program/service? How does the program coordinate and link participants to these resources?

Resource linkage is central to CHW work, and the most common referrals to other supports include:
- JFF social worker and the Allied Essentials Pantry
- PHMDC public health nurse
- Reach Dane/Head Start services
- Madison and Verona school social workers
- Madison and Fitchburg Senior Centers
- Hospitals/Health systems (e.g. UW Health, Meriter, GHC) and Health care clinics (e.g. Perry Family Clinic, Planned Parenthood, and Our Lady of Hope Clinic)
- financial assistance for medical costs/charity care at each of the hospitals
- Dane County Extension financial education staff
- housing resources (e.g. Tenant Resource Center, Urban Triage)
- Employment Sevices (e.g. Commonwealth Development Job Shop, Dane County Job Center)
- Food resources (e.g. Allied Food Pantry and Allied Fresh mobile pantry)
- domestic vioelnce providers (e.g. UNIDOS, DAIS)
-ESL resources (e.g. Madison College, Literacy Network, Catholic Multicultural Center)
- Immigration resources (e.g. DCDHS Office of Immigration Affairs, legal services, Voces de la Frontera)
- clothing and furniture resources (e.g. St. Vincent DePaul

CHWs have developed relationships with staff at these organizations, so they are often able to do a warm-handoff. The CHWs may make the connection to the referral agency themselves or they may support the client to make the connection, as part of the their capacity building work with clients. CHWs record referrals in the JotForm system, and will often follow up if there is a delay or other problem with the referral. By participating in the CIP cohort and the Dane County CHW collabortative, as well as participation in NRT, JFF, and LaSup meetings, CHWs continue to expand their knowledge of resources and network of contacts at those organizations. The AWC has also been successful in bringing some of those services to the neighborhood (e.g. Madison College ESL classes, Dane County Extension financial educators, and representative from Voces de la Frontera for a "Know Your Rights" educational event).

5. PROGRAM QUALITY, OUTPUTS, OUTCOMES AND MEASUREMENT

A. Program Outputs – Please tell us how you are measuring your output data such as: Unduplicated Youth, Individuals, Families, Community Events, Program Hours, etc. Please see Guidelines 1.1

AWC collects data about the following outputs through JotForm:
- Number of Allied residents engaged in one-on-one CHW services
- Number of participants that have reached at least one health/wellness goal
- Demographics of participants in one-on-one CHW services
- Number of referrals received for one-on-one CHW services as well as referrals to other needed resources

AWC uses a spreadsheet to track CHW training completed that is on the agency Google Drive.

AWC staff fill out a timesheet to track their hours. The timesheets are reviewed by the AWC Bookkeeper who is responsible for processing payroll.

B. Program Outcomes

Please describe the data and the data source used to choose your outcome objectives:
The primary data source for one-on-one CHW services are the referral, intake, progress notes, and client feedback forms in the JotForm system. In some cases, additional information may be gathered through a survey, interview or focus group.

Please complete the table(s) with your selected outcome objectives. Applicants must choose from the measurable outcomes listed in the RFP that correspond to the priority area for which they are applying. Youth-specific programs are **required** to report on the youth outcomes identified in the RFP. In addition to these required outcomes, applicants may propose additional program-specific outcomes they plan to track and evaluate. **Note: Outcome EXAMPLE Objective is not required and is ONLY meant to serve as an example outcome to reference as you complete the other tables**

Outcome EXAMPLE Objective: 75% of clients report services were accessible, inclusive, and responsive to their individual identities and experiences (this is an EXAMPLE ONLY and is NOT REQUIRED).				
Performance Standard	**Targeted Percent**	75%	**Targeted Number**	90 of 120 clients
	Actual Percent	78%	**Actual Number**	94 out of 120 clients
Measurement Tool(s) and Comments: Client exit survey and open-ended feedback forms				
Methodology: The primary measurement tool was an exit survey that used open-ended and multiple-choice prompts to allow participants to elaborate on their experiences. Surveys were distributed to all program participants at time of exit from services/at the point of program completion, surveys are voluntary and anonymous.				

Outcome Objective #1: 80% of participants in one-on-one CHW services will report an increase in mental, physical, family, social, and/or overall health				
Performance Standard	**Targeted Percent**	80	**Targeted Number**	40 out of 50 clients
	Actual Percent		**Actual Number**	
Measurement Tool(s) and Comments: Client feedback survey in JotForm				
Methodology: Clients provide feedback at multiple time points during and after services that include questions about satisfaction with services, as well as questions about health/wellness changes and increases in knowledge, skill, and confidence in managing their health and feelings of social connectedness with the community.				

Outcome Objective #2: 90% of participants in one-on-one CHW services will have achieved at least one of their health and wellness goals				
Performance Standard	**Targeted Percent**	90	**Targeted Number**	45
	Actual Percent		**Actual Number**	
Measurement Tool(s) and Comments: tracking of clients goals in the case notes form in the JotForm system				

Methodology: The current case note form includes a section on developing and tracking health and wellness goals for the clients engaged in one-on-one CHW service.

Outcome Objective #3: 80% of participants will report satisfaction with services, including feeling like the CHW respects and listens to them				
Performance Standard	**Targeted Percent**	80	**Targeted Number**	40
	Actual Percent		**Actual Number**	
Measurement Tool(s) and Comments: Client feedback form in the JotForm system				
Methodology: Clients provide feedback at multiple time points during and after services that include questions about satisfaction with services, as well as questions about health/wellness changes and increases in knowledge, skill, and confidence in managing their health and feelings of social connectedness with the community.				

To add additional outcome objectives, please copy and paste the table below as needed.

C. Data Tracking: What data tracking systems are in place or will be in place to capture the information needed to document demographics, program activities, outcome measures, and expenses?
Information about client demographics, client goals, resource linkage, and outcome measures are captured in various forms in the JotForm system, which is HIPAA compliant. AWC tracks grant expenditures using an online version of QuickBooks; receipts for all expenses are tracked on the agency Google Drive - invoices are based on actual expenses incurred by the AWC.

6. PROGRAM STAFFING AND RESOURCES:

A. Program Staffing: Full-Time Equivalent (FTE) – Include employees, with direct program implementation responsibilities. **Please be sure to list all required certifications and training.** FTE = % of 40 hours per week. Use chart below and use one line per individual employee.

Position Title	FTE	Required Certifications and Training	Location(s)
CHW Program Manager - .5FTE		AHEC Community Health Worker Certification; CHW and other field-adjacent Supervisor training; tailored trainings on health/health systems topics with Dr. Lee and the Whole Health framework with Osher Center staff	Allied - AWC office or other community spaces
Community Health Worker - 1.0FTE		AHEC Community Health Worker Certification; tailored trainings on health/health systems topics with Dr. Lee and the Whole Health Framework with Osher Center staff	Allied - AWC office or other community space

Community Health Worker - 1.0 FTE		AHEC Community Health Worker Certification; tailored trainings on health/health systems topics with Dr. Lee and the Whole Health Framework with Osher Center staff	Allied - AWC office or other community space
Community Health Worker - .5 FTE		AHEC Community Health Worker Certification; tailored trainings on health/health systems topics with Dr. Lee and the Whole Health Framework with Osher Center staff	Allied - AWC office or other community space
Community Health Worker - .5FTE		AHEC Community Health Worker Certification; tailored trainings on health/health systems topics with Dr. Lee and the Whole Health Framework with Osher Center staff	Allied - AWC office or other community space

B. Volunteers: Describe your process for screening, training, and supervising volunteers who will have direct contact with program participants.
The majority of the volunteers with the AWC are connected with the Allied Partner Churches, and they participate in some of the group-based activities, like the Learning Garden and community events, as well as the Learning to Drive initiative. We also have some volunteers from the UW Grow Program that supports the Allied Fresh Mobile pantry that also help with health education activities and community events. The CHW Program Coordinator screens and supports volunteers for the AWC. She meets with potential volunteers to better understand their skills and interests and will assign them tasks that are well-aligned with those skills and interests. Volunteers are screened using the Wisconsin Circuit Court Access (formerly CCAP) website.

C. Other Program Resources Please list any other program resources or inputs (e.g., program space, transportation, equipment, or other supports) that are necessary for the success of your program. Are these resources currently in place? If not, describe your plan and timeline for securing them.
We have sufficient space at the new AWC office at the Derby to accommodate the current staffing, that also includes a more comfortable meeting space for CHWs and their clients and we have access to a classroom for smaller group gatherings. All of the CHWs have agency-issued cell phones and laptops that they use for work purposes, and they use their own transportation for home visits and any group-based activities.

7. BUDGET

A. The budget workbook should be submitted with the proposal using the template provided in an Excel document or as a PDF. There are six tabs within the Excel spreadsheet: Cover Page, Board & Staff

Demographics, Revenue, Expenses, Personnel, and Program Summary. **The Cover Page, Program Summary, and relevant Program Budgets must be submitted with this document for a proposal to be complete.**

Joint/Multi-Agency Applications

B. The Lead Applicant will be responsible for submitting the Budget Workbook and Budget Narrative(s) alongside all required materials.
    a. The budget template and budget narrative can be found on the CDD Funding Opportunities Website.

8. If applicable, please complete the following:

A. Disclosure of Conflict of Interest

Disclose any potential conflict of interest due to any other clients, contracts, or property interests, e.g. direct connections to other funders, City funders, or potentially funded organizations, or with the City of Madison.

B. Disclosure of Contract Failures, Litigations

Disclose any alleged significant prior or ongoing contract failures, contract breaches, any civil or criminal litigation.

APPLICATION FOR 2025 CRISIS INTERVENTION AND PREVETNION SERVICES PROGRAMS

1. ORGANIZATION CONTACT INFORMATION

Legal Name of Organization	Allied Wellness Center
Mailing Address	4689 Atticus Way, Madison, WI 53711
Telephone	608-213-3009
FAX	
Director	Leslie McAllister, Board President
Email Address	leslie_mcallister@hotmail.com
Additional Contact	Janice Ferguson
Email Address	jferguson@alliedwellnesscenter.org
Legal Status	Private: Non-Profit
Federal EIN:	52-2454644

2. PROPOSED PROGRAMS

		2026	If currently City funded	
Program Name:	Letter	Amount Requested	2025 Allocation	Joint/Multi Application - SELECT Y/N
CHWs: Partners in Health	A	$109,221	$70,000	
Contact:	Leslie McAllister			
Community Roots: Growing Allied	B	$70,965		
Contact:	Leslie McAllister			
Teens Taking Charge	C	$34,739		
Contact:	Leslie McAllister			
	D			
Contact:				
	E			
Contact:				
TOTAL REQUEST		$214,925		

DEFINITION OF ACCOUNT CATEGORIES:

Personnel: Amount reported should include salary, taxes and benefits. Salary includes all permanent, hourly and seasonal staf Taxes/benefits include all payroll taxes, unemployment compensation, health insurance, life insurance, retirement benefits, etc.

Operating: Amount reported for operating costs should include all of the following items: insurance, professional fees and audit postage, office and program supplies, utilities, maintenance, equipment and furnishings depreciation, telephone, training and conferences, food and household supplies, travel, vehicle costs and depreciation, and other operating related cost

Space: Amount reported for space costs should include all of the following items: Rent/Utilities/Maintenance: Rental costs for office space; costs of utilities and maintenance for owned or rented space. Mortgage Principal/Interest/Depreciation/Taxes: Costs with owning a building (excluding utilities and maintenance).

Special Costs: Assistance to Individuals - subsidies, allowances, vouchers, and other payments provided to clients. Payment to Affiliate Organizations - required payments to a parent organization. Subcontracts - the organization subcontracts for service being purchased by a funder to another agency or individual. Examples: agency subcontracts a specialized counseli service to an individual practitioner; the agency is a fiscal agent for a collaborative project and provides payment to other agenc

3. SIGNATURE PAGE

AFFIRMATIVE ACTION
If funded, applicant hereby agrees to comply with City of Madison Ordinance 39.02 and file either an exemption or an affirmative action plan with the Department of Civil Rights. A Model Affirmative Action Plan and instructions are available at cityofmadison.com/civil-rights/contract-compliance.

CITY OF MADISON CONTRACTS
If funded, applicant agrees to comply with all applicable local, State and Federal provisions. A sample contract that includes standard provisions may be obtained by contacting the Community Development Division at 266-6520. If funded, the City of Madison reserves the right to negotiate the final terms of a contract with the selected agency.

INSURANCE
If funded, applicant agrees to secure insurance coverage in the following areas to the extent required by the City Office of Risk Management: Commercial General Liability, Automobile Liability, Worker's Compensation, and Professional Liability. The cost of this coverage can be considered in the request for funding.

4. SIGNATURE

Enter name: _____

By entering your initials in the box you are electronically signing your name and agreeing to the terms listed above.

DATE _____ INITIALS: _____

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ies.

5. BOARD-STAFF DEMOGRAPHICS

Indicate by number the following characteristics for your agency's current board and staff. Refer to application instructions for definitions. You will receive an "ERROR" until you finish completing the demographic information.

DESCRIPTOR	BOARD		STAFF		MADISON*		
					GENERAL	POVERTY	R/POV**
	Number	Percent	Number	Percent	Percent	Percent	Percent
TOTAL	5	**100%**	4	**100%**			
GENDER							
MAN		0%	1	25%			
WOMAN	5	100%	3	75%			
NON-BINARY/GENDERQUEER		0%		0%			
PREFER NOT TO SAY		0%		0%			
TOTAL GENDER	5	100%	4	100%			
AGE							
LESS THAN 18 YRS		0%		0%			
18-59 YRS	2	40%	4	100%			
60 AND OLDER	3	60%		0%			
TOTAL AGE	5	100%	4	100%			
RACE							
WHITE/CAUCASIAN	3	60%	1	25%	**80%**	**67%**	**16%**
BLACK/AFRICAN AMERICAN	2	40%	1	25%	**7%**	**15%**	**39%**
ASIAN		0%		0%	**8%**	**11%**	**28%**
AMERICAN INDIAN/ALASKAN NATIVE		0%		0%	**<1%**	**<1%**	**32%**
NATIVE HAWAIIAN/OTHER PACIFIC ISLANDER		0%		0%	**0%**	**0%**	**0%**
MULTI-RACIAL		0%		0%	**3%**	**4%**	**26%**
BALANCE/OTHER		0%	2	50%	**1%**	**2%**	**28%**
TOTAL RACE	5	100%	4	100%			
ETHNICITY							
HISPANIC OR LATINO		0%	2	50%	**7%**	**9%**	**26%**
NOT HISPANIC OR LATINO	5	100%	2	50%	**93%**	**81%**	**74%**
TOTAL ETHNICITY	5	100%	4	100%			
PERSONS WITH DISABILITIES		0%		0%			

*REPORTED MADISON RACE AND ETHNICITY PERCENTAGES ARE BASED ON 2009-2013 AMERICAN COMMUNITY SURVEY FIGURES.

AS SUCH, PERCENTAGES REPORTED ARE ESTIMATES. See Instructions for explanations of these categories.

**R/POV=Percent of racial group living below the poverty line.

6. Does the board composition and staff of your agency represent the racial and cultural diversity of the residents you serve? If not, what is your plan to address this? (to start a new paragraph, hit ALT+ENTER)

At this point we do not have a Latine representative on the board, nor do we have any gender representation besides female. Our newest board member, a Latina trained nurse and mother of an adult child with disabilities, was unable to continue serving after only a year on the board due to family and job demands. We have created an ad hoc committee of the existing board to work on board recruitment; we are prioritizng identifying some potential Latine candidates of any gender for both resident and non-residents board positions.

7. AGENCY GOVERNING BODY

How many Board meetings were held in 2024	7
How many Board meetings has your governing body or Board of Directors scheduled for 2024?	6
How many Board seats are indicated in your agency by-laws?	11-May

List your current Board of Directors or your agency's governing body.

Name	**Leslie McAllister**				
Home Address	23 Mondale Court, Madison, WI 53705				
Occupation	social worker				
Representing	non-resident board member				
Term of Office		From:	mm/yyyy	To:	mm/yyyy
Name	**Molly Plunkett**				
Home Address	4413 Crescent Road, Fitchburg, WI 53711				
Occupation	retired Corporation Counsel for DCDHS				
Representing	resident member, Allied Partners representative				
Term of Office		From:	mm/yyyy	To:	mm/yyyy
Name	**Carmella Harris**				
Home Address	2001 Tracewway Drive #328, Fitchburg, WI 53711				
Occupation	crisis intervention specialist				
Representing	non-resident member/neighborhood service provider				
Term of Office		From:	mm/yyyy	To:	mm/yyyy
Name	**Katy Farrens**				
Home Address	4605 Crescent Road, Madison, WI 53711				
Occupation	MMSD school aide				
Representing	resident member, ADMNA representative				
Term of Office		From:	mm/yyyy	To:	mm/yyyy
Name	**Betty Banks**				
Home Address	1331 South Street, Madison, WI 53715				
Occupation	retired non-profit manager				
Representing	non-resident member/family support services expert				
Term of Office		From:	mm/yyyy	To:	mm/yyyy
Name					
Home Address					
Occupation					
Representing					
Term of Office		From:	mm/yyyy	To:	mm/yyyy
Name					
Home Address					
Occupation					
Representing					
Term of Office		From:	mm/yyyy	To:	mm/yyyy
Name					
Home Address					
Occupation					
Representing					
Term of Office		From:	mm/yyyy	To:	mm/yyyy

AGENCY GOVERNING BODY cont.

Name					
Home Address					
Occupation					
Representing					
Term of Office		From:	mm/yyyy	To:	mm/yyyy
Name					
Home Address					
Occupation					
Representing					
Term of Office		From:	mm/yyyy	To:	mm/yyyy
Name					
Home Address					
Occupation					
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Term of Office		From:	mm/yyyy	To:	mm/yyyy
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Name					
Home Address					
Occupation					
Representing					
Term of Office		From:	mm/yyyy	To:	mm/yyyy
Name					
Home Address					
Occupation					
Representing					
Term of Office		From:	mm/yyyy	To:	mm/yyyy

Instructions: Complete this workbook in tab order, so the numbers will autofill correctly.* *Only fill in the yellow cells.
Only use whole numbers, if using formulas or amounts with cents, convert to whole number before submitting to CDD.

Please fill out all expected revenues for the programs you are requesting funding for in this application.
All programs not requesting funding in this application, should be combined and entered under NON APP PGMS (last column)

REVENUE SOURCE	AGENCY 2026	PROGRAM A	PROGRAM B	PROGRAM C	PROGRAM D	PROGRAM E	NON APP PGMS
DANE CO HUMAN SVCS	0						
UNITED WAY DANE CO	30,000	15,000	10,000	5,000			
CITY CDD (This Application)	214,925	109,221	70,965	34,739			
City CDD (Not this Application)	0						
OTHER GOVT*	47,500	22,500	25,000				
FUNDRAISING DONATIONS**	42,790	13,004	24,745	5,041			
USER FEES	0						
TOTAL REVENUE	335,215	159,725	130,710	44,780	0	0	0

*OTHER GOVERNMENT: Includes all Federal and State funds, as well as funds from other counties, other Dane County Departments, and all other Dane County cities, villages, and townships.

**FUNDRAISING: Includes funds received from foundations, corporations, churches, and individuals, as well as those raised from fundraising events.

Enter all expenses for the programs in this application under the PGM A-E columns. Enter the amount you would like the City to pay for with this funding under the CITY SHARE

****Use whole numbers only, please.**

ACCOUNT CATEGORY	AGENCY 2026	TTL CITY REQUEST	PGM A	CITY SHARE	PGM B	CITY SHARE	PGM C	CITY SHARE	PGM D	CITY SHARE	PGM E	CITY SHARE	NON APP PGMS
A. PERSONNEL													
Salary	240,760	162,760	116,896	83,200	87,672	52,520	36,192	27,040					
Taxes/Benefits	25,673	17,416	12,509	8,903	9,381	5,619	3,783	2,894					
Subtotal A.	266,433	180,176	129,405	92,103	97,053	58,139	39,975	29,934	0	0	0	0	0
B. OTHER OPERATING													
Insurance	3,000	1,918	3,000	1,918									
Professional Fees/Audit	3,000	1,600	3,000	1,600									
Postage/Office & Program	0	0											
Supplies/Printing/Photocopy	21,453	11,734	3,000	2,500	15,848	6,629	2,605	2,605					
Equipment/Furnishings/Depr.	0	0											
Telephone	7,320	4,500	4,620	1,800	1,000	1,000	1,700	1,700					
Training/Conferences	5,000	2,000	4,000	1,000	500	500	500	500					
Food/Household Supplies	0	0											
Travel	0	0											
Vehicle Costs/Depreciation	0	0											
Other	0	0											
Subtotal B.	39,773	21,752	17,620	8,818	17,348	8,129	4,805	4,805	0	0	0	0	0
C. SPACE													
Rent/Utilities/Maintenance	9,600	6,000	7,200	4,800	2,400	1,200							
Mortgage Principal/Interest	0	0											
Depreciation/Taxes	0	0											
Subtotal C.	9,600	6,000	7,200	4,800	2,400	1,200	0	0	0	0	0	0	0
D. SPECIAL COSTS													
Assistance to Individuals	5,000	3,000	5,000	3,000									
Partner/Joint Agency/Agencies	0	0											
Contractors/Subcontractors	12,612	2,200	500	500	12,112	1,700							
Pymt to Affiliate Orgs	0	0											
Other	1,797	1,797					1,797	1,797					
Subtotal D.	19,409	6,997	5,500	3,500	12,112	1,700	1,797	1,797	0	0	0	0	0
TOTAL (A.-D.)	335,215	214,925	159,725	109,221	128,913	69,168	46,577	36,536	0	0	0	0	0

***List all staff positions related to programs requestiong funding in this application, and the amount of time they will spend in each program.**

Title of Staff Position*	2026 Program A FTE**	2026 Program B FTE**	2026 Program C FTE**	2026 Program D FTE**	2026 Program E FTE**	2026 Total FTE	2026 Annualized Salary	2026 Payroll Taxes and Fringe Benefits	2026 Total Amount	2026 Hourly Wage***	2026 Amount Requested from the City of Madison
CHW Program Coordinator	0.30	0.20				0.50	36,400	3,895	40,295	35.00	36,265
Community Health Worker	0.70	0.15	0.15			1.00	54,080	5,787	59,867	26.00	59,867
Community Health Worker	0.50	0.30	0.20			1.00	58,240	6,232	64,472	28.00	44,900
Community Health Worker	0.10	0.30	0.10			0.50	27,040	2,893	29,933	26.00	14,968
Community Health Worker	0.20	0.30				0.50	29,120	3,116	32,236	28.00	0
AWC Bookkeeper	0.20	0.15				0.35	25,480	2,726	28,206	35.00	24,176
AWC Community Health Intern		0.25				0.25	10,400	1,113	11,513	0.00	0
						0.00			0	0.00	0
						0.00			0	0.00	0
						0.00			0	0.00	0
						0.00			0	0.00	0
						0.00			0	0.00	0
						0.00			0	0.00	0
						0.00			0	0.00	0
						0.00			0	0.00	0
						0.00			0	0.00	0
						0.00			0	0.00	0
						0.00			0	0.00	0
						0.00			0	0.00	0
						0.00			0	0.00	0
						0.00			0	0.00	0
						0.00			0	0.00	0
						0.00			0	0.00	0
SUBTOTAL/TOTAL:	2.00	1.65	0.45	0.00	0.00	4.10	240760.00	25762.00	266522.00	178.00	180176.00

CONTINUE BELOW IF YOU NEED MORE ROOM FOR STAFF POSITIONS

*List each staff position separately. Indicate number of weeks to be employed if less than full year in parentheses after their title.

**Full Time Equivalent (1.00, .75, .60, .25, etc.) 2,080 hours = 1.00 FTE

List all staff positions related to programs requestiong funding in this application, and the amount of time they will spend in each program.

Title of Staff Position*	2025 Program A FTE**	2025 Program B FTE**	2025 Program C FTE**	2025 Program D FTE**	2025 Program E FTE**	2025 Total FTE	2025 Annualized Salary	2025 Payroll Taxes and Fringe Benefits	2025 Total Amount	2025 Hourly Wage***	2025 Amount Requested from the City of Madison
						0.00			0	0.00	0
						0.00			0	0.00	0
						0.00			0	0.00	0
						0.00			0	0.00	0
						0.00			0	0.00	0
						0.00			0	0.00	0
						0.00			0	0.00	0
						0.00			0	0.00	0
						0.00			0	0.00	0
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						0.00			0	0.00	0
						0.00			0	0.00	0
						0.00			0	0.00	0
						0.00			0	0.00	0
						0.00			0	0.00	0
						0.00			0	0.00	0
TOTAL:	2.00	1.65	0.45	0.00	0.00	4.10	240760.00	25762.00	266522.00	178.00	180176.00

*List each staff position separately. Indicate number of weeks to be employed if less than full year in parentheses after their title.

**Full Time Equivalent (1.00, .75, .60, .25, etc.) 2,080 hours = 1.00 FTE

Program Summary

This tab should be completely filled in by your previous answers.

Pgm Letter	Program Name	Program Expenses	2026 City Request
A	CHWs: Partners in Health	PERSONNEL	92,103
		OTHER OPERATING	8,818
		SPACE	4,800
		SPECIAL COSTS	3,500
		TOTAL	**109,221**
B	Community Roots: Growing Allied Health Together	PERSONNEL	58,139
		OTHER OPERATING	8,129
		SPACE	1,200
		SPECIAL COSTS	1,700
		TOTAL	**69,168**
C	Teens Taking Charge	PERSONNEL	29,934
		OTHER OPERATING	4,805
		SPACE	0
		SPECIAL COSTS	1,797
		TOTAL	**36,536**
D	0	PERSONNEL	0
		OTHER OPERATING	0
		SPACE	0
		SPECIAL COSTS	0
		TOTAL	**0**
E	0	PERSONNEL	0
		OTHER OPERATING	0
		SPACE	0
		SPECIAL COSTS	0
		TOTAL	**0**
		TOTAL FOR ALL PROGRAMS	**214,925**