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>Meadowood Health Partnership, Inc.</td><td>Total Amount Requested:</td><td>$ 85,000</td></tr>
<tr><td rowspan="2">All program(s) connected to your organization:</td><td>Program Name: Meadowood Health Partnership Crisis Intervention and Prevention
Applicant Type: Prevention Services and Activities
Program Type: Community-based Individual/Family Support
List Program Partner(s) (if applicable):</td><td colspan="2">Amount Requested: $ 85,000</td></tr>
<tr><td>Program Name:
Applicant Type: Choose an item.
Program Type: Choose an item.
List Program Partner(s) (if applicable):</td><td colspan="2">Amount Requested: $</td></tr>
</table>

	Program Name: Applicant Type: Choose an item.	Amount Requested: $	
	Program Type: Choose an item. List Program Partner(s) (if applicable):		
	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):	Sheray Wallace	Email:	sheraywallace44@gmail.com
Organization Address:	5902 Raymond Road	Telephone:	608-896-5287
501 (c) 3 Status:	X☐ 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).

   Meadowood Health Partnership (MHP) is a trusted Community Health Worker (CHW) led organization that provides front-line housing, health, and essential service navigation. MHP is Dany County's only CHW-led, neighborhood based Community Health Office. MHP's mission is to improve access to equitable, culturally responsive care and services for vulnerable individuals and families—especially communities of color, immigrant populations, and low-income households. MHP is led by a Black woman who has lived on the Southwest side of Madison for over 20 years, bringing invaluable lived experience and community knowledge to this work.

   The work of MHP provides many examples of proactive crisis prevention. While the team of CHWs will respond to immediate needs, the true impact lies in addressing the root causes of instability before they escalate into full-blown crises. For example, instead of waiting for an eviction notice to be served, MHP

helps families navigate housing challenges early. This upstream intervention approach prevents a housing issue from spiraling into homelessness, which can lead to further health or financial crises. In addition, MHP's neighborhood-based model and reliance on community participation creates an informal early warning system. Staff and volunteers, who are also members of the community, are often the first to notice subtle signs of distress—whether it's a family struggling with food insecurity or an individual lacking access to critical health information. MHP's regular programming builds social cohesion and collective resilience. A strong, connected community is better equipped to support its members and withstand shocks, from economic downturns to public health emergencies. MHP's work strengthens the fabric of the neighborhood, ensuring that when a crisis does occur, the community has a built-in network of support to fall back on.

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 response to a January 2022 shooting of a 17-year-old in front of her apartment in the Meadowood Neighborhood, MHP Founder and Director, Sheray Wallace, was asked to partner with Kim Neuschel and Jessica LeClair from Madison and Dane County Public Health Department. This collaboration focused on addressing this traumatic event and providing critical resources, such as mental health support, directly to the Meadowood neighborhood. This community-based initiative was instrumental in building relationships and fostering resilience in the wake of this traumatic event.

   The Weekly Table Talks series, which began in 2018, is a key factor in MHP's effectiveness as a Crisis Intervention and Prevention program. By regularly addressing topics such as community violence, interpersonal violences, violence prevention, emergency preparedness, disaster response, chronic illness, and mental health, the series creates a sustained platform for community engagement and learning. This consistent programming fosters a sense of predictability, which in turn facilitates the development of strong relationships among participants. The design of these talks reflects our ability to provide services that are culturally and linguistically responsive to the needs of diverse populations .The trust and rapport built through consistent programming transforms a group of individuals into a supportive network. This peer support system becomes a vital resource during times of crisis, as individuals are better equipped to navigate challenges together and can be connected to the broader system of care. This approach is informed by our ability to develop individualized service plans informed by comprehensive client assessments in real-time.

   The Community Supper program, which began in 2015, serves as another program providing consistent Crisis Intervention and Prevention. Held on a bi-monthly basis, each supper provides a consistent gathering point where neighbors can connect and build relationships. The deliberate inclusion of community resources for social and health-related needs at every event ensures that attendees not only share a meal but also gain access to vital support systems. This regular, informal setting fosters relationship-building and networking, which in turn strengthens community connectedness. Trust is built in this space, allowing individuals to feel more comfortable reaching out to both MHP and their neighbors for help and resources when they need them.

Since 2014, MHP's Founder and Director, Sheray Wallace, has served as a dedicated community leader on the Meadowood Neighborhood Resource Team (NRT), a group coordinated by the City of Madison's Office of Civil Rights. In her role, Sheray has been crucial in connecting residents with resources and helping to implement these priorities. This is a direct example of our active participation in a city-facilitated community provider workgroup of support collaborations and shared learning. This engagement ensures our programming is aligned with broader city priorities and reflects a commitment to a unified approach to community well-being. Additionally, our organization has a long-standing commitment to ongoing staff training, professional development, and continuous quality improvement, ensuring our team remains at the forefront of best practices in crisis intervention.

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."

   In March 2025 MHP opened our dedicated community health office at 5902 Raymond Road. This change has significantly impacted our work by providing a stable, central hub for our programs. Having a physical location enhances community visibility and trust, making it easier for people to access resources and connect with our CHW team. This office serves as a consistent space for relationship-building, allowing us to foster stronger ties with community members and partners. It also provides a private, professional setting for one-on-one consultations and confidential discussions, which is especially important for crisis intervention and prevention services. The office location streamlines our operations, providing a central point for coordinating care and ensuring a more efficient and effective delivery of all our community health programs. It also provided a more accessible walk in location for community members to access services.

   The CHWs for COVID Responses and Resilient Communities (CCR 2109) grant, awarded by the CDC to the Wisconsin Department of Health Services' Chronic Disease Prevention Unit in 2021, ended in June 2025. This funding was crucial for advancing Community Health Worker (CHW) initiatives in Dane County including furthering the work of MHP. The grant facilitated collaboration among CHWs, their allies, and community partners across Wisconsin, enabling them to collectively address pandemic-related challenges. This funding was a consistent and stable source of financial stability for MHP for four years. MHP continues to work on additional grants and donation opportunities to try and manage this change without letting it impact our programming. However, the ability to do so does require other sources of funding to come through. This is where this City of Madison grant opportunity would be of great impact by providing stable, consistent current and future funding for MHP programming.

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."

   MHP is applying to expand its services by operating an adult day care and respite care program at our 5902 Raymond Road office. This new service is in direct response to the community's expressed need for additional support for aging and disabled residents.Caregiving can be physically and emotionally exhausting. Without support, caregivers often face burnout, which can lead to neglect or a health crisis for the person they're caring

for. Respite care provides a necessary break, allowing caregivers to rest, attend to their own needs, and recharge, thus preventing a crisis. Adult day care programs provide a structured, supervised, and safe environment. For individuals with conditions like dementia or mobility issues, this reduces the risk of accidents, falls, or wandering. These programs often include health monitoring and medication management, catching potential health crises (like a decline in a condition or the onset of an illness) early. Social isolation is a major risk factor for both physical and mental health decline in older adults and people with disabilities. Adult day care provides social engagement and a sense of community, which can prevent depression and anxiety. For caregivers, the opportunity to connect with others in similar situations can also reduce feelings of isolation.

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.).

   Our three Community Health Workers (CHW) have all been trained and certified through the Milwaukee Area Health Education Center (AHEC). The certification curriculum is designed to equip CHWs with a broad range of skills necessary for their role. This program trains CHWs on understanding the fundamental role of a CHW and its importance in the healthcare system, explaining the factors that affect community health and the implications of health statistics, applying strategies to educate community members, serving as part of a healthcare team, advocating for community needs, developing communication, interpersonal and relationship-building skills, navigating health and social service systems, demonstrating professional skills, documentation and ethical behavior. Beyond the initial certification program, Milwaukee AHEC also offers advanced training sessions for current CHWs to deepen their skills and knowledge on specific health topics, such as cancer prevention and management. These sessions provide an opportunity for peer learning and are often offered at no cost. The organization also provides resources and training for CHW supervisors, recognizing the importance of effective management in the CHW field. The CHWs at MHP take part in these continued training experiences when time allows.

   The Community Health Workers at MHP actively engage in advanced learning opportunities through the organization Envision. This organization is composed of CHW allies whose mission is to support CHW programs and networks in expanding and maximizing CHW leadership and the potential of the CHW workforce. Envision uses CHW best practices while applying their collective years of diverse professional and lived experience in realizing their mission. Their work has financial and administrative support from the Centers for Disease Control and Prevention (CDC) Community Health Workers for COVID Response and Resilient Communities (CCR) Program.

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?

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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.

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.**

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Part 2 - Program Narrative Form

Program Name:	Meadowood Health Partnership Crisis Intervention and Prevention	Total Amount Requested for this Program:			$ 85,000
Legal Name of Organization:	Meadowood Health Partnership, Inc.	Total amount Requested for Lead/Single Applicant			$
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	Sheray Wallace	Email:	sheraywallace44@gmail.com	Phone:	608-896-5287

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

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

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

X☐ **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.

The Meadowood Neighborhood is in State Decile 2 for the Area Deprivation Index (ADI), indicating it is among the least socioeconomically disadvantaged in Wisconsin. The ADI, developed at the University of Wisconsin-Madison, considers factors like income, education, employment, and housing. Low-income communities face a higher risk of crisis and violence due to a complex combination of factors rooted in economic hardship and social disadvantage. Economic desperation can drive individuals to crime as a means of survival when legitimate opportunities for jobs and education are scarce. This is exacerbated by social disorganization, a condition where the lack of community resources, weakened social networks, and high residential instability erode the social fabric, making it harder for residents to collectively prevent crime and support one another. The constant stress of poverty also has significant psychological impacts, contributing to mental health issues and substance abuse,

which can further increase the likelihood of violence. Ultimately, these interconnected challenges create an environment where individuals are more vulnerable to both personal and community-level crises.

In addition to these internal community dynamics, systemic inequality also plays a significant role. Low-income neighborhoods often experience a lack of investment in infrastructure, public services, and law enforcement, which can lead to poorer living conditions and a perception of neglect. This can create a sense of powerlessness and mistrust toward institutions, including the police, making residents less likely to report crimes or cooperate with investigations. Furthermore, these communities are often disproportionately targeted by aggressive policing tactics, which can lead to higher rates of incarceration and further destabilize families and the community. This cycle of disinvestment and over-policing perpetuates a state of vulnerability, making it difficult for residents to escape poverty and violence.

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 goal of this program is to provide immediate, comprehensive coordination and resource linkage to individuals affected by any type of violence, including providing access to safety measures such as temporary relocation, housing assistance, and covering essential daily living expenses. MHP has well established, working relationships with referral partner agencies who can provide in-depth mental health first aid and ongoing support. Through this program MHP will continue to build a comprehensive system of support for individuals and families. MHP is strongly connected to neighborhoods on the Southwest side of Madison, specifically the Meadowood neighborhood. MHP has established collaborations with Public Health Madison & Dane County and the City of Madison Meadowood Neighborhood Resource Team.

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.

Population Served: The program serves individuals and families in the City of Madison who have been directly impacted by violence or another type of crisis. We will focus on assisting those who have been involved in a crisis including those who might need to be relocated for their safety. The program is designed to be accessible to all, regardless of socioeconomic status, race, or background, with a specific focus on underserved and at-risk populations in the Meadowood neighborhood.

Core Services & Activities: Our services are centered on two main pillars: immediate crisis response and long-term community resilience.

1. Immediate Crisis Response: This involves providing direct, tangible support to victims of violence. This includes resource navigation, emergency relocation assistance (hotel stays, transportation out of Madison), and financial assistance for daily living expenses (food, gas, bus passes) to help them during the transition.
2. Long-Term Community Resilience: This pillar is built around our established community programs: the Table Talks series and Community Suppers. In collaboration with our partner agencies who attend these events and present on crisis prevention topics (i.e, Journey Mental Health, National Alliance for Mental Illness, etc..). MHP will continue to provide specialized programming that addresses trauma, violence prevention, and mental health.

Service Delivery: Services will be delivered through a combination of in-person and confidential off-site support. Our newly established community health office at 5902 Raymond Road will serve as the central hub for one-on-one consultations and case management. Immediate support, such as hotel and transportation arrangements, will be coordinated confidentially to ensure the safety of the individual. The community

resilience activities take place at the Community Health Office with our church partner, Good Shepherd Lutheran Church.

Key Expected Outcomes: Through this program, we expect to see several key immediate outcomes. We anticipate participants to report increased confidence in navigating systems to meet their health, legal, educational and other personal needs. We expect participants to report a greater understanding of trauma, prevention, stress management and coping strategies. Individuals will also report increased confidence in managing their own health and wellbeing. Lastly, participants will report that services were accessible, inclusive and responsive to their individual identities and lived experiences. In the long term, we aim to build a more resilient community. We expect to see an increase in participants' knowledge of violence prevention strategies, a greater sense of community connectedness and peer support, and improved access to trauma-informed care. Ultimately, this initiative seeks to empower individuals to heal from trauma and collectively work towards a safer, more supportive 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?

MHP serves the Southwest Madison neighborhoods of Meadowood, Allied Dunn's Marsh, Greentree and Prairie Hills. According to the City of Madison Neighborhood Indicators Project, racial demographics in Madison indicate that 24.3% of people identify as part of the BIPOC community. However, within these specific neighborhoods the percentages are generally much higher; Meadowood (31.4%), Allied Dunn's Marsh (67.9%), Greentree (23.3%) and Prairie Hills (42.8%). Based on the demographic indicators, individuals living in these areas are at a disproportionately higher rate of economic instability. This Southwest neighborhood cluster has a low income population of 32%, which is significantly higher than the City of Madison's poverty rate of 18%. Participants of MHP's Table Talk programs give input on programming on a regular basis. These participants are from the Meadowood and surrounding neighborhoods and have been consistently attending programming for over a year.

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	71	18
Black/African American	270	68
Asian		
American Indian/Alaskan Native		
Native Hawaiian/Other Pacific Islander		
Multi-Racial		
Balance/Other		
Total:	398	

Ethnicity		
Hispanic or Latino	57	14
Not Hispanic or Latino	341	86
Total:	398	
Gender		
Man	120	30
Woman	378	70
Non-binary/GenderQueer		
Prefer Not to Say		
Total:	398	

Comments (optional): Data is gathered though the intake process and entered into our secure database system.

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.

To serve non-Engish speaking youth, individuals, and families, our program employs a Bilingual Health Advocate to ensure both language access and cultural relevance. This dedicated role provides direct communication and support in Spanish for all clients and their families. The advocate facilitates intake, scheduling, and ensuring that a client's first language is prioritized throughout their care. This approach builds trust and rapport while serving as a cultural bridge for our staff, helping them understand and respect the unique needs and cultural contexts of the Spanish-speaking community.

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.

The process of engaging with families in need of support begins with a proven successful outreach strategy. MHP, operating from its community health office on Raymond Road, actively collaborates with a network of key partners to identify and connect with potential clients. These partners include Meadowridge Library, Meadowood Community Center, Joining Forces for Families, Children's Hospital of Wisconsin, Journey Mental Health, Pharmacy Society of Wisconsin, National Alliance for Mental Health and health systems such as UW Health and Access Community Health Centers. In addition to these referrals, MHP conducts direct outreach by tabling at local community events and providing information about its Community Health Worker services at the bimonthly community supper events.

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?

Our program is designed with a deep understanding of the specific barriers our populations face, particularly those stemming from living in a state of crisis. We recognize that clients grappling with trauma, stress, and mental health issues may have reduced capacity to engage. To address this, our approach is flexible and client-centered starting with immediate needs and gradually transitioning to therapeutic work. Our partnerships are crucial here, as they help clients with basic needs such as

housing and financial instability, removing fundamental obstacles so individuals can focus on their long-term healing.

We address this significant barrier of lack of trust by utilizing Community Health Workers (CHWs). These CHW's are from the communities we serve and have a unique ability to build rapport and serve as a trustworthy bridge between clients and services. This approach is essential for individuals who have had negative past experiences with social services.

Furthermore, stigma surrounding mental health or addiction can prevent individuals from seeking help or fully participating once they do. Clients might feel shame or embarrassment, making them less likely to be open and honest about their struggles. Our staff, who are trained in trauma-informed care and live in the communities we serve, are uniquely positioned to provide humane and impactful support. This approach helps destigmatize seeking help and empowers clients to better focus on their needs.

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).

MHP currently enrolls participants in our programs through collaboration with existing trusted community organizational partners. In addition, MHP develops and distributes outreach materials such as flyers and social media posts to provide information to the community about existing programs. MHP offers participants small participation incentives such as gift cards or food, in order to reduce barriers to attendance. MHP has a formal intake process that includes gathering detailed information about the client's specific situation. The intake and assessment process MHP uses are based on the CHW Common Core Indicators. In 2015 CHWs and researcher allies from five states founded the National CHW Common Indicators (CI) Project. The purpose of the CI Project was to contribute to the integrity, sustainability, and viability of CHW programs through the collaborative development, adoption, and use of a set of common process and outcome constructs and indicators for evaluating CHW practice.

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.,).

Intake: The process begins with a comprehensive intake and assessment to understand the individual's specific circumstances, including their strengths, challenges, and goals. This intake process is based on the CHW Common Core Indicators as referenced above.

Assessment: Following the assessment, a personalized service plan is co-developed with the participant, outlining clear, actionable steps and identifying the necessary resources. The assessment is based on the CHW Common Core Indicators as referenced above.

Implementation: Based on the service plan the CHWs assist the participant with navigating community resources and work to connect the individual to a network of services, which may include housing navigation assistance, employment training, or navigating legal assistance. Throughout the process, CHWs provides ongoing support and advocacy, regularly checking in with the participant to monitor progress, adjust the service plan as needed, and advocate on their behalf to overcome systemic barriers.

Evaluation: The final step involves monitoring outcomes and transitioning the participant to self-sufficiency, ensuring they have the skills and resources to independently manage their well-being in the future

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.

Research demonstrates that Community Health Workers (CHWs) have a significant impact on improving racial health and socioeconomic disparities. Studies show they are effective in improving the management of chronic diseases like diabetes and hypertension by increasing patient education, medication adherence, and follow-up care. CHWs play a crucial role in advancing health equity by addressing the social determinants of health and bridging the gap between community members and the formal healthcare system. CHWs are uniquely positioned to provide both crisis intervention and prevention because of their strong, trusting relationships with the communities they serve. They act as a vital link between individuals and formal healthcare and social services. MHP is often the first point of contact for individuals and families who are experiencing a crisis. Rather than directly acting as a mental health professional, the CHWs at MHP are trained to recognize the signs of a crisis and to provide immediate, supportive communication. Their primary role in this moment is to de-escalate the situation, offer psychological first aid, and, most importantly, connect the individual to appropriate professional help. This is especially crucial in communities where there is a deep-seated distrust of formal systems or where stigma prevents people from seeking help on their own.
In addition to intervention, CHWs are a powerful force in prevention. The day-to-day work at MHP addresses the underlying factors that can lead to a crisis. By conducting home visits and community outreach, CHWs identify and address social determinants of health like food insecurity, housing instability, or social isolation. They help individuals navigate complex systems to secure resources, access preventive care, and manage chronic conditions. This proactive approach helps to stabilize a person's life, build resilience, and reduce the chronic stress that can trigger a mental or physical health crisis. The team at MHP delivers health education in a culturally competent manner, making information on topics like stress management, substance abuse prevention, and healthy coping mechanisms more accessible and relatable to the community.

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 Drop In Hours	9:00am	5:00pm
Tuesday Drop In Hours	9:00am	5:00pm
Wednesday Drop In Hours	9:00am	5:00pm
Thursday Drop In Hours	9:00am	5:00pm
Friday Drop In Hours	9:00am	5:00pm
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:

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.

We engage our current participants in the development of all programming through regular community conversations, surveys, and ongoing assessments. This direct feedback loop ensures that our programming addresses not only violence prevention but long-term healing and identifies the most current needs of the community.

During implementation, participants will be actively involved as co-creators. Families will be encouraged to take on active roles, such as sharing lived experiences and leading small group discussions, to foster trust and strengthen peer-to-peer relationships. We will use a flexible, responsive model where program materials and workshops are continually adapted based on real-time participant feedback throughout the year. This ensures that our activities remain accessible and engaging, directly addressing any new or ongoing barriers.

For assessment, we will involve participants in a two-tiered evaluation process. First, the facilitator will use pre-and post-test surveys to track attitudes and gather quantitative data. Second, we will hold a year-end community event where participants will be invited to discuss their experiences, provide qualitative feedback, and co-develop recommendations for future programming. This final step is crucial as it positions participants not just as recipients of services but as partners in the program's evolution, honoring their experiences and empowering them to shape the future of our efforts.

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

Our neighborhood and community are included in the description above. The individuals and families that we serve are from the neighborhood and community. They are our current participants and will continue to recruit and support additional participants for our programming.

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)?
See below			

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

Our approach to partnerships is a fluid, community-driven model designed for maximum responsiveness to resident needs. While we do not operate with formal MOU's, we maintain a robust and active referral network with a variety of organizations and agencies throughout Madison. These relationships have been intentionally stewarded over the past 10 years by our Founder and Director, Sheray Wallace. Today, MHP maintains trust based referral partner agencies across Madison.

Our collaboration process is centered around direct community engagement. We invite partner organizations to host community-based workshops, talks, and presentations at our Community Health Office located at 5902 Raymond Road. During these sessions, our CHWs facilitate a direct, real-time connection between residents identifying needs and service providers on-site. This model effectively removes traditional barriers to access.

Each partner's role is defined by the service they provide directly to the community through these sessions:

- Journey Mental Health: Provides mental health education and immediate, on-side connections to telephonic crisis services and ongoing care
- Public Health Madison and Dane County: Hosts presentations on key health topics and connects residents to public health programs
- Legal & Medical Services: Partners like LiftWisconsin and providers from UW Health and Access Community Health offer real-time consultations and resource referrals
- Neighborhood Supports: Our close relationship with the Joining Forces for Families Social Workers and the Children's Hospital of Wisconsin's community based social service program allows for direct and seamless hand-offs for residents requiring broader family support

How do these partnerships enhance this proposal?

Our extensive network of partnerships is a cornerstone of our service model, significantly enhancing our proposal's effectiveness. These collaborations are not merely a list of contacts; they represent a robust, integrated system of support that allows us to address the holistic needs of each individual. By operating as a central point of entry, we can conduct a comprehensive assessment of a client's situation and connect them with the most appropriate resources.

This streamlined referral process eliminates the need for clients to navigate a fragmented and often confusing social service and healthcare landscape on their own. Our partnerships with key organizations ensure that we can provide a seamless transition to a wide range of specialized services, including mental health support, coordinated healthcare, housing assistance, employment services, child care, and legal aid. This collaborative approach minimizes administrative hurdles and maximizes our capacity to deliver timely and targeted interventions. Ultimately, these strategic alliances amplify our ability to provide a comprehensive, effective, and person-centered approach to care, demonstrating a strong, sustainable framework for achieving the proposed outcomes.

What are the decision-making agreements with each partner?

Decision-making with our partner organizations is highly effective and rooted in long-standing relationship-based trust. This framework operates beyond formal agreements, relying instead on a history of successful collaboration and deep understanding of each other's services. This allows us to proactively intervene and prevent crises by addressing root causes and potential risk factors at the earliest possible stage.

Our team maintains open lines of communication, allowing for agile and real-time decisions. During our community workshops or one-on-one conversations, our staff can identify potential needs and confidently make a direct referral. This mutual confidence and shared commitment to client well-being allow for agile and informal

communication. Rather than navigating bureaucratic hurdles, we can make swift, effective decisions based on established relationships. Rather than waiting for a situation to escalate, we ensure our clients get the support they need without delay, demonstrating the power of a flexible, trust-based network committed to crisis prevention.

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?

Coordinating referrals to resources provided by partner organizations is a key part of our collaborative approach. This process ensures a seamless transition for individuals to a wide range of specialized services, including mental health support, such as individual counseling and substance abuse treatment; coordinated healthcare, including assistance with accessing primary care and specialist appointments; housing assistance, which can involve help with shelter placement, rental assistance, and transitional housing programs; employment services, such as job training, resume building, and placement support; child care options; and legal aid for issues like family law and immigration matters. Our partnerships with these key organizations minimize administrative hurdles and maximize our capacity to deliver timely and targeted interventions. Ultimately, these strategic alliances increase our ability to provide a comprehensive, effective, and person-centered approach to care, ensuring that individuals receive the precise support they need.

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

Number of intakes completed: 25 per month
Number of attendees at the Table Talks: 30-50 people unduplicated over the year
Number of attendees at the Community Supper: 150-200 per event

B. Program Outcomes

Please describe the data and the data source used to choose your outcome objectives:

MHP maintains a formal and rigorous data collection process to ensure the accuracy and integrity of our client information. All data is managed through Provision, a secure and industry-standard database that serves as our primary data source. This system allows us to collect, store, and manage comprehensive client records efficiently.

Through our continuous intake and assessment process, we systematically gather a wide range of demographic data, including but not limited to age, gender, race, ethnicity, and household size. We also collect critical information related to client needs, such as housing status, income levels, and employment status, which allows us to identify key trends and unmet needs within our service population. Furthermore, client cases are updated in real-time to track the specific services they receive, the outcomes of these interventions, and any changes in their circumstances. This detailed data collection and ongoing case management provide a rich, longitudinal dataset that is essential for evaluating program effectiveness, demonstrating impact, and informing strategic decisions.

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: 75% of participants will report confidence in navigating systems to meet health, legal, educational or other personal needs.				
Performance Standard	**Targeted Percent**	75	**Targeted Number**	100
	Actual Percent		**Actual Number**	
Measurement Tool(s) and Comments: Pre and post test assessments				
Methodology: The primary measurement tools will be a pre and post test assessment that will use open ended and multiple choice prompts to gather information about their experiences.				

Outcome Objective #2: 75% of participants will report greater understanding of trauma, prevention stress management and coping strategies.				
Performance Standard	**Targeted Percent**	75	**Targeted Number**	100
	Actual Percent		**Actual Number**	
Measurement Tool(s) and Comments: Pre and post test assessments				
Methodology: The primary measurement tools will be a pre and post test assessment that will use open ended and multiple choice prompts to gather information about their experiences.				

Outcome Objective #3: 75% of participants will report increased confidence in managing their own health and overall wellbeing.				
Performance Standard	**Targeted Percent**	75	**Targeted Number**	100
	Actual Percent		**Actual Number**	
Measurement Tool(s) and Comments: Pre and post test assessments				
Methodology: The primary measurement tools will be a pre and post test assessment that will use open ended and multiple choice prompts to gather information about their experiences.				

Outcome Objective #4: 75% of participants will report that services were accessible, inclusive, and responsive to their individual identities and lived experiences.				
Performance Standard	**Targeted Percent**	75	**Targeted Number**	100
	Actual Percent		**Actual Number**	
Measurement Tool(s) and Comments: Pre and post test assessments				

Methodology: The primary measurement tools will be a pre and post test assessment that will use open ended and multiple choice prompts to gather information about their experiences.

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?

Using Provision as a central data management system, MHP captures all the information needed for comprehensive program documentation. The database is used to record demographic data during the intake process, providing a clear profile of each client served. As clients engage with our services, staff log all program activities in real-time, detailing the type, duration, and frequency of support provided. Furthermore, Provision enables us to track outcome measures by recording progress toward individual goals, which is essential for evaluating the effectiveness of our interventions. MHP's in depth financial tracking system captures expenses related to each program, from direct costs to administrative overhead, ensuring a complete and auditable record of all program expenditures. This integrated approach provides a robust and centralized platform for documenting all aspects of our work, from initial client contact to final outcomes and financial reporting. With strict financial processes in place, MHP has the personnel and administrative capacity to manage fiscal responsibilities for this grant. MHP will meet all reporting requirements in accordance with city standards, as evidenced by our successful administration of the CDC 2109 COVID grant.

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)
Sheray Wallace	.25	Certified Community Health Worker, Founder and Director	5902 Raymond Road
Puree Hill	.25	Certified Community Health Worker	5902 Raymond Road
Lane Hanson	.25	Certified Community Health Worker	5902 Raymond Road
Nazka Serrano	.25	Bilingual Health Advocate	5902 Raymond Road

B. Volunteers: Describe your process for screening, training, and supervising volunteers who will have direct contact with program participants.

Volunteers play an integral role in MHP programming through a developing internship program. MHP recruits, trains and supervises pre- health students enrolled at the University of Wisconsin Madison to assist

with creation and presentation of health education table talks. Student interns also volunteer at the bi monthly Community Supper events when their schedule allows. The screening process involves a formal application and interview to assess the student's communication skills and commitment, followed by background and reference checks. Once selected, the students receive comprehensive training that covers the foundational principles of the CHW model, specific health education content, and critical soft skills like communication and cultural competence. Each student is trained by a current intern in order to facilitate peer based learning. Sheray Wallace is the supervisor and she conducts regular check-ins, reviews their documentation of activities, and provides constructive feedback. A formal evaluation at the end of their volunteer period helps assess their performance and contributes to their professional development, ensuring both the student and MHP benefit from the collaboration. Community members who participate in MHP programming have the opportunity to train future health care professionals about the importance of community involvement in program design and implementation.

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.

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.

None

B. Disclosure of Contract Failures, Litigations

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

None

APPLICATION FOR 2025 CRISIS INTERVENTION AND PREVETNION SERVICES PROGRAMS

1. ORGANIZATION CONTACT INFORMATION

Legal Name of Organization	Meadowood Health Partnership, Inc.
Mailing Address	5902 Raymond Road Madison, WI 53711
Telephone	608-896-5287
FAX	n/a
Director	Sheray Wallace
Email Address	sheraywallace44@gmail.com
Additional Contact	Lane Hanson
Email Address	lanelhanson@gmail.com
Legal Status	Private: Non-Profit
Federal EIN:	93-1465551

2. PROPOSED PROGRAMS

		2025	If currently City funded	
Program Name:	Letter	Amount Requested	2024 Allocation	Joint/Multi Application - SELECT Y/N
Meadowood Health Partnership Crisis Intervention and Prevention	A	$85,000		No
Contact:	Sheray Wallace, sheraywallace44@gmail.com			
	B			
Contact:				
	C			
Contact:				
	D			
Contact:				
	E			
Contact:				
TOTAL REQUEST		$85,000		

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: Sheray Wallace

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

DATE 9/22/2025 INITIALS: SW

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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*		
	Number	Percent	Number	Percent	GENERAL Percent	POVERTY Percent	R/POV** Percent
TOTAL		**100%**		**0%**			
GENDER							
MAN		0%		0%			
WOMAN	7	100%		0%			
NON-BINARY/GENDERQUEER		0%		0%			
PREFER NOT TO SAY		0%		0%			
TOTAL GENDER	7	100%	0	0%			
AGE							
LESS THAN 18 YRS		0%		0%			
18-59 YRS	3	43%		0%			
60 AND OLDER	4	57%		0%			
TOTAL AGE	7	100%	0	0%			
RACE							
WHITE/CAUCASIAN	5	71%		0%	**80%**	**67%**	**16%**
BLACK/AFRICAN AMERICAN	2	29%		0%	**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%		0%	**1%**	**2%**	**28%**
TOTAL RACE	7	100%	0	0%			
ETHNICITY							
HISPANIC OR LATINO		0%		0%	**7%**	**9%**	**26%**
NOT HISPANIC OR LATINO	7	100%	0	0%	**93%**	**81%**	**74%**
TOTAL ETHNICITY	7	100%	0	0%			
PERSONS WITH DISABILITIES	0	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)

Yes. The majority of our board members live in the Meadwood Neighborhood. This representation means that they are familiar with the needs of the community.

7. AGENCY GOVERNING BODY

How many Board meetings were held in 2023	1
How many Board meetings has your governing body or Board of Directors scheduled for 2024?	2
How many Board seats are indicated in your agency by-laws?	7

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

Name	**Sheray Wallace**				
Home Address	5630 Schroeder Road Apt 424 Madison, WI 53711				
Occupation	Founder and Director of MHP				
Representing	MHP				
Term of Office	ongoing	From:	05/2023	To:	Current
Name	**Puree HIII**				
Home Address	110 Windstone Drive Madison, WI 53718				
Occupation	Hotel Manager				
Representing	Community Health Workers				
Term of Office	2 years	From:	05/2023	To:	Current
Name	**Lane Hanson**				
Home Address	2411 Tawhee Drive Apt 203 Fitchburg WI 53711				
Occupation	Director of Finance and Development				
Representing	Community Health Workers				
Term of Office	2 years	From:	05/2023	To:	current
Name	**Michelle Heitzinger**				
Home Address	6709 Mader Drive #304 Madison, WI 53719				
Occupation	Community Outreach				
Representing	National Alliance for Mental Illness (NAMI)				
Term of Office	2 years	From:	05/2023	To:	current
Name	**Elizabeth Schulz**				
Home Address	1317 Lyndale Road Madison, WI 53711				
Occupation	Retired				
Representing	Meadowood Neighborhood Association				
Term of Office	2 years	From:	05/2023	To:	current
Name	**Lisa Veldran**				
Home Address	5738 Kroncke Drive Madison, WI 53711				
Occupation	Retired				
Representing	Meadowood Neighborhood Association				
Term of Office	2 years	From:	01/2025	TO	current
Name	**Theresa Evanson**				
Home Address	1609 Redwood Lane Madison, WI 53711				
Occupation	Retired				
Representing	Meadowood Neighborhood Association				
Term of Office	2 years	From:	05/2023	To:	current
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					
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Term of Office		From:	mm/yyyy	To:	mm/yyyy
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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 2025	PROGRAM A	PROGRAM B	PROGRAM C	PROGRAM D	PROGRAM E	NON APP PGMS
DANE CO HUMAN SVCS	0						
UNITED WAY DANE CO	0						
CITY CDD (This Application)	85,000	85,000					
City CDD (Not this Application)	0						
OTHER GOVT*	35,000	35,000					
FUNDRAISING DONATIONS**	147,500	147,500					
USER FEES	0						
TOTAL REVENUE	267,500	267,500	0	0	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 2025	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	187,200	72,800	187,200	72,800									
Taxes/Benefits	0	0											
Subtotal A.	187,200	72,800	187,200	72,800	0	0	0	0	0	0	0	0	0
B. OTHER OPERATING													
Insurance	500	0	500										
Professional Fees/Audit	0	0											
Postage/Office & Program	0	0											
Supplies/Printing/Photocopy	2,000	0	2,000										
Equipment/Furnishings/Depr.	0	0											
Telephone	0	0											
Training/Conferences	0	0											
Food/Household Supplies	0	0											
Travel	0	0											
Vehicle Costs/Depreciation	0	0											
Other	0	0											
Subtotal B.	2,500	0	2,500	0	0	0	0	0	0	0	0	0	0
C. SPACE													
Rent/Utilities/Maintenance	22,800	9,600	22,800	9,600									
Mortgage Principal/Interest	0	0											
Depreciation/Taxes	0	0											
Subtotal C.	22,800	9,600	22,800	9,600	0	0	0	0	0	0	0	0	0
D. SPECIAL COSTS													
Assistance to Individuals	55,000	2,600	55,000	2,600									
Partner/Joint Agency/Agencies	0	0											
Contractors/Subcontractors	0	0											
Pymt to Affiliate Orgs	0	0											
Other	0	0											
Subtotal D.	55,000	2,600	55,000	2,600	0	0	0	0	0	0	0	0	0
TOTAL (A.-D.)	267,500	85,000	267,500	85,000	0	0	0	0	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*	2025 FTE**	2025 FTE**	2025 FTE**	2025 FTE**	2025 FTE**	2025 Total FTE	2025 Salary	2025 Taxes and	2025 Amount	2025 Wage***	2025 Requested
Founder and Director	1.00					1.00	83,200		83,200	0.00	20,800
CHW #1	0.50					0.50	36,400		36,400	0.00	18,200
CHW #2	0.50					0.50	36,400		36,400	0.00	18,200
Bilingual Health Advocate	0.50					0.50	31,200		31,200	0.00	15,600
						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	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:	2.50	0.00	0.00	0.00	0.00	2.50	187200.00	0.00	187200.00	0.00	72800.00

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 FTE**	2025 FTE**	2025 FTE**	2025 FTE**	2025 FTE**	2025 Total FTE	2025 Salary	2025 Taxes and	2025 Amount	2025 Wage***	2025 Requested
						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	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
TOTAL:	2.50	0.00	0.00	0.00	0.00	2.50	187200.00	0.00	187200.00	0.00	72800.00

*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	2025 City Request
A	Meadowood Health Partnership Crisis Intervention and Prevention	PERSONNEL	72,800
		OTHER OPERATING	0
		SPACE	9,600
		SPECIAL COSTS	2,600
		TOTAL	**85,000**
B	0	PERSONNEL	0
		OTHER OPERATING	0
		SPACE	0
		SPECIAL COSTS	0
		TOTAL	**0**
C	0	PERSONNEL	0
		OTHER OPERATING	0
		SPACE	0
		SPECIAL COSTS	0
		TOTAL	**0**
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	**85,000**