# Care Connections Community Partner Stipend Overview

Background

The Healthcare Association of New York State, Inc. (HANYS) through the Healthcare Educational and Research Fund, Inc., (HERF) with support from the Mother Cabrini Health Foundation, is pleased to offer 8 cost-reimbursable stipends for up to $10,000 each.Stipends will support chronic disease prevention and management projects/community health, co-led by Care Connections hospitals and 501(c)(3) not-for-profit community partner organizations. Stipend projects may have the potential to advance health equity. One or more community partners collaborating with a Care Connections hospital or health system may apply for and be awarded stipend funds.

Eligibility

To apply for the Care Connections Community Partner Stipend, an organization must:

* be a 501(c)(3) not-for-profit community-based organization;
* provide service to New York state residents;
* have an existing partnership with a hospital or health system participating in HANYS’ Care Connections program, or plan to partner with a Care Connections hospital or health system by April 1, 2025; and
* have a mission, vision and values that align with the ethical principles, tenets and teachings of the Roman Catholic Faith, according to the [Mother Cabrini Health Foundation](https://cabrinihealth.org/catholic-values/#:~:text=Rooted%20in%20Catholic%20Values&text=Mother%20Cabrini's%20lifelong%20commitment%20to,the%20work%20of%20the%20Foundation.&text=Other%20key%20principles%2C%20such%20as,of%20serving%20vulnerable%20New%20Yorkers.).

Applicants will provide their mission statement, EIN, a copy of their 501(c)(3) paperwork, a list of board members and a letter of support from their partner hospital or health system, along with their written application.

Selection criteria

Applications will be evaluated within the three categories below on a scale of 1 to 5 (1: strongly disagree, 2: somewhat disagree, 3: neutral, 4: somewhat agree, 5: strongly agree), then ranked by cumulative score.

1. Project feasibility: this organization’s project is clearly defined with measurable goals and outcomes.
2. Potential impact: the project selected by this organization focuses on chronic disease prevention and management and has potential to advance health equity.
3. Fiscal integrity**:** this organization has demonstrated fiscal integrity in handling grant funds.

Timeline

The Care Connections Community Partner Stipend program uses the following timeline:

Participation requirements:

Stipend recipients will complete the following requirements:

* Enter into an agreement with HERF to be reimbursed for up to $10,000 for chronic disease/community health work done in partnership with a Care Connections hospital;
* Attend one mandatory hour and a half-long online educational presentation in May 2025 a stipend reporting overview, and a financial orientation, which will cover expense reporting requirements.
* Meet at least monthly with their HANYS project manager and partner hospital or health system, between May and October 2025.
* Submit the first reimbursement request form and required attachments by June 24, 2025
* Submit the interim report by August 10, 2025
* Submit the second reimbursement request form and required attachments by September 10, 2025
* Submit the final report, financial reimbursement request form and other required attachments by November 10, 2025.

Reporting requirements

Stipend recipients will submit an interim report to their HANYS Project Manager by August 10, 2025, and a final report by November 10, 2025. A word document template will be provided to you that will allow you to explain progress towards goals, how the funds were used and the impact the funds had per your stipend application.

Financial reimbursement

Reimbursement requests may be submitted after expenses have been incurred. Payments will be issued within 30 days of HANYS receiving a completed Financial Reimbursement Request form.

Stipend recipients are required to submit for reimbursement on June 24, September 10 and November 10, but may choose to submit for reimbursement as frequently as once per month. The following documents are used to request reimbursement:

* Reimbursement Request Workbook (Excel) documenting all expenses incurred under stipend agreement;
* Supporting financial documentation, including invoices and proof of payment;
  + If requesting reimbursement for staff hours, you must provide the hourly rate of each employee during the pay periods covered, total hours per period, and fringe rate calculations. Proof of payment may include labor distribution reports, earnings statements that display hourly rate and hours worked, payroll registers, or a confirmation from Human Resources on letterhead.
* Form W9 Request for Taxpayer Identification Number and Certification (PDF): a completed and signed [Form W9](https://www.irs.gov/pub/irs-pdf/fw9.pdf) identifying the TIN to which payment will be made. This is submitted one time only.

# Community Partner Stipend Application

Organization’s legal name (the "Recipient"):

DBA/AKA (if applicable):

EIN:

Signing authority

Please list the signatory for this stipend, including full name, credentials, role, email and phone number.

Project contact

Please list the project contact for this stipend, including full name, credentials, role, email and phone number. This person is responsible for planning and implementing the project in partnership with a hospital or health system and the HANYS Project Manager.

**Financial contact**

Please list the contact who, if awarded the stipend, will manage all financial responsibilities, including reimbursement requests and collection of supporting documentation.

**Organization type**

Please provide your organization’s mission, vision and values, indicate the type of work done by your organization and describe the population your organization serves. (150 words).

**Project narrative**

1. Please briefly describe why this project was selected (1-2 sentences).
2. Please briefly describe the intended project (1-2 sentences).
3. What population will be impacted by this project? (a few words).
4. How many people will this project impact? (an estimate is fine).
5. Please list the major goals of your project (1-3 goals).
6. Please list the steps you will take to achieve your goals (up to five bullet points).
7. Describe your evaluation plan. How will you measure improvement?

4. Organizations that receive a stipend must complete their work in partnership with a Care Connections hospital.

1. Please list the hospital you intend to work with in 2025.
2. Please select the most accurate statement below:

* My organization is currently partnering with a Care Connections hospital.
* My organization intends to partner with a Care Connections hospital in 2025.

**Proposed use of funds**

Please indicate your proposed use of funds by selecting one or more of the four options below:

* **Technology enhancements**: funds will be used for new or upgraded hardware and/or software to improve access, screening or referral processes (example: referral tracking software and laptops).
* **Staff hours**: funds will cover salary and fringe expenses for staff time spent on the project. Eligible staff include client-facing and project management staff (example: funding a community health navigator).
* **Staff education and training**: funds will cover training expenses for staff in your organization or at your Care Connections partner hospital. Educational topics must relate to chronic disease prevention and/or management. (Examples: formal certificate or credentialing programs for key staff, or informal or one-time training by an outside organization).
* **Client education and outreach:** funds will be used for client-facing education designed to improve self-management of chronic disease, address social care needs and/or reduce healthcare disparities.

**Budget**

Please use the budget template below to provide an estimate of your expenses.

|  |  |  |  |
| --- | --- | --- | --- |
| *Example proposed budget: supportive housing organization* | | | |
| *Item description* | ***Unit cost*** | ***Total cost*** | ***Justification*** |
| *Salary expense:  Program coordinator* | *$6,000* | *$6,000* | *Hire part-time program coordinator to help with the referral process 1-2 days per week. (April 1, 2025 – Oct. 31, 2025); 300 total hours @ $20 per hour* |
| *Fringe rate* | *$1,500* | *$1,500* | *25% fringe rate applied to salary expense* |
| *Supplies: Two laptops* | *$1,000* | *$1,000* | *Purchase two laptops. Three staff all share one desktop computer. Laptops would make us more efficient.* |
| *Miscellaneous: Implement referral system* | *$1,000* | *$1,000* | *Implement a computer-based referral system so hospitals can refer clients to us directly and we can track closed loop referrals.* |
| *Consultant: Referral system training* | *$500* | *$500* | *Staff will be trained on the new computer-based referral system.* |
| *Total amount: $10,000* | | | |

**Please complete the template below.** In the Unit cost column, please indicate the cost of each item. In the Justification column, provide the rationale for your funding request.

|  |  |  |  |
| --- | --- | --- | --- |
| **Proposed budget** | | | |
| **Item description** | **Unit cost** | **Total cost** | **Justification** |
| ***Salary expense***  *(include hourly rate, period of time and total hours)* |  |  |  |
| ***Fringes*** *(indicate total fringe rate)* |  |  |  |
| ***Supplies*** |  |  |  |
| ***Miscellaneous*** |  |  |  |
| ***Consultant*** |  |  |  |
| ***Other*** |  |  |  |
| **Total amount:** | | | |

**Questions**

Please contact Maria Baum, stipend program lead, at [mbaum@hanys.org](mailto:mbaum@hanys.org).