Concept Paper

Program Director/Principal Investigator:

Prefix: ____ First Name: _____ Middle Initial: _____ Last Name: _____ Suffix: ___

Title:_____

Organization: _____

Email: _____ Secondary Email: _____

Telephone: _____

Address (Line 1): _____

Address (Line 2): _____

City: _____ County: _____ State: _____ Zip Code: _____

Title of Project: _____

Select the program for your submission: Community Matching Grant Program ___

Investigator Initiated Research Program ___ Physician Investigator Research Award Program __

Addresses (select one or more): Healthcare Cost ___ Quality of Care ___ Access to Healthcare ___

Ability Status: ___ Persons with at least one disability ___ Persons without a disability

If the proposed project addresses ability status, please provide description of disability/disabilities addressed:

Total Project Budget: _____

Grant Request Amount: _____ Duration (in months): ____

Estimated Start Date: _____

Purpose of Project (include target population; word limit: 150)

Description of Project (include rationale and target population; word limit: 350)

How this Project Addresses Health Equity and/or the Social Determinants of Health (word limit: 200)

Expected Impact/Outcomes (Include measurable outcomes and what impacts and outcomes you expect the target population to experience as a result of the project; word limit: 250)

How Expected Impact/Outcomes Will Be Measured (word limit: 250)

Email completed concept paper to: **foundation@bcbsm.com**