UChicago Medicine
Urban Health Initiative
Community Benefit Grant Program
Community Health Grant

Request for Proposals (RFP)

Contents

Note for Applicants:

The following grant guidelines will help you prepare the required documentation. Prior to submission, please review all information outlined in this document.

All materials for Community Health grant must be submitted by deadline. Any materials submitted past the deadlines will not be reviewed.

Link to RFP and reference materials: www.uchicagomedicine.org/about-us/community/grants-sponsorships
Link to Information Webinar registration: https://CBgrant2026.eventbrite.com
Link to submit Letter of Intent (LOI) Form: https://redcap.link/CH2026LOI

Part I. Grant Overview and Application Timeline

- **Funding Organization:** University of Chicago Medicine, Urban Health Initiative
- **Request for Proposal**: Community Health Grant
- **Announcement Type:** New
- **Range of Number of Awards:** 3-4 awards ($150,000 total funding available)
- **Range of Award Amounts:** $25,000 - $50,000 for 1 year
- **Estimated Award Date:** June 2026
- **Grant Period:** June 15, 2026 – June 14, 2027
- **Total Project Period Length:** 1 year
- **Cost Sharing or Matching Requirement:** No. Cost sharing or matching funds are not required for applicants. Leveraging other resources and related ongoing efforts to promote sustainability is strongly encouraged.

Application Timeline

- **Informational Webinar (optional):** Wednesday, March 18, 2026,11AM CST
- **Letter of Intent Form Deadline:** Friday, March 20, 2026, 12PM CST
- **Finalists Invited to Submit Full Application*:** Wednesday, March 25, 2026
- **Application Deadline*:** Wednesday, April 22, 2026, 12PM CST

  *Please note that application guidelines will only be sent to finalists invited to submit full applications.

Executive Summary

UChicago Medicine's Urban Health Initiative will award grants to community-based organizations through a competitive request for proposal (RFP) process. The purpose of this funding is to improve the health and well-being of residents on Chicago's South Side, as outlined in the University of Chicago Medical Center Strategic Implementation Plan. **In recognition of the need for additional streams of funding available to South Side social service organizations, these grants aim to provide critical support for individuals affected by heart disease and/or diabetes.**

Recognizing the essential role that community organizations play in advancing health, this grant program invests in initiatives that address the root causes of heart disease and diabetes. For example, funding will support community-based efforts such as nutrition access programs or transportation support for medical appointments.

Funding will be awarded to agencies or organizations that implement programs or services within the University of Chicago Medical Center service area.

- The University of Chicago Medical Center primary service area (PSA) is comprised of the following 12 zip codes: 60609, 60615, 60617, 60619, 60620, 60621, 60628, 60636, 60637, 60643, 60649, and 60653. All programs or services funded by this grant must be provided in the Medical Center PSA, whether that be provided to persons residing in the PSA or at a

location (i.e., office, facility, event or mobile unit) in the PSA.

- Grants will target the social or environmental drivers influencing diabetes and heart disease risks and outcomes.

Applicants must demonstrate the ability to implement their proposed program at the start of the grant period. Grant award amounts will be determined based on the proposed scope of work, including the target number of residents to be served and/or the depth and intensity of engagement with participants from the identified audiences. Both reach and meaningful engagement will be considered in determining award levels.

Applicants must align their proposed program or service objectives with the following goal and ***at least one of the strategies*** and accompanying objectives below:

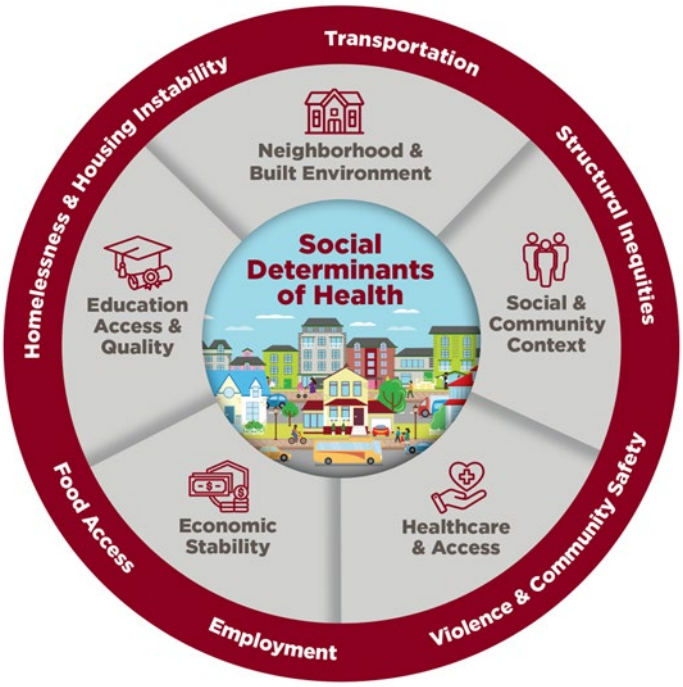
Goal
Prevent and manage diabetes and/or heart disease by focusing on one of following social determinants of health (SDOH): 1. Access to care & navigation 2. Food access & security

Strategy	**Objectives**
Strategy 1. Improve access to healthcare navigation and care coordination programs	a. Build a network of allied health professionals
	b. Expand programming and resource access in the communities served
	c. Develop public programming focused on improving care access and navigation
Strategy 2. Expand SDOH screenings and referrals	a. Develop system- or program-wide SDOH screening and referrals processes
	b. Develop an internal resource database for SDOH referrals for your program and/or organization (e.g. a heart disease education program also screens for SDOH)
	c. Embed SDOH screening and referrals process into programs

Part II. Background

UChicago Medicine is committed to advancing health equity—ensuring everyone has a fair opportunity to live their healthiest life. To address deep-rooted health inequities on the South Side of Chicago, we are focusing on the social determinants of health (SDOH) and their impact on people living with diabetes or heart disease. These SDOH- non-medical, systemic factors such as housing stability, food access, or transportation - directly influence health outcomes and quality of life.

- The Centers for Disease Control and Prevention (CDC) encourage health organizations to address the underlying factors related to key categories of SDOH. SDOH Categories include:
- Economic Stability
- Education Access & Quality
- Health Care Access & Quality
- Neighborhood & Built Environment
- Social and Community Context



Graphic Source: UChicago Medicine Urban Health Initiative SDOH (2025)

On the South Side of Chicago, these factors create significant barriers to health, particularly for those managing chronic conditions. The Community Health Grant Program targets these root causes, aiming to intervene "midstream" to prevent and manage heart disease and diabetes. Findings from the 2024-2025 University of Chicago Medical Center Community Health Needs Assessment (CHNA) show that the 12-ZIP code Primary Service Area (PSA[1]) suffers from higher rates of diabetes, heart disease, high blood pressure, and obesity, emphasizing the critical need for targeted investment in our community.

Unmanaged chronic diseases like diabetes and heart disease can have life-threatening consequences. According to the 2024–2025 CHNA conducted by the University of Chicago Medical Center, people living in the PSA are more likely to die from chronic diseases than residents across Illinois overall. These disparities are not only about medical care—they are deeply connected to the social and economic conditions in which people live.

Community members who participated in the CHNA focus groups and interviews spoke candidly about

[1] More information on the PSA can be found on page 15 of the 2024-2025 Medical Center CHNA.

the daily realities that make managing chronic conditions difficult. Many described the challenge of navigating healthcare services in neighborhoods with high poverty rates and limited healthcare facilities. The PSA poverty rate (25%) is substantially higher than in Chicago (17%), Cook County (13%), and Illinois (12%). Unemployment is also higher, and median household income is lower than the Cook County average. For individuals living with diabetes or heart disease, these financial pressures can mean making impossible choices. As one CHNA focus group participant shared, "There are lots of times when I ask myself, should I buy food or medicine?" When resources are stretched thin, preventive care, medications, and healthy food often become secondary to more immediate needs.

Access to healthcare providers is another critical factor. Limited transportation, lack of centralized information about services, gaps in insurance coverage, language barriers, and long distances to clinics all contribute to delays in care. The PSA has fewer primary care providers than surrounding areas and a higher percentage of residents covered by Medicaid and Medicare. These barriers can make it harder for residents to receive routine check-ups, refill prescriptions, or get timely support to manage blood sugar or blood pressure—key components of preventing complications from diabetes and heart disease.

Healthy food access is just as essential. Nearly one in five adults in the PSA (19%) report limited access to healthy foods or uncertainty about whether they will have access, compared to 12% in other parts of Cook County. For individuals managing diabetes or heart disease, consistent access to affordable, nutritious food is not optional—it is a cornerstone of disease management.

Together, these factors—access to quality healthcare and availability of healthy foods—illustrate how social determinants of health directly influence the ability of community members to prevent and manage chronic conditions. Addressing diabetes and heart disease in the Medical Center PSA requires more than clinical care alone; it requires coordinated strategies that reduce financial strain, improve healthcare access, and expand healthy food availability so residents can successfully manage their health every day.

Part III. Eligibility Criteria

Who Should Apply? Organizations seeking funding to implement proven (i.e., evidence-based) or promising practices, supported by evaluation data, that aim to improve access to healthcare or expand access to healthy foods for people preventing or managing heart disease or diabetes.

To be eligible for this grant, organizations must meet all of the following criteria:

1. Applicant must currently be a 501(c)(3) nonprofit.
2. The Community Health Grant is to implement programs or services in the University of Chicago Medical Center Primary Service Area (PSA). The PSA is comprised of the following 12 zip codes: 60609, 60615, 60617, 60619, 60620, 60621, 60628, 60636, 60637, 60643, 60649, and 60653. All programs or services funded by the grant must be provided in the PSA, whether that be provided to persons residing in the PSA or at a location (i.e., office, facility, event, or mobile unit) in the PSA.
3. Programs must serve individuals within the PSA that are impacted by heart disease or diabetes.

4. The proposed program, service, or project must address one of the following social determinants of health (SDOH): access to care and navigation or food access and security that affect individuals with chronic conditions, specifically heart disease or diabetes. Eligible programs must focus on improving access to healthcare or expanding access to healthy foods for people affected by these conditions. Applicants must clearly articulate how their work will support prevention and/or disease management for these populations. This funding approach aligns with the strategies outlined in the FY 2026-2028 University of Chicago Medical Center Strategic Implementation Plan.
5. Programs/services must be modeled on evidence-based, effective, or promising practices (see glossary for more information). The funded program or service must be based on at least preliminary evidence or an established framework of effectiveness.
6. Applicants must provide services to all persons in the target audience within the target geographic area, regardless of race, religion, sex, gender identity, age, disability, national origin or sexual orientation.
7. Applicants must demonstrate a readiness to serve at the beginning of the grant period, defined as the capability to provide oversight and ensure consistent and quality implementation of the proposed new or existing program, including descriptions of key staff and volunteers and their roles and responsibilities.
8. All applications must include an evaluation framework for the monitoring of program outcomes. Proposal activities must be written in the SMART format (Specific, Measurable, Attainable, Realistic, and Time- Bound) that align with UChicago Medicine defined strategies and objectives. (Applicants invited to submit full application must use template in Appendix A provided by UChicago Medicine.)
9. Applicants invited to submit full application must use budget template provided (Appendix B).
10. All grantees must use the worksheet templates provided to track progress of granted dollars, goals, target metrics, etc. noted to date, as aligned with the UChicago Medicine strategic framework.
11. In addition to funding, grantees will participate in workshops focused on supporting community organizations including technical assistance, shared learning opportunities and long-term sustainability.
12. Grantees may be asked to work with UChicago Medicine communications staff to discuss the best ways to share the organization's story and the impact its project, program, or service has on improving community health. At no cost to the organization, UChicago Medicine staff may create materials in the form of a written story, video package, and/or other digital storytelling that the organization can use to promote its work and secure additional funding. The materials may also be disseminated by UChicago Medicine. The organization and UChicago Medicine will be able to review and approve all material before publishing.

Part IV. Exclusions

Generally, applicants requesting the following types of support are excluded and will not be considered:

1. Applications from partisan political organizations.
2. Applications from for-profit organizations.
3. Applications requesting support for fundraising activities such as sponsorships, advertising or event tickets.
4. Applications from individuals.
5. Applications for memorials or endowments.
6. Applications for programs, projects, or services operating and/or serving people outside of the University of Chicago Medical Center primary service area.
7. Applications requesting support solely for strategic planning or program development (i.e., "planning year").

Part V. Types of Projects Funded

UChicago Medicine is committed to preventing and managing chronic diseases within its 12 zip-code community benefit primary service area (PSA). The UChicago Medicine Community Health Grant will increase the community's capacity to impact health outcomes by addressing root causes. For the purposes of this grant, we are focused on the following:

- Chronic diseases: heart disease and diabetes.
- Social determinants of health: Access to care and navigation; Food access and security

In order to be eligible for consideration, proposed projects must address UChicago Medicine's goals and objectives for preventing and managing chronic diseases on the South Side of Chicago as it is outlined on page 6 of the FY 2026-2028 University of Chicago Medical Center Strategic Implementation Plan UChicago Medicine will accept proposals requesting funding for 12 months for proven and promising practices, backed by evaluation data.

Only one application per organization or collaborative group will be accepted for this round of applications.

An example of a fundable program is listed below. Please see evaluation guidance in reference materials for more examples.

- ***Example: Food Pantry Program for People Diagnosed with Heart Disease and Diabetes***
  The program partners with local community gardens to provide fresh produce to individuals in the community, with a focus on supporting individuals diagnosed with heart disease and/or diabetes.
  - **Strategy:** Increase investment in food access and community outreach to expand produce distribution and participant enrollment.
  - **Relevant Outcomes:**

- Improved access to healthy foods for individuals with heart disease or diabetes.
- Improved self-reported clinical indicators among participants (e.g., lower average blood pressure readings)

Part VI. Instructions for Letter of Intent Form

Submit a Letter of Intent (LOI) form by entering the requested information in the REDCAP form here: https://redcap.link/CH2026LOI
Please note that the Letter of Intent is completed as an online form. It is not a document to upload. Applicants will enter the required information directly into the form rather than uploading a separate letter.

The deadline for the LOI form is Friday, March 20, 2026, 12PM CST. Applications submitted without an LOI form or with a late LOI form will not be considered for funding.

The LOI form requests the following information

A. Applicant Information

1. Name of Organization:
2. Tax ID:
3. Tax Status:
4. Mailing Address, City, State, Zip:
5. Organization's Website Address:
6. Contact Person:
7. Contact Person Title:
8. Contact Phone:
9. Contact Email:
10. Program Title:
11. Start Date of Project:
12. End Date of Project:
13. Proposed Program Service Area (zip codes):
14. Proposed Program Target Audience(s):
15. Amount of funding dollars requested:

B. Organization Description (100 words maximum)**:** Brief description of organization.

C. Program Description (500 words maximum): Provide a clear description of the proposed program, service, or project, including the specific community need it addresses and the social and environmental factors it seeks to influence. Describe the program objectives, the target population and how the proposed activities contribute to the prevention and/or management of heart disease and diabetes. Please also indicate the current stage of development or implementation and your organization's

readiness to carry out the proposed work.

D. **Evaluation** (250 words maximum): Description of anticipated measurable outcomes and how they will be measured.

E. **Budget** (150 words maximum): Complete budget is not required at this stage. Provide a brief explanation of total project budget and the portion being requested through grant. Outline how the grant funding will be used.
   - The budget does not have to be for the total program cost.
   - The primary purpose of this grant is to fund direct programs or services for community members, so you may not include your indirect rate and corresponding dollars in your budget. Applicants may include minimal administrative expenses but should not apply for funds solely for technology, program space, or other indirect costs.
   - Staff positions that drive the program can be included as a budget line item. However, they need to be solely focused on the program.
   - Minimal administrative expenses are permitted.

Part VII. Next Steps

Organizations submitting an LOI form will receive notification of whether or not they will be invited to submit full application.

The UChicago Medicine Grant Review Workgroup adheres to a strict conflict of interest policy and selects potential grantees based on the merits of each proposal.

Finalists invited to submit full applications will be notified and sent application materials on **Wednesday, March 25, 2026**. Please note that application guidelines will only be sent to finalists invited to submit full applications.

Please direct all questions to communitybenefit@uchicagomedicine.org

Part VIII: Reference Materials

1. Guidance on drafting activities, outputs and outcomes.

2. Appendix A: Evaluation Measures Template - Appendix A **will not be submitted with LOI Form**. It is **for reference only** and is meant to help frame thinking on evaluation.

Guidance on drafting activities, outputs and outcomes

Activities should align with specific strategies and objectives. They are the specific actions your program will carry out to achieve our shared goal and produce your intended outputs and outcomes. They describe **what you will do**, **who will do it**, and often **how** or **how often**.

Metrics fall under two categories: outputs and outcomes. Outputs and outcomes are frequently mislabeled or mixed up. **Outputs** are the direct results of activities, often labeled "process metrics". **Outcomes** are short, intermediate, or long-term effects of activities.

We provide two examples below to apply these concepts.

Example Program: Diabetes care navigation program to support community members with diabetes. The program also holds larger education and resources fairs for open to the public, focused on navigating diabetes in the workplace.

- EXAMPLE 1: **A strategy would be: Improve access to healthcare navigation and care coordination programs.**
    - **An objective would be: Expand programming and resource access in the communities served**
        - An **activity** would be: enroll 3 cohorts of 10 community members in diabetes care navigation program during grant timeframe.
            - A relevant **output** would be: number of community members with diabetes enrolled in care navigation program.
                - A relevant **outcome** would be: percent of participants that report improved medication adherence

- EXAMPLE 2: Another **strategy** example: Increase investment in workforce development and community outreach
    - An **objective** would be: Increase community outreach paired with workforce and economic stability initiatives, such as providing health screenings, mobile clinic outreach, healthy food, and information on local resources.
        - An **activity** would be: host 3 in-person sessions on EEOC rights for accommodations in the workplace
            - A relevant **output** would be: number of session attendees who received information materials on rights and how to request workplace accommodations for diabetes
                - A relevant **outcome** would be: % of surveyed attendees who report increased awareness of their rights and available workplace

accommodations, resulting in greater self-advocacy and higher rates of requesting and using accommodations

Both **outputs** and **outcomes** require internal tracking and documentation to be able to report on what happened during the grant period. In the provided example 1, the output could be measured by: enrollment sign in sheets and the outcome could be measured by participant surveys administered at set timepoints via computer or paper. Paper-based surveys need data entered into a spreadsheet.

When developing metrics (outputs and outcomes), please ask yourself some key questions:

1. What will your program do (i.e., what are your program's activities)?

2. What change(s) will those activities result in?

3. How can you quantify, count, and measure that change?

4. What is a realistic goal to set for counts/quantities?

We strongly recommend including only the most important activities your program engages in and their related outputs and outcomes. Further, make sure these activities are reportable at 6-months and 12-months. Focus on the quality of the metrics rather than the quantity. Please only enter one metric per table row. The table below shows example 1 in a different format.

Example table

Example: Completed Discretionary Metrics Table **Program Activities**	**Program Outputs**	**Output Target**	**Outcome**	**Outcome Target**
Example: enroll 3 cohorts of community members in diabetes care navigation program during grant timeframe.	*Example: Number of community members with diabetes enrolled in program*	*Example: 30 people with diabetes*	*Example: percent of participants that report improved medication adherence*	*Example: 90%*

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Note: Appendix A **will not be submitted with LOI Form.** This is included **for reference only** and is meant to help frame thinking on evaluation.

Appendix A: Evaluation Measures

Grant Period: June 15, 2026 – June 14, 2027

Applicant Organization Name: _____

Description: Address diabetes and/or heart disease through an upstream approach that targets underlying social or environmental drivers influencing diabetes and heart disease risks and outcomes.

Goal - *What we achieve*

Prevent and manage chronic conditions (diabetes and/or heart disease) by focusing on SDOH drivers, specifically: Access to care & navigation and/or Food access and security.

Strategies and corresponding objectives, to be incorporated into proposed programs or initiatives - *What we do*

TO BE ADDRESSED THROUGH PROGRAMMING:

Strategy 1. Improve access to healthcare navigation and care coordination programs	a. Build a network of allied health professionals b. Expand programming and resource access in the communities served c. Develop public programming focused on improving care access and navigation
Strategy 2. Expand SDOH screenings and referrals	a. Develop system- or program-wide SDOH screening and referrals processes b. Develop an internal resource database for SDOH referrals for your program and/or organization (e.g. a heart disease education program also screens for SDOH) c. Embed SDOH screening and referrals process into programs

Other Strategies and Objectives

(OPTIONAL) List any additional strategies and objectives specific to your program below. They must focus on chronic conditions management or prevention through an SDOH lens.

Strategy 3.	Objectives
Strategy 4.	Objectives

DIRECTIONS FOR TABLE: Complete the table below, ensuring activities are specific, measurable, achievable, realistic, and time-bound (SMART). Include target numbers or NA if not applicable. The strategies and objectives from the application are pre-populated in the table.

Required:

- Applicants should meet 1 strategy, at minimum, through their application.

- Include, at minimum, two outcomes that demonstrate impact. No more than 4 total outcomes should be included. There should be at least 1 outcome per strategy row completed.

- Outcomes should demonstrate how grantee has made impact on Chronic Conditions (diabetes and heart disease), SDOH (food access, access to care) or both.

Optional:

- Blank rows are provided for additional strategies and objectives, but are not required and do not result in additional points awarded.

Strategies	Objectives	Activities	Outputs	Output Target	Outcomes	Timeframe
Strategy 1. Improve access to healthcare navigation and care coordination programs	a. Build a network of allied health professionals					
	b. Expand programming and resource access in the communities served					
	c. Develop public programming focused on improving care access and navigation					
Strategy 2. Expand SDOH screenings and referrals	a. Develop system- or program-wide SDOH screening and referrals processes					
	b. Develop an internal resource database for SDOH referrals for your program and/or organization (e.g. a heart disease education program also screens for SDOH)					
	c. Embed SDOH screening and referrals process into programs					
(OPTIONAL) Strategy						

Part IX. Glossary

Glossary

Activities – In this application, activities refer to what are typically thought of as **process objectives**. These are the interventions delivered through program implementation in order to achieve the outcome objectives. What activities will your program and its staff deliver?

Chronic Diseases - For the purpose of this grant we are focused on the following chronic diseases: heart disease and diabetes.

Evidence-based – Using proven strategies/practices (e.g. interventions, frameworks, approaches) to improve population health. Key components include making decisions on the basis of the best available scientific evidence, using data and information systems systematically, applying program-planning frameworks, engaging the community in decision making, conducting sound evaluation, and disseminating what is learned (Brownson et al., 2009).

Goal(s) – Broad statements about the impact to be achieved with your target audience, but generally apply to longer time periods such as five years. Goals do not typically include specific, measurable terms.

Indicators – specific information that will be collected and used to measure your program's activities and objectives; performance benchmarks used to determine programmatic success.

Intended Outcomes – Broader statements describing the intended effects of the program in the program's target audience. These are defined, high-level goals that align with the University of Chicago Medical Center Strategic Implementation Plan and guide programs to address a specific health priority issue – preventing and managing chronic disease.

Objectives – In this application, objectives refer to **outcome objectives**. These are specific statements about outcomes to be achieved that are stated in measurable terms (i.e. SMART Objectives). The expected results to be achieved by the program.

Social Determinants of Health – Social, economic, and physical conditions in which people are born, live and work that affect their health and well-being.

Target audience – Those for whom a program and/or service is intended.