**RACIAL AND ETHNIC APPROACHES TO community HEALTH/LEAD DeKalb**

**CONTACT INFORMATION**

|  |  |
| --- | --- |
| Name of Organization  |  |
| Street Address |  |
| City/State/Zip Code |  |
| Website address |  | Facebook |  |
| Twitter |  | Other |  |
| Organization Type | ❒ Nonprofit – 501(c)3 | ❒ For profit | ❒ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  Contact Name |  |  |
| Contact Information | Email |  | Fax: |  |
|  | Phone | Work: |  | Cell: |  |
|  |  |  |  |  |  |
| Director’s Name |  | Phone |  |
| Director’s Signature | (required) |  |  |
| Amount requested |  | $ | Date |  |
|  |  | *Cannot exceed* ***$30,000*** *total*  |  |  |

***Breastfeeding Continuity of Care***

***Questionnaire***

***Submit questionnaire with proposal.***

Please provide answers to the following questions:

1. What is the demographic make-up of clients served in your breastfeeding programs/organization?
	1. Race/ethnicity
	2. Average income of participants’ household
2. Approximately what percentage of your program participants reside in DeKalb County?
3. Does your organization have the capacity to train parents, caregivers, health care workers, etc.? Describe your experience with providing virtual and in-person training around lactation support and breastfeeding continuity of care.
4. Briefly describe your organization’s experience with establishing referral networks and creating linkages to care.
5. Tell us why you would like to partner with the DeKalb County Board of Health and how addressing continuity of care in breastfeeding will be beneficial to the population that you serve. Also, include any current or previous work around organizational breastfeeding policy, breastfeeding friendly designations, and hosting lactation support clinics.