



# Thank you for your interest in applying for a Chicago Housing Authority (CHA) Health Partnership!

## Process

We appreciate your interest in partnering with CHA. As you complete your application, please keep in mind:

- The partnership is intended to bring valuable health information to CHA residents and is not to be used for solicitation or marketing. Health Partner presentations are for informational purposes only and are not considered professional advice in lieu of a resident’s own healthcare professional.
- Handwritten and/or incomplete applications will not be reviewed and will be not be returned.
- Supplemental documents are optional and maybe submitted along with a completed application.
- All partnership applications will be reviewed by a CHA committee for approval/denial (per the protocol outlined on CHA’s website (<https://www.thecha.org/health-partners>). Applications are reviewed within 60 calendar days.
- Incomplete applications will not be reviewed (signatures required on page 6 and 8 to be considered complete)
- CHA may request additional information upon application submission.
- All applicants will receive a letter approving or denying the partnership within 60 calendar days of submission.
- Partnership applications are valid for 24 months from the date of the approval letter. This application may be utilized for an initial application or a renewal.
- Please return your completed application by email to: **healthpartnerships@thecha.org**

or by mail to:

**Health Partnership Program, Resident Service Division 10<sup>th</sup> Floor  
Chicago Housing Authority  
60 E. Van Buren  
Chicago, IL 60605**

## Components

Part	What we want to know	Supplemental documents
Part 1: Applicant Information	Basic organizational information	N/A
Part 2: Partnership Opportunities	How you envision working with CHA	N/A
Part 3: Organizational Profile and Capacity	Service capacity and outcomes	Program materials and reports
Part 4: Partnership History	Your partnership history and experience serving public housing residents.	Partnership success stories and recommendations



What type of application is this (check one)?

Initial application

Renewal Application (If this is a renewal application complete Appendix A)

**Part 1: Applicant Information**

<b>A. Name of your organization:</b>			
<b>B. Tax ID #:</b>			
<b>C. Company/Agency Headquarter Information</b>			
Address:			
Telephone:		Fax:	
<b>D. Applying Location (if applicable):</b>			
Address:			
Telephone:		Fax:	
<b>E. Web address:</b>			
<b>H. Primary contact – location:</b> <input type="checkbox"/> Headquarters <input type="checkbox"/> Applying location (this contact will be listed on CHA website)			
Name:		Title:	
Phone:		Email:	
<b>I. Secondary contact – location:</b> <input type="checkbox"/> Headquarters <input type="checkbox"/> Applying location			
Name:		Title:	
Phone:		Email:	
<b>J. How would you classify your organization? Check all that apply:</b>			
<input type="checkbox"/> Non-profit	<input type="checkbox"/> For-profit	<input type="checkbox"/> LLC	<input type="checkbox"/> Other:



## Part 2: Partnership Opportunities

We would like to learn more about how you envision working with CHA.

**A. Describe in detail the health and wellness educational programs you propose to offer to CHA residents. (Please see Health Partnership Protocol for examples of eligible programs/services).**

**B. Are there specific CHA buildings/developments you propose to target?**

Yes (list them below and the reason why they are targeted)  No



**C. Are there specific geographic areas in the city of Chicago you propose to target? Check all that apply.**

North Side

Central/West Side

South Side

**D. Please describe what your organization hopes to gain from partnering with CHA.**



### Part 3: Organizational Profile and Capacity

We would like to better understand the work you do. CHA values partners with a commitment to high-quality services and attention to outcomes and performance management.

<b>A. Tell us more about your organization.</b>
<b>B. Does your organization have any existing contracts with City departments, sister agencies or other local government agencies?</b> <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, please list the top two and describe the nature and amount awarded.
<u>Contract 1</u>
<u>Contract 2</u>
<b>C. Is your organization accredited or licensed by a 3<sup>rd</sup> party?</b>
<input type="checkbox"/> No <input type="checkbox"/> Yes
If yes, please list the body accrediting/licensing your agency or company and a contact phone number for verification)
<b>D. Please describe the professional licenses, certificates, or medical training held by staff who will provide health partner presentations.</b>
<b>E. Has your organization ever had a contract with the Chicago Housing Authority, City of Chicago, or Chicago Sister Agency (Transit Authority, Public Library, Park District, Police Department, Fire Department, or Public Schools) terminated?</b>
<input type="checkbox"/> No <input type="checkbox"/> Yes
If yes, please explain the reason for termination.



## Part 4: Partnership History

CHA is interested in creating partnerships with health and wellness providers who are committed to serving public housing senior residents. Use this section to tell us about your experience serving public housing residents and your history partnering with City departments and sister agencies.

<b>A. Have you worked with CHA in the past?</b> <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, please describe in detail the nature of your partnership and tell us about your experience.	
<b>B. Please use the space below to add any additional information that you feel would add value to your application.</b>	
<b>C. Supplemental documents</b> If you have partnership success stories or letters of recommendation, please include them with your application.	
<b>Signature of authorized representative*</b>	
*By signing, you affirm that all information contained in this application is accurate and complete.	

**Thank you! We appreciate the time you have taken to complete this application and we look forward to reviewing your responses.**





## Health Partnership Agreement

Chicago Housing Authority’s Health Partnership program is a voluntary program managed solely by the Chicago Housing Authority. By applying and signing this agreement, I understand and agree to the following:

- I understand that the Chicago Housing Authority reserves the right to confirm the accuracy of the information in this application. Including the status of any licenses, certificates, or accreditation listed on the application.
- I understand that if my company/agency is invited to a CHA site I cannot solicit, enroll, or market my company/agency or it’s services.
- If my agency/company is approved as a Health Partner, I agree to respond to the CHA’s request for data and feedback, including but not limited to:
  - Number of Events facilitated by my agency/company
  - Number of attendees at each event
  - Address/location of each event
  - Estimated monetary value of donated time and materials for each event/service provided.
- I understand that an approval to be a health partner is non-transferable; if I wish to collaborate with other organizations in providing services through this partnership, the other organizations will need to complete a partnership application and be approved.
- I understand that health partnership approvals are valid for 24 months. All health partners must reapply if they wish to continue after the 24-month period.
- I understand the CHA may limit the number of specific organization types accepted as a health partner.
- I understand the CHA reserves the right to cancel partnerships with written notice.
- I understand that I must have a scheduled appointment to enter CHA buildings.
- I understand that I must exit the building immediately after a presentation and cannot remain in the building.
- I understand I must provide a government issued identification (i.e. driver’s license, state identification card, or US passport) to enter CHA buildings.
- I understand CHA cannot guarantee a certain number of attendees for presentations.
- I understand that I cannot charge money for any presentations, workshops, or activities.
- I understand approved partner presentations are for informational purposes only and are not considered professional advice in lieu of a resident’s own healthcare professional.

\_\_\_\_\_  
Applying Organization

\_\_\_\_\_  
Signature of authorized representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name