**Vitamin Angels Grant Application**

### **Introduction**

Vitamin Angels (VA) supports the delivery of evidence-based nutrition interventions by providing commodities and technical assistance. VA donates vitamin A supplements and deworming tablets for children under the age of 5. **We donate only in-kind, and do not offer monetary or financial assistance.**

Vitamin Angels donations should not replace or duplicate existing government distribution of vitamin A and/or deworming in your area. Your request to Vitamin Angels should be serving beneficiaries who are NOT already receiving these interventions (i.e. beneficiaries who are hard-to-reach).

For more information about our grants or eligibility requirements, visit our website: [www.vitaminangels.org/field-partners](http://www.vitaminangels.org/field-partners)

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| Date of application: | |
| Organization (Full Legal Name): | |
| Organization’s Website: | |
| Name (Signatory Contact): | Name (VA Project Contact): |
| Title: | Title: |
| Phone Number: | Phone Number: |
| Email Address: | Email Address: |

### **General Information**

### **In-Country Information**

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| Name of registered organization (if different than above): | |
| NGO Registration Number:       Please attach a copy of your registration certificate (required) | |
| Does your organization have a valid FCRA registration to work on health and nutrition?  Yes /  No | |
| FCRA Registration Number:       Please attach a copy of your valid FCRA certificate (required) | |
| FCRA Expiry Date: | |
| Primary Office Location: City: | State or Province: |
| Country: | |

Vitamin Angels requires organizations to be locally registered in the country where you are administering Vitamin Angels nutrition interventions.

### **Authorization for Use of Organization’s Name**

As a Vitamin Angels partner, we may want to share the name and/or location of your organization to show Vitamin Angels' impact (for example: on our website [www.vitaminangels.org](http://www.vitaminangels.org) or with our donors). No specific contact information will be shared. Please check the box below to allow Vitamin Angels to use your organization's name in the manner specified above.

I agree to Vitamin Angels’ use of our organization’s name

### **Shipping Address and Contact Information**

Vitamin Angels requires organizations complete shipping address along with contact details of persons-in-charge of managing the VA grant implementation. If delivery is required in multiple locations, the Programs Team will reach out directly for all addresses.

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| Address Line 1: | | | |
| Address Line 2: | | | |
| City: | State: | | Pin code: |
| **Name (Primary Contact):** | | | |
| Mobile No.: | | Email ID: | |
| **Name (Secondary Contact):** | | | |
| Mobile No.: | | Email ID: | |

### **Organization Detail**

1. **Please describe your organization’s broad vision:**
2. **Please describe your organization’s current programs and services:**
3. **Please describe the population you serve (for example: why are they hard-to-reach?):**
4. **Please describe your organization’s current top sources of funding:**
5. **Please list down details of your organization’s board members:**

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| **Name of the board member** | **Age** | **Board Member since** | **Brief Bio (educational qualification, professional expertise, and contribution to the organization)** | **Attendance in the last 5 board meetings** |
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1. What is your annual turnover/expenditure? *(Optional)*

### **Nutrition Interventions**

1. **Select the nutrition interventions you are requesting: (check all that apply)**

Vitamin A Supplements for children 6-59 months

Deworming (Albendazole) for children 12-59 months

1. **For each of the interventions you are requesting, please explain why the beneficiaries you serve do not receive these interventions from another source (e.g. National/District Ministry of Health, local NGO/CBO, etc.).**
2. Vitamin A Supplements:
3. Deworming:
4. **Does your organization already provide any of these interventions i.e vitamin A and Albendazole?**

Yes /  No

If yes, please list the other sources and explain **why** your organization is requesting an additional supply?

1. **Please explain your plans to coordinate with government and/or other organizations (e.g. UNICEF or NGOs) in order to avoid overlapping vitamin A, albendazole in the same geographic area.**

### **Commodity Request and Distribution Plan**

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| Use this guide to inform your responses to the questions that follow. | | | |
|  | **Vitamin A**  **100,000 IU** | **Vitamin A**  **200,000 IU**  A red moon in a black sky  Description automatically generated with medium confidence | A picture containing night sky  Description automatically generatedA moon in the sky  Description automatically generated with low confidence**Albendazole**  **or** |
| **Target Age Group** | Infants 6-11 months | Children 12-59 months | Children 12-59 months  *Do not give to children under 12 months* |
| **How Often** | Give every 4-6 months | Give every 4-6 months | Give every 4-6  months |
| **How to Distribute** | Given by a trained service provider\* | Given by a trained service provider\* | Tablets should be crushed and given by a trained service provider\*:  Children 12-23 months: ½ tablet  Children 24-59 months: full tablet |
| \*Comprehensive training tools for service providers will be offered after grant is awarded. For more information on Vitamin Angels training, visit <https://www.vitaminangels.org/vasd-service-delivery> | | | |

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| **PLEASE NOTE:**  Vitamin Angels requires the submission of a report every six months to check on inventory and progress. Examples of Vitamin Angels’ reporting forms and recordkeeping tools can be found on our website at: [www.vitaminangels.org/field-resources](http://www.vitaminangels.org/field-resources)  In addition, Vitamin Angels recommends you use local government recordkeeping tools and reporting forms. | Diagram  Description automatically generated |

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| **In the table below, indicate how many beneficiaries (children and/or pregnant women) you plan to reach with each Vitamin Angels nutrition intervention.**  **PLEASE NOTE:**   * Write only the number you can reach in one year. * If exact numbers are not available, write an estimate. * Vitamin Angels does NOT offer financial assistance. Your organization is responsible for the transportation and distribution costs. Please limit your request to what your organization can currently afford to distribute. | | | | | | | |
| **Name of Organization Distributing Commodities** | **Will your organization be directly involved in distribution?** | **Distribution Location** | | **Vitamin A 100,000 IU** | **Vitamin A 200,000 IU**  A red moon in a black sky  Description automatically generated with medium confidence | **Albendazole 400 mg**  A moon in the sky  Description automatically generated with low confidence |
| **1st geographic area:**  (State/Province) | **2nd geographic area:**  (District/Municipality) | **No. of Infants**  **6-11 months** | **No. of Children 12-59 months** | **No. of Children 12-59 months** |
|  | Yes /  No |  |  |  |  |  |
|  | Yes /  No |  |  |  |  |  |
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|  | Yes /  No |  |  |  |  |  |
|  | Yes /  No |  |  |  |  |  |
|  | Yes /  No |  |  |  |  |  |
| **Total No. of Beneficiaries:** | | | |  |  |  |

1. **How did you estimate the number of beneficiaries to be reached?** (for example: Are they based on population figures? Current programs?)
2. **What is your distribution plan for** **vitamin A and deworming**? For example, how will you mobilize beneficiaries, will distribution occur as part of an existing program, where will the distributions take place, how will you track inventory/beneficiaries, etc.
3. **In which geographical areas will you be providing vitamin A and deworming?** (For example, name of taluka, district and state)
4. **Who will be administering the interventions from Vitamin Angels? (check one)**

Staff of your organizations

Your organization and government workers

Only government workers

1. **How do you ensure that your beneficiaries haven’t already received vitamin, albendazole, and/or MMS from another source** (for example: you consult the child health card or clinic register)?

### **Effective Implementation Support**

1. **For the implementation of the proposed program and strengthening the organizational systems what type of** **capacity development initiatives do you foresee for the staff?**
2. **Do you foresee requirement of a coalition and networking with other organizations/local governments for the implementation of the proposed program activities and achievement of goals?**
3. Who are the current network partners of the organization? What is the nature of this partnership? (*Optional)*
4. **What is the change you want to achieve from the program? (check all that apply)**

Reaching the under/un-reached

Achieving nutritional equity among children

Support to ongoing government program

Any other? Please explain:

1. **How will you monitor the progress of the intervention? What monitoring and evaluation practices will you follow to ensure the impact desired is achieved?**
2. If you have been an existing partner of Vitamin Angels, please let us know how this partnership has benefitted your organization? *(Optional)*
3. **How will your organization cover the operational cost involved in distributing vitamin A and Albendazole to eligible children under-five?**
4. **References**

References are critical to your application. We rely very heavily on these objective opinions of your ongoing programs. Please provide local references of two persons / institutions who can be contacted by Vitamin Angels for reference purposes.

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| **Name** | **Contact No.** | **Email ID** | **Institutional Association and Relation to Grant Applicant** |
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| **Terms and Conditions** | **Do you agree to this term/condition?** | |
| 1. Grantee must provide interventions in the country/countries that you specified in your application. | | Yes  No |
| 1. Grantee must provide interventions to beneficiaries that are a priority to Vitamin Angels:  * Children 6-59 months living in underserved areas | | Yes  No |
| 1. Grantee must not deny availability, access, or use of a donation by Vitamin Angels to any beneficiary on the basis of ethnicity, race, religion or ability to pay. | | Yes  No |
| 1. Grantee must not charge a fee to anyone, including beneficiaries, for a Vitamin Angels’ donation. | | Yes  No |
| 1. Grantee must provide an annual report to Vitamin Angels that specifies quantity and location of interventions. | | Yes  No |
| 1. Grantee must accept generic commodities produced to Vitamin Angels’ specification. All Vitamin Angels micronutrient donations meet USFDA, USP, and/or local requirements for manufacture and distribution as dietary supplements for human consumption, and are not expired. Deworming treatments donated by Vitamin Angels meet the WHO Ph. Int. and/or local requirements for manufacture and distribution as pharmaceuticals for human consumption, and are not expired. | | Yes  No |
| 1. Grantee recognizes that most Vitamin Angels donations are labeled in English. Grantee must ensure proper instructions are given for non-English speaking beneficiaries. | | Yes  No |
| 1. Grantee must not use donation by Vitamin Angels to influence or otherwise persuade prospective beneficiary towards any decision regarding the direction of their pregnancy. | | Yes  No |
| 1. Grantee accepts Vitamin Angels to conduct a monitoring visit of the grantee’s project sites. Vitamin Angels will pay its own expenses, and will coordinate with your staff to conduct the visit in the most appropriate way. The purpose is to ensure that projects are conducted in accordance with internationally accepted best practices. | | Yes  No |
| 1. Grantee must administer Vitamin Angels’ interventions consistent with best practices (i.e. according to the training/materials provided by Vitamin Angels) | | Yes  No |
| 1. Grantee is responsible for distributing all commodities provided by Vitamin Angels prior to the expiration date. If unable to do so and expired commodities need to be disposed of, Grantee is responsible for the destruction process and all costs associated with it. | | Yes  No |
| 1. Grantee accepts that Vitamin Angels accepts no responsibility for any donated commodity after delivery of that commodity; and Grantee will hold Vitamin Angels harmless from and against any and all liabilities, losses, damages, adverse events, costs, and expenses associated with any claim or action brought against the grantee in connection with the use of the commodities donated by Vitamin Angels. | | Yes  No |
| 1. Grantee must seek approval from Vitamin Angels prior to any public statement that features our logo, images of our commodities or describes our work. Vitamin Angels is happy to provide approved content and our logo usage kit and welcomes the publicity. For details: <https://www.vitaminangels.org/logo-download-form> | | Yes  No |

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| 1. Grantee acknowledges that through its work with Vitamin Angels it may have access to various Vitamin Angels photographs, videos and other content (collectively, the “Materials”). Grantee agrees to follow any guidelines or limitations with respect to such Materials, agrees not to make any use of such Materials without Vitamin Angels’ approval, and acknowledges that Vitamin Angels cannot be responsible for Grantee’s use of any such Materials. Grantee agrees to be solely responsible for its use of the Materials, which may include the determination about whether it is necessary or advisable to secure any permissions or agreements in connection with use of the Materials, and the obtaining of any such consents. | Yes  No |
| 1. Grantee assumes responsibility for ensuring that all Terms & Conditions are passed on and abided by all organizations listed in the Vitamin Angels Grant Request. | Yes  No |

### **Submission**

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| --- | --- |
| Organization Name: | **Submit application, NGO registration and FCRA certificate to:** [**smenon@vitaminangels.org**](mailto:smenon@vitaminangels.org)**,** [**pratap@vitaminangels.org**](mailto:pratap@vitaminangels.org) |
| Primary Contact Name: |
| Title: |
| Date: |
| **Original Signature and Stamp (required):** |