



FREDERICK

HOUSING & HUMAN SERVICES

September 9, 2026

Maryland State Clearinghouse
Maryland Department of Planning

RE: Executive Order 12372 Intergovernmental Review – HRSA FY2027 Expanding Nutrition Services (HRSA-27-099)

Dear Maryland State Clearinghouse:

The City of Frederick, through the Department of Housing and Human Services and the City of Frederick Community Health Center, is submitting the enclosed application materials for review under Executive Order 12372 and Maryland's intergovernmental review process.

The City is applying to the Health Resources and Services Administration for FY2027 Expanding Nutrition Services funding (HRSA-27-099). The proposed project will expand access to nutrition services for Community Health Center patients in Frederick County, Maryland, including clinical nutrition services, nutrition-related care coordination, food-access support, and nutrition services for pediatric patients at the Hillcrest School-Based Health Center.

The City is requesting \$350,000 in federal funding for the first budget year and \$700,000 over the two-year project period. The proposed period of performance is December 1, 2026, through November 30, 2028.

Enclosed are materials describing the proposed project, budget, service area, staffing, and other information relevant to Clearinghouse review. The City's federal application is due to the Health Resources and Services Administration on September 9, 2026.

Thank you for your review. If any additional information is required, please contact me at rwelton@cityoffrederickmd.gov or 703-839-0022.

Sincerely,

Robert Welton

Robert Welton
Grants Manager
Department of Housing and Human Services
City of Frederick

HRSA-27-099 Expanding Nutrition
HRSA-27-099 – PKG00293608
Workspace ID: WS01746366

Project Narrative

NEED

1. Need for Expanded Nutrition Services

The City of Frederick Community Health Center (CFCHC) serves a patient population that would benefit from expanded access to dedicated nutrition services to prevent and manage chronic disease. CFCHC's 2025 Uniform Data System (UDS) data demonstrate both an existing foundation for identifying nutrition-related health risks and an opportunity to strengthen services after those risks are identified. For UDS Table 6B, Line 12, Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents, 355 of 490 eligible patients met the measure (approximately 72.4 percent). For Table 6B, Line 13, Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan, 645 of 744 eligible patients met the measure (approximately 86.7 percent). These results demonstrate an established foundation for weight assessment, nutrition and physical-activity counseling, BMI screening, and follow-up while identifying opportunities to strengthen nutrition-related prevention and intervention.

Nutrition-related chronic conditions are present among CFCHC patients and throughout the surrounding service area. CFCHC's 2025 UDS documents patients diagnosed with diabetes mellitus, hypertension, overweight and obesity, and heart disease. At the community level, the 2025 Frederick County Community Health Needs Assessment (CHNA) reports that 32.8 percent of Frederick County adults were obese in 2022, up from 27.0 percent in 2020, while 9.7 percent had been diagnosed with diabetes, up from 7.3 percent in 2021. These conditions are responsive to prevention and management strategies that include improved nutrition, healthy eating behaviors, and appropriate clinical nutrition intervention.

Access to adequate, nutritious food is another challenge. Feeding America's 2024 *Map the Meal Gap* estimates that 36,330 Frederick County residents, or 12.7 percent of the population, experience food insecurity, with an estimated annual food-budget shortfall of approximately \$27.8 million. Feeding America further estimates that 62 percent of food-insecure Frederick County residents have incomes above the SNAP threshold used in its analysis, demonstrating that food-access challenges extend beyond populations traditionally identified through eligibility

for nutrition-assistance programs.¹ This finding aligns with broader measures of financial hardship: in 2023, 35,557 Frederick County households, or 33 percent of all households, were below the ALICE Threshold—either living in poverty or earning above the Federal Poverty Level but not enough to afford the basic costs of living.²

These conditions are particularly relevant to CFCHC's patient population. Among CFCHC patients for whom income was known in the 2025 UDS, approximately 96 percent had household incomes at or below 200 percent of the Federal Poverty Level.³ For these patients, managing chronic disease through healthy eating may be complicated by the affordability and availability of nutritious foods. CFCHC's location within HHS provides an important foundation for addressing these interconnected clinical and social needs through existing primary care, health education, case management, outreach, and other enabling services.

Despite this foundation, CFCHC currently lacks dedicated clinical nutrition-service capacity. Its 2025 UDS reports no dedicated registered dietitian/nutritionist FTEs, nutrition visits, or nutrition patients, and Nutrition is not currently included as an approved service on CFCHC's Form 5A. This creates an identifiable gap between CFCHC's ability to screen for nutrition-related risk and provide basic nutrition guidance within primary care and its ability to connect patients consistently with dedicated services such as nutritional assessment and treatment, medical nutrition therapy when appropriate, individualized counseling and education, and ongoing nutrition intervention and follow-up.

ENS funding will allow CFCHC to close this gap by integrating dedicated nutrition services into an established primary-care system serving patients with documented economic vulnerability, food-access challenges, and nutrition-related chronic-disease risk. Rather than creating a stand-alone service disconnected from existing care, the proposed expansion will build upon CFCHC's existing screening, primary-care, care-coordination, and enabling-service infrastructure to create a stronger continuum from risk identification to specialized nutrition intervention, food-access support, follow-up, and chronic-disease prevention and management.

2. Health Center Workforce Challenges

CFCHC's principal workforce challenge in expanding nutrition services is the absence of dedicated nutrition-service capacity within its current staffing model. As documented in the 2025 UDS, CFCHC reported no registered dietitian/nutritionist FTEs, nutrition visits, or nutrition

¹ Feeding America, [Map.the.Meal.Gap;Frederick.County?Maryland](#), 2024, accessed August 31, 2026.

² United Way of Frederick County and United For ALICE, [The.State.of.ALICE.in.Frederick.County;868](#) Update on Financial Hardship (2025), 2.

³ City of Frederick Community Health Center, 868 Uniform.Data.System.Report, Table 4, "Selected Patient Characteristics."

patients.⁴ Although its existing clinical and enabling-services workforce provides a strong foundation for identifying nutrition-related risks and addressing patients' broader health and social needs, CFCHC currently lacks sufficient specialized nutrition capacity to provide nutritional assessment, individualized counseling, medical nutrition therapy when appropriate, and sustained nutrition-focused follow-up.

This gap limits CFCHC's ability to move consistently from identification of nutrition-related risk to specialized intervention. Existing providers must address nutrition within broader clinical responsibilities, while patients who would benefit from more intensive nutrition services currently lack a consistent pathway to dedicated nutrition care through CFCHC. Expanding access therefore requires both specialized nutrition expertise and the infrastructure necessary to integrate that expertise into the patient's broader care.

Integration presents an additional workforce challenge. Primary-care and enabling-services staff need clear processes to identify appropriate patients, make and track referrals, coordinate with nutrition professionals, incorporate nutrition-service information into the medical record, support patient engagement and follow-up, and connect patients with food-access resources when social needs affect their ability to implement nutrition recommendations. CFCHC's existing case-management capacity must continue to support a broad range of patient needs. It cannot independently absorb the additional enrollment, referral, and care-coordination workload associated with a substantial expansion of nutrition services.

CFCHC must also strengthen the skills and knowledge of its broader workforce, so expanded nutrition services integrate into routine patient care rather than functioning as an isolated specialty service. ENS provides an opportunity to strengthen staff capacity to identify nutrition and food-access risks, make appropriate referrals, reinforce nutrition care plans, and coordinate nutrition interventions with chronic-disease management and available community resources.

Through ENS, CFCHC proposes to address these interconnected workforce challenges by expanding access to specialized nutrition expertise while strengthening the referral, care-coordination, workforce-development, and enabling-service infrastructure needed to integrate nutrition services into primary care. This approach will expand access to specialized nutrition intervention while building the interdisciplinary capacity necessary to sustain nutrition-focused care throughout the health center.

RESPONSE

1. Proposed Nutrition Services Expansion

⁴ City of Frederick Community Health Center, 868 Uniform.Data.System.Report, Table 5, "Staffing and Utilization," Line 22.

a. Increasing Nutrition Services Patients and/or Visits

CFCHC will use ENS funding to establish the clinical and care-coordination infrastructure needed to integrate expanded nutrition services into its primary-care delivery system for both adult and pediatric patients. ENS funding will support a full-time contracted pediatric nutritionist who will provide dedicated nutrition services to children and adolescents served through the Hillcrest School-Based Health Center. For adult patients, CFCHC will partner with Luro Health, which will provide access to virtual nutrition professionals offering nutrition assessment, individualized nutrition counseling and education, clinical weight-management and chronic-disease support, and structured longitudinal follow-up. Luro will provide these adult clinical nutrition services without using ENS funds, allowing CFCHC to leverage the partnership while directing ENS resources toward pediatric nutrition services, care coordination, food-access support, referral and patient-engagement systems, training, and other infrastructure needed to expand access to nutrition services.

CFCHC will develop a new nutrition referral workflow integrated into the electronic health record. Primary-care providers and other appropriate clinical staff will identify patients who may benefit from nutrition services based on clinical history, chronic-disease status, screening results, weight or BMI-related risk, and other identified nutrition needs. ENS-supported care coordination will facilitate outreach and enrollment, help patients access the appropriate adult or pediatric nutrition service, address barriers to participation, and support communication between CFCHC providers and nutrition professionals. Relevant nutrition-service information and outcomes will be incorporated into the patient's medical record so nutrition services complement, rather than operate separately from, the patient's ongoing primary care.

The project will provide opportunities for initial nutrition assessment and sustained follow-up. Nutrition care may include individualized counseling and education, chronic-disease-focused nutrition intervention, weight-management support, goal setting, meal-planning education, and other services appropriate to the patient's clinical needs. CFCHC will also incorporate patient education and practical skill-building activities, including opportunities to strengthen patients' ability to select and prepare healthy meals. ENS-supported staff training, food-access interventions, and care coordination will reinforce these clinical services and help patients remain engaged in recommended nutrition care.⁵

CFCHC anticipates serving 125 unduplicated patients through 375 nutrition-service visits in Year 1 and 250 unduplicated patients through 850 nutrition-service visits in Year 2. CFCHC

⁵ Health Resources and Services Administration, "ENS Frequently Asked Questions," Bureau of Primary Health Care, last reviewed August 2026, accessed September 1, 2026.

will monitor enrollment, service utilization, referral completion, follow-up participation, and other available utilization measures throughout implementation. Luro will provide CFCHC with participation, utilization, follow-up, and longitudinal outcome data, allowing CFCHC to assess whether the expanded model increases access and identify opportunities to improve referral completion, patient engagement, retention, and service delivery.

b. Prevention and Management of Chronic Conditions

CFCHC will integrate expanded nutrition services into its primary-care model to strengthen the prevention and management of nutrition-related chronic conditions, with a particular focus on diabetes and hypertension. Adult patients identified through clinical assessment, screening, referral, or chronic-disease management activities will access virtual nutrition professionals through Luro Health. In contrast, pediatric patients needing dedicated nutrition intervention will access the ENS-funded pediatric nutritionist at Hillcrest. Services will be individualized to patients' clinical needs. They will complement their medical care by helping them understand and implement dietary changes that support disease prevention, treatment, and long-term health.⁶

For patients with diabetes or hypertension, nutrition services will include individualized nutrition assessment, counseling and education, goal setting, weight-management support when clinically appropriate, and longitudinal follow-up. Nutrition professionals will document nutrition care and relevant progress so that information can be incorporated into the patient's medical record and coordinated with CFCHC providers. This bidirectional communication will allow nutrition interventions to reinforce the patient's broader treatment plan rather than operate as a separate service.

CFCHC will also use expanded nutrition services preventively for patients with identifiable nutrition-related risk factors who have not yet developed, or are at risk for progression of, chronic disease. Existing weight assessment, BMI screening, primary-care encounters, and other clinical information will provide opportunities to identify patients who could benefit from earlier nutrition intervention. Rather than waiting for modifiable risk factors to progress, CFCHC will connect appropriate patients with individualized nutrition education, counseling, and follow-up designed to support healthier behaviors.

Clinical nutrition services will be reinforced through practical education and food-access strategies. Patient education may include meal-planning and food-preparation skills that help patients translate nutrition recommendations into healthy meals they can prepare themselves. CFCHC also proposes an ENS-supported Produce Rx intervention through which eligible

⁶ Health Resources and Services Administration, Fiscal Year 2026. [Expanding Nutrition Services? HRSA_83655](#) (2026), "Program Description."

participating patients may receive produce boxes or similar healthy-food support when the food is specifically incorporated into their individualized prevention or treatment plan. Nutrition counseling and follow-up will help patients connect the healthy-food intervention to identified clinical goals. Because ENS-funded food must be specific to patient prevention and treatment plans and approved by HRSA, CFCHC will administer the intervention in accordance with HRSA requirements.⁷

Through this integrated approach, CFCHC will strengthen the continuum from nutrition-risk identification to individualized clinical intervention, practical skill building, food-access support, and follow-up. For participating patients with diabetes and hypertension, CFCHC will monitor clinically appropriate outcomes, including HbA1c, blood pressure, and weight, allowing the health center to assess whether expanded nutrition services contribute to improved chronic-disease prevention and management.

c. Coordinating Care for Patients with Inconsistent Access to Nutritious Foods

CFCHC recognizes that clinical nutrition recommendations are most effective when patients have meaningful access to the foods needed to implement them. As documented in the Need section, food insecurity and financial hardship affect a significant portion of the surrounding community, while approximately 96 percent of CFCHC patients with known income are at or below 200 percent of the Federal Poverty Level. Accordingly, expanded nutrition services will address both patients' clinical nutrition needs and barriers that may limit their ability to follow recommended nutrition plans.

As part of ENS implementation, CFCHC will establish a standardized process for identifying food-access barriers among participating patients. CFCHC does not currently use a standardized food-insecurity screening tool; the project will therefore strengthen the health center's infrastructure by incorporating systematic food-insecurity screening into the expanded nutrition-service pathway. Screening results, clinical information, and information identified during nutrition encounters will help the care team determine when patients require food-access support in addition to clinical nutrition intervention.

ENS-supported care coordination will connect these activities across the patient's care pathway. The Case Manager/Referral Coordinator will support patient enrollment, referral completion, communication with Luro, and follow-up. At the same time, the Food Bank Liaison/Coordinator will coordinate food-access assistance for participating patients. The Food Bank Liaison/Coordinator will serve as a point of connection between clinical nutrition care and available food resources, coordinate eligible patients' access to food support, and

⁷ Health Resources and Services Administration, "ENS Frequently Asked Questions."

track utilization. Luro's proposed partnership framework identifies these functions as mechanisms to ensure food-access assistance is delivered and tracked, rather than relying solely on informal referrals.

CFCHC's location within HHS provides an existing foundation for this coordination. Patients experiencing food-access barriers may be connected with HHS food resources, including the Food Bank and Community Table, as appropriate to their needs. CFCHC will also refer patients to appropriate community food resources to expand the options available to them. CFCHC will coordinate information about food-access barriers and resulting referrals with the patient's broader nutrition and primary-care plan so nutrition recommendations reflect foods the patient can realistically obtain and afford.

The proposed Produce Rx intervention will provide an additional strategy for patients whose ability to implement their individualized nutrition plan is constrained by access to healthy foods. When clinically appropriate and consistent with HRSA requirements, eligible participating patients may receive produce boxes or similar healthy-food support specifically tied to their prevention or treatment plans. Nutrition professionals and CFCHC providers will reinforce the relationship between the food provided, the patient's nutrition goals, and management or prevention of conditions such as diabetes and hypertension. Patient progress and use of the intervention will be monitored during follow-up with the nutrition professional and CFCHC provider.

Through these coordinated strategies, CFCHC will create a pathway linking food insecurity identification, clinical nutrition services, individualized food-access support, and follow-up. This approach will help ensure that patients with inconsistent access to nutritious food receive not only recommendations about healthier eating, but also practical support that improves their ability to act on those recommendations.

d. Workforce Skills and Knowledge

CFCHC will use ENS funding to strengthen the skills and knowledge of its existing clinical and enabling-services workforce so that expanded nutrition services integrate into routine patient care. Workforce development will focus on improving staff capacity to identify nutrition-related and food-access risks, make appropriate referrals, reinforce nutrition recommendations, and coordinate nutrition interventions with patients' broader chronic-disease care.

A principal workforce-development activity will be diabetes educator certification for appropriate CFCHC clinicians.⁸ Because diabetes is one of the project's priority chronic conditions, this investment will strengthen clinicians' knowledge and skills related to diabetes prevention and management and improve their ability to reinforce nutrition and self-management goals as part of ongoing primary care. ENS-supported training will complement, rather than replace, the specialized virtual nutrition services available through Luro.

CFCHC will also train appropriate staff to screen for food insecurity and respond to identified food-access needs. As described in Section 1(c), CFCHC does not currently use a standardized food-insecurity screening tool. Training will therefore accompany implementation of the new screening process so that staff understand how to administer the selected screening approach, interpret results, initiate appropriate referrals, and connect patients with the Food Bank Liaison/Coordinator, Produce Rx intervention, HHS food resources, and other available supports.

The Luro partnership will provide an additional opportunity for knowledge transfer. Nutrition professionals serving CFCHC patients will provide staff education, case consultation, guidance, and technical support as appropriate. This collaboration will help primary-care and enabling-services staff better understand nutrition-related care needs, reinforce individualized nutrition plans between nutrition visits, and coordinate effectively with the virtual nutrition team.

Together, these workforce-development activities will extend ENS's impact beyond individual nutrition encounters. By strengthening diabetes-related expertise, food-insecurity screening and response, referral practices, interdisciplinary coordination, and staff access to nutrition expertise, CFCHC will build broader organizational capacity to incorporate nutrition into chronic-disease prevention and management throughout the health center.

2. Quality Improvement Plan

CFCHC will integrate the ENS project into its existing quality-improvement processes and use project data to monitor implementation, assess patient engagement and outcomes, identify barriers, and make adjustments throughout the two-year performance period. Project performance will be reviewed quarterly, and findings will be used to refine referral, care-coordination, patient-engagement, food-access, and service-delivery processes.

⁸ Health Resources and Services Administration, "ENS Frequently Asked Questions."

CFCHC will monitor a combination of service-utilization, process, and clinical measures. Service-utilization measures will include unduplicated patients receiving nutrition services and nutrition-service visits, with progress assessed against the established targets of 125 patients and 375 visits in Year 1 and 250 patients and 850 visits in Year 2. Process measures will include patient enrollment, referrals and referral completion, participation in follow-up nutrition services, retention in nutrition care, food-insecurity screening, and connection to food-access supports such as the Produce Rx intervention and HHS food resources.

Clinical measures will focus on the project's principal chronic-disease priorities and will be assessed when clinically appropriate for participating patients. These measures will include HbA1c among patients with diabetes, blood pressure among patients with hypertension, and weight-related outcomes. CFCHC will also continue to monitor applicable UDS quality measures, including Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents and Preventive Care and Screening: BMI Screening and Follow-Up Plan.

Data will be drawn from CFCHC's electronic health record and existing clinical and quality-improvement systems, supplemented by information provided through the Luro partnership. Luro will provide data on patient participation, service utilization, follow-up, and longitudinal outcomes. CFCHC will incorporate relevant information from nutrition encounters into the patient's medical record and use available project data to evaluate both individual patient progress and overall program performance.

Quarterly review will focus not only on whether targets are being achieved, but also on identifying where patients encounter barriers within the nutrition-care pathway. For example, lower-than-anticipated referral completion may indicate a need to modify outreach, enrollment, scheduling, or care-coordination procedures. Low participation in follow-up services may indicate a need for additional patient engagement or assistance addressing telehealth barriers. Patterns in food-insecurity screening and food-resource utilization may inform adjustments to Produce Rx, Food Bank coordination, or other food-access strategies. Trends in HbA1c, blood pressure, weight, and other appropriate clinical measures will help CFCHC assess whether nutrition interventions are contributing to improved chronic-disease prevention and management.

CFCHC will use findings from these reviews to make targeted improvements throughout the award period and assess whether changes produce better results in subsequent quarters. This continuous quality-improvement approach will allow CFCHC to strengthen the nutrition-service model as implementation proceeds while building effective workflows and practices that can be incorporated into ongoing patient care.

3. Equipment and/or Minor A/R

Not Applicable. CFCHC is not requesting ENS funding for equipment or minor alteration/renovation activities.

COLLABORATION

1. Collaboration with Nutrition and Health Partners

CFCHC will implement the ENS project through collaboration with clinical, food-access, and technical-assistance partners that complement the health center's role as the patient's primary-care home. These relationships will expand access to nutrition expertise, strengthen connections between clinical care and food resources, and support integration of nutrition services into CFCHC's existing clinical and enabling-services infrastructure.

Luro Health will serve as a principal clinical nutrition partner. Through this partnership, CFCHC patients will have access to virtual nutrition professionals who can provide individualized nutrition assessment, counseling and education, clinical weight-management and chronic-disease support, and longitudinal follow-up. CFCHC will maintain responsibility for identifying and referring appropriate patients, supporting enrollment and continued engagement, coordinating nutrition services with primary care, and incorporating relevant nutrition information into the patient's medical record. Luro will provide participation, utilization, follow-up, and longitudinal outcome information to support CFCHC's monitoring and quality-improvement activities. This partnership allows CFCHC to leverage specialized virtual nutrition expertise. At the same time, ENS resources support the health center staff, workflows, patient engagement, food-access interventions, and workforce development necessary to integrate expanded nutrition services into patient care.

Within HHS, CFCHC will coordinate with programs that address food access and other barriers affecting patients' ability to implement nutrition recommendations. This includes the HHS Food Bank and Community Table, as well as case management and outreach services that can help identify and address barriers affecting patient health. The ENS-supported Food Bank Liaison/Coordinator will strengthen this coordination by providing a defined connection between the clinical nutrition pathway and available food-access assistance. Specific patient referral and linkage processes are described in Collaboration Question 2.

CFCHC will also collaborate with community organizations that can extend the reach and effectiveness of expanded nutrition services. Farm to School Frederick's Veggie Van is one such community resource, increasing access to locally grown fresh produce throughout Frederick

County.⁹ CFCHC will use appropriate community relationships and referral resources to complement individualized nutrition services and provide patients with practical opportunities to obtain foods consistent with their nutrition and chronic-disease management goals.

Finally, CFCHC will leverage the expertise of the Mid-Atlantic Association of Community Health Centers (MACHC), its Primary Care Association, and other applicable Health Center Program technical-assistance resources. CFCHC will use relevant training, technical assistance, and shared-learning opportunities to support implementation of expanded nutrition services, workforce development, workflow integration, and continuous improvement throughout the project period.

2. Linking Patients to Healthy Food Resources

CFCHC will connect expanded clinical nutrition services with food-access resources so that patients who have difficulty obtaining nutritious foods receive practical support alongside individualized nutrition care. As described in the Response section, CFCHC will implement a standardized process for identifying food-access barriers among participating patients and incorporate food-insecurity screening into the expanded nutrition-service pathway. When CFCHC staff identify a food-access need, they will connect the patient with resources appropriate to the patient's needs and nutrition care plan.

The ENS-supported Case Manager/Referral Coordinator and Food Bank Liaison/Coordinator will serve as the primary link between clinical nutrition services and food-access resources. The Case Manager/Referral Coordinator will help coordinate identified needs across the patient's care team. At the same time, the Food Bank Liaison/Coordinator will connect patients with appropriate food resources, assist with referrals and eligibility processes as needed, and track utilization of food-access assistance. Nutrition professionals and CFCHC providers will reinforce these connections during follow-up so that food-access support remains coordinated with the patient's clinical nutrition and chronic-disease management goals.

CFCHC will leverage existing HHS food-access resources, including the Food Bank and Community Table, and connect patients with appropriate community resources such as Farm to School Frederick's Veggie Van. Rather than relying solely on providing resource information, CFCHC will establish referral and follow-up processes designed to help patients successfully connect with available healthy-food resources. The Food Bank Liaison/Coordinator will serve as a point of contact for this process and help identify barriers that may prevent patients from accessing recommended resources.

⁹ Farm to School Frederick, "Veggie Van," accessed September 2, 2026, <https://www.f2sfrederick.org/f2s-veggie-van>.

CFCHC's proposed Produce Rx intervention will provide an additional way to connect eligible participating patients with healthy foods. When clinically appropriate and consistent with HRSA requirements, CFCHC may incorporate produce boxes or similar healthy-food support into individualized prevention or treatment plans. The Food Bank Liaison/Coordinator will help coordinate access and track utilization. At the same time, nutrition professionals and CFCHC providers will reinforce the relationship between the food provided, the patient's nutrition goals, and prevention or management of conditions such as diabetes and hypertension.

CFCHC will incorporate referral and follow-up information into its care-coordination processes and, where appropriate, the patient's electronic health record. This closed-loop approach will create a coordinated pathway from identification of a food-access barrier to referral, connection with an appropriate healthy-food resource, and follow-up as part of the patient's broader nutrition care plan.

3. Alignment with Other Federal Programs and Avoidance of Duplication

CFCHC will implement ENS in coordination with existing federal nutrition-assistance and chronic-disease prevention programs available to Frederick County residents. ENS will address a distinct need within CFCHC's delivery system by expanding access to individualized clinical nutrition services, integrating nutrition intervention with primary care, strengthening food-insecurity screening and care coordination, and linking patients with food-access resources. The project will complement rather than replace benefits, services, or interventions available through other federally supported programs.

Federal nutrition-assistance programs operating in the service area include the Supplemental Nutrition Assistance Program (SNAP) and the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC). Frederick County's WIC program provides eligible pregnant and postpartum women, infants, and children with nutrition education, healthy supplemental foods, breastfeeding support, and referrals.¹⁰ Frederick County also participates in the USDA-funded Farmers' Market Nutrition Program, through which eligible WIC participants receive benefits to purchase fresh fruits and vegetables at participating farmers' markets.¹¹ ENS funds will not replace or duplicate these benefits. Instead, CFCHC will identify patients' clinical nutrition and food-access needs, connect eligible patients with existing assistance programs when appropriate, and use ENS-supported services to address needs that extend beyond those programs.

¹⁰ Frederick County Health Department, "WIC," accessed September 9, 2026, <https://health.frederickcountymd.gov/200/WIC>.

¹¹ Frederick County Health Department, "Farmers' Market Nutrition Program," accessed September 9, 2026, <https://health.frederickcountymd.gov/726/Farmers-Market-Nutrition-Program>.

CFCHC will similarly coordinate its nutrition services with existing diabetes-prevention and management resources. National Diabetes Prevention Program and diabetes self-management resources are available within Frederick County.¹² CFCHC's ENS project will not duplicate these structured programs. Rather, CFCHC will provide an integrated pathway connecting primary care, individualized nutrition intervention, food-access support, and follow-up, while referring patients to appropriate community-based prevention or self-management programs when those services complement the patient's care plan.

The proposed Produce Rx intervention will also be structured to avoid duplication of existing federal food benefits or nutrition incentives. When healthy-food support is incorporated into an individualized prevention or treatment plan, CFCHC will coordinate that intervention with the patient's existing resources and apply ENS funding only in accordance with HRSA requirements. The intervention will help patients implement clinically appropriate nutrition recommendations, not substitute for SNAP, WIC, Farmers' Market Nutrition Program benefits, or other available federal nutrition assistance.

Through this approach, ENS funding will fill an identified clinical and care-coordination gap while leveraging existing federal and community resources. CFCHC will use screening, referral, care coordination, and follow-up to connect patients with appropriate existing programs and reserve ENS-supported activities for the expanded nutrition services and related supports necessary to achieve the project's objectives.

IMPACT

1. Impact During the Two-Year Period of Performance

a. Nutrition Services Patients and/or Visits

CFCHC will measure the impact of the ENS project by tracking growth in both the number of patients receiving nutrition services and the number of nutrition-service visits provided over the two-year performance period. CFCHC's 2025 UDS reported no dedicated registered dietitian/nutritionist staffing, patients, or visits, establishing a baseline from which the health center can measure the expansion of dedicated nutrition-service capacity.

CFCHC anticipates serving 125 unduplicated patients through 375 nutrition-service visits in Year 1 and 250 unduplicated patients through 850 nutrition-service visits in Year 2. These targets reflect both expansion in the number of patients reached and increased opportunity for longitudinal nutrition care through initial and follow-up encounters. Adult patients will

¹² Maryland Department of Health, "Diabetes Self-Management Education and Support (DSMES) Locator," accessed September 9, 2026, <https://health.maryland.gov/phpa/ccdpc/Pages/DSMES-Locator.aspx>.

access virtual nutrition professionals through Luro Health, while pediatric patients will access the ENS-funded pediatric nutritionist at Hillcrest. ENS-supported care coordination, referral, patient engagement, food access, and workforce development activities will support successful connection to and continued participation in nutrition services.

CFCHC will track nutrition-service patients and visits throughout implementation and review progress quarterly as part of the quality-improvement process described in the Response section. CFCHC will use utilization data to identify barriers affecting patient identification, referral completion, enrollment, engagement, and follow-up, and to guide adjustments when actual performance differs from established targets.

CFCHC will also report nutrition-service utilization through the applicable UDS measures. HRSA plans to add nutrition-services measures to UDS Table 5 and Table 6A beginning in 2027 and will use changes between 2027 and 2028 data to determine whether recipients have achieved the ENS objective.¹³ CFCHC will use these new measures, together with its internal project-monitoring data, to assess whether the expanded model is producing a measurable increase in access to nutrition services.

b. Other Measures Demonstrating Prevention and Management of Chronic Conditions

In addition to measuring increases in nutrition-services patients and visits, CFCHC will evaluate whether expanded nutrition services contribute to improved prevention and management of nutrition-related chronic conditions. Clinical measures will focus on the project's priority conditions and will be assessed when clinically appropriate for participating patients.

For patients with diabetes, CFCHC will monitor HbA1c to assess changes in glycemic control. For patients with hypertension, CFCHC will monitor blood pressure to assess changes in disease management. CFCHC will also monitor weight-related outcomes when clinically appropriate, including among patients receiving nutrition services for weight management or prevention of nutrition-related chronic disease. These measures will allow CFCHC to evaluate changes over time among participating patients rather than relying solely on service volume.

CFCHC will complement these clinical measures with process measures that demonstrate whether patients are successfully engaging in the expanded nutrition-care pathway. These measures will include referral completion, participation in initial and follow-up nutrition services, continued engagement in nutrition care, food-insecurity screening, and connection

¹³ Health Resources and Services Administration, "ENS Frequently Asked Questions."

to food-access supports when indicated. For patients participating in the proposed Produce Rx intervention, CFCHC will also track participation and utilization of healthy-food support as part of the patient's broader nutrition care plan.

CFCHC will review clinical and process measures quarterly through the quality-improvement process described in the Response section. Data from CFCHC's electronic health record and existing clinical and quality-improvement systems, supplemented by relevant information from Luro, will be used to assess patient progress and project performance. CFCHC will use these findings to identify barriers, refine referral and care-coordination processes, and determine whether expanded nutrition services are contributing to improved prevention and management of diabetes, hypertension, and other nutrition-related health risks.

2. Impact Beyond the Two-Year Period of Performance

a. Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents

CFCHC will assess the longer-term impact of expanded nutrition services by continuing to monitor the UDS measure for Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents. As described in the Need section, CFCHC's 2025 UDS reported that 355 of 490 eligible patients ages 3–17, or 72.4 percent, met this measure. This baseline provides an opportunity to assess whether the clinical capacity, referral pathways, workforce development, and nutrition-focused practices strengthened through ENS contribute to sustained improvement beyond the two-year performance period.

Through ENS, CFCHC will strengthen the pathway from pediatric weight assessment and identification of nutrition-related risk to appropriate counseling, referral, and follow-up. When pediatric patients are identified as needing additional nutrition support, CFCHC providers will connect them with the ENS-funded pediatric nutritionist serving Hillcrest through coordinated referral and documentation processes. Nutrition-related information and follow-up will be incorporated into the patient's medical record, allowing the primary-care team to reinforce appropriate nutrition and physical-activity recommendations during subsequent encounters.

ENS-supported workforce development will further strengthen CFCHC's capacity to address pediatric nutrition needs. Training, improved referral processes, and greater access to nutrition expertise will help clinical staff identify patients who may benefit from additional intervention and reinforce healthy nutrition and physical-activity behaviors as part of routine preventive care.

Beyond the ENS period of performance, CFCHC will continue to monitor performance on this UDS measure and compare results with the established 2025 baseline. Sustained improvement would provide evidence that the workflows, workforce knowledge, referral pathways, and nutrition-service capacity developed through ENS have become integrated into routine pediatric care.

b. BMI Screening and Follow-Up Plan

CFCHC will also assess the longer-term impact of expanded nutrition services by continuing to monitor the UDS measure for Preventive Care and Screening: BMI Screening and Follow-Up Plan. As described in the Need section, CFCHC's 2025 UDS reported that 645 of 744 eligible patients, or 86.7 percent, met this measure. This baseline demonstrates a strong existing foundation for BMI screening and appropriate follow-up planning while providing a benchmark for assessing whether ENS-supported improvements can be sustained and strengthened over time.

ENS will build on this foundation by strengthening CFCHC's capacity to identify patients for whom BMI screening indicates that appropriate follow-up may be warranted and connect them with expanded nutrition services. When appropriate, patients will be referred for individualized nutrition assessment, counseling, education, and follow-up, with nutrition care coordinated with the patient's primary-care plan. Improved referral workflows, access to nutrition expertise, and documentation of nutrition-related care in the medical record will help reinforce continuity between screening, intervention, and subsequent primary-care follow-up.

Workforce development will further support the sustainability of these improvements by strengthening staff knowledge of nutrition-related risk, chronic-disease prevention and management, and appropriate referral pathways. CFCHC's quarterly quality-improvement process will provide opportunities during the award period to identify gaps between screening, referral, and follow-up and refine workflows before they become incorporated into routine practice.

Beyond the two-year period of performance, CFCHC will continue to monitor the BMI Screening and Follow-Up Plan measure and compare performance with the established 2025 baseline. Sustained or improved performance, together with continued use of the referral and follow-up processes developed through ENS, will demonstrate that expanded nutrition-service capacity has become integrated into routine preventive and chronic-disease care.

c. Targeted Patient Health Outcomes

Beyond the two-year performance period, CFCHC will assess whether the expanded nutrition-service model contributes to sustained improvement in the patient health outcomes targeted through ENS. Consistent with the project's focus on preventing and managing nutrition-related chronic conditions, CFCHC will continue to monitor HbA1c among patients with diabetes, blood pressure among patients with hypertension, and weight-related outcomes when clinically appropriate.

During the ENS period, these measures will help CFCHC evaluate changes among participating patients receiving nutrition services. Longer term, CFCHC will use its electronic health record and existing clinical and quality-improvement systems to assess whether improvements achieved during nutrition intervention are sustained and whether the nutrition-focused practices developed through ENS continue to support chronic-disease prevention and management. Because patients will remain connected to CFCHC's primary-care system, providers can monitor relevant clinical outcomes during subsequent encounters and reinforce nutrition and self-management goals as part of ongoing care.

CFCHC will also assess the sustainability of the service-delivery practices that contribute to these outcomes. Continued use of nutrition referral and follow-up workflows, food-insecurity screening and response, coordination with food-access resources, and integration of nutrition information into the medical record will demonstrate whether the infrastructure developed through ENS has become embedded in routine patient care. CFCHC will use ongoing clinical and quality-improvement review to identify trends, determine whether adjustments are needed, and preserve effective practices beyond the federal award period.

Together, continued monitoring of HbA1c, blood pressure, weight-related outcomes, and applicable UDS measures will allow CFCHC to assess both the clinical and organizational legacy of the ENS investment. Sustained or improved patient outcomes, along with continued integration of nutrition services into primary care, will show that ENS has strengthened CFCHC's long-term capacity to prevent and manage nutrition-related chronic conditions.

CAPACITY

1. Skills, Expertise, and Organizational Capacity

CFCHC has the clinical, administrative, and organizational capacity necessary to implement and sustain expanded nutrition services through ENS. As a federally qualified health center, CFCHC operates an established primary-care delivery system serving patients with complex medical and socioeconomic needs. Its clinical infrastructure provides multiple opportunities to identify

nutrition-related risk through primary-care encounters, preventive screenings, chronic-disease management, and other patient interactions and to integrate nutrition services into patients' broader plans of care.

CFCHC's existing workforce and service structure provide a strong foundation for the proposed expansion. Primary-care providers and other clinical staff can identify patients who may benefit from individualized nutrition intervention and coordinate nutrition services with ongoing medical care. CFCHC also provides health education, case management, outreach, and other enabling services that can help address barriers affecting patients' ability to participate in care and implement nutrition recommendations. As part of HHS, CFCHC can further coordinate nutrition care with food-access and supportive resources, including the HHS Food Bank and Community Table.

The ENS project will build on this capacity through specialized nutrition expertise and strengthened internal care coordination. A full-time contracted pediatric nutritionist will provide dedicated nutrition services to children and adolescents served through Hillcrest. Through its partnership with Luro Health, CFCHC's adult patients will have access to virtual nutrition professionals providing individualized nutrition assessment, counseling and education, clinical weight-management and chronic-disease support, and longitudinal follow-up. ENS-supported Case Manager/Referral Coordinator and Food Bank Liaison/Coordinator functions will provide the internal infrastructure needed to identify and enroll patients, coordinate referrals and follow-up, address food-access needs, and connect nutrition services with the patient's broader care plan.

CFCHC will also strengthen its existing workforce through diabetes-focused training, including diabetes educator certification for appropriate clinicians and training on food-insecurity screening and response. Collaboration with Luro will provide additional opportunities for staff education, case consultation, guidance, and technical support. Together, these activities will increase CFCHC's clinical and enabling-services workforce's ability to identify nutrition-related needs, make appropriate referrals, reinforce individualized nutrition recommendations, and coordinate effectively with specialized nutrition services.

CFCHC has established systems for clinical documentation, data collection, UDS reporting, and quality improvement that can support implementation and evaluation of the expanded model. These systems will incorporate nutrition-service utilization, referrals, follow-up, food-access activities, and appropriate clinical outcomes, allowing project leadership to monitor implementation and make adjustments throughout the period of performance.

Together, CFCHC's established primary-care infrastructure, enabling services, HHS food-access resources, clinical and quality-improvement systems, ENS-supported care-coordination capacity, workforce development, and access to specialized nutrition expertise through Luro provide the

organizational foundation necessary to implement expanded nutrition services and integrate them into ongoing patient care.

2. Nutritional Screening and Risk Identification

CFCHC does not currently use a standardized screening tool specifically designed to assess patients' nutritional status or food insecurity. However, the health center routinely identifies nutrition-related risk through established primary and preventive care processes. Patient encounters provide opportunities to assess height, weight, BMI, chronic-disease diagnoses, and other clinical information relevant to nutritional health. CFCHC's performance on the UDS measures for Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents and Preventive Care and Screening: BMI Screening and Follow-Up Plan provides an existing foundation for identifying patients who may benefit from additional nutrition-related assessment or intervention.

CFCHC also uses patients' clinical histories and chronic-disease status to identify nutrition-related risk. Particular attention will be given to patients with or at risk for conditions such as diabetes and hypertension, for whom nutrition intervention can complement ongoing primary and chronic-disease care. These existing clinical indicators will help CFCHC identify and prioritize patients for referral as the expanded nutrition-service model is implemented.

Through ENS, CFCHC will strengthen this approach by establishing a more systematic pathway from risk identification to nutrition assessment, intervention, and follow-up. Primary-care providers and other appropriate staff will use screening results, clinical history, chronic-disease diagnoses, and other identified risk factors to determine when referral for expanded nutrition services is appropriate. Following referral, nutrition professionals, either the ENS-funded pediatric nutritionist or an adult nutrition professional available through Luro, will conduct an assessment appropriate to the patient's needs and use the findings to inform individualized nutrition counseling, education, intervention, and longitudinal follow-up.

The ENS project will also add a standardized process for identifying food-access barriers among participating patients. CFCHC will select and incorporate an appropriate food-insecurity screening approach into the expanded nutrition-service workflow and train staff to administer, interpret, and respond to referrals. When screening identifies inconsistent access to adequate nutritious food, the Case Manager/Referral Coordinator and Food Bank Liaison/Coordinator will help connect the patient with appropriate food-access supports while coordinating those services with the patient's nutrition and primary-care plan.

Information generated through clinical risk identification, food-insecurity screening, nutrition assessment, referrals, and follow-up will also inform continued development of the ENS

program. CFCHC will review patterns in identified nutrition risks, chronic conditions, food-access barriers, referrals, and service utilization to refine referral criteria, workforce training, patient education, food-access strategies, and other components of the expanded nutrition-service model.

3. Implementation, Monitoring, and Adaptation

CFCHC will use its existing clinical, administrative, and quality-improvement infrastructure to implement the ENS project, monitor progress, and make adjustments throughout the two-year performance period. Dr. Jacqueline Douge, CFCHC Clinical Director and ENS Project Director, will lead implementation in coordination with appropriate clinical and administrative staff, ENS-supported care-coordination personnel, and Luro Health. This structure will maintain clear responsibility for project oversight while integrating expanded nutrition services into CFCHC's existing patient-care system.

Initial implementation will focus on establishing the workflows and infrastructure necessary to connect patients effectively with expanded nutrition services. Activities will include defining roles and responsibilities; establishing standardized processes for patient identification, referral, enrollment, and follow-up; implementing a standardized approach to food-insecurity screening and response; establishing procedures for documentation and communication through the medical record; coordinating food-access referrals and the proposed Produce Rx intervention; and orienting and training appropriate CFCHC staff. CFCHC will also establish processes to collect the service-utilization, clinical, and process measures needed to evaluate project performance.

Throughout implementation, CFCHC will monitor progress through its existing quality-improvement processes, with formal project review conducted **quarterly**. Measures will include nutrition-services patients and visits; referrals and referral completion; participation in initial and follow-up nutrition services; continued patient engagement; food-insecurity screening and connection to food-access supports; and relevant clinical outcomes, including HbA1c, blood pressure, and weight when clinically appropriate. CFCHC will also monitor applicable UDS measures, including Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents and BMI Screening and Follow-Up Plan.

CFCHC will use its electronic health record, existing clinical and quality-improvement systems, and relevant information from Luro to assess performance. Project leadership and appropriate clinical, care-coordination, and quality-improvement staff will review these data to identify barriers affecting patient identification, referral completion, enrollment, engagement, follow-up, food access, service delivery, and patient outcomes.

CFCHC will use findings from ongoing monitoring to make targeted adjustments during the project period. For example, if patients are identified for nutrition services but do not successfully connect with services, CFCHC may modify referral, outreach, enrollment, scheduling, or follow-up processes. If food-insecurity screening identifies barriers that are not being effectively addressed through existing referral pathways, CFCHC can strengthen coordination with HHS and community food resources or refine the proposed Produce Rx intervention. Trends in clinical outcomes, service utilization, or UDS measures may similarly identify opportunities to modify patient education, staff training, care coordination, or other elements of the expanded nutrition-service model.

This continuous quality-improvement approach will allow CFCHC to respond to implementation challenges as they emerge, identify successful practices, and incorporate effective workflows into ongoing operations. By combining defined project leadership, quarterly performance review, clinical and process data, and the ability to adapt service delivery based on results, CFCHC will support both the effectiveness of the ENS project during the two-year period of performance and the sustainability of expanded nutrition-service capacity beyond the award.

Budget Narrative and Staff Justification Tables
City of Frederick Community Health Center
H80CS29007
FY2027 Expanding Nutrition Services (HRSA-27-099)

Personnel				
	Year 1		Year 2	
Object Class Category	Federal Request	Non-Federal Request	Federal Request	Non-Federal Request
No costs requested	\$0	\$0	\$0	\$0
Total Personnel	\$0	\$0	\$0	\$0

CFCHC does not request ENS funding for personnel costs. Existing CFCHC staff will provide project leadership and oversight without charging personnel costs to the ENS award. The Case Manager/Referral Coordinator, Food Bank Liaison/Coordinator, and Pediatric Nutritionist supported by ENS funds will be engaged as contracted personnel and are therefore included under Contractual, not Personnel.

Fringe Benefits				
	Year 1		Year 2	
Object Class Category	Federal Request	Non-Federal Request	Federal Request	Non-Federal Request
No costs requested	\$0	\$0	\$0	\$0
Total Fringe Benefits	\$0	\$0	\$0	\$0

CFCHC does not request ENS funding for fringe benefit costs. ENS-funded positions will be engaged as contracted personnel and are budgeted under Contractual; therefore, no fringe benefits are charged to the ENS award.

Travel				
	Year 1		Year 2	
Object Class Category	Federal Request	Non-Federal Request	Federal Request	Non-Federal Request
Project-related travel and training	\$5,000	\$0	\$5,000	\$0
Total Travel	\$5,000	\$0	\$5,000	\$0

CFCHC requests \$5,000 annually to support project-related travel and training for staff implementing ENS. Funds will support registration, transportation, lodging, and other allowable travel costs associated with relevant nutrition services training, conferences, and professional development opportunities. Travel will strengthen staff capacity to implement and sustain integrated nutrition services and will follow City of Frederick travel policies and applicable federal requirements. The \$5,000 annual amount is a planning estimate based on anticipated project-related training and travel needs; specific travel will be determined during implementation based on available training opportunities and project needs.

Equipment				
	Year 1		Year 2	
Object Class Category	Federal Request	Non-Federal Request	Federal Request	Non-Federal Request
No costs requested	\$0	\$0	\$0	\$0
Total Equipment	\$0	\$0	\$0	\$0

CFCHC does not request ENS funding for equipment costs.

Supplies				
	Year 1		Year 2	
Object Class Category	Federal Request	Non-Federal Request	Federal Request	Non-Federal Request
Teaching-kitchen supplies	\$10,000	\$0	\$10,000	\$0
Nutrition-class participation/education supplies	\$5,000	\$0	\$5,000	\$0
Nutrition education and program supplies	\$20,000	\$0	\$20,000	\$0
Total Supplies	\$35,000	\$0	\$35,000	\$0

CFCHC requests \$35,000 annually for supplies supporting nutrition education and patient engagement. Teaching-kitchen supplies (\$10,000 annually) will support approximately six cooking demonstrations, meal-planning activities, and food-preparation education sessions each year. Nutrition-class participation and education supplies (\$5,000 annually), including measuring cups and other small kitchen tools, will reinforce practical nutrition education and skills demonstrated during program activities. An additional \$20,000 annually will support nutrition education and program supplies needed to implement ENS activities across CFCHC service locations.

Contractual				
	Year 1		Year 2	
Object Class Category	Federal Request	Non-Federal Request	Federal Request	Non-Federal Request
Case Manager/ Referral Coordinator	\$75,000	\$0	\$75,000	\$0
Food Bank Liaison/Coordinator	\$75,000	\$0	\$75,000	\$0
Pediatric Nutritionist	\$75,000	\$0	\$75,000	\$0
EHR/Referral Workflow Configuration and Support	\$25,000	\$0	\$25,000	\$0
Total Contractual	\$250,000	\$0	\$250,000	\$0

CFCHC requests \$250,000 annually for contracted services necessary to implement and integrate expanded nutrition services. A full-time contracted Case Manager/Referral Coordinator (\$75,000 annually) will coordinate patient referrals, enrollment, outreach, follow-up, and connection to appropriate adult and pediatric nutrition services. A full-time contracted Food Bank Liaison/Coordinator (\$75,000 annually) will coordinate connections between eligible patients and healthy-food resources, support food-access referrals, and strengthen integration between CFCHC's clinical services and HHS food and nutrition resources.

A full-time contracted Pediatric Nutritionist (\$75,000 annually) will provide nutrition services to pediatric patients at the Hillcrest School-Based Health Center, including nutrition assessment, counseling and education, and follow-up appropriate to identified patient needs. Adult patients will access virtual nutrition professionals through CFCHC's partnership with Luro Health; ENS funds will not be used to contract with Luro Health.

CFCHC also requests \$25,000 annually for contracted EHR and referral-workflow configuration and support necessary to integrate nutrition screening, referrals, care coordination, and relevant nutrition-service information into existing clinical workflows and patient records. These investments will support coordinated delivery, monitoring, and quality improvement of ENS activities.

Contracted personnel costs are budgeted at \$75,000 per full-time contracted position annually based on anticipated costs for the scope and level of effort required for each role. EHR and referral-workflow support is budgeted at \$25,000 annually based on anticipated configuration and implementation needs. Final contractual arrangements will be established in accordance with City of Frederick procurement requirements and applicable federal requirements.

Construction				
	Year 1		Year 2	
Object Class Category	Federal Request	Non-Federal Request	Federal Request	Non-Federal Request
No costs requested	\$0	\$0	\$0	\$0
Total Construction	\$0	\$0	\$0	\$0

CFCHC does not request ENS funding for construction or minor alteration/renovation costs.

Other				
	Year 1		Year 2	
Object Class Category	Federal Request	Non-Federal Request	Federal Request	Non-Federal Request
Produce Rx/Healthy Food Support	\$60,000	\$0	\$60,000	\$0
Total Other	\$60,000	\$0	\$60,000	\$0

CFCHC requests \$60,000 annually to support a Produce Rx/healthy-food intervention for eligible participating patients with identified nutrition-related health needs. Funds will support access to healthy foods when clinically appropriate and connected to individualized prevention or treatment plans. The intervention will complement clinical nutrition services by helping address financial and food-access barriers that may otherwise limit patients' ability to implement nutrition recommendations. CFCHC will ensure that ENS-funded food purchases are necessary to accomplish the ENS objective and will obtain HRSA approval as required before using federal funds for these costs.

The \$60,000 annual allocation establishes the maximum amount available for eligible Produce Rx/healthy-food support during each budget year. Actual expenditures will be based on patient participation and approved program implementation.

Total Costs				
	Year 1		Year 2	
Object Class Category	Federal Request	Non-Federal Request	Federal Request	Non-Federal Request
Total Direct Costs	\$350,000	\$0	\$350,000	\$0
Total Indirect Costs	\$0	\$0	\$0	\$0
Total Costs	\$350,000	\$0	\$350,000	\$0

CFCHC requests \$350,000 in federal ENS funding in Year 1 and \$350,000 in Year 2, for a total federal request of \$700,000 over the two-year period of performance. No non-federal or indirect costs are included in the ENS project budget. There are no substantive budget changes between Year 1 and Year 2.

Staff Justification Tables

Year 1: Staff Justification Table					
Staff Name	Position Title	% FTE	Salary		Federal Amount Requested
			Full-Time Base	Adjusted Annual	
To be hired	Contracted Case Manager/Referral Coordinator	1.0	\$75,000	No Adjustment	\$75,000
To be hired	Contracted Food Bank Liaison/Coordinator	1.0	\$75,000	No Adjustment	\$75,000
To be hired	Contracted Pediatric Nutritionist	1.0	\$75,000	No Adjustment	\$75,000
Total Costs					\$225,000

For contracted positions, the amounts shown reflect the estimated annual cost of each full-time contract rather than City of Frederick employee salaries.

Year 2: Staff Justification Table					
Staff Name	Position Title	% FTE	Salary		Federal Amount Requested
			Full-Time Base	Adjusted Annual	
To be hired	Contracted Case Manager/Referral Coordinator	1.0	\$75,000	No Adjustment	\$75,000
To be hired	Contracted Food Bank Liaison/Coordinator	1.0	\$75,000	No Adjustment	\$75,000
To be hired	Contracted Pediatric Nutritionist	1.0	\$75,000	No Adjustment	\$75,000
Total Costs					\$225,000

Affected Areas Map



Area Affected by Project

The proposed project will serve patients of the City of Frederick Community Health Center (CFCHC) throughout Frederick County, Maryland. The attached map depicts Frederick County and the communities within CFCHC's service area that may benefit from expanded nutrition services supported through the HRSA Expanding Nutrition Services initiative.

Application for Federal Assistance SF-424

* 1. Type of Submission:

- ☐ Preapplication
☒ Application
☐ Changed/Corrected Application

* 2. Type of Application:

- ☐ New
☐ Continuation
☒ Revision

* If Revision, select appropriate letter(s):

E: Other (specify)

* Other (Specify):

Competing Supplement

* 3. Date Received:

Completed by Grants.gov upon submission.

4. Applicant Identifier:

H80CS29007

5a. Federal Entity Identifier:

5b. Federal Award Identifier:

H80CS29007

State Use Only:

6. Date Received by State:

7. State Application Identifier:

8. APPLICANT INFORMATION:

* a. Legal Name:

The City of Frederick

* b. Employer/Taxpayer Identification Number (EIN/TIN):

52-6000789

* c. UEI:

W6EPTJAJ14J9

d. Address:

* Street1:

100 S. Market Street

Street2:

* City:

Frederick

County/Parish:

Frederick County

* State:

MD: Maryland

Province:

* Country:

USA: UNITED STATES

* Zip / Postal Code:

21701-5527

e. Organizational Unit:

Department Name:

Housing and Human Services

Division Name:

CoF Community Health Center

f. Name and contact information of person to be contacted on matters involving this application:

Prefix:

* First Name:

Robert

Middle Name:

* Last Name:

Welton

Suffix:

Title:

Grants Manager

Organizational Affiliation:

City of Frederick HHS

* Telephone Number:

703-839-0022

Fax Number:

* Email:

rwelton@cityoffrederickmd.gov

Application for Federal Assistance SF-424

* 9. Type of Applicant 1: Select Applicant Type:

C: City or Township Government

Type of Applicant 2: Select Applicant Type:

Type of Applicant 3: Select Applicant Type:

* Other (specify):

* 10. Name of Federal Agency:

Health Resources and Services Administration

11. Assistance Listing Number:

93.224

Assistance Listing Title:

Health Center Program

* 12. Funding Opportunity Number:

HRSA-27-099

* Title:

Fiscal Year 2027 Expanding Nutrition Services

13. Competition Identification Number:

HRSA-27-099

Title:

Fiscal Year 2027 Expanding Nutrition Services

14. Areas Affected by Project (Cities, Counties, States, etc.):

Affected Areas Map.pdf

Add Attachment

Delete Attachment

View Attachment

* 15. Descriptive Title of Applicant's Project:

Expanding Nutrition Services (ENS) - CFCHC will expand integrated nutrition services for children and adults in Frederick County, Maryland.

Attach supporting documents as specified in agency instructions.

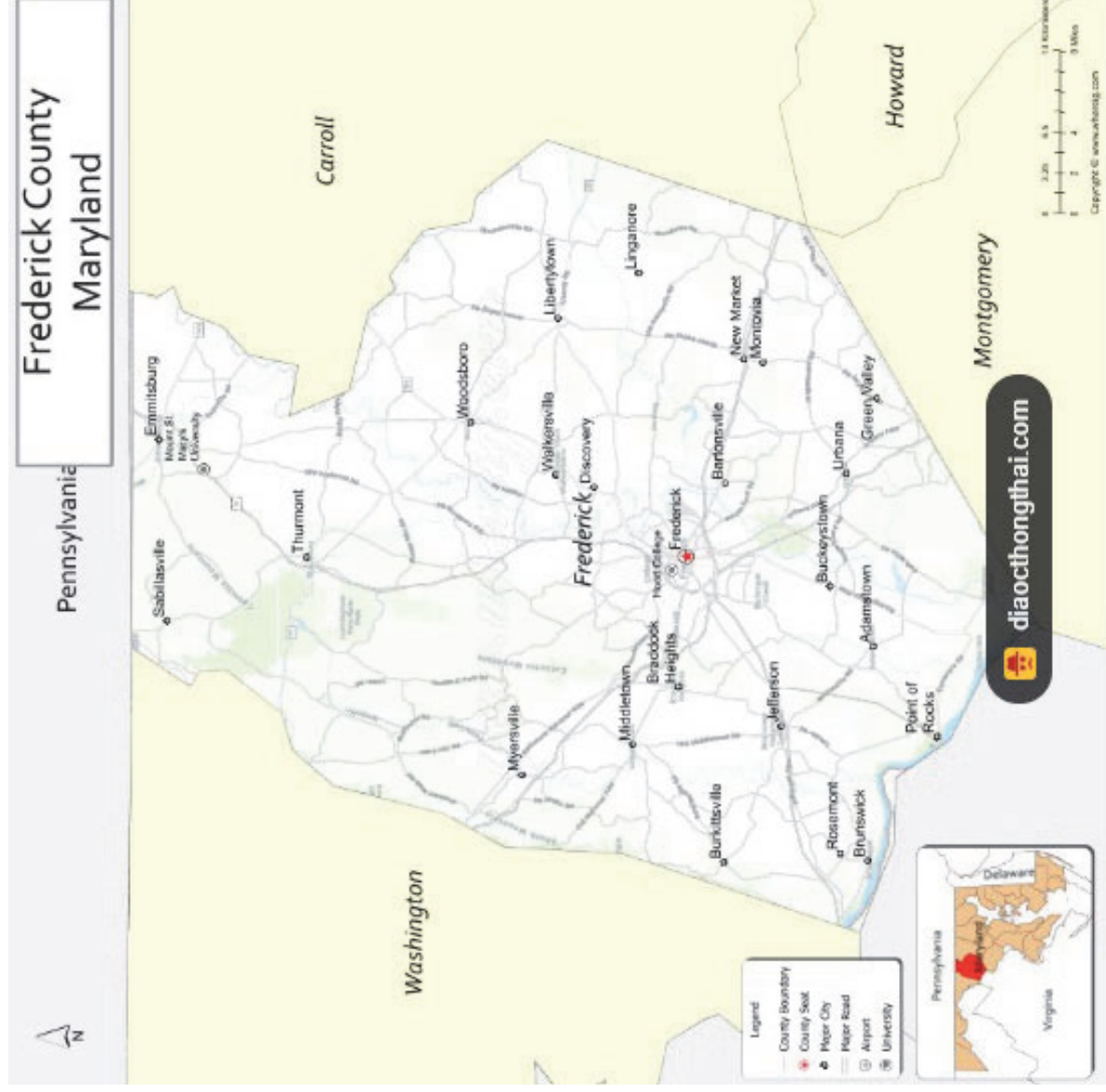
Add Attachments

Delete Attachments

View Attachments

Application for Federal Assistance SF-424			
16. Congressional Districts Of:			
* a. Applicant	MD-006	* b. Program/Project	MD-006
Attach an additional list of Program/Project Congressional Districts if needed.			
	Add Attachment	Delete Attachment	View Attachment
17. Proposed Project:			
* a. Start Date:	12/01/2026	* b. End Date:	11/30/2028
18. Estimated Funding (\$):			
* a. Federal	350,000.00		
* b. Applicant			
* c. State			
* d. Local			
* e. Other			
* f. Program Income			
* g. TOTAL	350,000.00		
* 19. Is Application Subject to Review By State Under Executive Order 12372 Process?			
☐	a. This application was made available to the State under the Executive Order 12372 Process for review on .		
☐	b. Program is subject to E.O. 12372 but has not been selected by the State for review.		
☐	c. Program is not covered by E.O. 12372.		
* 20. Is the Applicant Delinquent On Any Federal Debt? (If "Yes," provide explanation in attachment.)			
☐ Yes	☒ No		
If "Yes", provide explanation and attach			
	Add Attachment	Delete Attachment	View Attachment
21. *By signing this application, I certify (1) to the statements contained in the list of certifications** and (2) that the statements herein are true, complete and accurate to the best of my knowledge. I also provide the required assurances** and agree to comply with any resulting terms if I accept an award. I am aware that any false, fictitious, or fraudulent statements or claims may subject me to criminal, civil, or administrative penalties. (U.S. Code, Title 18, Section 1001)			
☒ ** I AGREE			
** The list of certifications and assurances, or an internet site where you may obtain this list, is contained in the announcement or agency specific instructions.			
Authorized Representative:			
Prefix:		* First Name:	Michael
Middle Name:			
* Last Name:	O'Connor		
Suffix:			
* Title:	Mayor, City of Frederick		
* Telephone Number:	301-600-1184	Fax Number:	
* Email:	moconnor@cityoffrederickmd.gov		
* Signature of Authorized Representative:	Completed by Grants.gov upon submission.	* Date Signed:	Completed by Grants.gov upon submission.

Affected Areas Map



Area Affected by Project

The proposed project will serve patients of the City of Frederick Community Health Center (CFCHC) throughout Frederick County, Maryland. The attached map depicts Frederick County and the communities within CFCHC's service area that may benefit from expanded nutrition services supported through the HRSA Expanding Nutrition Services initiative.