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COMMUNITY HEALTH INVESTMENT COMMITTEE MEETING

Monday, November 16, 2026

5:00pm – 6:30pm

A G E N D A

1. **Call to Order**

2. **Approval of Minutes –** September 14, 2026 Pg. 1-2

3. **Impact Partner Program: San Bruno Park School District**
   Presentation - Angelica Zermeno, Assistant Superintendent, Educational Services and Student Services and Amira Elmukhtar, Educational Services Program Coordinator Pg. 3-15

4. **Community Grant Application Review and Recommendations** Pg. 16-31
   a. Review Recommended Funding for Applicants
   b. Discuss Undecided Applications

5. **Final Board Recommendations: Receipts and Amounts**
   a. Grants Ceremony

6. **Committee Membership for 2027**

7. **Adjournment**

Community Health Investment Committee

Monday, September 14, 2026 Meeting Minutes

1. **Call to Order:** Chairman Sanchez called the meeting to order at 5:04pm. CHIC members present were Sanchez, Navarro, Martinez, Baker, Miran, and Mitchell.
   Members Absent: Bryan Neider
   Note: Bonnie Jue arrived at 5:15pm.
2. **Approval of Minutes:** July 20, 2026
   Motion to Approve the Consent Calendar
   Motion: By Director Navarro; Susan Baker
   Vote: 7-0.
   Outcome: Motion approved.
3. **Community Grants Program: Letters of Interest**

   2026-27 Community Grant Funding Summary

   - Total grant funding was increased to $5 million with $1.1 million allocated to prior impact partners, $3.75 million available for new grants, $100,00 for sponsorships, and $50,000 for health care workforce support funds.
   - There were 53 letters of interest received.
     - 38 LOIs were returning agencies with 15 new applicants.
     - 18 of the returning agencies were approved; 14 were up for further discussion, and 6 did not meet the criteria.
     - 6 of the new agencies were accepted, 7 were up for discussion, and 2 did not move forward.
   - Agencies that were considered “no” were due to two-year agencies confused about the criteria outlined for applying as a two-year agency as it relates to the safety net services and some lacked comprehensive answers in their applications.

   Application Review and Adjustments

   - Several agencies were asked to reduce funding requests based on resident served ratio.

- Other agencies were asked to focus their applications on single programs as outlined by the criteria and amend their budgets accordingly.

Process and Timeline

- Application review portal opens October 14
  - Application reviews due November 4
  - Review completion on November 16 meeting at 5pm
  - Board approval scheduled for December 10
- Reference materials from prior year applications to be provided.
  - Live spreadsheet for recommendations and rationales will be shared.

Discussion

Vice Chair Navarro noted that despite having the possibility of some funds leftover after going through the applications, the committee should be cautious and prepared due to post-election budget cuts. There are potential emergency meetings to support partners if needed.

CEO Pulido added that they will be monitoring agencies addressing food insecurity.

4. **Adjournment: 6:10pm**

Grant Application 27: San Bruno Park School District - 2027

Linked 2027 Profile

Linked 2027 LOI
San Bruno Park School District - Preventative Health

Admin Fields

Record Label
Preventative Health Grant- SBPSD

Organization Name
San Bruno Park School District

First Name
Anjelica

Last Name
Zermeno

Which application cycle are you applying for?
2027

2027 Application:

SUMMARY INFORMATION

Organization Name
San Bruno Park School District

Vision And Mission
The San Bruno Park School District educates and empowers all students to thrive academically, socially and emotionally and be contributing members of society.

Program Title
Preventative Health

Year program was established
1906

Program Description SAMPLE (150-word limit): This program uses three strategies to achieve improved youth mental health: group presentations by grade about adolescent development including mental health challenges and healthy coping strategies; school-based drop-in group counseling; and individual counseling to youth in grades 7-12. These are school-based services are provided at four San Mateo School District schools. Group counseling is led by licensed LMFT counselors who use evidence-based practices. One-on-one counseling is offered to youth who express the need for help on a feedback form distributed during group presentations and group counseling. PHCD funds will be used to maintain funding at all four schools and provide more individual counseling sessions by expanding hours of existing counselors.

Program description - refer to sample
SBPSD has developed a strong foundation of programs, partnerships and school based activities that can help establish larger, long term goals for improving student and family health and wellness. Our approach recognizes that student health is directly connected ti attendance, engagement and academic achievement. Through our community schools model, SBPSD has worked to reduce barriers to health and wellness by connecting students and families with preventive healthcare, mental health resources, dental and vision screening, vaccinations, food, and basic needs assistance. Moving forward, the district has an opportunity to build upon these efforts through a more comprehensive school based nursing and preventive health model.

Grant Focus Area (Select what you consider to be the PRIMARY area.)
Preventive Health Grants

Priority Area(s) (Select all that apply)
Health Education, Healthy Eating and Nutrition

Will requested funds launch, maintain or expand this program?
Expand

PROGRAM INFORMATION

Describe how your program aligns with PHCD's Vision and 2027 Grant Focus Areas.
San Bruno Park School District's program strongly aligns with Peninsula Health Care District's vision of creating a community where everyone has the opportunity to achieve optimal health and well-being. Our approach recognizes that student health, academic success, and family well-being are deeply interconnected. By bringing preventive health services, education, screenings, referrals, and care coordination directly to schools, we reduce barriers to care and create more equitable access for children and families who may otherwise go without needed services.

Our program particularly aligns with PHCD's **Preventive Health** focus area. Through school-based health supports, we aim to identify health concerns early, connect families to appropriate services, and strengthen health literacy. Priority activities include oral health and dental services, preventive screenings, health education, support with Medi-Cal enrollment and renewal, and coordination of community-based health resources. These services are especially important for families facing financial, language, transportation, or healthcare-access barriers.

The program also supports PHCD's **Mental and Behavioral Health** priorities by strengthening a whole-child approach to student wellness. School-based health coordination allows staff to recognize when physical health, behavioral health, adverse childhood experiences, or family circumstances may be affecting a student's attendance, engagement, and ability to learn. Students and families can then be connected to appropriate school and community-based resources before needs escalate.

Our work is grounded in **health equity and prevention**. Rather than waiting for families to navigate complex healthcare systems independently, we bring resources into trusted school settings and provide culturally responsive navigation and follow-up. This is particularly important for low-income families, newcomers, multilingual families, students experiencing housing instability, and families who are uninsured or underinsured.

Ultimately, this program advances PHCD's 2027 priorities by creating an accessible, prevention-focused system of support that addresses health needs early, strengthens connections between schools, families, and healthcare providers, and helps ensure that every child has the opportunity to be healthy, present, and ready to learn.

How does your program support the advancement of 2027 Grant Priority Areas? Please be specific.
San Bruno Park School District's proposed program directly advances PHCD's **2027 Grant Priority Areas, particularly Preventive Health and Mental & Behavioral Health**, by expanding school-based preventive services, strengthening early intervention, and reducing barriers to healthcare for students and families.

Preventive Health is at the center of this initiative. District data demonstrate a significant need for accessible preventive services. Most notably, **32% of SBPSD students have untreated tooth decay**, highlighting a substantial oral health need among our student population. In response, the district has developed partnerships to provide school-based dental screenings, preventive dental services, referrals, and follow-up care. Grant funding will allow us to strengthen this work while expanding prevention efforts to include health screenings, lice prevention and education, management of student health needs, family health education, and connections to primary and specialty care.

Our experience demonstrates that **bringing services directly to schools increases access**. During our recent school-based vaccination initiative, **more than 40 families received services and approximately 50 flu and childhood vaccines were administered**. By providing services in familiar and trusted school settings, we reduce barriers associated with transportation, cost, language, insurance status, and navigating complex healthcare systems.

The program will also strengthen **healthcare access and benefits navigation**. Through previous on-site partnerships, **78 parents were connected to Medi-Cal, CalFresh, and/or CalWORKs benefits and enrollment support**. Building on this success, the proposed program will help families enroll in and maintain Medi-Cal coverage, understand available preventive services, access healthcare providers, and complete referrals. This is particularly important for families who may face language, financial, transportation, or system-navigation barriers.

The initiative further advances **Mental & Behavioral Health** through early identification, referral, and coordinated support. Students presenting with health concerns frequently experience overlapping social-emotional, behavioral, attendance, or family challenges. A dedicated school-based health professional will help identify concerns earlier, coordinate with school staff and community providers, connect families to appropriate mental and behavioral health resources, and provide follow-up to help ensure that referrals result in actual access to services.

SBPSD has demonstrated both significant community need and the capacity to reach families effectively. During the **2025–26 school year, approximately 1,100 families accessed services through the district's Community Schools initiative**, including food assistance, case management, health services, benefits enrollment, adult education, and other basic-needs supports. This existing infrastructure provides a strong foundation for integrating preventive health services into a coordinated, whole-child system of care.

Equity is embedded throughout the proposed program. Rather than expecting families to independently navigate fragmented health and social-service systems, SBPSD will bring services and navigation support into the schools where families already have trusted relationships. Outreach, interpretation, referrals, and follow-up will prioritize students and families experiencing the greatest barriers to accessing care.

Through PHCD funding, SBPSD will build upon an established network of school and community partnerships to create a stronger continuum of **prevention, early identification, health education, referral, care coordination, and follow-up**. The goal is not simply to respond when students become ill, but to prevent avoidable health problems, identify needs earlier, connect families to sustainable sources of care, and address physical and mental health barriers before they interfere with attendance, learning, and long-term well-being.

What particular service gaps would your program address through this funding support?
San Bruno Park School District (SBPSD) has identified significant gaps in **school-based preventive health services, early intervention, oral health, healthcare navigation, and consistent care coordination**. PHCD funding would allow the district to address these gaps by establishing a more accessible and coordinated system of preventive health support for students and families.

One of the most significant gaps is **limited dedicated school-based health capacity**. SBPSD does not currently have sufficient staffing to consistently provide preventive health education, early identification of health concerns, follow-up with families, and coordination between schools, healthcare providers, and community agencies. As a result, health needs may not be addressed until they become more serious or begin affecting attendance, behavior, and learning. Funding would support dedicated nursing capacity to provide preventive services, respond to emerging health needs, coordinate care, and ensure appropriate follow-up.

Oral health is another critical service gap. District data indicate that approximately **32% of students have untreated tooth decay**. While SBPSD has developed partnerships to bring dental services onto school campuses, there remains a need for stronger coordination, family education, referral tracking, and follow-up to ensure students identified with dental needs actually receive treatment.

The district also faces a gap in **healthcare access and benefits navigation**, particularly for families experiencing language, financial, transportation, or system-navigation barriers. Our previous on-site enrollment efforts connected **78 parents with Medi-Cal, CalFresh, and/or CalWORKs support**, demonstrating both the level of need and the effectiveness of bringing services directly to families. Funding would allow SBPSD to provide more consistent assistance with Medi-Cal enrollment and renewal, healthcare referrals, and connections to community providers.

There is also a need for stronger **preventive health education and early intervention**. Families need accessible information and support related to communicable conditions such as lice, routine immunizations, oral health, chronic health conditions, and when and how to access appropriate medical care. Our previous school-based vaccine clinics served **more than 40 families and provided approximately 50 flu and childhood vaccinations**, demonstrating that families utilize preventive services when they are accessible within trusted school settings.

Finally, there is a significant gap in **continuity of care**. Referring a family to a provider does not necessarily mean that the family successfully receives services. Families may encounter insurance, transportation, language, scheduling, or other barriers after a referral is made. This funding would allow SBPSD to strengthen the critical link between **identification, referral, follow-up, and confirmed connection to care**.

With approximately **1,100 families accessing Community Schools services during the 2025–26 school year**, SBPSD already has an established infrastructure and trusted relationships with families. PHCD funding would help close these identified service gaps by transforming existing partnerships and referrals into a more coordinated school-based preventive health system—one that provides **early identification, health education, nursing support, care navigation, referrals, and consistent follow-up**, particularly for students and families facing the greatest barriers to healthcare access.

What specific features or aspects of your program uniquely support optimal health for residents and promote health equity in the District?
San Bruno Park School District's program uniquely promotes optimal health and health equity by bringing preventive health services, basic-needs supports, and care navigation directly into trusted school and community settings. Rather than expecting families to independently navigate complex health and social-service systems, our model reduces barriers related to cost, transportation, language, insurance status, and access to information.

A key feature of our program is its **school-based, whole-family approach**. Through Community School Centers and partnerships with county and

community agencies, families can access health screenings, preventive dental services, vaccination clinics, Medi-Cal enrollment and renewal assistance, CalFresh and CalWORKs navigation, food assistance, mental-health referrals, and individualized case management. In 2025–26, approximately **1,100 families accessed Community School supports**, demonstrating both the level of need and the effectiveness of schools as accessible hubs for services.

Our program also responds to health disparities identified within our student population. District data indicate that approximately **32% of students have untreated tooth decay**, highlighting a significant preventive-health gap. By coordinating school-based dental services and connecting students to preventive care regardless of insurance status, the program reaches children who might otherwise go without treatment. Similarly, previous school-based vaccination clinics provided flu and childhood immunizations to students and families, while benefits-enrollment events connected **78 parents** with Medi-Cal, CalFresh, and/or CalWORKs assistance.

Another distinguishing feature is the integration of **food security as a health-equity strategy**. Food insecurity directly affects physical health, emotional well-being, concentration, attendance, and readiness to learn. Our food distributions have historically reached hundreds of families, and our developing school-based food access model combines fresh-food distribution, pantry access, and emergency grocery assistance. This allows families experiencing short-term crises as well as persistent food insecurity to receive support without having to navigate multiple agencies.

Most importantly, our model prioritizes populations that traditionally experience the greatest barriers to care, including low-income families, newcomers and multilingual families, students experiencing homelessness, and families facing transportation or insurance barriers. Services are delivered through trusted neighborhood schools, supported by culturally and linguistically responsive outreach and individualized navigation.

This combination of **prevention, early intervention, basic-needs support, health-system navigation, and school-based access** makes the program uniquely positioned to advance health equity. PHCD funding would strengthen an existing infrastructure that already reaches families where they are, while allowing the District to move from responding to health crises toward preventing them—improving access, reducing disparities, and creating healthier conditions for children and families across the District.

Describe the program's timetable for a one-year grant cycle from Jan-Dec 2026, including major milestones. If your program application is for a two-year grant, include timetable from Jan 2027 - Dec 2028.
San Bruno Park School District (SBPSD) will implement the proposed initiative through a structured 12-month cycle focused on **preventive health, early intervention, healthcare access, health education, and health equity**. Implementation will build upon the District’s Community Schools infrastructure and existing partnerships to bring services directly to students and families who experience barriers to accessing care.

January–March 2026 | Planning, Baseline Data, and Program Infrastructure

The District will begin by reviewing student and family health needs, existing referral data, service-utilization trends, and barriers to care. Particular attention will be given to students and families experiencing economic hardship, food or housing insecurity, language barriers, lack of insurance or difficulty navigating healthcare systems, and other barriers to preventive care.

During this period, SBPSD will formalize partner roles, establish referral and follow-up procedures, develop multilingual outreach materials, and establish baseline measures for evaluating program impact.

Key milestones: establish baseline health-access and referral data; confirm healthcare and community partners; implement a standardized referral and follow-up process; identify priority populations and service gaps; and establish a system for tracking referrals, services received, and outcomes.

April–June 2026 | Preventive Health Service Delivery

The District will expand access to school-connected preventive health services, including oral-health prevention and treatment referrals, health screenings, health education, benefits navigation, and connections to medical, behavioral-health, and community resources.

Services will be designed to reduce common access barriers, including transportation, cost, insurance status, language, limited knowledge of available resources, and difficulty navigating healthcare systems. Whenever possible, services will be brought directly to school campuses or coordinated through trusted community partners.

Key milestones: increase student participation in preventive health and oral-health services; provide targeted referrals and follow-up for students with identified health needs; provide families with assistance accessing Medi-Cal and other eligible benefits; conduct multilingual family outreach and health education; and monitor referral completion rates.

July–September 2026 | Data Review, Targeted Outreach, and School-Year Launch

The District will conduct a midyear review of participation, referral, and service data to determine which populations are being reached and where gaps remain. Findings will guide adjustments for the 2026–27 school year.

At the beginning of the school year, SBPSD will conduct targeted outreach to newly enrolled students, newcomer families, students experiencing homelessness or food insecurity, and families facing barriers to healthcare access. School personnel and community partners will receive updated information about available services and referral pathways.

Key milestones: complete a midyear program and equity review; identify populations that remain underserved; conduct targeted outreach to high-need families; strengthen school-to-provider referral pathways; and increase awareness of available preventive-health resources across District schools.

October–December 2026 | Full Implementation, Outcomes Evaluation, and Sustainability

During the final quarter, the District will continue direct services while conducting a comprehensive evaluation of program reach and impact. SBPSD will analyze the number of students and families served, preventive services accessed, referrals made and completed, benefits-navigation assistance provided, and demographic or access patterns that may indicate continuing disparities.

Family and partner feedback will be incorporated into program improvement and sustainability planning. The District will also identify opportunities to leverage existing Community Schools resources, healthcare partnerships, public benefits, and additional grant or community funding to sustain successful

REQUEST AND RESIDENTS SERVED

Total number of people expected to be served with this funding request
2,000

Projected number of PHCD residents to be served with this funding request
2,000

Projected number of unduplicated PHCD residents to be served with this funding? (required)
1,000

To better understand the geographic area(s) where your organization provides services, we would like to ask you the following questions:

Program Location Name
San Bruno Park School

Program Location Address
500 Acacia Avenue

Program Location City
San Bruno

Program Location State
California

Program Location Zip
94066

Additional Program sites: Include the location name(s) and full address(es).
All campuses

If your program has a mobile or virtual component that goes beyond your physical location, please describe here:
N/A

Your program will serve residents from the following PHCD zip codes: (Check all that apply.)
94066 - San Bruno

For the selected zip code(s), specify what geographic area of the zip code is covered by your program? Ex.) NW area of XXXXX zip code; east of El Camino.
The program serves San Bruno Park School District students and families residing within the Peninsula Health Care District (PHCD) service area, with a primary focus on neighborhoods surrounding the District's school communities in San Bruno, including ZIP Codes 94066 and 94080 where applicable to PHCD eligibility. Services are delivered districtwide, with particular emphasis on families connected to Belle Air Elementary, Allen Elementary, Portola Elementary, John Muir Elementary, and Parkside Intermediate School.

Rather than limiting services to one section of a ZIP code, the program reaches eligible PHCD residents throughout the portions of the selected ZIP codes that fall within the PHCD geographic boundaries. Outreach and direct services prioritize neighborhoods with higher concentrations of low-income families, English learners, newcomers, and families experiencing barriers to accessing preventive health care and other essential services.

What percentage (%) of clients receiving your services reside in the selected PHCD zip code(s)? Ex. 75% in 94030, 50% in 94010
96%

How will you track/demonstrate that requested funds are serving PHCD residents?
SBPSD will maintain a centralized grant-tracking system that documents:

Number of unduplicated PHCD residents served

Residential ZIP codes of participants

School/site where services were provided

Type and frequency of services received

Number of health screenings, referrals, and preventive services provided

Participation in health education and resource-navigation activities

Referral completion and connection to community or health-care resources, when available

Describe client demographics along these dimensions: Race/ethnicity, Socioeconomic status, Age, Gender, Other)
San Bruno Park School District — Client Demographics

San Bruno Park School District (SBPSD) serves approximately **1,997 students in grades TK–8** across four elementary schools and Parkside Intermediate. The district describes its student population as linguistically and culturally diverse. CDE California Department of Education+1

Dimension	Description
Race / ethnicity	The student population is racially and ethnically diverse, with **Hispanic/Latino and Asian students representing substantial portions of enrollment**, alongside White, Filipino, Pacific Islander, Black/African American, multiracial, and other groups. The district's ethnic-diversity index is **58**, indicating a fairly diverse student body. Ed-Data
Socioeconomic status	Students come from a range of socioeconomic backgrounds. Recent district accountability data identify **socioeconomically disadvantaged students as a significant subgroup**. Title I status also varies by school: for example, Allen and Belle Air are Title I schoolwide schools, while John Muir is not Title I. Thrillshare+3
Age	The district primarily serves **school-age children from transitional kindergarten through 8th grade**, roughly ages **4–14**. The largest age concentration is therefore elementary and middle-school-aged children rather than adults. San Bruno Park School District+1
Gender	Students include both boys and girls, with district/state school datasets generally reporting enrollment by **male and female** categories. Public district-level sources reviewed here do not provide a current percentage breakdown by gender, so it would be inappropriate to estimate one.
Other — language	**English learners are an important part of the client population:** 472 of 1,997 students, or **23.6%**, were classified as English learners in 2025–26. The proportion varies considerably by school—for example, Belle Air reported **45.1%**, Allen **29.5%**, Parkside **25.6%**, and Portola **12.4%**. CDE California Department of Education+4
Other — educational needs	The district also serves students with disabilities and other student groups requiring additional educational supports. Its current accountability plan specifically tracks English learners, students with disabilities, and socioeconomically disadvantaged students as important subgroups. Thrillshare
Other — community context	The broader San Bruno community is itself diverse: the city is approximately **31.7% Asian, 33.2% White, 29.2%

Hispanic/Latino, 15.8% multiracial, and 2.3% Black**, with **35.9% of residents foreign-born**. These are community-level figures, not direct measures of the district's student population. Census.gov |

Overall client profile

 San Bruno Park School District serves a diverse, predominantly school-age client population with substantial racial/ethnic, linguistic, and socioeconomic diversity. The approximately 2,000 students are concentrated in TK–8, and nearly **one in four students is an English learner**, making multilingual and culturally responsive services particularly relevant. The district also serves meaningful populations of socioeconomically disadvantaged students and students with disabilities. CDE California Department of Education+1

Provide an analysis of the program’s risk and limitations.
The primary risks and limitations of the proposed program relate to staffing capacity, family participation, sustainability, service-provider availability, and the ability to address health needs that extend beyond the scope of school-based services.

A key risk is the recruitment and retention of qualified health personnel, particularly a registered nurse, in a competitive Bay Area labor market. Delays in hiring could affect the timeline for full implementation. To mitigate this risk, San Bruno Park School District will leverage existing Educational Services, school-site staff, and community health partnerships to maintain preventive health activities and referral coordination during recruitment or staffing transitions.

Family participation may also vary because of work schedules, transportation, language barriers, immigration-related concerns, limited health literacy, and competing family priorities. The program will address these barriers by providing services in trusted school-based settings, offering multilingual and culturally responsive outreach, coordinating directly with families, and connecting families to community-based resources when needs exceed the District's capacity.

Another limitation is that the program is designed primarily for prevention, early identification, care coordination, and referral rather than comprehensive medical treatment. Students identified with significant dental, physical, behavioral, or other health needs may require services from outside providers. The District will therefore maintain and strengthen partnerships with county agencies, dental providers, health organizations, and community-based agencies to create clear referral pathways and reduce gaps between identification and treatment.

Funding sustainability represents an additional risk. Grant funding can establish and strengthen the infrastructure for school-based preventive health services, but maintaining staffing and expanded services beyond the grant period will require diversified funding. During the grant cycle, the District will evaluate utilization, health needs, referral

PROGRAM BUDGET

Requested ANNUAL amount
$100,000

If you are requesting an increase over the previous year, please provide a clear rationale for the request. (If not applicable, please type N/A.
To help cover the salary of the school nurse, and to provide preventive health care.

IRS 501c3 - Letter of Determination.
Determination notification PHCD .pdf

Recent audited financial statement or most recent IRS form 990. Please note that we will not accept statement or forms older than 2023.
2025 Audit Report (2).pdf

Organization's Budget
2026-2027 Adopted Budget.pdf

Explain how your organization leverages funds through community collaborations and other grant opportunities
San Bruno Park School District (SBPSD) maximizes grant funding by leveraging strong community partnerships, existing district resources, and complementary public and philanthropic funding. Rather than duplicating services, the District uses grant funds to strengthen an established network of community-based providers that expands access to preventive health, behavioral health, food security, benefits enrollment, and other essential supports for students and families.

Through the Community Schools model, SBPSD collaborates with organizations such as San Mateo County Health, YMCA Community Resource Center, CORA, San Mateo County Human Services Agency, San Mateo Adult Education, local dental and health providers, food assistance organizations, and other community partners. Many of these partners provide services, staff time, referrals, outreach, workshops, case management, or other resources at little or no additional cost to the District. By hosting services directly at school and Community School Center sites, the District also contributes existing facilities, staff coordination, family outreach, interpretation, and administrative infrastructure, allowing grant dollars to be directed primarily toward services that directly benefit residents.

SBPSD also actively pursues complementary grant opportunities. For example, the District secured a $30,000 San Bruno Community Foundation grant for food insecurity that is being leveraged through matching philanthropic funding to expand food access for families. The District's approximately $5 million California Community Schools Partnership Program implementation grant has similarly helped establish the infrastructure, partnerships, and systems that allow additional health-focused funding to have greater reach and sustainability.

PHCD funding would therefore not operate as a stand-alone investment. It would build upon existing Community Schools infrastructure and partnerships while filling critical gaps in preventive health services. This braided-funding approach enables SBPSD to reduce duplication, extend the impact of each funding source, reach more residents, and create a more sustainable system of coordinated school- and community-based health supports beyond the individual grant period.

Program Budget Worksheet - upload spreadsheet provided in email invitation to submit full application.
2026-2027 PHCD Budget Worksheet - PHCD Budget Worksheet.pdf

Evaluation Table (upload)
2026-2027 PHCD Evaluation Table.xlsx - Projected Residents Served.pdf

Input from Program Budget Worksheet

Total Program PHCD Request
1.00

Total Personnel/Staffing PHCD Request
2.00

Total Program Funding from Other Source(s)
100,000.00

Total Direct Costs (Salary & Benefits + Program Expenses)
100,000.00

COMMUNITY PARTNERSHIPS

Please describe how partnerships with other organizations may impact the success of your program over the duration of the grant. Indicate whether these are ongoing collaborations or newly established relationships.
Partnerships with community organizations are essential to the success and sustainability of San Bruno Park School District’s proposed program. Most of these relationships are established, ongoing collaborations developed through the District’s Community Schools initiative and will allow the program to build upon an existing network of trusted providers rather than creating a new system of services during the grant period.

Ongoing partners include San Mateo County Health, San Mateo County Human Services Agency (HSA), YMCA Community Resource Center, CORA, San Mateo Adult Education, dental and preventive health providers, and community-based food and basic-needs organizations. These partnerships provide coordinated referrals, benefits enrollment, case management, health and dental services, family education, food access, and connections to additional community resources. The District has also developed relationships with organizations that provide legal assistance, housing stabilization, mental health referrals, and other supports addressing social determinants of health.

These established relationships strengthen the proposed program by creating a coordinated continuum of care. For example, families identified by school staff as needing health coverage or food assistance can be connected to HSA and community partners, while students requiring preventive or oral health services can be referred to existing health and dental partners. The proposed health-focused services will therefore serve as an important bridge between schools, families, and community providers, helping identify needs earlier and improving follow-through on referrals.

The partnerships also extend the impact of PHCD funding. Community organizations contribute professional expertise, direct services, referral

pathways, outreach, and other resources, while SBPSD provides school-based space, coordination, family communication, interpretation, and trusted relationships with students and caregivers. This shared-resource model reduces duplication and allows grant funds to address service gaps that cannot be fully supported through existing resources.

During the grant period, SBPSD will continue strengthening these ongoing collaborations while establishing new partnerships when gaps are identified, particularly in preventive health, oral health, behavioral health, and health education. By embedding the proposed program within an established Community Schools infrastructure and multidisciplinary partner network, the District will increase accessibility, continuity of services, and the likelihood that successful components can be sustained beyond the grant period.

COMMUNICATION / OUTREACH PLAN AND REFERRALS

Describe your communication and outreach plan to ensure residents are aware of program offering, eligibility requirements, etc.
San Bruno Park School District (SBPSD) will implement a multilingual, culturally responsive communication and outreach strategy to ensure that students, families, and residents are aware of available health and wellness services, eligibility requirements, and how to access support. Because many of the families we serve face language, transportation, technology, and other access barriers, outreach will use multiple communication channels rather than relying solely on digital communication.

Program information will be shared through district and school newsletters, email, text messaging, the district website, social media, school flyers, parent meetings, DELAC, school events, and direct outreach from Community Schools and Educational Services staff. Materials will be translated into families' primary languages whenever possible, and interpretation will be provided to support families with limited English proficiency.

SBPSD will also conduct targeted outreach to students and families who may have greater barriers to accessing preventive health services. School staff, including administrators, teachers, office staff, and student support personnel, will help identify and refer families who may benefit from services. Direct phone calls and individualized follow-up will be used when appropriate to ensure that families understand available services, eligibility criteria, required documentation, appointment procedures, and whether services are available regardless of insurance status.

Our Community Schools Centers at Belle Air and Allen will serve as trusted, accessible outreach hubs where families can receive information and assistance in person. Health-related outreach will also be incorporated into existing family engagement activities, food distributions, adult education programs, resource fairs, and other school-based events. This approach allows the District to reach families in settings they already know and trust.

Community partners will further extend our outreach. Existing partnerships with San Mateo County Health and Human Services, health and dental providers, case-management organizations, and other community-based agencies will support cross-referrals and help connect residents to services beyond those directly provided through the grant.

The

Describe your referral process.
San Bruno Park School District (SBPSD) uses a coordinated, needs-based referral process to identify students and families experiencing barriers to health, wellness, attendance, and academic success and connect them to appropriate school- and community-based services.

A central component of this approach is our **Tier 3 Referral Process**, which provides individualized support for students and families with significant or urgent needs. Referrals may be initiated by teachers, administrators, counselors, office staff, attendance teams, or other school personnel when they identify concerns such as food insecurity, housing instability, chronic absenteeism, lack of health or dental care, mental health needs, financial hardship, transportation barriers, or difficulty accessing public benefits.

Once a Tier 3 referral is received, the Educational Services/Community Schools team reviews the family's needs, contacts the parent or caregiver, and conducts an individualized assessment to determine the appropriate level of support. Families are then connected through a **warm-handoff process** to district services or trusted community partners rather than simply being provided with a list of resources. When appropriate, staff assist families with applications, appointments, interpretation, transportation coordination, documentation, and follow-up.

Depending on the identified need, referrals may connect families to food assistance, Medi-Cal/CalFresh/CalWORKs enrollment and renewal support, preventive health and dental services, mental health services, housing and rental assistance, legal services, adult education, transportation, or other basic-needs resources. Families may also access services through the district's Community Schools Centers, allowing services to be provided in familiar and accessible school-based settings.

The referral does not end when a family is connected to a provider. Staff conduct follow-up and case management to determine whether the family successfully accessed the service and whether additional barriers remain. Referrals and outcomes are tracked to monitor service delivery, identify

recurring needs and service gaps, and reduce duplication of services.

This process has demonstrated the district's capacity to effectively coordinate intensive family support. During recent Community Schools implementation, **58 Tier 3 referrals were received and 100% were addressed**, demonstrating a strong system for moving families from identification of need to connection with services.

For PHCD-funded services, this established referral infrastructure will allow SBPSD to quickly identify eligible residents with preventive health needs and connect them to

METRICS and OUTCOMES In this section, each program goal will cascade to a targeted metric and health outcome for that goal. We have defined metrics as "an output or result of an activity", such as # of program participants or # of health screenings, while health outcomes are the effects of the output, such as an increase in screening rates for mammograms among women ages 45-64.

If your organization has previously received PHCD grant support, how does this new application expand upon or enhance past initiatives to further drive impact?
San Bruno Park School District’s new application builds upon prior PHCD-supported health and wellness efforts by moving from individual or periodic services toward a more coordinated, preventive, and sustainable school-based health support model. Previous initiatives helped strengthen access to health resources for students and families; this proposal expands that foundation by addressing persistent gaps in preventive care, health education, early identification of needs, and connections to community-based services.

The proposed program will enhance prior efforts by increasing consistent access to preventive health supports across the district, with particular attention to students and families who experience barriers related to income, language, transportation, insurance, or access to a regular healthcare provider. Rather than relying primarily on episodic interventions, the district will strengthen systems for identifying needs early, providing direct support, and connecting families to appropriate healthcare and community resources.

This application also expands the district’s capacity to integrate health services with its existing Community Schools infrastructure. During the 2025–26 school year, approximately **1,100 families accessed Community School supports**, demonstrating both significant community need and an established system for reaching families. Existing partnerships have already connected families with Medi-Cal, CalFresh, CalWORKs, vaccination services, case management, food assistance, and other basic-needs supports. The proposed PHCD funding would

List program goals
3

Goal 1:
Health ED

Goal 2:
Screening

Goal 3:
Evidence Based and Innovative Programs that increase access to services.

Target Metric(s) and Health Outcome(s) for Goal 1:
Target Metrics and Health Outcomes for Goal 1: Health Education

San Bruno Park School District will increase access to culturally responsive health education and preventive health resources for students and families, with an emphasis on reducing barriers experienced by low-income, immigrant, multilingual, and underserved families.

Target Metrics:
- Provide at least **10 health education workshops/outreach activities** during the grant year, addressing priority topics such as oral health, nutrition, diabetes prevention, lice prevention, mental and behavioral wellness, preventive care, and accessing health insurance and community health services.
- Reach at least **250 unduplicated PHCD residents** through health education, workshops, individual navigation, and outreach activities.
- Ensure at least **80% of participating families** report increased knowledge of available preventive health resources and how to access appropriate services.

- Provide health information and outreach in families' preferred languages whenever possible to reduce language and cultural barriers.
- Track referrals generated through the district's **Tier 3 referral process**, including referrals to dental care, medical services, behavioral health resources, Medi-Cal/insurance navigation, and other community-based health providers.
- Achieve at least an **80% successful connection or documented follow-up rate** for families receiving health-related referrals.

Anticipated Health Outcomes:
The program will increase health literacy, strengthen families' ability to navigate healthcare and preventive services, and promote earlier identification and response to student health needs. Over time, these efforts are expected to increase utilization of preventive health and dental services, improve continuity of care, reduce unmet health needs, and decrease health-access disparities among PHCD residents served by the district.

Target Metric(s) and Health Outcome(s) for Goal 2:
Target Metrics:
- Provide annual dental and vision screenings to **at least 50% of students**, prioritizing students from low-income, uninsured/underinsured, newcomer, and other underserved families.
- Achieve a **90% screening completion rate** among students identified for screening.
- Ensure **100% of students with identified dental or vision concerns receive a referral** to an appropriate provider or community resource.
- Provide follow-up navigation to **at least 80% of families referred for additional care**, including assistance accessing low-cost/no-cost services, insurance/Medi-Cal resources, and appointments.
- Track screening completion, identified needs, referrals, and confirmed connection to follow-up services.
- Provide families with culturally and linguistically accessible education on preventive oral health, vision care, and available community resources.

Health Outcomes:
- Increase early identification of untreated dental decay, vision impairment, and other conditions that can interfere with students' health, attendance, concentration, and learning.
- Reduce the percentage of students with untreated oral health needs, with particular attention to the district's identified need related to untreated tooth decay.
- Increase access to preventive dental care and corrective vision services for students who experience financial, insurance, language, transportation, or other barriers to care.
- Improve continuity of care by connecting students with identified needs to community-based dental and vision providers.
- Advance health equity by ensuring that students with the greatest barriers to healthcare receive timely screening, referral, follow-up, and care coordination.

Target Metric(s) and Health Outcome(s) for Goal 3:
San Bruno Park School District's proposed program combines evidence-based prevention, early identification, and coordinated referral strategies with an innovative school-based service delivery model that brings health resources directly to students and families. By using schools as trusted access points, the program reduces common barriers to care, including cost, transportation, language, limited health-system navigation, and difficulty accessing services during traditional business hours.

The program will expand access through health education, dental and vision screenings, preventive dental services, and connections to follow-up care. Rather than providing screenings as stand-alone activities, students identified with health concerns will be connected to appropriate community providers and resources through the District's established Tier 3 referral process. Community Schools staff will track referrals, conduct follow-up with families, assist with navigation, and help address barriers that may prevent families from completing recommended services.

The model builds upon existing partnerships with San Mateo County Health, dental providers, community-based organizations, and other health and social-service partners. These collaborations allow the District to leverage existing expertise and resources while creating a more coordinated continuum of prevention, screening, referral, and follow-up.

The program is particularly responsive to health disparities affecting underserved families. District data indicate that approximately **32% of students have untreated tooth decay**, demonstrating a significant need for accessible preventive oral-health services. Grant funding will allow the District to respond to identified needs earlier, increase the number of students receiving preventive services, and strengthen connections between families, schools, and community health providers.

Innovation is reflected not simply in adding services, but in integrating health access into the District's existing Community Schools infrastructure. Health education, screenings, referrals, family outreach, interpretation, case management, and follow-up will operate as a coordinated system. This approach supports PHCD's emphasis on prevention and health equity by meeting residents where they are, identifying needs early, and helping ensure that a referral results in meaningful access to care.

Program Activities
San Bruno Park School District will implement a coordinated, school-based preventive health initiative designed to increase access to health education, early screening, preventive services, and referrals for students and families, particularly those experiencing financial, linguistic, transportation, insurance, or other barriers to care.

Program activities will include:

- **Health Education and Prevention:** Provide culturally responsive health education for students and families focused on preventive health, oral health, vision care, nutrition, hygiene, chronic disease prevention, and navigating available health resources. Information will be provided through workshops, school communications, Community School Centers, and family engagement events.

- **Dental Screening and Preventive Services:** Coordinate on-site dental screenings and preventive dental services at district schools in partnership with community dental providers. Students identified with untreated decay or other oral health concerns will receive referrals and assistance connecting to appropriate follow-up care.

- **Vision Screening and Referral:** Provide or coordinate vision screenings to identify students who may have unrecognized vision concerns that can affect learning and overall well-being. Families of students who do not pass screenings will receive referrals and navigation support for follow-up evaluation and treatment.

- **Health Care Navigation and Referral:** Connect students and families to medical, dental, vision, behavioral health, insurance enrollment, and other preventive health resources. Staff will assist families in overcoming barriers such as language, transportation, cost, insurance status, and difficulty navigating health systems.

- **Tier 3 Referral and Case Management:** Integr

Instruments & Tools - please indicate how you are tracking and measuring your metrics/outputs and health outcomes. For example, a client survey, database, etc.
San Bruno Park School District will use multiple data collection and evaluation tools to track program outputs, participant reach, service utilization, and health outcomes. Data will be reviewed regularly to measure progress toward grant targets and identify service gaps.

Key instruments and tools will include:

- **District student information system (Aeries):** Used to track student demographics, school enrollment, attendance, and other relevant student-level indicators.
- **Program participation and service logs:** Used to document the number of students and families receiving health education, dental and vision screenings, referrals, preventive services, and follow-up support. Unduplicated participant counts will be maintained to accurately report PHCD residents served.
- **Screening and provider records:** Dental and vision partners will document the number of students screened, identified with health concerns, referred for additional care, and, when available, connected to treatment or preventive services.
- **Tier 3 Referral Tracking System:** Community Schools staff will document referrals, identified needs, services provided, community partner connections, follow-up activities, and referral resolution. This will allow the District to measure both the volume of referrals and the percentage successfully addressed.
- **Pre/post surveys and participant feedback:** Brief surveys will measure changes in student and family knowledge, awareness of preventive health practices, confidence in accessing services, satisfaction with services, and reported barriers to care.
- **Health education participation records:** Sign-in sheets, workshop attendance, outreach records, and educational material distribution will be used to measure participation and reach.
- **Partner data and referral reports:** Community health and service partners will provide aggregate utilization

Please download and complete the Evaluation Core Metric Table & Budget Worksheet.. Complete it separately and upload it below.

[Evaluation Core Metric Table](https://appriver3651007539-my.sharepoint.com/:x:/g/personal/matthew_ordona_peninsulahealthcaredistrict_org/IQDCoItDxf17S7MMpu01ri8FAepOxM9J7vHrh-JSP_O5kWg?e=1Xcdge)
[Budget Worksheet](https://appriver3651007539-my.sharepoint.com/:x:/g/personal/matthew_ordona_peninsulahealthcaredistrict_org/IQDlP2SGp0W2Q7wMYhcDfzz_AWQI5L8J9if-LsJKczkE8uY?e=Qipqhg)
ADDITIONAL INFORMATION

What is the future of this program, in terms of other funding support or sustainability, beyond the grant period?
The long-term vision is to establish this program as a sustainable, integrated component of San Bruno Park School District's Community Schools and student support infrastructure rather than a stand-alone, grant-dependent initiative. PHCD funding will provide critical support to strengthen preventive health education, dental and vision screenings, referral pathways, care coordination, and access to health services while the District develops a diversified sustainability strategy.

Beyond the grant period, the District will pursue a braided funding model that combines district resources, future competitive grants, public and private foundation support, and in-kind contributions from community health partners. We will also continue leveraging existing Community Schools resources and partnerships with San Mateo County Health, health and dental providers, community-based organizations, and other agencies serving children and families. These partnerships reduce duplication, extend the reach of grant dollars, and connect families to services that already exist within the broader community health system.

A key sustainability strategy will be embedding health access into existing District systems. Health education, screening opportunities, Tier 3 referrals, family outreach, care coordination, and follow-up will be incorporated into established Community Schools and student-support processes. This approach allows the District to maintain critical components of the program even as individual funding sources change.

During the grant period, we will also collect participation, screening, referral, service-access, and health outcome data to demonstrate impact and identify the services with the greatest need and return on investment. This data will strengthen future funding applications, inform District resource allocation, and support continued investment from philanthropic, public, and healthcare partners.

Ultimately, PHCD funding will serve as a catalyst for building a sustainable school-community health infrastructure. Our goal is to move from grant-supported services toward a coordinated model in which preventive health education, early identification, screenings, referrals, and connections to care become part of how the District routinely supports students and families—particularly those who experience financial, linguistic, transportation, insurance, or other barriers to accessing healthcare.

Is there additional information about your program that you would like to share with the Committee? Please limit to 200 words.
San Bruno Park School District views student health as essential to academic success, attendance, and overall well-being. This program builds upon our existing Community Schools infrastructure to create a coordinated, accessible system of prevention, early identification, referral, and follow-up for students and families who may otherwise experience barriers to care.

Our greatest strength is our ability to connect health services directly to trusted school environments. Through health education, dental and vision screenings, preventive services, Tier 3 referrals, and partnerships with community-based and county agencies, families can access support where they already feel connected. Our established referral process also allows us to identify needs, connect families to appropriate providers, and follow up to help ensure that referrals result in services.

The District has demonstrated its capacity to reach historically underserved families through culturally responsive outreach, multilingual communication, Community Schools Centers, and strong community partnerships. In 2025–26 alone, approximately 1,100 families accessed Community Schools supports.

PHCD funding would allow us to strengthen this existing infrastructure rather than create a stand-alone program—building a sustainable, prevention-focused model that reduces barriers to care, advances health equity, and helps students arrive at school healthy and ready to learn.

System Fields

Grant Application 27: File Attachments

IRS 501c3 - Letter of Determination.
Determination notification PHCD .pdf

Recent audited financial statement or most recent IRS form 990. Please note that we will not accept statement or forms older than 2023.
2025 Audit Report (2).pdf

Organization's Budget
2026-2027 Adopted Budget.pdf

Program Budget Worksheet - upload spreadsheet provided in email invitation to submit full application.

	A	B	C	D	E	F
1	**Organization Name**	**Primary Focus Area: *Priorities**	**Program Title**	**Program Summary**	**Annual Funding Request**	**Total Program Budget (simple)**
2	**AnewVista Community Services**	Healthy Living across the Life Span Grants	Leveling the Tech Playing Field: Reducing Senior Loneliness by Treating Digital Access as a Social Determinant of Health	AnewVista Community Services is seeking to renew its partnership with the Peninsula Health Care District (PHCD) in 2027 to continue providing free, hands-on technology education to older adults. Recognizing digital access as an important social determinant of health, AnewVista helps seniors develop the skills and confidence to access healthcare, protect themselves online and at home, and stay socially connected. Through its Competency Journey, AnewVista offers progressive learning in three areas: Access, Safety, and Connection. Its curriculum includes more than 150 topics, ranging from MyChart and online benefits management to scam prevention, home safety technology, AI tools, and video communication. Recent participant surveys found that 91.6% feel more socially connected as a result of their learning. Programs are delivered through monthly in-person classes at trusted community venues, 3–5 weekly online classes (including Spanish-language instruction), on-demand educational resources, remote and in-home technology support, and annual surveys measuring participant outcomes. With three years of PHCD support, AnewVista has developed an adaptable, comprehensive program that meets seniors at every skill level. Continued funding in 2027 will help sustain and expand these efforts, reducing digital barriers and improving	$ 40,000.00	$ 300,000.00
3	**Aspire House (formerly California Clubhouse)**	Mental & Behavioral Health Grants	Aging Well Together: Senior Social Connection	Aspire House, the only accredited Clubhouse in San Mateo County, provides free, voluntary, lifelong membership and daily social connection for adults living with serious mental illness. This request focuses on supporting its older members, who represent 46% of its 544-member community (255 individuals), including 56 currently active members. Through its Monday–Friday Work-Ordered Day, older members work alongside staff as colleagues in Business and Hospitality, taking on meaningful responsibilities such as reception, data entry, meal planning, welcoming new members, and outreach to peers. This structure provides purpose, routine, independence, and meaningful social interaction while helping prevent isolation. In 2025, Aspire House recorded 18,986 hours of member engagement across nearly 5,000 visits, served 3,900 affordable, nutritious lunches, and hosted 74 social events extending into evenings and weekends. To maintain connections with members who become less engaged, staff and members also made 5,200 phone calls, sent 25,000 text messages, and 20,000 emails. Aspire House helps older adults combat isolation, maintain meaningful relationships, and find purpose and belonging through daily work, shared meals, and ongoing social activities.	$ 45,000.00	$ 1,072,000.00
4	**BAY AREA CANCER CONNECTIONS**	Preventive Health Grants	Bridging the Gap: Mobile Cancer Education, Navigation & Community Support	Bay Area Cancer Connections (BACC) is requesting $70,000 from the Peninsula Health Care District (PHCD) to expand its Mobile Resource Center (MRC), bringing free cancer education, personalized navigation, referrals, and practical support directly to individuals affected by breast and ovarian cancer throughout the District. With more than 30 years of experience, BACC helps patients and families navigate the emotional, financial, practical, and educational challenges of cancer beyond clinical treatment. Its services include year-round cancer education, individual counseling, resource navigation, financial assistance, and partnerships with healthcare providers and community organizations. The Mobile Resource Center increases access by bringing these services into familiar community settings, particularly for individuals facing transportation, financial, language, or cultural barriers. MRC utilization has grown from 58 clients in FY2023–24 to 104 in FY2024–25, with more than 150 projected in FY2025–26. Expanded funding could increase annual reach to 200–250 individuals and an additional 400–600 family members and caregivers. PHCD funding will support increased community outreach, stronger healthcare and community partnerships, participation in additional local events, and expanded access to cancer education and individualized support. Ultimately, BACC aims to bridge the gap between clinical cancer treatment and community-based support, ensuring that patients and their families have access to trusted information, resources, and guidance throughout their cancer journey.	$ 70,000.00	$ 94,000.00

	A	B	C	D	E	F
1	**Organization Name**	**Primary Focus Area: *Priorities**	**Program Title**	**Program Summary**	**Annual Funding Request**	**Total Program Budget (simple)**
5	**Bay Area Community Health Advisory Council (BACHAC) - fiscally sponsored by Community Initiatives, Inc.**	Preventive Health Grants	Community Mammograms and Prostate Screenings Program	We are requesting continued support of the Community Mammogram Program, BACHAC's longest-running health outreach effort. For 28 years, it has provided education and free mammograms to San Mateo County residents who lack insurance or face barriers to regular screenings, including individuals who are unhoused, low-income, or unfamiliar with how to access care. The program conducts outreach through four community Health Village pop-up clinics led by trusted community partners; offers bilingual, culturally relevant services through community health outreach professionals (CHOPs); provides instructions on self-exams, breast health, and early symptom recognition; partners with a health care provider for mammograms and medical follow-up; and delivers Medi-Cal and Medi-Care education and re-enrollment assistance. In addition to the mammogram program, we are requesting funding to launch a pilot project to meet the dire need for prostate screenings. Prostate screenings are recommended every 2-4 years for men over 50+, or at 45 for those recognized to have a higher risk, including African American men or those with a family history. Screenings would be offered once yearly, with outreach via the Health Village program.	$ 60,000.00	$ 564,179.00
6	**Burlingame Parks and Recreation**	Healthy Living across the Life Span Grants	Let the Sunshine In	Let the Sunshine In is a year-round healthy aging program designed to promote physical activity, social connection, mental well-being, and community engagement among adults 55+. Through monthly accessible day trips, a monthly Walking Club, and monthly social gatherings, participants have meaningful opportunities to stay active, explore new places, learn, build relationships, and enjoy shared meals and experiences. The program offers a diverse range of experiences designed to engage older adults with different interests, abilities, and activity levels. Examples of past excursions include visiting the Sacramento Train Museum, kayaking in Elkhorn Slough, hiking Mt. Tam, cruising the Bay aboard the USS Potomac, touring the Rosie the Riveter Museum, taking guided walking tours in San Francisco and Capitola, riding trains through the Santa Cruz Mountains, and walking through Muir Woods. Walking activities can offer different pace options, from leisure walks to more active groups, while excursions range from more physically active experiences such as kayaking and hiking to mobility-inclusive opportunities such as whale watching. These are just a sampling of the many destinations and experiences offered through the program. Social gatherings celebrate culture, connection, and community through experiences such as Diwali, St. Patrickâ€™s Day, Chinese New Year, Older Americans Month, and AAPI Heritage Month. The program addresses social isolation and barriers to participation by providing more affordable, inclusive opportunities for older adults, including transportation support and reduced program fees. By combining physical activity, socialization, healthy eating opportunities, learning, and meaningful community engagement, Let the Sunshine In supports healthy aging and helps older adults remain active, connected, and engaged in their communities.	$ 60,000.00	$ 192,000.00
7	**CALL Primrose**	Healthy Living across the Life Span Grants	CALL Primrose Community Pantry	CALL Primrose is a nonprofit organization that has provided free, nutritious groceries to low-income individuals and families in San Mateo County since 1984. In 2025, CALL served approximately 78,000 individuals and distributed more than 110,000 grocery bags. The organization operates Monday through Friday on a walk-in basis, with no appointment required, ensuring accessible food assistance for anyone experiencing food insecurity. Through partnerships with Second Harvest of Silicon Valley, local grocery rescue programs, and food wholesalers, CALL provides a variety of fresh produce, dairy, meat, vegan options, and pantry staples. CALL uses a client-choice distribution model, allowing individuals to select foods that best meet their household's needs, preferences, and dietary requirements. This approach promotes dignity and independence while reducing food waste by ensuring groceries are wanted and consumed. To improve accessibility, forms and instructions are available in English and Spanish, with additional translation support as needed. CALL also engages its Board of Directors in community outreach to expand awareness and reach. CALL Primrose's mission is to reduce food insecurity by providing reliable, nutritious, and accessible grocery assistance while continually improving its services to meet the evolving needs of the community.	$ 60,000.00	$ 580,000.00
8	**CASA of San Mateo County**	Mental & Behavioral Health Grants	Beyond an Advocate: Advancing Mental Health Support for Court-Involved Children and Youth	Our Beyond an Advocate Program equips CASA volunteers to provide well-rounded support that extends far beyond the courtroom. CASA volunteers are trained to address the full spectrum of their youth's needs, from mental and physical health to educational success to long-term independence. These dedicated volunteers are carefully paired with one child who is under the jurisdiction of the San Mateo County courts, offering mentorship, advocacy, and the support needed to empower young people. The program centers on four core goals: first, training volunteers to understand the deep impact of Positive Childhood Experiences (PCEs) on mental health, development, and educational outcomes; second, providing volunteers with the tools and flexible funding to facilitate meaningful PCEs for their youth while supplementing state assistance to address material and financial gaps; third, expanding youth-led programming through intentional partnerships with community organizations; and fourth, growing participation in the Stay Connected program to better serve young adults ages 18 to 25 as they transition out of the foster care and juvenile justice systems.	$ 70,000.00	$ 235,133.00

	A	B	C	D	E	F
1	**Organization Name**	**Primary Focus Area: *Priorities**	**Program Title**	**Program Summary**	**Annual Funding Request**	**Total Program Budget (simple)**
9	**Catholic Charities CYO of the Archdiocese of San Francisco**	Healthy Living across the Life Span Grants	Adult Day Services San Mateo	Catholic Charities' Adult Day Services program in San Mateo County offers a licensed, supervised setting where older adults and adults with disabilities receive therapeutic day care designed around their individual needs. Many participants are coping with declining physical abilities, memory loss, or a shrinking support network, and the program meets them with engaging, structured activities that support both independence and overall well-being. Family caregivers benefit as well, gaining regular respite alongside a dedicated monthly caregiver support group and a Memory Cafe, where those newly navigating a dementia diagnosis can build community with others facing similar circumstances. Compared to in-home care or residential placement, Adult Day Services offers families a dependable and more accessible option. Core services at our San Mateo site include: - Activities structured around each participant's cognitive and physical abilities - Daily hot lunch and snacks, paired with education that helps clients adopt healthy eating habits suited to their stage of life - Assistance with personal care needs - Early morning and late afternoon extended care beyond standard program hours - Support groups, education, referrals, and information for family caregivers	$ 70,000.00	$ 543,140.00
10	**Changing Perspectives**	Mental & Behavioral Health Grants	Advancing Youth Mental & Behavioral Health Through Social-Emotional Learning	Changing Perspectives seeks funding to provide school-based, preventive mental and behavioral health programming in Burlingame and Millbrae during the 2026–27 school year. Partnering with at least four schools, the program will build educators' and parents'/caregivers' capacity to support students' social-emotional and mental health needs. By equipping adults with practical strategies and resources, students can strengthen emotional regulation, relationships, resilience, and overall well-being. Changing Perspectives uses social-emotional learning (SEL) as an upstream approach to prevention, focusing on five core competencies: self-awareness, self-management, social awareness, relationship skills, and responsible decision-making. The initiative includes four interconnected components: K–7 Curriculum Resources: More than 1,000 customizable, standards-aligned lesson plans, discussions, and activities based on the CASEL framework and California SEL Guiding Principles. Professional Development: Training for educators and school staff to strengthen student relationships, model healthy SEL skills, and support emotional regulation and well-being. Site Visits: Individualized school support through focus groups, observations, co-teaching, needs assessments, and consultation to help schools translate training into sustainable practice. Family Workshops: Practical strategies for parents and caregivers focused on communication, relationships, emotional regulation, and growth mindsets. Together, these components create consistent social-emotional support across school and home environments. By strengthening protective factors early, students are better prepared to manage stress, navigate adversity, seek support, and develop confidence and belonging. Rather than providing a short-term intervention, Changing Perspectives builds lasting adult capacity, school systems, and shared practices that can continue beyond the grant period, creating healthier school communities and stronger pathways to long-term mental and emotional well-being.	$ 20,000.00	$ 60,000.00
11	**Chinese Community Health Resource Center (CCHRC)**	Healthy Living across the Life Span Grants	Holistic Healthy Aging Initiative	In 2027, CCHRC proposes to expand and strengthen this established program by increasing its reach to more District seniors and/or senior communities, increasing opportunities for participation, and enhancing program components based on lessons learned during the first year. CCHRC will particularly strengthen interactive health education while continuing the physical and social activities that demonstrate strong resident engagement. The Holistic Healthy Aging Initiative provides accessible, engaging healthy-aging programs directly within senior residential communities. In 2026, CCHRC proposed expanding its successful residential wellness model to Peninsula seniors through three core areas: healthy eating and nutrition education, physical activity, and socialization, along with caregiver resources and community partnerships. With PHCD support, at the mid-year milestone, CCHRC implemented the program at three Peninsula senior living communities: Trousdale, Sunrise San Mateo, and Mills Estate Villa (CiminoCare). In July 2026, CCHRC had completed four visits at each site, reaching 50 unique seniors and generating 158 resident engagements through physical activity, socialization, and health education activities. We served 50 unique residents and 158 duplicates of 250 services to residents, achieving 20% and 63% per cent of the proposal goals respectively. Participating residents completed a total of 265 of 540 planned minutes of physical activity, achieving 49% of the program goal. As well as completed a total of 385 of 540 planned minutes of social activity, achieving 71% of the program goal. We have all the residents and building staff's permission to use their photos for reporting purposes. Please see the Google link below for photos that we would like to share. https://drive.google.com/drive/folders/1YnQPTBH9qaMeLinaysSjFpUcobUKHjG5	$ 42,000.00	$ 70,000.00

	A	B	C	D	E	F
1	**Organization Name**	**Primary Focus Area: *Priorities**	**Program Title**	**Program Summary**	**Annual Funding Request**	**Total Program Budget (simple)**
12	**City of Millbrae**	Healthy Living across the Life Span Grants	Fitness Court with the National Fitness Campaign	The City of Millbrae is seeking Peninsula Health Care District (PHCD) support to install and activate a National Fitness Campaign Fitness Court at Monterey Street Linear Park. The project will create a free, publicly accessible outdoor fitness resource that expands opportunities for physical activity, preventive health, and healthy aging across the lifespan. The Fitness Court will provide bodyweight exercise stations supporting strength, balance, mobility, and cardiovascular fitness at various ability levels. Unlike traditional gyms or recreation programs, it will require no membership, registration, or fees, reducing barriers to regular physical activity. Monterey Street Linear Park is an ideal location because it is adjacent to an existing trail already used for walking and recreation. The Fitness Court will complement these activities by allowing residents to combine aerobic exercise with strength and functional fitness. Program Activities Free daily access: Year-round use during regular park hours without fees or membership. Walking and fitness integration: Residents can combine trail activity with strength, mobility, balance, and functional exercises. Community programming: Introductory fitness activities and wellness events will help residents safely and confidently use the Court. Healthy aging: Accessible opportunities for adults and older adults to maintain strength, mobility, balance, and functional fitness. Preventive health education: Recreation outreach will promote regular movement and strength training as part of a healthy lifestyle. Social connection: A shared fitness space will encourage residents to exercise together and participate in community activities. The goal is to create a permanent community wellness resource, not simply install equipment. By building on an existing recreational trail, the Fitness Court will make physical activity more accessible and easier to incorporate into daily life. PHCD funding will expand equitable access to preventive health and physical activity through a high-quality, free public fitness amenity. The project directly supports PHCD's Healthy Aging Across the Lifespan – Physical Activity priority while promoting regular exercise, healthier lifestyles, and sustained community wellness.	$ 70,000.00	$ 270,167.00
13	**Coastside Adult Day Health Center**	Healthy Living across the Life Span Grants	Aging in Place	Coastside Adult Day Health Center provides a four hour daytime healthcare program which supports seniors and adults with disabilities throughout all of San Mateo County. Throughout the program day, our services include nursing, physical, occupational and speech therapy, personal care, social services, activities, nutrition services and transportation. Overall, our goal is to prevent premature institutionalization and participants with aging in place in the communities they helped build. Our program provides comprehensive healthcare services in a social environment designed to help individuals thrive in a community setting. Further, we provide a caregiver support group meant to provide care referrals, advice and emotional support to individuals currently caring for a loved one. These services are essential for the lives of seniors and adults with disabilities throughout all of San Mateo County.	$ 70,000.00	$ 1,500,000.00

	A	B	C	D	E	F
1	**Organization Name**	**Primary Focus Area: *Priorities**	**Program Title**	**Program Summary**	**Annual Funding Request**	**Total Program Budget (simple)**
14	**Each Green Corner**	Mental & Behavioral Health Grants	Living Campus	Each Green Corner (EGC) empowers communities throughout San Mateo County to increase food sovereignty and climate resiliency through sustainable urban agriculture. We do this by training and assisting communities in building sustainable food-producing gardens at schools and community centers to grow culturally-diverse fresh produce for donation to nonprofit food distribution partners and/or directly to communities in need. Simultaneously, we educate our communities about nutrition and food security, environmental justice and sustainable agriculture through school-based curriculum, the creation of resources for the general public, and outreach events. Through our programs we are able to tailor our training and education to adults/seniors as well as to youth, while maintaining an intergenerational focus via volunteer opportunities for all ages across all programming. Since our launch in 2019, we have scaled to 19 active garden sites throughout San Mateo County (8 of which are at Title One schools) impacting over 7,000 students, their families and their neighbors. Importantly and uniquely, EGC does not merely create gardens - it provides continuing support to garden site partners in the form of volunteer and garden management, curriculum development and delivery, and ongoing maintenance via public workdays, hands-on clinics, and other volunteer events. The success of our model is demonstrated not just by the thousands of pounds of fresh produce that EGC donates each year, but also by the hundreds of volunteers reached and thousands of students impacted by our work. The EGC program we are asking the PHCD to support is the Living Campus Program. Living Campus, EGC's largest program, serves as the connection between school districts, community centers, and their educational goals for promoting physical activity, nutrition and healthy eating, social justice, empathy-building, civic engagement, and STEM-learning in a garden-centered setting. School gardens and outdoor classrooms provide opportunities that benefit students, volunteers, and the community as a whole. The Living Campus Program's impact is three-fold: (1) education of students, communities, and volunteers to develop a connection between sustainable small-scale and/or urban agricultural techniques, our food system, the environment, public health, nutrition and health equity, and food security through our Food Explorers Program curriculum; (2) production/distribution of fresh and diverse produce to combat food insecurity and health inequity throughout San Mateo County; and (3) increasing environmental viability through conversion of under- or poorly-utilized land into sustainable agriculture and native planting uses, tree canopy development, and cultivation of native ecosystems.	$ 65,000.00	$ 272,640.00
15	**Edgewood**	Safety Net Services	Edgewood Drop-In Program for Transitional Age Youth	Edgewood seeks PHCD funding to support six Peer Partners, an essential component of its Drop-In Program and a strong fit with PHCD's goal of supporting Community Health Workers through its Safety Net funding portfolio. The Drop-In Program serves Transition Age Youth (TAY) ages 18–25 through a Drop-In Center and Mobile Drop-In vans, providing a safe, judgment-free space where young adults can access support, resources, and skills needed to transition successfully to adulthood. Peer Partners are on-staff Community Health Workers with lived experience who understand the challenges participants face. Their shared experiences help build trust, reduce barriers to care, and provide positive role models. The Drop-In Center is open 23 hours per week with no referral or provider connection required. TAY can access hot meals, a food pantry, clothing, hygiene supplies, computers, workshops, activities, and connections to Edgewood and community resources. Peer Partners are trained in motivational interviewing, harm reduction, de-escalation, crisis intervention, and trauma-informed care. They work directly with participants, prepare meals, lead workshops and activities, organize outings, and gather participant feedback through Town Halls and one-on-one conversations. One-third of Peer Partners are former Edgewood clients, strengthening trust and peer connection. Peer Partners also support Edgewood's Mobile Drop-In vans, which reach underserved TAY in locations such as community colleges, adult ESL programs, and Half Moon Bay. The vans provide essential supplies, outreach materials, and connections to the Drop-In Center and other free resources. Funding six Peer Partners will strengthen a low-barrier, peer-led model that connects underserved young adults with trusted support, basic needs assistance, life skills, and pathways to longer-term services.	$ 15,000.00	$ 1,226,028.00

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16	**El Concilio of San Mateo County**	Safety Net Services	Nuestra Salud Community-led Health and Wellness Program	Through our Nuestra Salud Community-led Health and Wellness program, ECSMC plays a key role increasing health access by providing linguistically, culturally, and other client and community appropriate direct service to low-income families and individuals. Ours is a full life cycle program both serving clients across the age spectrum and assisting them over time to access, renew, manage, and understand health and wellness programs and services. 1. Health and Wellness Case Management Our Health and Wellness program provides culturally relevant support for residents in the district who need resources or other critical services that will improve their health and quality of life. Our program provides direct service to immigrant and low-income families and individuals that face barriers preventing them from accessing services and resources available to them. Clients get connected to our program through our promotores who conduct community outreach and canvassing in hard-to-reach communities. Our promotores engage with communities, share resources and knowledge about services available to them. Promotores refer clients who need further assistance for a deeper 1:1 case management session with a case worker to 1) Provide advocacy, education, information, and referrals to preventive health services including mental health, vaccination, and basic needs such as food, shelter, housing, and financial assistance. 2) Provide translation, enrollment, forms assistance for preventive and support services, including medical coverage applications, screening appointments and programs. 2) Community Health Education We provide Spanish-language environmental health and justice education to PHCD residents on topics including air quality, climate resilience, disaster preparedness, and healthy homes (safer cleaning products, mold, pests, lead). We will continue supporting this community capacity-building and civic engagement and increase our ability to support development of community-led projects through the new North Central San Mateo Community Climate Change Team (CCCT) program we recently launched with Climate Resilient Communities. This program will convene community members, government representatives, and community / faith organizations with a focus on climate resilience and environmental health and justice. The CCCT provides an on-going space for community dialogue and on the ground education to take place directly with residents.	$ 70,000.00	$ 776,073.00
17	**Food Connect Co.**	Healthy Living across the Life Span Grants	Peninsula Healthy Food Access & Delivery Initiative	Food Connect requests $40,000 from Peninsula Health Care District to expand its established Bay Area food access model for residents within the District. The Peninsula Healthy Food Access & Delivery Initiative will increase reliable access to fresh produce and other nutritious foods for residents who face barriers to getting the food they need, particularly low-income families, older adults, people with disabilities or limited mobility, residents without reliable transportation, and people managing diet-related health conditions. Food Connect's role is to solve the logistical gap between food availability and food access. We work with food donors, food hubs, community organizations, schools, healthcare partners, and other local organizations to coordinate the pickup and delivery of nutritious food. Depending on partner and resident needs, food can be delivered to trusted community sites or directly to households. Our model is built around Food Rescue, Household Delivery, and Food as Medicine. Food Rescue allows Food Connect to recover fresh, perishable, and nutrient-dense food and move it quickly to communities rather than allowing it to go to waste. Household Delivery removes transportation and mobility barriers by bringing food directly to residents. Food as Medicine connects reliable access to nutritious food with efforts to improve health and manage diet-related conditions. Food Connect has spent five years refining this model in the Bay Area. In 2025, Food Connect Bay Area delivered 2.5 million last-mile pounds of food, reached approximately 1 million people, and provided 2.1 million meals while operating dozens of programs with more than 20 local partners. Food Connect also transported approximately 825,000 pounds from SF Market to community organizations, schools, and distribution partners. PHCD support will allow Food Connect to direct this proven infrastructure toward District residents and strengthen access to healthy food as a practical component of preventive health.	$ 40,000.00	$ 40,000.00

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18	**Healthier Kids Foundation**	Preventive Health Grants	HearingFirst	Healthier Kids Foundation's (HKF) HearingFirst program provides school-based hearing screenings and follow-up support to children in the San Bruno Park School District, helping identify potential hearing concerns early and connect families to appropriate care. Through this funding request, HKF anticipates screening approximately 1,000 children from preschool through 8th grade. HearingFirst uses Otoacoustic Emissions (OAE) screening devices and audiometers to identify potential hearing concerns, including non-verbal screening technology that allows HKF to effectively screen young children and students who may have difficulty participating in traditional hearing screenings. HKF screeners are Community Health Worker (CHW)-certified, hold School Audiometry Certifications, and are trained to provide audiometry and Conditioned Play Audiometry (CPA) screenings. When a child receives an initial referral, HKF conducts a second screening approximately four to six weeks later, when appropriate, to determine whether temporary conditions such as illness, allergies, or congestion may have affected the initial results. Children who continue to demonstrate a potential hearing concern are referred for additional evaluation. Importantly, HearingFirst extends beyond screening. HKF's Care Navigators provide individualized follow-up support to families, helping parents understand screening results, navigate their child's health insurance, and connect with pediatricians, audiologists, and other appropriate providers. By bringing preventive screening directly into schools and pairing early identification with Care Navigation, HearingFirst helps reduce barriers to preventive healthcare and ensures families have support in accessing the care their children need.	$ 40,000.00	$ 446,574.00
19	**Jasper Ridge Farm**	Mental & Behavioral Health Grants	Sustaining and Expanding Animal-Assisted Mental Wellness for PHCD Youth	Jasper Ridge Farm is requesting support to sustain and expand animal-assisted experiences for ~7 children in Peninsula Health Care District communities. The project brings together two established JRF programs: WellnessBuddies, which provides animal-assisted experiences alongside mental health and school-based support, and Animals Helping Children, which connects children facing difficult circumstances with gentle animals. Experiences take place at Jasper Ridge Farm or through mobile visits in the community. A child may sit quietly with a rabbit, groom a goat or miniature horse, walk beside an animal, or simply spend time nearby. The activities are intentionally simple and give children space to slow down, feel grounded, and become more comfortable engaging with the people and activities around them. JRF already provides youth programming through community partners in San Mateo, Burlingame, and San Bruno. PHCD support would help us sustain that existing work while expanding it, building new relationships and creating more opportunities for District children to participate.	$ 20,000.00	$ 465,505.00
20	**Kara**	Mental & Behavioral Health Grants	Bereavement Support, Grief Education, and Crisis Response	As the Bay Area's only stand-alone grief-focused agency, Kara provides bereavement support to children, adults, families, and organizations through integrated youth, adult, Spanish, community engagement, and therapy services. Peer support and crisis response are free, while therapy and grief education are offered on a sliding scale. Services are available in English and Spanish, in person and via telehealth. PHCD funding will expand access to grief support for District residents and organizations, directly addressing PHCD priorities including Pediatric Mental and Behavioral Health, Senior Mental Health, and reducing ACEs and toxic stress. Kara's all-ages approach ensures individuals and families receive appropriate support throughout the grieving process. Key Services Children & Families: Age-specific peer groups for children and teens, concurrent caregiver support, family consultations, therapy, school-based grief groups, and Camp Kara, an annual weekend bereavement camp for ages 6–17. Adults: Individual peer counseling, loss- and identity-specific support groups, drop-in groups, and specialized programming for young adults ages 18–35. Therapy: Grief-focused clinical services for individuals experiencing complicated grief alongside depression, anxiety, PTSD, substance use, or other mental health concerns. Community Crisis Response: Timely support for schools, businesses, and organizations following deaths or traumatic losses, available in English and Spanish. Education & Outreach: Grief education for educators, healthcare providers, first responders, and other professionals, plus community workshops and remembrance events. Seniors & Volunteers: Culturally responsive bereavement support for adults 55+, including a Spanish-language peer group in East Palo Alto. Kara engages approximately 230 volunteers, more than half of whom are seniors, providing meaningful opportunities for connection, purpose, and service. Through accessible and culturally responsive services, Kara helps people navigate loss, reduce isolation, strengthen resilience, and move toward renewed hope and meaning.	$ 50,000.00	$ 1,680,000.00

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21	**MELP/ AbleCloset**	Healthy Aging as Focus Area	Free Durable Medical Equipment For All	MELP and AbleCloset are two programs within the nonprofit named MELP/AbleCloset. The MELP program (Medical Equipment Loan Program) handles standard mobility and safety equipment such as walkers, crutches, wheelchairs, commodes, shower chairs, etc., mostly for adults, as well as donated personal care items in original packaging such as incontinence supplies and first aid items. The AbleCloset program handles highly specialized equipment for children with moderate to severe disabilities. In both programs, we receive donated DME (durable medical equipment), we clean and repair the items as needed, and then we loan them out at no cost to anyone who needs them. The most important activity for achieving the desired health outcome is the actual interaction with clients, where we provide them with the equipment or supplies they need. This happens every Saturday. But there are many supporting activities that must happen to allow the primary service to occur: 1. Our receiving team inspects donated equipment or DME being returned by clients who no longer need it. We clean each item and may do minor repairs as needed. Equipment is then tagged, photographed, and entered into our database. 2. Equipment which is broken, excessively worn, or surplus to our inventory (approximately 1/3 of what we receive) is distributed to other non-profit organizations that may repair such equipment, or recycle it, or even send it to another country. Every effort is made to avoid equipment going to landfill. 3. The aforementioned primary activity happens each Saturday at both locations. Our volunteers distribute the warehoused medical equipment and personal care items to our clients free of charge. The volunteers provide the items requested by the clients and guide them through the process of filling out a form with their name and contact information. In this manner equipment is provided to both adults (MELP) and families of disabled children (AbleCloset). 4. The data entry team enters all of the information into our database for accurate tracking of the equipment and to give us the ability to summarize statistics on our volume of services and some demographics on the clients served. 5. We have a strong core team of volunteers that meets every Friday to assess and manage weekly performance, and a Board of Directors that meets quarterly and provides strategic guidance. 6. We train every new volunteer by providing a procedure manual, videos created by a local licensed Occupational Therapist on the characteristics and proper use of each type of DME, and an on-site walk through the facility to familiarize them with the process. 7. We are very intentional in attending outreach events that will make the public aware of our services, and will draw volunteers to join us to sustain the program.	$ 49,660.00	$ 175,475.00
22	**Mental Health Services YMCA, a branch of the YMCA of Greater San Francisco**	Safety Net Services - Move them to Healthy Aging	Safety Net Services at YMCA Community Resource Center	As San Mateo County's Core Agency for San Bruno, South San Francisco, and Brisbane, the YMCA Community Resource Center provides safety net services and assistance to residents of all three communities. Specific services include client centered assessments to determine clients' needs; emergency food and connections to ongoing food resources; housing information and support services; assistance to clients with accessing emergency financial assistance/homelessness prevention services; provide referrals to a broad range of services, including public benefits programs, tax preparation, and legal, and basic necessary materials goods resources, transportation, plus any other services we do not provide. We also directly distribute food, diapers, hygiene items, clothing, and transportation passes. We operate weekly food pantries at two sites, provide emergency food from main office, and provide case management and other support at our main office in South San Francisco and satellite sites in San Bruno and Brisbane. We request funding to expand these services for our San Bruno and southeast corner South San Francisco residents.	$ 50,000.00	$ 1,018,758.00

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23	**NAMI San Mateo County**	Mental & Behavioral Health Grants	Advancing Mental Health Equity, Access, and Outcomes for PHCD Youth and Seniors	NAMI SMC proposes targeted mental health services for youth and seniors to increase mental health knowledge, reduce isolation, and strengthen access to preventive support. Given rising mental health needs among San Mateo County youth, NAMI SMC will provide two evidence-based trainings to teachers and school staff in PHCD elementary and middle schools. Educators will integrate these curricula into classrooms to strengthen emotional wellbeing, resilience, and help-seeking skills. Me in Mind (MIM): A K–8 curriculum using age-appropriate activities to build emotional awareness, coping skills, empathy, and resilience. In pilot testing, 85% of youth learned something new about their emotions and 90.5% said they would seek help during a difficult time. NAMI FLARE: A 23-lesson middle school curriculum that builds mental health literacy, reduces stigma, and strengthens help-seeking skills. In pilot testing, 100% of teachers were likely to recommend FLARE, and 90% of youth showed increased mental health literacy six months later. For seniors, NAMI SMC will provide: MH 101: Mental health education, warning signs, and connections to local resources. Connections 55+: Peer-led support for older adults living with mental health conditions. Family-to-Family: A free, nine-week course for family members, offered in English and Spanish, focused on communication, problem-solving, and self-care. Family Support Groups: Monthly peer-led groups for caregivers and family members, offered in English and Spanish. Together, these free services address mental health and access gaps among youth and seniors. Offered in multiple languages through virtual and in-person formats, NAMI SMC will strengthen knowledge, connection, resilience, and access to ongoing support.	$ 70,000.00	$ 150,962.00
24	**One Life Counseling Center**	Mental & Behavioral Health Grants	Free and Low-Fee Mental Health Counseling	One Life Counseling Center's Free and Low-Fee Mental Health Counseling program will use three strategies to improve the mental health of PHCD residents of all ages: (1) Learn each clients cultural and linguistic needs, schedules, income, and specific mental health needs at intake and connect them with an appropriate therapist and low-fee payment plan. (2) Provide culturally and linguistically competent individual counseling services to children, families, and individuals who are in mental health crises and cannot afford therapy. (3) Provide culturally and linguistically competent individual counseling services in-home to seniors who face barriers to care. (4) Connect clients to additional services to provide a continuum of care for basic needs. All of the clients served in this program are economically disadvantaged, and nearly all have acute mental health needs that are not otherwise being addressed due to the inability to pay for services, inaccessible scheduling, transportation challenges, and/or language or cultural barriers. This program eliminates these barriers and ensures that clients are able to receive professional mental health counseling. The program subsidizes the costs of mental healthcare, allowing clients to pay what they can afford. Recently, One Life launched specialty outreach to ensure this program's accessibility to seniors and now offers this service population in-home counseling to ensure those who are place-bound can receive services. On average, each client served through the program receives 8-10 free or low-cost mental health therapy sessions. Clients with greater needs continue to receive therapy as needed through the program. Each client is also connected to a Peer Counselor who helps them identify other needs, such as food insecurity, housing, transportation, or medical care. Seniors will have access to music bingo as well. Counseling is provided by One Life's diverse team of 180 mental health therapists. Our therapists live in the community, are bilingual and bicultural, and have similar life experiences as our clients. In total, they provide therapy in 9 different languages and over 10 mental health treatment modalities that address over 30 issue areas, including trauma, depression, anxiety, substance use disorder, domestic violence, and suicidal ideation. One Life is the only service provider in the community that provides free and low-fee, high-quality, culturally and linguistically competent therapy to anyone in need within a week of them reaching out with appointments offered on evenings and weekends as well as weekdays.	$ 45,000.00	$ 1,022,000.00

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25	**Peninsula Bridge**	Mental & Behavioral Health Grants	Mental Health Wellness Program	Peninsula Bridge's Mental Health Wellness Program advances PHCD priorities in pediatric mental and behavioral health and preventive care by providing early, culturally responsive support to low-income youth and families. Through licensed therapists, the program provides: Individual Counseling: One-on-one support and crisis intervention focused on coping, emotional regulation, mindfulness, grief, and resilience. Parent/Caregiver Support: Sessions that help families reinforce students' mental health goals at home. Parent Workshops: Education on anxiety, depression, cyberbullying, internet safety, and reducing family stress. Student Wellness Workshops: Preventive group sessions that build resilience, coping skills, healthy habits, and emotional awareness. Working directly with partner schools, Peninsula Bridge identifies needs early and connects students and families to appropriate support before challenges escalate. Services are offered in English, Spanish, and Portuguese, helping reduce barriers to care, strengthen protective factors, and support students' social, emotional, behavioral, and academic well-being.	$ 30,000.00	$ 431,257.00
26	**Peninsula Conflict Resolution Center**	Safety Net Services	SHEroes for Change	We're asking PHCD to support SHEroes of Change, our promotora-led System Navigation Services program connecting San Mateo County's most vulnerable residents to the benefits and care they're entitled to but don't know exists. As VLF shortfalls reduce county and city capacity to reach residents directly, and as federal changes to benefit rules ripple down into what counties must implement, this work has become critical, both to help residents access care before problems escalate and to help them navigate updates that can otherwise disrupt their food, housing, education, and health benefits. Our SHEroes come from the neighborhoods they serve. That lived experience means they don't guess at what communities need, they hear it directly from their neighbors and tailor outreach accordingly. They're trained in depth on County benefits systems, then deliver that knowledge in-language, shaped by what's actually relevant to people's daily lives. This work sits squarely within PHCD's Safety Net Services priority: community health worker-led outreach and care coordination, with a direct line to Medi-Cal enrollment, renewal, and benefits navigation. We work countywide, with a focus on underserved census tracts within the PHCD region. Three core activities: - Health education and benefits workshops: presentations to faith groups, parent groups, and neighborhood associations on what's available (Medi-Cal, health screenings, social services) and exactly how to access it - Direct referrals: connecting individuals to specific clinics and programs matched to their needs - On-the-ground outreach: door-to-door when needed, tabling at health fairs, farmers markets, and school events, and partnering with school districts, law enforcement, and local businesses to reach people where they already gather We reach nearly 1,000 individuals a year. Information without access isn't help. SHEroes deliver both.	$ 26,000.00	$ 99,921.00
27	**Pink Ribbon Good**	Healthy Living across the Life Span Grants	Essential Nutrition and Concierge Transportation for PHCD Cancer Patients	Pink Ribbon Good (PRG) bridges the gap between cancer treatment and the practical challenges families face during a diagnosis. By addressing key social determinants of health—particularly food and transportation insecurity—PRG helps patients focus on treatment and recovery while reducing financial stress and barriers to care. PRG provides three core services: Healthy Household Meals: Through a partnership with ModifyHealth, PRG delivers chef-prepared, nutrient-dense meals directly to clients' homes. During a four-week period, each household member receives three ready-to-heat meals per week at no cost. This support helps families manage the fatigue and side effects of treatment while reducing food insecurity and treatment-related malnutrition. Concierge Transportation: PRG funds and coordinates up to 10 round-trip Uber Health rides per client for cancer-related appointments, including chemotherapy, radiation, labs, and clinical trials. Program coordinators schedule and monitor each ride, removing financial and logistical barriers that could otherwise lead to missed care. Peer Support & Education: PRG provides virtual and in-person peer support through programs including Young Survivor Connection, Thrivers Wellness Club, and Linked by Hope for teens navigating a family cancer diagnosis. These programs reduce isolation and strengthen social connection during treatment. PRG integrates directly with local healthcare systems, receiving referrals from oncology navigators at Stanford Health Care, Sutter, Kaiser Permanente, El Camino Health, and San Mateo Medical Center through a secure portal. A PRG coordinator then contacts each patient to assess needs and create a personalized support plan. By providing immediate, practical support at no cost, PRG helps local cancer patients maintain treatment, reduce financial and logistical burdens, and navigate cancer with greater stability, dignity, and connection.	$ 20,000.00	$ 1,500,000.00

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28	**Ravenswood Family Health Network (RFHN)**	Preventive Health Grants	RFHN'S Health Education and Prevention Programs	We respectfully request PCHD's support for our Health Education and Prevention Programs, which include two core initiatives. The first is our Comprehensive Diabetes Management Program, through which Health Coaches, certified Medical Assistants who are bilingual in English/Spanish or English/Tongan, support patients with chronic conditions such as diabetes and hypertension. Health Coaches provide medication counseling, coordinate care, address gaps in care, and ensure appropriate follow-up with external providers. They also monitor vital signs, perform glucose and foot exams, teach self-management practices, and conduct retinal screenings. The second is our Breast and Cervical Cancer Screening Program, through which Program Assistants provide intensive outreach, care coordination, and health education. They identify patients who are overdue for screenings or who have received abnormal screening results, maintain referral networks, and provide education on the importance of early detection. They also assist patients with applying for financial aid and connecting to support services, helping reduce the financial and practical burdens associated with a cancer diagnosis.	$ 25,000.00	$ 218,647.00
29	**Samaritan House**	Safety Net Services	Samaritan House Free Dental Clinic and Food Services Programs	Free Dental Clinic Samaritan House's Free Clinic of San Mateo is one of only two free clinics in San Mateo County, providing zero-fee primary, dental, vision, behavioral health, specialty, and preventive care to uninsured residents below 250% of the federal poverty level. Established in 1996, the Dental Program provided 871 visits to 252 patients in FY26 and offers comprehensive services including cleanings, fillings, crowns, extractions, root canals, periodontal care, and dentures. The clinic also trains local dental and dental hygiene students. Led by Dental Director Dr. Rob Rideau, DDS, the program is supported by a hygienist, two dental assistants, and volunteers. Demand exceeds capacity. Funding will support an Associate Dental Director, expanding access for District patients, serving hundreds more annually, and strengthening clinical leadership and succession planning. Integrating dental and primary care helps prevent serious, costly complications by addressing oral health needs before they require emergency care, while improving overall health and quality of life. Food Services Program Samaritan House operates 17 food programs serving food-insecure residents across San Mateo County. In FY26, the program provided 5.3 million meals—including 450,152 hot meals and 643,356 grocery bags—to 26,837 residents, generating an estimated $26.68 million in community savings and helping 13,631 households redirect income toward housing, healthcare, transportation, and other essentials. Following the temporary federal halt in SNAP benefits in fall 2025, PHCD funded two temporary Food Services positions. Continued high demand and expanding food rescue efforts have made these positions essential, particularly as Samaritan House increases recovery of prepared food from hotels, restaurants, caterers, and other Tier 2 generators. Funding will make these positions permanent, maintaining capacity for food rescue, inventory management, meal and grocery preparation, and distribution. Together, these efforts provide reliable access to nutritious food while strengthening the health and financial security of local families.	$ 70,000.00	$ 11,447,599.00
30	**San Mateo County Health Foundation**	Safety Net Services	Caring Hands in Health	Caring Hands in Health is a rapid-response safety-net assistance program of the San Mateo County Health Foundation, operating in partnership with San Mateo Medical Center (SMMC) — the county's only public hospital. When a healthcare crisis creates a need that insurance, public benefits, or existing social services can't meet in time, Caring Hands provides flexible, short-term support: housing and eviction prevention, temporary lodging following hospitalization or treatment, transportation to medical appointments, food and basic necessities, medications, medical equipment, and accessibility needs. For low-income, uninsured, underinsured, and otherwise financially vulnerable residents, these practical barriers can directly interfere with the ability to access care and recover safely. Caring Hands fills the gaps that coverage and existing services often can't reach — helping patients remain housed, attend appointments, maintain nutrition, and avoid preventable complications after treatment. Through referrals and coordination with SMMC providers and community partners, patients are also connected to longer-term healthcare, public benefits, and community resources whenever possible. Each year, Caring Hands provides direct assistance to approximately 800 patients and families throughout San Mateo County. Demand for this safety net is growing as changes to public benefits and healthcare programs create new coverage gaps for financially vulnerable residents. Caring Hands is designed to be the flexible, rapid-response resource that steps in when nothing else can — keeping patients stable and connected to care while longer-term solutions are identified.	$ 70,000.00	$ 400,000.00

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31	**San Mateo County Pride Center**	Healthy Living across the Life Span Grants	Building Belonging: Reducing Isolation, Advancing Social Connection, and Increasing Wellbeing for PHCD's Older LGBTQ+ Adults	Caring Hands in Health is a rapid-response safety-net assistance program of the San Mateo County Health Foundation, operating in partnership with San Mateo Medical Center (SMMC) — the county's only public hospital. When a healthcare crisis creates a need that insurance, public benefits, or existing social services can't meet in time, Caring Hands provides flexible, short-term support: housing and eviction prevention, temporary lodging following hospitalization or treatment, transportation to medical appointments, food and basic necessities, medications, medical equipment, and accessibility needs. For low-income, uninsured, underinsured, and otherwise financially vulnerable residents, these practical barriers can directly interfere with the ability to access care and recover safely. Caring Hands fills the gaps that coverage and existing services often can't reach — helping patients remain housed, attend appointments, maintain nutrition, and avoid preventable complications after treatment. Through referrals and coordination with SMMC providers and community partners, patients are also connected to longer-term healthcare, public benefits, and community resources whenever possible. Each year, Caring Hands provides direct assistance to approximately 800 patients and families throughout San Mateo County. Demand for this safety net is growing as changes to public benefits and healthcare programs create new coverage gaps for financially vulnerable residents. Caring Hands is designed to be the flexible, rapid-response resource that steps in when nothing else can — keeping patients stable and connected to care while longer-term solutions are identified.	$ 34,712.00	$ 69,424.00
32	**San Mateo County Pride Center**	Safety Net Services	Pathways to Stability: Providing LGBTQ+ PHCD Residents with Connections to Resources and Support	The San Mateo County Pride Center provides accessible, culturally responsive case management services to support individuals of all ages across San Mateo County to access the vital services they need. The goal of this program is to enhance participants' abilities to resolve issues, overcome obstacles, and lead fulfilling, productive lives. The Pride Center's in-house case manager works closely with case management program participants to create a customized service plan that considers each person's unique strengths, needs, and circumstances. Functioning as a liaison, mediator, and advocate for participants' health and wellbeing, our case manager oversees their care and connects them to the appropriate resources and service providers whenever necessary. Case management services can include (but is not limited to) the following areas: - Navigating Healthcare - Housing/Shelter - Financial Assistance - Transportation - Employment/Job Search - Legal Name / Gender Change Assistance and Other Legal Aid - Social and Peer Support Through providing consistent support and connections to vital resources and care, our case management services work to address urgent and longstanding needs specific to the LGBTQ+ community members we serve. All services to be provided will be strength-based, evidence-based, trauma-informed, client-centered, and utilize a harm reduction approach. The case management staff delivering services have many years of experience providing effective case management services to San Mateo County's LGBTQ+ communities, are reflective of the diverse communities we serve, and deeply knowledgeable about local needs, challenges and resources.	$ 35,000.00	$ 165,929.00

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1	**Organization Name**	**Primary Focus Area: *Priorities**	**Program Title**	**Program Summary**	**Annual Funding Request**	**Total Program Budget (simple)**
33	**San Mateo Highlands Recreation District**	Healthy Living across the Life Span Grants	San Mateo Highlands Recreation District - Senior Activities	Proposed Program With grant support, HRD proposes to expand its weekly enrichment, fitness, and social activities for older adults. Programming will offer a range of activities appropriate to different interests, abilities, and stages of healthy aging. Proposed activities include: -Mahjong classes to encourage learning, social interaction, and cognitive engagement. -Qigong and Tai Chi to promote fitness, flexibility, balance, and fall prevention. -Square dancing to provide enjoyable physical activity and social engagement. -Card games, Cribbage and Bridge to encourage cognitive stimulation and regular social interaction. -Ukulele activities to promote creativity, learning, and group participation. -Pickleball to provide adaptable recreational exercise and opportunities for social connection. -Monthly potluck lunches to strengthen community relationships and provide opportunities to share information about medical equipment loan programs, transportation resources, health and wellness programs, and other services available to older adults. Together, these programs are intended to address several important components of healthy aging: physical activity, balance and mobility, cognitive stimulation, social connection, lifelong learning, and access to community resources. Addressing Accessibility and Social Isolation A particular priority of this initiative is reaching seniors who may have difficulty participating in traditional recreational programs because of disability, reduced mobility, transportation limitations, or other age-related barriers. For these residents, accessible activities offered within their own community can provide more than recreation. They can create regular opportunities to develop friendships, maintain independence, establish healthy routines, and remain connected to neighbors and community resources. Expanding HRD's programming will also help reduce the risk of social isolation among older adults and their caregivers who may otherwise have limited opportunities for regular community engagement.	$ 15,000.00	$ 15,000.00
34	**Self-Help for the Elderly**	Mental & Behavioral Health Grants	Circle Together	Circle Together: Kitchen Table Series Circle Together is an inclusive program designed for hard-to-reach, isolated, and vulnerable seniors. The project is an informal, safe, and welcoming space for older adults to engage in socialization, peer support, education, cultural sharing, and community outings. For seniors who feel unheard, unseen, and disconnected, Circle Together provides a gentle, supportive step toward re-engaging with peers and the broader community. The project is a low-barrier-to-entry, with comfortable conversation, familiar snacks, and music, and building up to collaborative group activities and outings. Frequency & Activities: -Daily: Online Class schedule reminders, Bay Area news updates, and safety/wellness check-ins - Weekly: Health Education Class (Zoom), Group Discussion Class (Zoom), Digital Q&A (In-person), and English Class (In-person). - Biweekly (Every other week): Stress Relief Class (Zoom) and Field Trips (Twice a month). - Monthly: Health Talk (Zoom) -Quarterly: Asian American Medical Group Health Education Workshop (In-person), Field Trip (museum, botanical garden, library, Other onsite activities: Arts and Crafts, Digital Literacy (navigating today's smart devices), storytelling, chair Tai Chi, mental health education, guest speakers on nutrition, financial scams, and others.	$ 65,000.00	$ 102,600.00

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1	**Organization Name**	**Primary Focus Area: *Priorities**	**Program Title**	**Program Summary**	**Annual Funding Request**	**Total Program Budget (simple)**
35	**Somatice-cotherapy, Inc**	Healthy Living across the Life Span Grants	Nature as Preventive Health: Supporting Healthy Aging & Connection	Nature for Healthy Aging: Connection, Resilience & Wellbeing is a community-based preventive health initiative designed to make evidence-informed Forest Therapy and nature-based wellbeing more accessible to seniors, family caregivers, and communities with limited access to restorative nature experiences. With PHCD support, Somatic Ecotherapy will partner with senior-serving, caregiver, healthcare, and community organizations to offer 12 monthly, three-hour guided Forest Therapy experiences in accessible natural settings, such as local parks. Each experience will combine sensory nature connection, gentle movement, somatic practices, social connection, and practical tools participants can use independently. Each monthly program will include: Partner coordination and participant preparation A welcome letter explaining what to expect and how to prepare A three-hour guided Forest Therapy experience Simple self-guided nature practices and accessible resources Post-program follow-up encouraging continued Forest Bathing Participant feedback and outcome measurement The goal is not simply a one-time restorative experience, but to help participants develop Forest Bathing as an ongoing, accessible preventive-health practice. With guidance from PHCD and a community advisor, we will identify and certify an accessible Forest Therapy site, potentially located between a healthcare center and senior housing, offering both guided and self-guided experiences. Working with Colorado State University, we will evaluate outcomes including perceived stress, loneliness/social connection, and nature connection. Paid community advisors will help identify participation barriers, shape programming around local needs, and select an accessible natural space near where people live, gather, or receive healthcare. Community members will also have opportunities to shadow programs and develop skills as future Community Wellbeing Ambassadors, supporting a model that becomes increasingly community-informed, community-led, and sustainable. Our approach is simple: Experience → Listen → Measure → Co-Design → Create a Place → Sustain. Ultimately, the program will demonstrate how nearby nature can support preventive health, healthy aging, caregiver wellbeing, stress reduction, and meaningful social connection.	$ 17,250.00	$ 17,250.00
36	**Square Peg Foundation**	Mental & Behavioral Health Grants	Adaptive Horsemanship Sessions	Square Peg provides an adaptive horsemanship program specifically tailored for children and young adults with ASD, their families and individuals with ADD/ADHD, anxiety/depression, and trauma. Our Adaptive horsemanship offers a powerful, non-verbal pathway to emotional regulation, self-esteem, and social-emotional skill-building for children who may not respond as well to conventional clinical settings.	$ 25,000.00	$ 350,000.00

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37	**The HEAL Project**	Preventive Health Grants	Farm Field Trip Program for PHCD Residents	The HEAL Project's Farm Field Trip Program has served San Mateo County schools for 17 years, welcoming more than 4,000 students annually. Curtis Chan, Deputy Health Officer, SMC, recently called The HEAL Project "the most impactful place to connect children with growing food and healthy eating in San Mateo County." Students engage in hands-on lessons focused on Health, Environmental, and Agricultural Literacy by planting seeds, harvesting and tasting fresh produce, and preparing nutritious snacks. Teachers and parents consistently report that students are more willing to try new fruits and vegetables when they harvest them themselves. Over the past three years of partnering with PHCD, more than 3,500 students from the PHCD service area have participated. In the two most recent program years, 42% and 40% of students served were from PHCD. Last year, 71% of participating classes came from schools with a UPC above 25% and attended for free or at a reduced rate. Grant-Supported Improvements Streamlined teacher registration Grade-specific field trip options Indigenous knowledge program developed with a local Indigenous group Social-emotional learning and mental wellness activities Field Trip Activities Taste Tour: Students harvest and taste fresh produce while learning about healthy eating and whole foods. (30–45 minutes) Plant Part Tacos/Farm on a Cracker: Students prepare a seasonal, healthy snack using freshly harvested produce. (30–45 minutes; 2nd grade+) Give Back to the Farm: Students plant, weed, sift compost, or spread wood chips while learning about food systems and environmental health. (~30 minutes) Compost and Soil Health: Students explore decomposition, composting, and healthy soil practices. (~30 minutes) Nature Hike and Mindfulness: Students explore local ecology while practicing mindfulness and aerobic activity. (~30 minutes)	$ 68,964.00	$ 209,000.00
38	**Upward Scholars**	Mental & Behavioral Health Grants	Whole-Student Support: Reducing Toxic Stress and Building Resilience for Adult Immigrant Learners and Their Families	Upward Scholars reduces toxic stress and adverse conditions for low-income immigrant adults and their families by addressing interconnected barriers such as financial insecurity, isolation, limited belonging, and unstable employment. Our integrated model builds stability, confidence, relationships, and agency while creating pathways to education and economic mobility. We provide four complementary areas of support: Financial Support: Textbooks, laptops, transportation, groceries, and emergency assistance for expenses such as rent, utilities, and medical costs, helping families manage financial shocks that contribute to chronic stress. Academic Support: Peer tutoring, mentoring, and English Conversation Club build confidence, connection, and a sense of belonging. Career Development: Education and career pathways help participants secure higher-wage, more stable employment and reduce long-term financial stress. Holistic Support: Our bilingual, bicultural Pláticas program provides 1:1 and small-group counseling, appointment accompaniment, and referrals to behavioral health and community resources. Because services extend to spouses, children, and extended family, the benefits reach beyond individual participants. Reducing parental stress, strengthening household stability, and increasing economic security can reduce children's exposure to adverse and toxic conditions. Our approach centers on understanding participants' experiences, building protective factors such as relationships, belonging, stability, and skills, strengthening agency, and creating pathways to greater opportunity. Together, these supports	$ 12,000.00	$ 1,673,369.00

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39	**Vista Center for the Blind and Visually Impaired**	Healthy Living across the Life Span Grants	Vision Loss Rehabilitation: Restoring Independence through Independent Living Skills and Life Enrichment Services	Vista Center for the Blind and Visually Impaired requests $70,000 to provide Vision Loss Rehabilitation (VLR) services to 37 low-income PHCD residents, most of whom are seniors. Vista Center is the only regional provider of comprehensive VLR services and the only remaining Low Vision Clinic in Santa Clara County since Kaiser San Jose closed its program in 2025. As the District's senior population grows, so does the need for vision loss services. Vision impairment increases risks of falls, medication errors, isolation, caregiver strain, and depression. Vista's services directly support PHCD priorities including caregiver support, health education, healthy aging, senior socialization, and senior mental health, helping residents remain safe, independent, and connected. Vista's Vision Loss Rehabilitation Program uses a whole-person approach tailored to each client's needs and includes two core areas: Independent Living Skills: One-on-one instruction in cooking, medication management, home safety, technology, and independent travel. These practical skills restore confidence, autonomy, and the ability to age safely in place. Life Enrichment Services: Counseling, fitness, music, pottery, and other activities that help clients cope with vision loss, reduce isolation, maintain social connections, and support emotional well-being. Vista's Low Vision Clinic also works alongside clients' primary care providers to screen for progressive conditions such as diabetic retinopathy. Together, these services help people with vision loss maintain independence, safety, connection, and quality of life, ensuring that vision loss does not prevent them from living full and meaningful lives.	$ 70,000.00	$ 2,246,611.00
40	**We Make it Matter**	Healthy Living across the Life Span Grants	CAREGIVER WELLNESS CIRCLES	Caregiver Wellness Circles. Monthly facilitated peer gatherings for family caregivers and community members carrying sustained caregiving strain, held in accessible venues across the district and offered online for those who cannot leave the home. Groups are intentionally capped at approximately 25 participants — small enough that people speak honestly. Sessions are non-clinical and confidential, structured around shared experience, practical coping, and reconnection with the basics of personal wellbeing: rest, movement, nutrition, and social contact. Peer Companions. Trained volunteers providing sustained one-to-one check-ins between gatherings, addressing the isolation that makes caregiving strain compound. WMIM currently has 5–6 active volunteers and will use grant funds to formalise recruitment, training, and supervision. Training covers active listening, boundaries, and recognising when to refer someone to clinical or county services. The WMIM App. A free wellness companion for iOS and Android offering mood tracking, encrypted private journaling, and daily reflection prompts. Journaling is encrypted and never leaves the user's control. For a caregiver whose only unclaimed moment is late at night, it is often the only support that fits the shape of their day. Free permanently — no cost, no insurance, no barrier. Referral pathway. WMIM is explicitly non-clinical. Facilitators and volunteers are trained to recognise when someone needs clinical support and to refer them to district-funded providers and county services. WMIM functions as an on-ramp to the	$ 35,000.00	$ 35,000.00
41	**Youth Leadership Institute**	Preventive Health Grants	Youth-Led Substance Use Prevention & Health Education	Youth Leadership Institute (yli) is seeking support from Peninsula Health Care District (PHCD) to expand its youth-led alcohol and other drug (AOD) prevention and health education programming for young people in Mid-San Mateo County. The program will provide culturally responsive, youth-centered health education focused on alcohol, cannabis, tobacco/vaping, addiction, protective factors, and help-seeking behaviors, while developing young peopleâ€™s leadership skills and ability to promote healthier choices among their peers. Programming will combine interactive health education presentations, peer-to-peer prevention activities, youth leadership development, and youth-led outreach and messaging. Presentations use evidence-based prevention strategies and experiential activities such as games, hands-on exercises, impairment simulations, and youth-designed calls to action. Youth participants will also help identify emerging health concerns in their schools and communities and develop prevention activities such as presentations, social media content, public service announcements (PSAs), and other educational materials. PHCD funding will allow yli to expand this established model within District communities, with particular attention to young people who experience barriers to accessing traditional prevention and health education resources.	$ 15,000.00	$ 166,547.00
42				**Total:**	**$ 1,825,586.00**	