

2026 Grant Work Plan

Department Name and #: **Health Department – 0015**

Job code **10050, 10070, 10080,**

10081, 20122, 20123, 21667, 21691, 22026, 23021, 23031, 23033, 23070, 23071, 23770, 30020, 30115, 30515, 30820, 31121, 37020, 40010, 40015, 40016, 40017.

Division and Fund #: **110, 125, 130 – Fund 125**

Dept Program Name and #: **Office of the Director - 610, Prevention Services - 625, Environmental Health - 630**

Grant Title: **Foundational Public Health Services/ FPHS-LHJ-Proviso / FPHS-LHJ FUNDS- GFS**

Purpose of grant (Brief description of work to be performed): **Foundational public health funding.**

Existing/ongoing program: ☒ Yes New Program: ☐ Yes

Source of grant funding: Federal ☐ State ☒ Local ☐ Other ☐

Grant Term: From 1/01/2026 to 6/30/2026

Grantor: Department of Health – Consolidated Contract

Grant Award: **\$6,831,000.00**

Is match required: ☐ Yes ☒ No If yes, match amount required: _____

Match Source (General Fund, Patient Fees, In-Kind, etc.). _____

If County-funded match, enter Charge Code Title and # below.

Charge Code Title and # _____ Amount: \$ _____

Charge Code Title and # _____ Amount: \$ _____

Total Resources: \$6,831,000.00

EXPENDITURES

1. Internal Operations (Admin., Operations, Direct Service, etc.) Estimated Cost: \$6,831,000.00

Who will complete the work?

Existing FTE(s) ☒ Existing project FTE(s) ☐ New FTE(s) ☐

If new FTEs are needed, complete the following. Attach additional sheet if needed.

# FTEs	Classification
_____	_____
_____	_____

Total FTEs: _____

2. Pass Thru (Estimated cost) \$ _____

Total Expenditures: \$6,831,000.00

2026 Grant Work Plan

Department Name and #: **Health Department – 0015**

Job code **10041**

Division and Fund #: **110 - 125**

Dept Program Name and #: **Office of the Director - 610**

Grant Title: **PH Infrastructure Comp A1-LHJ**

Purpose of grant (Brief description of work to be performed): To provide funding to establish, expand, train, and sustain the LHJ public health workforce in accordance with the CDC Public Health Infrastructure Grant (PHIG).

Existing/ongoing program: ☒ Yes New Program: ☐ Yes

Source of grant funding: Federal ☒ State ☐ Local ☐ Other ☐

Grant Term: From 1/01/2026 to 11/30/2027

Grantor: Department of Health – Consolidated Contract Grant Award: **\$191,366.00**

Is match required: ☐ Yes ☒ No If yes, match amount required: _____

Match Source (General Fund, Patient Fees, In-Kind, etc.). _____

If County-funded match, enter Charge Code Title and # below.

Charge Code Title and # _____ Amount: \$ _____

Charge Code Title and # _____ Amount: \$ _____

Total Resources: \$191,366.00

EXPENDITURES

1. Internal Operations (Admin., Operations, Direct Service, etc.) Estimated Cost: \$191,366.00

Who will complete the work?

Existing FTE(s) ☒ Existing project FTE(s) ☐ New FTE(s) ☐

If new FTEs are needed, complete the following. Attach additional sheet if needed.

# FTEs	Classification
_____	_____
_____	_____

Total FTEs: _____

2. Pass Thru (Estimated cost) \$ _____

Total Expenditures: \$191,366.00

2026 Grant Work Plan

Department Name and #: **Health Department – 0015**

Job code **10064**

Division and Fund #: **110 - 125**

Dept Program Name and #: **Office of the Director - 610**

Grant Title: **CDC COVID-19 PHWFD-LHJ (Public Health Work Force Development)**

Purpose of grant (Brief description of work to be performed): To provide funding to establish, expand, train, and sustain the LHJ public health workforce to support jurisdictional COVID-19 prevention, preparedness, response, and recovery initiatives, in accordance with the CDC Crisis Response Cooperative Agreement: COVID-19 Public Health Workforce.

Existing/ongoing program: ☒ Yes New Program: ☐ Yes

Source of grant funding: Federal ☒ State ☐ Local ☐ Other ☐

Grant Term: From 1/01/2026 to 12/31/2026

Grantor: Department of Health – Consolidated Contract Grant Award: **\$20,882.00**

Is match required: ☐ Yes ☒ No If yes, match amount required: _____

Match Source (General Fund, Patient Fees, In-Kind, etc.): _____

If County-funded match, enter Charge Code Title and # below.

Charge Code Title and # _____ Amount: \$ _____

Charge Code Title and # _____ Amount: \$ _____

Total Resources: \$20,882.00

EXPENDITURES

1. Internal Operations (Admin., Operations, Direct Service, etc.) Estimated Cost: \$20,882.00

Who will complete the work?

Existing FTE(s) ☒ Existing project FTE(s) ☐ New FTE(s) ☐

If new FTEs are needed, complete the following. Attach additional sheet if needed.

# FTEs	Classification
_____	_____
_____	_____

Total FTEs: _____

2. Pass-Thru Estimated cost: \$ _____

Total Expenditures: \$20,882.00

2026 Grant Work Plan

Department Name and #: **Health Department – 0015**

Job code **10073**

Division and Fund #: **110 - 125**

Dept Program Name and #: **Office of the Director - 610**

Grant Title: **Expanding the Public Health Workforce with the Disability Network: DD Councils.**

Purpose of grant (Brief description of work to be performed):

To create and utilize a communications reference guide focused on how to best communicate public health information equitably and effectively to Snohomish County residents with intellectual and developmental disabilities.

Existing/ongoing program: ☒ Yes New Program: ☐ Yes

Source of grant funding: Federal ☐ State ☒ Local ☐ Other ☐

Grant Term: From 10/01/2025 to 09/30/2026

Grantor: Washington State Department of Commerce

Grant Award **\$93,319.00**

Is match required: ☐ Yes ☒ No If yes, match amount required: _____

Match Source (General Fund, Patient Fees, In-Kind, etc.): _____

If County-funded match, enter Charge Code Title and # below.

Charge Code Title and # _____ Amount: \$_____

Charge Code Title and # _____ Amount: \$_____

Total Resources \$93,319.00

EXPENDITURES

1. Internal Operations (Admin., Operations, Direct Service, etc.) Estimated Cost: \$93,319.00

Who will complete the work?

Existing FTE(s) ☒ Existing project FTE(s) ☐ New FTE(s) ☐

If new FTEs are needed, complete the following. Attach additional sheet if needed.

# FTEs	Classification
_____	_____
_____	_____

Total FTEs: _____

2. Pass-Thru Estimated cost: \$_____

Total Expenditures \$93,319.00

2026 Grant Work Plan

Department Name and #: **Health Department – 0015**

Job code **10076**

Division and Fund #: **110 - 125**

Dept Program Name and #: **Office of the Director - 610**

Grant Title: **Community Navigation.**

Purpose of grant (Brief description of work to be performed): To develop a community navigator program where the Snohomish Health department contracts with community leaders in communities that are systemically excluded and disproportionately impacted by negative health outcomes including communicable and chronic diseases as well as mental health conditions to strengthen and maintain the public health presence and relationship within these communities.

Existing/ongoing program: ☐ Yes New Program: ☒ Yes

Source of grant funding: Federal ☐ State ☐ Local ☐ Other ☒

Grant Term: From 1/01/2026 to 12/31/2026

Grantor: Robert Wood Johnson Foundation

Grant Award **\$500,000.00**

Is match required: ☐ Yes ☒ No If yes, match amount required: _____

Match Source (General Fund, Patient Fees, In-Kind, etc.): _____

If County-funded match, enter Charge Code Title and # below.

Charge Code Title and # _____ Amount: \$ _____

Charge Code Title and # _____ Amount: \$ _____

Total Resources	\$500,000.00
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EXPENDITURES

1. Internal Operations (Admin., Operations, Direct Service, etc.) Estimated Cost: \$500,000.00

Who will complete the work?

Existing FTE(s) ☒ Existing project FTE(s) ☐ New FTE(s) ☐

If new FTEs are needed, complete the following. Attach additional sheet if needed.

# FTEs	Classification
_____	_____

Total FTEs: _____

2. Pass-Thru Estimated cost: \$ _____

Total Expenditures	\$500,000.00
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2026 Grant Work Plan

Department Name and #: **Health Department – 0015**

Job code **23053**

Division and Fund #: **110 - 125**

Dept Program Name and #: **Office of the Director - 610**

Grant Title: **EIP FLUSURVNET SURV CDC**

Purpose of grant (Brief description of work to be performed): To provide funding to perform active population-based surveillance on hospitalizations associated with those conditions related to RESP-NET (Respiratory Virus Hospitalization Surveillance Network), a general term for three separate projects (Flu Surv-NET, COVID-NET, RSV-NET).

Existing/ongoing program: ☒ Yes New Program: ☐ Yes

Source of grant funding: Federal ☒ State ☐ Local ☐ Other ☐

Grant Term: From 1/01/2026 to 12/31/2026

Grantor: Department of Health – Consolidated Contract Grant Award **\$42,648.00**

Is match required: ☐ Yes ☒ No If yes, match amount required: _____

Match Source (General Fund, Patient Fees, In-Kind, etc.): _____

If County-funded match, enter Charge Code Title and # below.

Charge Code Title and # _____ Amount: \$ _____

Charge Code Title and # _____ Amount: \$ _____

Total Resources	\$42,648.00
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EXPENDITURES

1. Internal Operations: (Admin., Operations, Direct Service, etc.) Estimated Cost: \$42,648.00

Who will complete the work?

Existing FTE(s) ☒ Existing project FTE(s) ☐ New FTE(s) ☐

If new FTEs are needed, complete the following. Attach additional sheet if needed.

# FTEs	Classification
_____	_____
_____	_____

Total FTEs: _____

2. Pass-Thru Estimated cost: \$ _____

Total Expenditures	\$42,648.00
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2026 Grant Work Plan

Department Name and #: **Health Department – 0015**

Job code **23055**

Division and Fund #: **110 - 125**

Dept Program Name and #: **Office of the Director - 610**

Grant Title: **EIP COVIDNET SURV CDC**

Purpose of grant (Brief description of work to be performed): To provide funding to perform active population-based surveillance on hospitalizations associated with those conditions related to RESP-NET (Respiratory Virus Hospitalization Surveillance Network), a general term for three separate projects (Flu Surv-NET, COVID-NET, RSV-NET).

Existing/ongoing program: ☒ Yes New Program: ☐ Yes

Source of grant funding: Federal ☒ State ☐ Local ☐ Other ☐

Grant Term: From 1/01/2026 to 12/31/2026

Grantor: Department of Health – Consolidated Contract

Grant Award **\$132,750.00**

Is match required: ☐ Yes ☒ No If yes, match amount required: _____

Match Source (General Fund, Patient Fees, In-Kind, etc.): _____

If County-funded match, enter Charge Code Title and # below.

Charge Code Title and # _____ Amount: \$ _____

Charge Code Title and # _____ Amount: \$ _____

Total Resources	\$132,750.00
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EXPENDITURES

1. Internal Operations: (Admin., Operations, Direct Service, etc.) Estimated Cost: \$132,750.00

Who will complete the work?

Existing FTE(s) ☒ Existing project FTE(s) ☐ New FTE(s) ☐

If new FTEs are needed, complete the following. Attach additional sheet if needed.

# FTEs	Classification
_____	_____
_____	_____

Total FTEs: _____

2. Pass-Thru Estimated cost: \$ _____

Total Expenditures	\$132,750.00
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2026 Grant Work Plan

Department Name and #: **Health Department – 0015**

Job code **37042**

Division and Fund #: **110 - 125**

Dept Program Name and #: **Office of the Director - 610**

Grant Title: **PHEP BP5 LHJ Funding**

Purpose of grant (Brief description of work to be performed): To support and sustain LHJ public health emergency preparedness as part of statewide public health emergency preparedness, resilience, and response.

Existing/ongoing program: ☒ Yes New Program: ☐ Yes

Source of grant funding: Federal ☒ State ☐ Local ☐ Other ☐

Grant Term: From 7/01/2025 to 6/30/2026

Grantor: Department of Health – Consolidated Contract Grant Award **\$302,555.00**

Is match required: ☐ Yes ☒ No If yes, match amount required: _____

Match Source (General Fund, Patient Fees, In-Kind, etc.): _____

If County-funded match, enter Charge Code Title and # below.

Charge Code Title and # _____ Amount: \$ _____

Charge Code Title and # _____ Amount: \$ _____

Total Resources \$302,555.00

EXPENDITURES

1. Internal Operations: (Admin., Operations, Direct Service, etc.) Estimated Cost: \$302,555.00

Who will complete the work?

Existing FTE(s) ☒ Existing project FTE(s) ☐ New FTE(s) ☐

If new FTEs are needed, complete the following. Attach additional sheet if needed.

# FTEs	Classification
_____	_____
_____	_____

Total FTEs: _____

2. Pass-Thru Estimated cost: \$ _____

Total Expenditures \$302,555.00

2026 Grant Work Plan

Department Name and #: **Health Department – 0015**

Job code **37043**

Division and Fund #: **110 - 125**

Dept Program Name and #: **Office of the Director - 610**

Grant Title: **Molina MRC Support Activities**

Purpose of grant (Brief description of work to be performed): To support the growth and development of MRC.

Existing/ongoing program: ☒ Yes New Program: ☐ Yes

Source of grant funding: Federal ☐ State ☐ Local ☐ Other ☒

Grant Term: From 1/01/2026 to 12/31/2026

Grantor: Molina Healthcare of Washington

Grant Award **\$2,500.00**

Is match required: ☐ Yes ☒ No If yes, match amount required: _____

Match Source (General Fund, Patient Fees, In-Kind, etc.): _____

If County-funded match, enter Charge Code Title and # below.

Charge Code Title and # _____ Amount: \$ _____

Charge Code Title and # _____ Amount: \$ _____

Total Resources	\$2,500.00
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EXPENDITURES

1. Internal Operations: (Admin., Operations, Direct Service, etc.) Estimated Cost: \$2,500.00

Who will complete the work?

Existing FTE(s) ☒ Existing project FTE(s) ☐ New FTE(s) ☐

If new FTEs are needed, complete the following. Attach additional sheet if needed.

# FTEs	Classification
_____	_____
_____	_____

Total FTEs: _____

2. Pass-Thru Estimated cost: \$ _____

Total Expenditures	\$2,500.00
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2026 Grant Work Plan

Department Name and #: **Health Department – 0015**

Job code **37044**

Division and Fund #: **110 - 125**

Dept Program Name and #: **Office of the Director - 610**

Grant Title: **NACCHO MRC Operational Readiness Award**

Purpose of grant (Brief description of work to be performed): To support the growth and development of MRC and expand training, exercise, and response capabilities.

Existing/ongoing program: ☒ Yes New Program: ☐ Yes

Source of grant funding: Federal ☐ State ☐ Local ☐ Other ☒

Grant Term: From 1/01/2026 to 12/31/2026

Grantor: NACCHO

Grant Award **\$10,000.00**

Is match required: ☐ Yes ☒ No If yes, match amount required: _____

Match Source (General Fund, Patient Fees, In-Kind, etc.): _____

If County-funded match, enter Charge Code Title and # below.

Charge Code Title and # _____ Amount: \$ _____

Charge Code Title and # _____ Amount: \$ _____

Total Resources	\$10,000.00
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EXPENDITURES

1. Internal Operations: (Admin., Operations, Direct Service, etc.) Estimated Cost: \$10,000.00

Who will complete the work?

Existing FTE(s) ☒ Existing project FTE(s) ☐ New FTE(s) ☐

If new FTEs are needed, complete the following. Attach additional sheet if needed.

# FTEs	Classification
_____	_____
_____	_____

Total FTEs: _____

2. Pass-Thru Estimated cost: \$ _____

Total Expenditures	\$10,000.00
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2026 Grant Work Plan

Department Name and #: **Health Department – 0015**

Job code **37059**

Division and Fund #: **110 - 125**

Dept Program Name and #: **Office of the Director - 610**

Grant Title: **PHEP CRI BP5 LHJ Funding**

Purpose of grant (Brief description of work to be performed): To establish funding and tasks to support and sustain LHJ public health emergency preparedness as part of statewide public health emergency preparedness, resilience, and response.

Existing/ongoing program: ☒ Yes New Program: ☐ Yes

Source of grant funding: Federal ☒ State ☐ Local ☐ Other ☐

Grant Term: From 7/1/2025 to 6/30/2026

Grantor: Department of Health – Consolidated Contract Grant Award **\$172,813.00**

Is match required: ☐ Yes ☒ No If yes, match amount required: _____

Match Source (General Fund, Patient Fees, In-Kind, etc.): _____

If County-funded match, enter Charge Code Title and # below.

Charge Code Title and # _____ Amount: \$ _____

Charge Code Title and # _____ Amount: \$ _____

Total Resources \$172,813.00

EXPENDITURES

1. Internal Operations: (Admin., Operations, Direct Service, etc.) Estimated Cost: \$172,813.00

Who will complete the work?

Existing FTE(s) ☒ Existing project FTE(s) ☐ New FTE(s) ☐

If new FTEs are needed, complete the following. Attach additional sheet if needed.

# FTEs	Classification
_____	_____
_____	_____

Total FTEs: _____

2. Pass-Thru Estimated cost: \$ _____

Total Expenditures \$172,813.00

2026 Grant Work Plan

Department Name and #: **Health Department – 0015**

Job code **xxxxx**

Division and Fund #: **110 - 125**

Dept Program Name and #: **Office of the Director - 610**

Grant Title: **Increasing immunization rates in Snohomish County**

Purpose of grant (Brief description of work to be performed): Using a population health approach to increase vaccination rates in the County.

Existing/ongoing program: ☐ Yes New Program: ☒ Yes

Source of grant funding: Federal ☐ State ☐ Local ☒ Other ☐

Grant Term: From 1/01/2026 to 12/31/2026

Grantor: MolinaCares Foundation

Grant Award **\$200,000.00**

Is match required: ☐ Yes ☒ No If yes, match amount required: _____

Match Source (General Fund, Patient Fees, In-Kind, etc.): _____

If County-funded match, enter Charge Code Title and # below.

Charge Code Title and # _____ Amount: \$ _____

Charge Code Title and # _____ Amount: \$ _____

Total Resources \$200,000.00

EXPENDITURES

1. Internal Operations: (Admin., Operations, Direct Service, etc.) Estimated Cost: \$200,000.00

Who will complete the work?

Existing FTE(s) ☒ Existing project FTE(s) ☐ New FTE(s) ☐

If new FTEs are needed, complete the following. Attach additional sheet if needed.

# FTEs	Classification
_____	_____
_____	_____

Total FTEs: _____

2. Pass-Thru Estimated cost: \$ _____

Total Expenditures \$200,000.00

2026 Grant Work Plan

Department Name and #: **Health Department – 0015**

Job code **xxxxx**

Division and Fund #: **110 - 125**

Dept Program Name and #: **Office of the Director - 610**

Grant Title: **Addressing BIPOC Health Equity.**

Purpose of grant (Brief description of work to be performed): To Co-sponsor a BIPOC community health event to highlight Black, Indigenous, and people of color (BIPOC) community health issues and community resources.

Existing/ongoing program: ☐ Yes New Program: ☒ Yes

Source of grant funding: Federal ☐ State ☐ Local ☒ Other ☐

Grant Term: From 1/01/2026 to 12/31/2026

Grantor: Collaborative Action Network-North Sound ACH

Grant Award **\$50,000.00**

Is match required: ☐ Yes ☒ No If yes, match amount required: _____

Match Source (General Fund, Patient Fees, In-Kind, etc.): _____

If County-funded match, enter Charge Code Title and # below.

Charge Code Title and # _____ Amount: \$ _____

Charge Code Title and # _____ Amount: \$ _____

Total Resources	\$50,000.00
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EXPENDITURES

1. Internal Operations: (Admin., Operations, Direct Service, etc.) Estimated Cost: \$50,000.00

Who will complete the work?

Existing FTE(s) ☒ Existing project FTE(s) ☐ New FTE(s) ☐

If new FTEs are needed, complete the following. Attach additional sheet if needed.

# FTEs	Classification
_____	_____
_____	_____

Total FTEs: _____

2. Pass-Thru Estimated cost: \$ _____

Total Expenditures	\$50,000.00
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2026 Grant Work Plan

Department Name and #: **Health Department – 0015**

Job code **30010**

Division and Fund #: **130 - 125**

Dept Program Name and #: **Environmental Health - 630**

Grant Title: **Strengthening Environmental Health Capacity (EHC) to Detect, Prevent, and Control Environmental Health Hazards through Data-driven, Evidence-based Approaches-CDC.**

Purpose of grant (Brief description of work to be performed):) Software Upgrade - Purchase, implementation, and migration of existing data into new Environmental Health Database Software.

Existing/ongoing program: ☒ Yes New Program: ☐ Yes

Source of grant funding: Federal ☒ State ☐ Local ☐ Other ☐

Grant Term: From 1/01/2026 to 12/31/2026

Grantor: CDC

Grant Award **\$300,000.00**

Is match required: ☐ Yes ☒ No If yes, match amount required: _____

Match Source (General Fund, Patient Fees, In-Kind, etc.): _____

If County-funded match, enter Charge Code Title and # below.

Charge Code Title and # _____ Amount: \$_____

Charge Code Title and # _____ Amount: \$_____

Total Resources \$300,000.00

EXPENDITURES

1. Internal Operations: (Admin., Operations, Direct Service, etc.) Estimated Cost: \$300,000.00

Who will complete the work?

Existing FTE(s) ☒ Existing project FTE(s) ☐ New FTE(s) ☐

If new FTEs are needed, complete the following. Attach additional sheet if needed.

# FTEs	Classification
_____	_____
_____	_____

Total FTEs: _____

2. Pass-Thru Estimated cost: \$_____

Total Expenditures \$300,000.00

2026 Grant Work Plan

Department Name and #: **Health Department – 0015**

Job code **30010**

Division and Fund #: **130 - 125**

Dept Program Name and #: **Environmental Health - 630**

Grant Title: **Technology for Social Impact.**

Purpose of grant (Brief description of work to be performed): Software Upgrade - Purchase, implementation, and migration of existing data into new Environmental Health Database Software.

Existing/ongoing program: ☒ Yes New Program: ☐ Yes

Source of grant funding: Federal ☒ State ☐ Local ☐ Other ☐

Grant Term: From 1/01/2026 to 12/31/2026

Grantor: Microsoft

Grant Award **\$300,000.00**

Is match required: ☐ Yes ☒ No If yes, match amount required: _____

Match Source (General Fund, Patient Fees, In-Kind, etc.): _____

If County-funded match, enter Charge Code Title and # below.

Charge Code Title and # _____ Amount: \$ _____

Charge Code Title and # _____ Amount: \$ _____

Total Resources \$300,000.00

EXPENDITURES

1. Internal Operations: (Admin., Operations, Direct Service, etc.) Estimated Cost: \$300,000.00

Who will complete the work?

Existing FTE(s) ☒ Existing project FTE(s) ☐ New FTE(s) ☐

If new FTEs are needed, complete the following. Attach additional sheet if needed.

# FTEs	Classification
_____	_____
_____	_____

Total FTEs: _____

2. Pass-Thru Estimated cost: \$ _____

Total Expenditures \$300,000.00

2026 Grant Work Plan

Department Name and #: **Health Department – 0015**

Job code **30010**

Division and Fund #: **130 - 125**

Dept Program Name and #: **Environmental Health - 630**

Grant Title: **DelBene- FY25 Appropriations Community Project Funding (CPF)**

Purpose of grant (Brief description of work to be performed): Software Upgrade - Purchase, implementation, and migration of existing data into new Environmental Health Database Software.

Existing/ongoing program: ☐ Yes New Program: ☒ Yes

Source of grant funding: Federal ☒ State ☐ Local ☐ Other ☐

Grant Term: From 8/01/2025 to 7/31/2026

Grantor: Health Resources and Services Administration

Grant Award **\$150,000.00**

Is match required: ☐ Yes ☒ No If yes, match amount required: _____

Match Source (General Fund, Patient Fees, In-Kind, etc.): _____

If County-funded match, enter Charge Code Title and # below.

Charge Code Title and # _____ Amount: \$ _____

Charge Code Title and # _____ Amount: \$ _____

Total Resources	\$150,000.00
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EXPENDITURES

1. Internal Operations: (Admin., Operations, Direct Service, etc.) Estimated Cost \$150,000.00

Who will complete the work?

Existing FTE(s) ☒ Existing project FTE(s) ☐ New FTE(s) ☐

If new FTEs are needed, complete the following. Attach additional sheet if needed.

# FTEs	Classification
_____	_____
_____	_____

Total FTEs: _____

2. Pass-Thru Estimated cost: \$ _____

Total Expenditures	\$150,000.00
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2026 Grant Work Plan

Department Name and #: **Health Department – 0015**

Job code **30137**

Division and Fund #: **130 - 125**

Dept Program Name and #: **Environmental Health - 630**

Grant Title: **Sanitary Survey Fees**

Purpose of grant (Brief description of work to be performed): To conduct sanitary surveys and provide technical assistance to small community and non-community Group A water systems.

Existing/ongoing program: ☒ Yes New Program: ☐ Yes

Source of grant funding: Federal ☒ State ☒ Local ☐ Other ☐

Grant Term: From 1/01/2026 to 12/31/2027

Grantor: Department of Health – Consolidated Contract

Grant Award **\$8,800.00**

Is match required: ☐ Yes ☒ No If yes, match amount required: _____

Match Source (General Fund, Patient Fees, In-Kind, etc.): _____

If County-funded match, enter Charge Code Title and # below.

Charge Code Title and # _____ Amount: \$ _____

Charge Code Title and # _____ Amount: \$ _____

Total Resources \$8,800.00

EXPENDITURES

1. Internal Operations: (Admin., Operations, Direct Service, etc.) Estimated Cost: \$8,800.00

Who will complete the work?

Existing FTE(s) ☒ Existing project FTE(s) ☐ New FTE(s) ☐

If new FTEs are needed, complete the following. Attach additional sheet if needed.

# FTEs	Classification
_____	_____
_____	_____

Total FTEs: _____

2. Pass-Thru Estimated cost: \$ _____

Total Expenditures \$8,800.00

2026 Grant Work Plan

Department Name and #: **Health Department – 0015**

Job code **30138**

Division and Fund #: **130 - 125**

Dept Program Name and #: **Environmental Health - 630**

Grant Title: **Sanitary Survey Fees Local Asst (15%) TA**

Purpose of grant (Brief description of work to be performed): To conduct sanitary surveys and provide technical assistance to small community and non-community Group A water systems.

Existing/ongoing program: ☒ Yes New Program: ☐ Yes

Source of grant funding: Federal ☐ State ☒ Local ☐ Other ☐

Grant Term: From 1/01/2026 to 12/31/2027

Grantor: Department of Health – Consolidated Contract

Grant Award **\$4,000.00**

Is match required: ☐ Yes ☒ No If yes, match amount required: _____

Match Source (General Fund, Patient Fees, In-Kind, etc.): _____

If County-funded match, enter Charge Code Title and # below.

Charge Code Title and # _____ Amount: \$ _____

Charge Code Title and # _____ Amount: \$ _____

Total Resources	\$4,000.00
------------------------	-------------------

EXPENDITURES

1. Internal Operations: (Admin., Operations, Direct Service, etc.) Estimated Cost: \$4,000.00

Who will complete the work?

Existing FTE(s) ☒ Existing project FTE(s) ☐ New FTE(s) ☐

If new FTEs are needed, complete the following. Attach additional sheet if needed.

# FTEs	Classification
_____	_____
_____	_____

Total FTEs: _____

2. Pass-Thru Estimated cost: \$ _____

Total Expenditures	\$4,000.00
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2026 Grant Work Plan

Department Name and #: **Health Department – 0015**

Job code **30140**

Division and Fund #: **130 - 125**

Dept Program Name and #: **Environmental Health - 630**

Grant Title: **Well Seal Inspections.**

Purpose of grant (Brief description of work to be performed): To identify and investigate water quality contamination and issues in sensitive water sheds.

Existing/ongoing program: ☒ Yes New Program: ☐ Yes

Source of grant funding: Federal ☐ State ☒ Local ☐ Other ☐

Grant Term: From 7/01/2026 to 6/30/2027

Grantor: Department of Ecology

Grant Award **\$50,000.00**

Is match required: ☐ Yes ☒ No If yes, match amount required: _____

Match Source (General Fund, Patient Fees, In-Kind, etc.): _____

If County-funded match, enter Charge Code Title and # below.

Charge Code Title and # _____ Amount: \$ _____

Charge Code Title and # _____ Amount: \$ _____

Total Resources \$50,000.00

EXPENDITURES

1. Internal Operations: (Admin., Operations, Direct Service, etc.) Estimated Cost: \$50,000.00

Who will complete the work?

Existing FTE(s) ☒ Existing project FTE(s) ☐ New FTE(s) ☐

If new FTEs are needed, complete the following. Attach additional sheet if needed.

# FTEs	Classification
_____	_____
_____	_____

Total FTEs _____

2. Pass-Thru Estimated cost: \$ _____

Total Expenditures \$50,000.00

2026 Grant Work Plan

Department Name and #: **Health Department – 0015**

Job code **30340**

Division and Fund #: **130 - 125**

Dept Program Name and #: **Environmental Health - 630**

Grant Title: **Solid Waste Services - Facilities.**

Purpose of grant (Brief description of work to be performed): Projects that educate the public on litter control, waste reduction, recycling, or composting, or for the implementation of a contamination reduction and outreach plan (CROP).

Existing/ongoing program: ☒ Yes New Program: ☐ Yes

Source of grant funding: Federal ☐ State ☒ Local ☐ Other ☐

Grant Term: From 1/01/2026 to 06/30/2027

Grantor: Department of Ecology

Grant Award **253,391.15**

Is match required: ☒ Yes ☐ No If yes, match amount required: \$84,463.72

Match Source (General Fund, Patient Fees, In-Kind, etc.): _____

If County-funded match, enter Charge Code Title and # below.

Charge Code Title and # _____ Amount: \$ _____

Charge Code Title and # _____ Amount: \$ _____

Total Resources \$337,854.87

EXPENDITURES

1. Internal Operations: (Admin., Operations, Direct Service, etc.) Estimated Cost: \$337,854.87

Who will complete the work?

Existing FTE(s) ☒ Existing project FTE(s) ☐ New FTE(s) ☐

If new FTEs are needed, complete the following. Attach additional sheet if needed.

# FTEs	Classification
_____	_____
_____	_____

Total FTEs _____

2. Pass-Thru Estimated cost: \$ _____

Total Expenditures \$337,854.87

2026 Grant Work Plan

Department Name and #: **Health Department – 0015**

Job code **30343**

Division and Fund #: **130 - 125**

Dept Program Name and #: **Environmental Health - 630**

Grant Title: **Solid Waste Enforcement**

Purpose of grant (Brief description of work to be performed): To provide regional solutions and intergovernmental cooperation; prevent or minimize environmental contamination through planning and project implementation; and comply with state and local solid and hazardous waste management plans and laws.

Existing/ongoing program: ☒ Yes New Program: ☐ Yes

Source of grant funding: Federal ☐ State ☒ Local ☐ Other ☐

Grant Term: From 1/01/2026 to 06/30/2027

Grantor: Department of Ecology

Grant Award **\$112,500.00**

Is match required: ☒ Yes ☐ No If yes, match amount required: \$37,500.00

Match Source (General Fund, Patient Fees, In-Kind, etc.): _____

If County-funded match, enter Charge Code Title and # below.

Charge Code Title and # _____ Amount: \$ _____

Charge Code Title and # _____ Amount: \$ _____

Total Resources	\$150,000.00
------------------------	---------------------

EXPENDITURES

1. Internal Operations: (Admin., Operations, Direct Service, etc.) Estimated Cost: \$150,000.00

Who will complete the work?

Existing FTE(s) ☒ Existing project FTE(s) ☐ New FTE(s) ☐

If new FTEs are needed, complete the following. Attach additional sheet if needed.

# FTEs	Classification
_____	_____
_____	_____

Total FTEs: _____

2. Pass-Thru Estimated cost: \$ _____

Total Expenditures	\$150,000.00
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2026 Grant Work Plan

Department Name and #: **Health Department – 0015**

Job code **30365**

Division and Fund #: **130 - 125**

Dept Program Name and #: **Environmental Health - 630**

Grant Title: **PPA- Pollution Prevention Assistance**

Purpose of grant (Brief description of work to be performed): To provide technical assistance and education outreach to small businesses in an effort to prevent pollution of waters of the state as part of the Pollution Prevention Assistance Partnership (formerly known as the Local Source Control (LSC) Partnership).

Existing/ongoing program: ☒ Yes New Program: ☐ Yes

Source of grant funding: Federal ☐ State ☒ Local ☐ Other ☐

Grant Term: From 7/1/2025 to 6/30/2027

Grantor: Department of Ecology

Grant Award **\$763,041.23**

Is match required: ☐ Yes ☒ No If yes, match amount required: _____

Match Source (General Fund, Patient Fees, In-Kind, etc.): _____

If County-funded match, enter Charge Code Title and # below.

Charge Code Title and # _____ Amount: \$ _____

Charge Code Title and # _____ Amount: \$ _____

Total Resources \$763,041.23

EXPENDITURES

1. Internal Operations: (Admin., Operations, Direct Service, etc.) Estimated Cost: \$763,041.23

Who will complete the work?

Existing FTE(s) ☒ Existing project FTE(s) ☐ New FTE(s) ☐

If new FTEs are needed, complete the following. Attach additional sheet if needed.

# FTEs	Classification
_____	_____
_____	_____

Total FTEs: _____

2. Pass-Thru Estimated cost: \$ _____

Total Expenditures \$763,041.23

2026 Grant Work Plan

Department Name and #: **Health Department – 0015**

Job code **30512**

Division and Fund #: **130 - 125**

Dept Program Name and #: **Environmental Health - 630**

Grant Title: **Environmental Justice Collaborative Problem-Solving Cooperative**

Purpose of grant (Brief description of work to be performed): Cover FTE costs associated with Environmental Health Educators, focusing on Lund Use, Food Safety, and Safe Environments work groups.

Existing/ongoing program: ☒ Yes New Program: ☐ Yes

Source of grant funding: Federal ☒ State ☐ Local ☐ Other ☐

Grant Term: From 1/01/2026 to 12/31/2026

Grantor: U.S. Environmental Protection Agency Grant Award **\$500,000.00**

Is match required: ☐ Yes ☒ No If yes, match amount required: _____

Match Source (General Fund, Patient Fees, In-Kind, etc.): _____

If County-funded match, enter Charge Code Title and # below.

Charge Code Title and # _____ Amount: \$ _____

Charge Code Title and # _____ Amount: \$ _____

Total Resources \$500,000.00

EXPENDITURES

1. Internal Operations: (Admin., Operations, Direct Service, etc.) Estimated Cost: \$500,000.00

Who will complete the work?

Existing FTE(s) ☒ Existing project FTE(s) ☐ New FTE(s) ☐

If new FTEs are needed, complete the following. Attach additional sheet if needed.

# FTEs	Classification
_____	_____
_____	_____

Total FTEs: _____

2. Pass-Thru Estimated cost: \$ _____

Total Expenditures \$500,000.00

2026 Grant Work Plan

Department Name and #: **Health Department – 0015**

Job code **30512**

Division and Fund #: **130 - 125**

Dept Program Name and #: **Environmental Health - 630**

Grant Title: **Community Development Block Grant Program - Savvy Septic**

Purpose of grant (Brief description of work to be performed): Cover a portion of costs related to maintenance and repair of existing septic systems for low-income residents.

Existing/ongoing program: ☒ Yes New Program: ☐ Yes

Source of grant funding: Federal ☒ State ☐ Local ☐ Other ☐

Grant Term: From 9/01/2025 to 8/31/2026

Grantor: U.S. Department of Housing and Urban Development

Grant Award **\$300,000.00**

Is match required: ☐ Yes ☒ No If yes, match amount required: _____

Match Source (General Fund, Patient Fees, In-Kind, etc.): _____

If County-funded match, enter Charge Code Title and # below.

Charge Code Title and # _____ Amount: \$ _____

Charge Code Title and # _____ Amount: \$ _____

Total Resources	\$300,000.00
------------------------	---------------------

EXPENDITURES

1. Internal Operations: (Admin., Operations, Direct Service, etc.) Estimated Cost: \$300,000.00

Who will complete the work?

Existing FTE(s) ☒ Existing project FTE(s) ☐ New FTE(s) ☐

If new FTEs are needed, complete the following. Attach additional sheet if needed.

# FTEs	Classification
_____	_____
_____	_____

Total FTEs: _____

2. Pass-Thru Estimated cost: \$ _____

Total Expenditures	\$300,000.00
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2026 Grant Work Plan

Department Name and #: **Health Department – 0015**

Job code **30512**

Division and Fund #: **130 - 125**

Dept Program Name and #: **Environmental Health - 630**

Grant Title: **PIC (Pollution Identification and Correction) in partnership with Snohomish County Surface Water Management**

Purpose of grant (Brief description of work to be performed): To identify and investigate water quality contamination and issues in sensitive water sheds.

Existing/ongoing program: ☒ Yes New Program: ☐ Yes

Source of grant funding: Federal ☐ State ☒ Local ☐ Other ☐

Grant Term: From 1/01/2026 to 12/31/2026

Grantor: Department of Ecology

Grant Award **\$100,000.00**

Is match required: ☐ Yes ☒ No If yes, match amount required: _____

Match Source (General Fund, Patient Fees, In-Kind, etc.): _____

If County-funded match, enter Charge Code Title and # below.

Charge Code Title and # _____ Amount: \$ _____

Charge Code Title and # _____ Amount: \$ _____

Total Resources \$100,000.00

EXPENDITURES

1. Internal Operations: (Admin., Operations, Direct Service, etc.) Estimated Cost: \$100,000.00

Who will complete the work?

Existing FTE(s) ☒ Existing project FTE(s) ☐ New FTE(s) ☐

If new FTEs are needed, complete the following. Attach additional sheet if needed.

# FTEs	Classification
_____	_____
_____	_____

Total FTEs: _____

2. Pass-Thru Estimated cost: \$ _____

Total Expenditures \$100,000.00

2026 Grant Work Plan

Department Name and #: **Health Department – 0015**

Job code **30512**

Division and Fund #: **130 - 125**

Dept Program Name and #: **Environmental Health - 630**

Grant Title: **DOH NEP (National Estuary Program) in partnership with Tulalip Tribes**

Purpose of grant (Brief description of work to be performed): To identify and investigate water quality contamination and issues in sensitive water sheds.

Existing/ongoing program: ☒ Yes New Program: ☐ Yes

Source of grant funding: Federal ☐ State ☒ Local ☐ Other ☐

Grant Term: From 1/01/2026 to 12/31/2026

Grantor: Department of Ecology

Grant Award **\$30,000.00**

Is match required: ☐ Yes ☒ No If yes, match amount required: _____

Match Source (General Fund, Patient Fees, In-Kind, etc.): _____

If County-funded match, enter Charge Code Title and # below.

Charge Code Title and # _____ Amount: \$ _____

Charge Code Title and # _____ Amount: \$ _____

Total Resources \$30,000.00

EXPENDITURES

1. Internal Operations: (Admin., Operations, Direct Service, etc.) Estimated Cost: \$30,000.00

Who will complete the work?

Existing FTE(s) ☒ Existing project FTE(s) ☐ New FTE(s) ☐

If new FTEs are needed, complete the following. Attach additional sheet if needed.

# FTEs	Classification
_____	_____
_____	_____

Total FTEs: _____

2. Pass-Thru Estimated cost: \$ _____

Total Expenditures \$30,000.00

2026 Grant Work Plan

Department Name and #: **Health Department – 0015**

Job code **30532**

Division and Fund #: **130 - 125**

Dept Program Name and #: **Environmental Health - 630**

Grant Title: **Puget Sound Partnership**

Purpose of grant (Brief description of work to be performed): To develop a one stop online tool that would allow property owners within Snohomish County the ability to gain access to all pertinent and critical information regarding their property and onsite septic system (OSS), such as last inspection report, built drawings, age and type of system.

Existing/ongoing program: ☒ Yes New Program: ☐ Yes

Source of grant funding: Federal ☐ State ☒ Local ☐ Other ☐

Grant Term: From 1/31/2025 to 6/30/2027

Grantor: Puget Sound Partnership

Grant Award **\$183,000.00**

Is match required: ☐ Yes ☒ No If yes, match amount required: _____

Match Source (General Fund, Patient Fees, In-Kind, etc.): _____

If County-funded match, enter Charge Code Title and # below.

Charge Code Title and # _____ Amount: \$ _____

Charge Code Title and # _____ Amount: \$ _____

Total Resources	\$183,000.00
------------------------	---------------------

EXPENDITURES

1. Internal Operations: (Admin., Operations, Direct Service, etc.) Estimated Cost: \$183,000.00

Who will complete the work?

Existing FTE(s) ☒ Existing project FTE(s) ☐ New FTE(s) ☐

If new FTEs are needed, complete the following. Attach additional sheet if needed.

# FTEs	Classification
_____	_____
_____	_____

Total FTEs: _____

2. Pass-Thru Estimated cost: \$ _____

Total Expenditures	\$183,000.00
---------------------------	---------------------

2026 Grant Work Plan

Department Name and #: **Health Department – 0015**

Job code **30533**

Division and Fund #: **130 - 125**

Dept Program Name and #: **Environmental Health - 630**

Grant Title: **Small Onsite Management (ALEA).**

Purpose of grant (Brief description of work to be performed): To fund implementation of the on-site sewage system (OSS) local management plan (LMP).

Existing/ongoing program: ☒ Yes New Program: ☐ Yes

Source of grant funding: Federal ☐ State ☒ Local ☐ Other ☐

Grant Term: From 1/01/2026 to 6/30/2027

Grantor: Department of Health – Consolidated Contract

Grant Award **\$56,046.00**

Is match required: ☐ Yes ☒ No If yes, match amount required: _____

Match Source (General Fund, Patient Fees, In-Kind, etc.): _____

If County-funded match, enter Charge Code Title and # below.

Charge Code Title and # _____ Amount: \$ _____

Charge Code Title and # _____ Amount: \$ _____

Total Resources	\$56,046.00
------------------------	--------------------

EXPENDITURES

1. Internal Operations: (Admin., Operations, Direct Service, etc.) Estimated Cost: \$56,046.00

Who will complete the work?

Existing FTE(s) ☒ Existing project FTE(s) ☐ New FTE(s) ☐

If new FTEs are needed, complete the following. Attach additional sheet if needed.

# FTEs	Classification
_____	_____
_____	_____

Total FTEs: _____

2. Pass-Thru Estimated cost: \$ _____

Total Expenditures	\$56,046.00
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2026 Grant Work Plan

Department Name and #: **Health Department – 0015**

Job code **30534**

Division and Fund #: **130 - 125**

Dept Program Name and #: **Environmental Health - 630**

Grant Title: **NEP Sil 2.0 Savvy Septic Program (PS SSI2 Subaward Management Task 3)**

Purpose of grant (Brief description of work to be performed): To provide direct financial assistance to low-income homeowners within the County to repair or replace failing septic systems, financial incentives in the form of rebates to homeowners to complete regular OSS inspections, and host homeowner educational workshops in the Snohomish and Stillaguamish watersheds.

Existing/ongoing program: ☒ Yes New Program: ☐ Yes

Source of grant funding: Federal ☒ State ☐ Local ☐ Other ☐

Grant Term: From 1/01/2026-07/30/2027

Grantor: Department of Health – Consolidated Contract Grant Award **\$711,990.00**

Is match required: ☐ Yes ☒ No If yes, match amount required: _____

Match Source (General Fund, Patient Fees, In-Kind, etc.): _____

If County-funded match, enter Charge Code Title and # below.

Charge Code Title and # _____ Amount: \$ _____

Charge Code Title and # _____ Amount: \$ _____

Total Resources	\$711,990.00
------------------------	---------------------

EXPENDITURES

1. Internal Operations: (Admin., Operations, Direct Service, etc.) Estimated Cost: \$711,990.00

Who will complete the work?

Existing FTE(s) ☒ Existing project FTE(s) ☐ New FTE(s) ☐

If new FTEs are needed, complete the following. Attach additional sheet if needed.

# FTEs	Classification
_____	_____
_____	_____

Total FTEs: _____

2. Pass-Thru Estimated cost: \$ _____

Total Expenditures	\$711,990.00
---------------------------	---------------------

2026 Grant Work Plan

Department Name and #: **Health Department – 0015**

Job code **30538**

Division and Fund #: **130 - 125**

Dept Program Name and #: **Environmental Health - 630**

Grant Title: **WQC Savvy Septic Program**

Purpose of grant (Brief description of work to be performed): To empower residential on-site sewage system (OSS) owners to engage in a collective water quality solution by using outreach, education, and financial incentives.

Existing/ongoing program: ☒ Yes New Program: ☐ Yes

Source of grant funding: Federal ☐ State ☒ Local ☐ Other ☐

Grant Term: From 7/01/2026 to 6/30/2027

Grantor: Department of Ecology

Grant Award **\$500,000.00**

Is match required: ☐ Yes ☒ No If yes, match amount required: _____

Match Source (General Fund, Patient Fees, In-Kind, etc.): _____

If County-funded match, enter Charge Code Title and # below.

Charge Code Title and # _____ Amount: \$ _____

Charge Code Title and # _____ Amount: \$ _____

Total Resources	\$500,000.00
------------------------	---------------------

EXPENDITURES

1. Internal Operations: (Admin., Operations, Direct Service, etc.) Estimated Cost: \$500,000.00

Who will complete the work?

Existing FTE(s) ☒ Existing project FTE(s) ☐ New FTE(s) ☐

If new FTEs are needed, complete the following. Attach additional sheet if needed.

# FTEs	Classification
_____	_____
_____	_____

Total FTEs: _____

2. Pass-Thru Estimated cost: \$ _____

Total Expenditures	\$500,000.00
---------------------------	---------------------

2026 Grant Work Plan

Department Name and #: **Health Department – 0015**

Job code **30539**

Division and Fund #: **130 - 125**

Dept Program Name and #: **Environmental Health - 630**

Grant Title: **Wastewater Management-GFS**

Purpose of grant (Brief description of work to be performed): To update funding code for GFS and add funding and rebate and incentive tasks for OSS inspections to increase inspections compliance.

Existing/ongoing program: ☒ Yes New Program: ☐ Yes

Source of grant funding: Federal ☐ State ☒ Local ☐ Other ☐

Grant Term: From 7/01/2026 to 6/30/2027

Grantor: Department of Health – Consolidated Contract Grant Award **\$31,821.00**

Is match required: ☐ Yes ☒ No If yes, match amount required: _____

Match Source (General Fund, Patient Fees, In-Kind, etc.): _____

If County-funded match, enter Charge Code Title and # below.

Charge Code Title and # _____ Amount: \$ _____

Charge Code Title and # _____ Amount: \$ _____

Total Resources \$31,821.00

EXPENDITURES

1. Internal Operations: (Admin., Operations, Direct Service, etc.) Estimated Cost: \$31,821.00

Who will complete the work?

Existing FTE(s) ☒ Existing project FTE(s) ☐ New FTE(s) ☐

If new FTEs are needed, complete the following. Attach additional sheet if needed.

# FTEs	Classification
_____	_____
_____	_____

Total FTEs: _____

2. Pass-Thru Estimated cost: \$ _____

Total Expenditures \$31,821.00

2026 Grant Work Plan

Department Name and #: **Health Department – 0015**

Job code **30540**

Division and Fund #: **130 - 125**

Dept Program Name and #: **Environmental Health - 630**

Grant Title: **Savvy Septic Program**

Purpose of grant (Brief description of work to be performed): To empower o empower residential on-site sewage system (OSS) owners to engage in a collective Puget Sound water quality solution by using outreach, education, and financial incentives.

Existing/ongoing program: ☒ Yes New Program: ☐ Yes

Source of grant funding: Federal ☐ State ☒ Local ☐ Other ☐

Grant Term: From 10/01/2024 to 9/30/2027

Grantor: Department of Ecology

Grant Award **\$500,000.00**

Is match required: ☐ Yes ☒ No If yes, match amount required: _____

Match Source (General Fund, Patient Fees, In-Kind, etc.): _____

If County-funded match, enter Charge Code Title and # below.

Charge Code Title and # _____ Amount: \$ _____

Charge Code Title and # _____ Amount: \$ _____

Total Resources	\$500,000.00
------------------------	---------------------

EXPENDITURES

3. Internal Operations: (Admin., Operations, Direct Service, etc.) Estimated Cost: \$500,000.00

Who will complete the work?

Existing FTE(s) ☒ Existing project FTE(s) ☐ New FTE(s) ☐

If new FTEs are needed, complete the following. Attach additional sheet if needed.

# FTEs	Classification
_____	_____
_____	_____

Total FTEs: _____

4. Pass-Thru Estimated cost: \$ _____

Total Expenditures	\$500,000.00
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2026 Grant Work Plan

Department Name and #: **Health Department – 0015**

Job code **30810**

Division and Fund #: **130 - 125**

Dept Program Name and #: **Environmental Health - 630**

Grant Title: **NEHA/FDA Grant (National Environmental Health Association and Food and Drug Administration)**

Purpose of grant (Brief description of work to be performed): To assist agencies with meeting FDA Food Safety program standards.

Existing/ongoing program: ☒ Yes New Program: ☐ Yes

Source of grant funding: Federal ☒ State ☐ Local ☐ Other ☐

Grant Term: From 1/01/2026 to 12/31/2026

Grantor: NEHA/FDA

Grant Award **\$26,500.00**

Is match required: ☐ Yes ☒ No If yes, match amount required: _____

Match Source (General Fund, Patient Fees, In-Kind, etc.): _____

If County-funded match, enter Charge Code Title and # below.

Charge Code Title and # _____ Amount: \$ _____

Charge Code Title and # _____ Amount: \$ _____

Total Resources \$26,500.00

EXPENDITURES

1. Internal Operations: (Admin., Operations, Direct Service, etc.) Estimated Cost: \$26,500.00

Who will complete the work?

Existing FTE(s) ☒ Existing project FTE(s) ☐ New FTE(s) ☐

If new FTEs are needed, complete the following. Attach additional sheet if needed.

# FTEs	Classification
_____	_____
_____	_____

Total FTEs: _____

2. Pass-Thru Estimated cost: \$ _____

Total Expenditures \$26,500.00

2026 Grant Work Plan

Department Name and #: **Health Department – 0015**

Job code **31215**

Division and Fund #: **130 - 125**

Dept Program Name and #: **Environmental Health - 630**

Grant Title: **Vector-borne T2&3 Epi ELC FPH.**

Purpose of grant (Brief description of work to be performed): To conduct weekly mosquito surveillance for West Nile virus (WNV) in Snohomish County during mosquito season, June through September.

Existing/ongoing program: ☒ Yes New Program: ☐ Yes

Source of grant funding: Federal ☒ State ☐ Local ☐ Other ☐

Grant Term: From 1/01/2026 to 12/31/2026

Grantor: Department of Health – Consolidated Contract Grant Award **\$3,000.00**

Is match required: ☐ Yes ☒ No If yes, match amount required: _____

Match Source (General Fund, Patient Fees, In-Kind, etc.): _____

If County-funded match, enter Charge Code Title and # below.

Charge Code Title and # _____ Amount: \$ _____

Charge Code Title and # _____ Amount: \$ _____

Total Resources \$3,000.00

EXPENDITURES

1. Internal Operations: (Admin., Operations, Direct Service, etc.) Estimated Cost: \$3,000.00

Who will complete the work?

Existing FTE(s) ☒ Existing project FTE(s) ☐ New FTE(s) ☐

If new FTEs are needed, complete the following. Attach additional sheet if needed.

# FTEs	Classification
_____	_____
_____	_____

Total FTEs: _____

2. Pass-Thru Estimated cost: \$ _____

Total Expenditures \$3,000.00

2026 Grant Work Plan

Department Name and #: **Health Department – 0015**

Job code **31410**

Division and Fund #: **130 - 125**

Dept Program Name and #: **Environmental Health - 630**

Grant Title **Rec Shellfish/Biotoxin:**

Purpose of grant (Brief description of work to be performed): To provide funds for shellfish harvesting safety.

Existing/ongoing program: ☒ Yes New Program: ☐ Yes

Source of grant funding: Federal ☐ State ☒ Local ☐ Other ☐

Grant Term: From 7/01/2026 to 12/31/2026

Grantor: Department of Health – Consolidated Contract

Grant Award **\$10,500.00**

Is match required: ☐ Yes ☒ No If yes, match amount required: _____

Match Source (General Fund, Patient Fees, In-Kind, etc.): _____

If County-funded match, enter Charge Code Title and # below.

Charge Code Title and # _____ Amount: \$ _____

Charge Code Title and # _____ Amount: \$ _____

Total Resources	\$10,500.00
------------------------	--------------------

EXPENDITURES

1. Internal Operations: (Admin., Operations, Direct Service, etc.) Estimated Cost: \$10,500.00

Who will complete the work?

Existing FTE(s) ☒ Existing project FTE(s) ☐ New FTE(s) ☐

If new FTEs are needed, complete the following. Attach additional sheet if needed.

# FTEs	Classification
_____	_____
_____	_____

Total FTEs: _____

2. Pass-Thru Estimated cost: \$ _____

Total Expenditures	\$10,500.00
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2026 Grant Work Plan

Department Name and #: **Health Department – 0015**

Job code **xxxxx**

Division and Fund #: **130 - 125**

Dept Program Name and #: **Environmental Health - 630**

Grant Title: **Alternative Drinking Water.**

Purpose of grant (Brief description of work to be performed): To provide technical assistance and testing for Group B water systems.

Existing/ongoing program: ☐ Yes New Program: ☒ Yes

Source of grant funding: Federal ☐ State ☒ Local ☐ Other ☐

Grant Term: From 1/01/2026 to 12/31/2026

Grantor: Department of Health – Consolidated Contract

Grant Award **\$150,000.00**

Is match required: ☐ Yes ☒ No If yes, match amount required: _____

Match Source (General Fund, Patient Fees, In-Kind, etc.): _____

If County-funded match, enter Charge Code Title and # below.

Charge Code Title and # _____ Amount: \$ _____

Charge Code Title and # _____ Amount: \$ _____

Total Resources	\$150,000.00
------------------------	---------------------

EXPENDITURES

1. Internal Operations: (Admin., Operations, Direct Service, etc.) Estimated Cost: \$150,000.00

Who will complete the work?

Existing FTE(s) ☒

Existing project FTE(s) ☐

New FTE(s) ☐

FTEs Classification

Total FTEs: _____

2. Pass-Thru Estimated cost: \$ _____

Total Expenditures	\$150,000.00
---------------------------	---------------------

2026 Grant Work Plan

Department Name and #: **Health Department – 0015**

Job code **xxxxx**

Division and Fund #: **130 - 125**

Dept Program Name and #: **Environmental Health - 630**

Grant Title: **Lead Hazard Reduction Grant.**

Purpose of grant (Brief description of work to be performed): To maximize the number of children under the age of six protected from lead poisoning and to identify and control lead-based paint hazards in eligible privately-owned rental or owner-occupied housing populations.

Existing/ongoing program: ☐ Yes New Program: ☒ Yes

Source of grant funding: Federal ☒ State ☐ Local ☐ Other ☐

Grant Term: From 10/01/2025 to 9/30/2026

Grantor: U.S. Department of Housing and Urban Development Grant Award **\$900,000.00**

Is match required: ☒ Yes ☐ No If yes, match amount required: \$100,000.00

Match Source (General Fund, Patient Fees, In-Kind, etc.): _____

If County-funded match, enter Charge Code Title and # below.

Charge Code Title and # _____ Amount: \$ _____

Charge Code Title and # _____ Amount: \$ _____

Total Resources	\$1,000,000.00
------------------------	-----------------------

1. Internal Operations: (Admin., Operations, Direct Service, etc.) Estimated Cost: \$1,000,000.00

Who will complete the work?

Existing FTE(s) ☒ Existing project FTE(s) ☐ New FTE(s) ☐

If new FTEs are needed, complete the following. Attach additional sheet if needed.

# FTEs	Classification
_____	_____
_____	_____

Total FTEs: _____

2. Pass-Thru Estimated cost: \$ _____

Total Expenditures	\$1,000,000.00
---------------------------	-----------------------

2026 Grant Work Plan

Department Name and #: **Health Department – 0015**

Job code **20009**

Division and Fund #: **125 - 125**

Dept Program Name and #: **Prevention Services - 625**

Grant Title: **Medicaid Administrative Claiming (MAC).**

Purpose of grant (Brief description of work to be performed): To support Medicaid related outreach and linkage activities performed by LocalHealth Jurisdictions (LHJ) to Washington State residents who live within its jurisdiction. These activities assist residents who have no or inadequate medical coverage, and includes explaining the benefits of the Medicaid program, assisting them in the Medicaid application and renewal processes, and linking them to Medicaid covered services.

Existing/ongoing program: ☒ Yes New Program: ☐ Yes

Source of grant funding: Federal ☐ State ☒ Local ☐ Other ☐

Grant Term: From 1/1/2026 to 12/31/2027

Grantor: Health Care Authority

Grant Award **\$60,000.00**

Is match required: ☒ Yes ☐ No If yes, match amount required: \$60,000.00

Match Source (General Fund, Patient Fees, In-Kind, etc.): _____

If County-funded match, enter Charge Code Title and # below.

Charge Code Title and # _____ Amount: \$ _____

Charge Code Title and # _____ Amount: \$ _____

Total Resources	\$120,000.00
------------------------	---------------------

EXPENDITURES

1. Internal Operations: (Admin./ Operations, Direct Service, etc.) Estimated Cost: \$120,000.00

Who will complete the work?

Existing FTE(s) ☒ Existing project FTE(s) ☐ New FTE(s) ☐

If new FTEs are needed, complete the following. Attach additional sheet if needed.

# FTEs	Classification
_____	_____
_____	_____

Total FTEs: _____

2. Pass-Thru Estimated cost: \$ _____

Total Expenditures	\$120,000.00
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2026 Grant Work Plan

Department Name and #: **Health Department – 0015**

Job code **20110, 20114, 20610, 20615**

Division and Fund #: **125 - 125**

Dept Program Name and #: **Prevention Services - 625**

Grant Title: **MCHBG LHJ Contracts**

Purpose of grant (Brief description of work to be performed): To support local interventions that impact the target population of the Maternal and Child Health Block Grant.

Existing/ongoing program: ☒ Yes New Program: ☐ Yes

Source of grant funding: Federal ☒ State ☐ Local ☐ Other ☐

Grant Term: From 10/01/2025 to 9/30/2026

Grantor: Department of Health – Consolidated Contract

Grant Award **\$444,879.00**

Is match required: ☐ Yes ☒ No If yes, match amount required: _____

Match Source (General Fund, Patient Fees, In-Kind, etc.): _____

If County-funded match, enter Charge Code Title and # below.

Charge Code Title and # _____ Amount: \$ _____

Charge Code Title and # _____ Amount: \$ _____

Total Resources	\$444,879.00
------------------------	---------------------

EXPENDITURES

1. Internal Operations: (Admin., Operations, Direct Service, etc.) Estimated Cost: \$444,879.00

Who will complete the work?

Existing FTE(s) ☒ Existing project FTE(s) ☐ New FTE(s) ☐

If new FTEs are needed, complete the following. Attach additional sheet if needed.

# FTEs	Classification
_____	_____
_____	_____

Total FTEs: _____

2. Pass-Thru Estimated cost: \$ _____

Total Expenditures	\$444,879.00
---------------------------	---------------------

2026 Grant Work Plan

Department Name and #: **Health Department – 0015**

Job code **20436**

Division and Fund #: **125 - 125**

Dept Program Name and #: **Prevention Services - 625**

Grant Title: **ABCD Dental Services.**

Purpose of grant (Brief description of work to be performed): To provide 'Access to Baby and Child Dentistry' (ABCD) services to detect and prevent early childhood dental decay by engaging dentists in seeing Apple Health/Medicaid-eligible Clients, ages birth to six (6), with an emphasis on children of color and children 0-2, ages six (6) to thirteen (13) who are clients of the Developmental Disabilities Administration and other eligible but underserved children in the service area, and engaging local public health departments in outreach and case management.

Existing/ongoing program ☒ Yes New program ☐ Yes
Source of grant funding: Federal ☐ State ☒ Local ☐ Other ☐

Grant Term: From 7/01/2026 to 6/30/2027

Grantor: Health Care Authority

Grant Award **\$212,576.00**

Is match required: ☐ Yes ☒ No If yes, match amount required: _____

Match Source (General Fund, Patient Fees, In-Kind, etc.): _____

If County-funded match, enter Charge Code Title and # below.

Charge Code Title and # _____ Amount: \$ _____

Charge Code Title and # _____ Amount: \$ _____

Total Resources	\$212,576.00
------------------------	---------------------

EXPENDITURES

1. Internal Operations: (Admin., Operations, Direct Service, etc.) Estimated Cost: \$212,576.00

Who will complete the work?

Existing FTE(s) ☒ Existing project FTE(s) ☐ New FTE(s) ☐

If new FTEs are needed, complete the following. Attach additional sheet if needed.

# FTEs	Classification
_____	_____
_____	_____

Total FTEs: _____

2. Pass-Thru Estimated cost: \$ _____

Total Expenditures	\$212,576.00
---------------------------	---------------------

2026 Grant Work Plan

Department Name and #: **Health Department – 0015**

Job code **20612**

Division and Fund #: **125 - 125**

Dept Program Name and #: **Prevention Services - 625**

Grant Title: **Lead Management (FPHS).**

Purpose of grant (Brief description of work to be performed): To support Childhood Lead Poisoning Prevention Program implementation to increase blood lead testing, provider outreach, case management, and community engagement.

Existing/ongoing program: ☒ Yes New Program: ☐ Yes

Source of grant funding: Federal ☐ State ☒ Local ☐ Other ☐

Grant Term: From 1/01/2026 to 12/31/2026

Grantor: DSHS

Grant Award **\$13,873.00**

Is match required: ☐ Yes ☒ No If yes, match amount required: _____

Match Source (General Fund, Patient Fees, In-Kind, etc.): _____

If County-funded match, enter Charge Code Title and # below.

Charge Code Title and # _____ Amount: \$_____

Charge Code Title and # _____ Amount: \$_____

Total Resources \$13,873.00

EXPENDITURES

1. Internal Operations: (Admin., Operations, Direct Service, etc.) Estimated Cost: \$13,873.00

Who will complete the work?

Existing FTE(s) ☒ Existing project FTE(s) ☐ New FTE(s) ☐

If new FTEs are needed, complete the following. Attach additional sheet if needed.

# FTEs	Classification
_____	_____
_____	_____

Total FTEs: _____

2. Pass-Thru Estimated cost: \$_____

Total Expenditures \$13,873.00

2026 Grant Work Plan

Department Name and #: **Health Department – 0015**

Job code **20613**

Division and Fund #: **125 - 125**

Dept Program Name and #: **Prevention Services - 625**

Grant Title: **WorkFirst Children with Special Needs**

Purpose of grant (Brief description of work to be performed): To assist DSHS staff in determining a parent's ability to participate in the WorkFirst program through an evaluation of a child's special needs.

Existing/ongoing program: ☒ Yes New Program: ☐ Yes

Source of grant funding: Federal ☐ State ☒ Local ☐ Other ☐

Grant Term: From 7/01/2025 to 6/30/2027

Grantor: DSHS

Grant Award **\$19,300.00**

Is match required: ☐ Yes ☒ No If yes, match amount required: _____

Match Source (General Fund, Patient Fees, In-Kind, etc.): _____

If County-funded match, enter Charge Code Title and # below.

Charge Code Title and # _____ Amount: \$ _____

Charge Code Title and # _____ Amount: \$ _____

Total Resources \$19,300.00

EXPENDITURES

1. Internal Operations: (Admin., Operations, Direct Service, etc.) Estimated Cost: \$19,300.00

Who will complete the work?

Existing FTE(s) ☒ Existing project FTE(s) ☐ New FTE(s) ☐

If new FTEs are needed, complete the following. Attach additional sheet if needed.

# FTEs	Classification
_____	_____
_____	_____

Total FTEs: _____

2. Pass-Thru Estimated cost: \$ _____

Total Expenditures \$19,300.00

2026 Grant Work Plan

Department Name and #: **Health Department – 0015**

Job code **20614**

Division and Fund #: **125 - 125**

Dept Program Name and #: **Prevention Services - 625**

Grant Title: **CDC Lead Prevention Grant.**

Purpose of grant (Brief description of work to be performed): A community-based approach to improving lead safety in Snohomish County. To eliminate childhood lead poisoning as a public health problem through strengthening blood lead testing, reporting, and surveillance, linking exposed children to recommended services, and targeted population-based interventions.

Existing/ongoing program: ☒ Yes New Program: ☐ Yes

Source of grant funding: Federal ☒ State ☐ Local ☐ Other ☐

Grant Term: From 10/01/2025 to 9/30/2026

Grantor: CDC

Grant Award **\$387,000.00**

Is match required: ☐ Yes ☒ No If yes, match amount required: _____

Match Source (General Fund, Patient Fees, In-Kind, etc.): _____

If County-funded match, enter Charge Code Title and # below.

Charge Code Title and # _____ Amount: \$ _____

Charge Code Title and # _____ Amount: \$ _____

Total Resources \$387,000.00

EXPENDITURES

1. Internal Operations: (Admin., Operations, Direct Service, etc.) Estimated Cost: \$387,000.00

Who will complete the work?

Existing FTE(s) ☒ Existing project FTE(s) ☐ New FTE(s) ☐

If new FTEs are needed, complete the following. Attach additional sheet if needed.

# FTEs	Classification
_____	_____
_____	_____

Total FTEs: _____

2. Pass-Thru Estimated cost: \$ _____

Total Expenditures \$387,000.00

2026 Grant Work Plan

Department Name and #: **Health Department – 0015**

Job code **21110**

Division and Fund #: **125 - 125**

Dept Program Name and #: **Prevention Services - 625**

Grant Title: **Refugee Health Screening.**

Purpose of grant (Brief description of work to be performed): To assist refugees in obtaining a domestic health screening outlined by the CDC and the Office of Refugee Resettlement.

Existing/ongoing program: ☒ Yes New Program: ☐ Yes

Source of grant funding: Federal ☒ State ☐ Local ☐ Other ☐

Grant Term: From 9/01/2025 to 8/31/2026

Grantor: Department of Social and Health Services

Grant Award **\$361,281.00**

Is match required: ☐ Yes ☒ No If yes, match amount required: _____

Match Source (General Fund, Patient Fees, In-Kind, etc.): _____

If County-funded match, enter Charge Code Title and # below.

Charge Code Title and # _____ Amount: \$ _____

Charge Code Title and # _____ Amount: \$ _____

Total Resources \$361,281.00

EXPENDITURES

1. Internal Operations: (Admin., Operations, Direct Service, etc.) Estimated Cost: \$361,281.00

Who will complete the work?

Existing FTE(s) ☒ Existing project FTE(s) ☐ New FTE(s) ☐

If new FTEs are needed, complete the following. Attach additional sheet if needed.

# FTEs	Classification
_____	_____
_____	_____

Total FTEs: _____

2. Pass-Thru Estimated cost: \$ _____

Total Expenditures \$361,281.00

2026 Grant Work Plan

Department Name and #: **Health Department – 0015**

Job code **21111**

Division and Fund #: **125 - 125**

Dept Program Name and #: **Prevention Services - 625**

Grant Title: **ELC EDE Refugee CDC.**

Purpose of grant (Brief description of work to be performed): To strengthen healthcare and community outbreak response and infection prevention and control among Local Health Jurisdictions (LHJs) by improving culturally responsive COVID-19 health outreach and education for immigrant communities.

Existing/ongoing program: ☒ Yes New Program: ☐ Yes

Source of grant funding: Federal ☒ State ☐ Local ☐ Other ☐

Grant Term: From 7/01/2025 to 6/30/2026

Grantor: Department of Social and Health Services

Grant Award **\$120,000.00**

Is match required: ☐ Yes ☒ No If yes, match amount required: _____

Match Source (General Fund, Patient Fees, In-Kind, etc.): _____

If County-funded match, enter Charge Code Title and # below.

Charge Code Title and # _____ Amount: \$ _____

Charge Code Title and # _____ Amount: \$ _____

Total Resources	\$120,000.00
------------------------	---------------------

EXPENDITURES

1. Internal Operations: (Admin., Operations, Direct Service, etc.) Estimated Cost: \$120,000.00

Who will complete the work?

Existing FTE(s) ☒ Existing project FTE(s) ☐ New FTE(s) ☐

If new FTEs are needed, complete the following. Attach additional sheet if needed.

# FTEs	Classification
_____	_____
_____	_____

Total FTEs: _____

2. Pass-Thru Estimated cost: \$ _____

Total Expenditures	\$120,000.00
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2026 Grant Work Plan

Department Name and #: **Health Department – 0015**

Job code **21114**

Division and Fund #: **125 - 125**

Dept Program Name and #: **Prevention Services - 625**

Grant Title: **Refugee Health PROMO DSHS IAR/ Continuation of Care Services Grant**

Purpose of grant (Brief description of work to be performed): To provide overview of the duties performed by Snohomish County in accordance with Refugee Community Health Worker Outreach project through Refugee Health Promotion which was awarded to DOH by DSHS ORIA. To hire culturally and linguistically appropriate Community Health Works (CHW) who will serve the refugees and humanitarian immigrants by providing health navigation and health education to ORR eligible populations. Education and service connections.

Existing/ongoing program: ☒ Yes New Program: ☐ Yes

Source of grant funding: Federal ☒ State ☐ Local ☐ Other ☐

Grant Term: From 1/01/2025 to 9/30/2026

Grantor: Department of Health – Consolidated Contract

Grant Award **\$239,438.00**

Is match required: ☐ Yes ☒ No If yes, match amount required: _____

Match Source (General Fund, Patient Fees, In-Kind, etc.): _____

If County-funded match, enter Charge Code Title and # below.

Charge Code Title and # _____ Amount: \$ _____

Charge Code Title and # _____ Amount: \$ _____

Total Resources	\$239,438.00
------------------------	---------------------

EXPENDITURES

1. Internal Operations: (Admin., Operations, Direct Service, etc.) Estimated Cost: \$239,438.00

Who will complete the work?

Existing FTE(s) ☒ Existing project FTE(s) ☐ New FTE(s) ☐

If new FTEs are needed, complete the following. Attach additional sheet if needed.

# FTEs	Classification
_____	_____
_____	_____

Total FTEs: _____

2. Pass-Thru Estimated cost: \$ _____

Total Expenditures	\$239,438.00
---------------------------	---------------------

2026 Grant Work Plan

Department Name and #: **Health Department – 0015**

Job code **21115**

Division and Fund #: **125 - 125**

Dept Program Name and #: **Prevention Services - 625**

Grant Title: **Ukrainian Resettlement**

Purpose of grant (Brief description of work to be performed): To conduct activities that will establish a community resource center that will provide the community with appropriate health and immunization guidance materials in a regularly accessible space.

Existing/ongoing program: ☒ Yes New Program: ☐ Yes

Source of grant funding: Federal ☒ State ☐ Local ☐ Other ☐

Grant Term: From 7/01/2025 to 6/30/2026

Grantor: Department of Health – Consolidated Contract Grant Award **\$22,234.00**

Is match required: ☐ Yes ☒ No If yes, match amount required: _____

Match Source (General Fund, Patient Fees, In-Kind, etc.): _____

If County-funded match, enter Charge Code Title and # below.

Charge Code Title and # _____ Amount: \$ _____

Charge Code Title and # _____ Amount: \$ _____

Total Resources \$22,234.00

EXPENDITURES

1. Internal Operations: (Admin., Operations, Direct Service, etc.) Estimated Cost: \$22,234.00

Who will complete the work?

Existing FTE(s) ☒ Existing project FTE(s) ☐ New FTE(s) ☐

If new FTEs are needed, complete the following. Attach additional sheet if needed.

# FTEs	Classification
_____	_____
_____	_____

Total FTEs: _____

2. Pass-Thru Estimated cost: \$ _____

Total Expenditures \$22,234.00

2026 Grant Work Plan

Department Name and #: **Health Department – 0015**

Job code **21611**

Division and Fund #: **125 - 125**

Dept Program Name and #: **Prevention Services - 625**

Grant Title: **Sound Foundation Vaccination Project**

Purpose of grant (Brief description of work to be performed): To protect vulnerable populations (low-income individuals, refugees, asylees and seniors) in Snohomish County from preventable diseases by increasing immunization rates through vaccination services.

Existing/ongoing program: ☐ Yes New Program: ☒ Yes

Source of grant funding: Federal ☐ State ☒ Local ☐ Other ☐

Grant Term: From 7/1/2025 to 6/30/2026

Grantor: Sound Foundation for Public Health

Grant Award **\$31,550.00**

Is match required: ☐ Yes ☒ No If yes, match amount required: _____

Match Source (General Fund, Patient Fees, In-Kind, etc.): _____

If County-funded match, enter Charge Code Title and # below.

Charge Code Title and # _____ Amount: \$ _____

Charge Code Title and # _____ Amount: \$ _____

Total Resources \$31,550.00

EXPENDITURES

1. Internal Operations: (Admin., Operations, Direct Service, etc.) Estimated Cost: \$31,550.00

Who will complete the work?

Existing FTE(s) ☒ Existing project FTE(s) ☐ New FTE(s) ☐

If new FTEs are needed, complete the following. Attach additional sheet if needed.

# FTEs	Classification
_____	_____
_____	_____

Total FTEs: _____

2. Pass-Thru Estimated cost: \$ _____

Total Expenditures \$31,550.00

2026 Grant Work Plan

Department Name and #: **Health Department – 0015**

Job code **21615**

Division and Fund #: **125 - 125**

Dept Program Name and #: **Prevention Services - 625**

Grant Title: **Immunizations IQIP CDC YR1**

Purpose of grant (Brief description of work to be performed): To define required Childhood Vaccine Program (CVP) activities for regional representatives.

Existing/ongoing program: ☒ Yes New Program: ☐ Yes

Source of grant funding: Federal ☒ State ☐ Local ☐ Other ☐

Grant Term: From 7/01/2025 to 6/30/2026

Grantor: Department of Health – Consolidated Contract

Grant Award **\$37,090.00**

Is match required: ☐ Yes ☒ No If yes, match amount required: _____

Match Source (General Fund, Patient Fees, In-Kind, etc.): _____

If County-funded match, enter Charge Code Title and # below.

Charge Code Title and # _____ Amount: \$ _____

Charge Code Title and # _____ Amount: \$ _____

Total Resources	\$37,090.00
------------------------	--------------------

EXPENDITURES

3. Internal Operations: (Admin., Operations, Direct Service, etc.) Estimated Cost: \$37,090.00

Who will complete the work?

Existing FTE(s) ☒ Existing project FTE(s) ☐ New FTE(s) ☐

If new FTEs are needed, complete the following. Attach additional sheet if needed.

# FTEs	Classification
_____	_____
_____	_____

Total FTEs: _____

4. Pass-Thru Estimated cost: \$ _____

Total Expenditures	\$37,090.00
---------------------------	--------------------

2026 Grant Work Plan

Department Name and #: **Health Department – 0015**

Job code **21615**

Division and Fund #: **125 - 125**

Dept Program Name and #: **Prevention Services - 625**

Grant Title: **FY24 IQIP Regional Representatives**

Purpose of grant (Brief description of work to be performed): To define required Childhood Vaccine Program (CVP) for regional representatives.

Existing/ongoing program: ☒ Yes New Program: ☐ Yes

Source of grant funding: Federal ☒ State ☐ Local ☐ Other ☐

Grant Term: From 7/01/2025 to 6/30/2026

Grantor: Department of Health – Consolidated Contract

Grant Award **\$109,714.00**

Is match required: ☐ Yes ☒ No If yes, match amount required: _____

Match Source (General Fund, Patient Fees, In-Kind, etc.): _____

If County-funded match, enter Charge Code Title and # below.

Charge Code Title and # _____ Amount: \$ _____

Charge Code Title and # _____ Amount: \$ _____

Total Resources	\$109,714.00
------------------------	---------------------

EXPENDITURES

1. Internal Operations: (Admin., Operations, Direct Service, etc.) Estimated Cost: \$109,714.00

Who will complete the work?

Existing FTE(s) ☒ Existing project FTE(s) ☐ New FTE(s) ☐

If new FTEs are needed, complete the following. Attach additional sheet if needed.

# FTEs	Classification
_____	_____
_____	_____

Total FTEs _____

2. Pass-Thru Estimated cost: \$ _____

Total Expenditures	\$109,714.00
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2026 Grant Work Plan

Department Name and #: **Health Department – 0015**

Job code **21665**

Division and Fund #: **125 - 125**

Dept Program Name and #: **Prevention Services - 625**

Grant Title: **FY24 VFC OPS**

Purpose of grant (Brief description of work to be performed): To contract with local health to conduct activities to improve immunization coverage rates.

Existing/ongoing program: ☒ Yes New Program: ☐ Yes

Source of grant funding: Federal ☒ State ☐ Local ☐ Other ☐

Grant Term: From 7/01/2025 to 6/30/2026

Grantor: Department of Health – Consolidated Contract

Grant Award **\$49,665.00**

Is match required: ☐ Yes ☒ No If yes, match amount required: _____

Match Source (General Fund, Patient Fees, In-Kind, etc.): _____

If County-funded match, enter Charge Code Title and # below.

Charge Code Title and # _____ Amount: \$ _____

Charge Code Title and # _____ Amount: \$ _____

Total Resources \$49,665.00

EXPENDITURES

1. Internal Operations: (Admin., Operations, Direct Service, etc.) Estimated Cost: \$49,665.00

Who will complete the work?

Existing FTE(s) ☒ Existing project FTE(s) ☐ New FTE(s) ☐

If new FTEs are needed, complete the following. Attach additional sheet if needed.

# FTEs	Classification
_____	_____
_____	_____

Total FTEs _____

2. Pass-Thru Estimated cost: \$ _____

Total Expenditures \$49,665.00

2026 Grant Work Plan

Department Name and #: **Health Department – 0015**

Job code **21666**

Division and Fund #: **125 - 125**

Dept Program Name and #: **Prevention Services - 625**

Grant Title: **Ukrainian Refugees.**

Purpose of grant (Brief description of work to be performed): To conduct activities that will better connect recently arrived Ukrainian refugees (and their sponsors) to basic health services, including childhood and adult immunizations.

Existing/ongoing program: ☒ Yes New Program: ☐ Yes

Source of grant funding: Federal ☒ State ☐ Local ☐ Other ☐

Grant Term: From 1/01/2026 to 12/31/2026

Grantor: Department of Health – Consolidated Contract Grant Award **\$42,840.00**

Is match required: ☐ Yes ☒ No If yes, match amount required: _____

Match Source (General Fund, Patient Fees, In-Kind, etc.): _____

If County-funded match, enter Charge Code Title and # below.

Charge Code Title and # _____ Amount: \$ _____

Charge Code Title and # _____ Amount: \$ _____

Total Resources \$42,840.00

EXPENDITURES

1. Internal Operations: (Admin., Operations, Direct Service, etc.) Estimated Cost: \$42,840.00

Who will complete the work?

Existing FTE(s) ☒ Existing project FTE(s) ☐ New FTE(s) ☐

If new FTEs are needed, complete the following. Attach additional sheet if needed.

# FTEs	Classification
_____	_____
_____	_____

Total FTEs: _____

2. Pass-Thru Estimated cost: \$ _____

Total Expenditures \$42,840.00

2026 Grant Work Plan

Department Name and #: **Health Department – 0015**

Job code **21666**

Division and Fund #: **125 - 125**

Dept Program Name and #: **Prevention Services - 625**

Grant Title: **FFY24 PPHF.**

Purpose of grant (Brief description of work to be performed): To define required Perinatal Hepatitis B activities, deliverable, and funding.

Existing/ongoing program: ☒ Yes New Program: ☐ Yes

Source of grant funding: Federal ☒ State ☐ Local ☐ Other ☐

Grant Term: From 1/01/2026 to 12/31/2026

Grantor: Department of Health – Consolidated Contract

Grant Award **\$23,650.00**

Is match required: ☐ Yes ☒ No If yes, match amount required: _____

Match Source (General Fund, Patient Fees, In-Kind, etc.): _____

If County-funded match, enter Title and # below.

Charge Code Title and # _____ Amount: \$ _____

Charge Code Title and # _____ Amount: \$ _____

Total Resources	\$23,650.00
------------------------	--------------------

EXPENDITURES

1. Internal Operations: (Admin., Operations, Direct Service, etc.) Estimated Cost: \$23,650.00

Who will complete the work?

If new FTEs are needed, complete the following. Attach additional sheet if needed.

Existing FTE(s) ☒ Existing project FTE(s) ☐ New FTE(s) ☐

# FTEs	Classification
_____	_____
_____	_____

Total FTEs: _____

2. Pass-Thru Estimated cost: \$ _____

Total Expenditures	\$23,650.00
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2026 Grant Work Plan

Department Name and #: **Health Department – 0015**

Job code **21670**

Division and Fund #: **125 - 125**

Dept Program Name and #: **Prevention Services - 625**

Grant Title: **Perinatal Hepatitis B.**

Purpose of grant (Brief description of work to be performed): To provide infectious disease (Perinatal Hepatitis) prevention services.

Existing/ongoing program: ☒ Yes New Program: ☐ Yes

Source of grant funding: Federal ☒ State ☐ Local ☐ Other ☐

Grant Term: From 1/01/2026 to 12/31/2026

Grantor: Department of Health – Consolidated Contract Grant Award **\$23,650.00**

Is match required: ☐ Yes ☒ No If yes, match amount required: _____

Match Source (General Fund, Patient Fees, In-Kind, etc.): _____

If County-funded match, enter Charge Code Title and # below.

Charge Code Title and # _____ Amount: \$ _____

Charge Code Title and # _____ Amount: \$ _____

Total Resources	\$23,650.00
------------------------	--------------------

EXPENDITURES

1. Internal Operations: (Admin., Operations, Direct Service, etc.) Estimated Cost: \$23,650.00

Who will complete the work?

Existing FTE(s) ☒ Existing project FTE(s) ☐ New FTE(s) ☐

If new FTEs are needed, complete the following. Attach additional sheet if needed.

# FTEs	Classification
_____	_____
_____	_____

Total FTEs: _____

2. Pass-Thru Estimated cost: \$ _____

Total Expenditures	\$23,650.00
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2026 Grant Work Plan

Department Name and #: **Health Department – 0015**

Job code **21670**

Division and Fund #: **125 - 125**

Dept Program Name and #: **Prevention Services - 625**

Grant Title: **Immunizations Discre CDC YR1**

Purpose of grant (Brief description of work to be performed): To define required Perinatal Hepatitis B activities, deliverables, and funding.

Existing/ongoing program: ☒ Yes New Program: ☐ Yes

Source of grant funding: Federal ☒ State ☐ Local ☐ Other ☐

Grant Term: From 7/01/2025 to 6/30/2026

Grantor: Department of Health – Consolidated Contract Grant Award **\$3,750.00**

Is match required: ☐ Yes ☒ No If yes, match amount required: _____

Match Source (General Fund, Patient Fees, In-Kind, etc.): _____

If County-funded match, enter Charge Code Title and # below.

Charge Code Title and # _____ Amount: \$ _____

Charge Code Title and # _____ Amount: \$ _____

Total Resources \$3,750.00

EXPENDITURES

1. Internal Operations: (Admin., Operations, Direct Service, etc.) Estimated Cost: \$3,750.00

Who will complete the work?

Existing FTE(s) ☒ Existing project FTE(s) ☐ New FTE(s) ☐

If new FTEs are needed, complete the following. Attach additional sheet if needed.

# FTEs	Classification
_____	_____
_____	_____

Total FTEs: _____

2. Pass-Thru Estimated cost: \$ _____

Total Expenditures \$3,750.00

2026 Grant Work Plan

Department Name and #: **Health Department – 0015**

Job code **22013**

Division and Fund #: **125 - 125**

Dept Program Name and #: **Prevention Services - 625**

Grant Title: **ADAP STATE (Rebate)**

Purpose of grant (Brief description of work to be performed): To provide infectious disease (HIV, STD and Adult Viral Hepatitis) prevention services.

Existing/ongoing program: ☒ Yes New Program: ☐ Yes

Source of grant funding: Federal ☐ State ☒ Local ☐ Other ☐

Grant Term: From 7/01/2025 to 6/30/2026

Grantor: Department of Health – Consolidated Contract

Grant Award **\$335,835.00**

Is match required: ☐ Yes ☒ No If yes, match amount required: _____

Match Source (General Fund, Patient Fees, In-Kind, etc.): _____

If County-funded match, enter Charge Code Title and # below.

Charge Code Title and # _____ Amount: \$ _____

Charge Code Title and # _____ Amount: \$ _____

Total Resources	\$335,835.00
------------------------	---------------------

EXPENDITURES

1. Internal Operations: (Admin., Operations, Direct Service, etc.) Estimated Cost \$335,835.00

Who will complete the work?

Existing FTE(s) ☒ Existing project FTE(s) ☐ New FTE(s) ☐

If new FTEs are needed, complete the following. Attach additional sheet if needed.

# FTEs	Classification
_____	_____
_____	_____

Total FTEs: _____

2. Pass-Thru Estimated cost: \$ _____

Total Expenditures	\$335,835.00
---------------------------	---------------------

2026 Grant Work Plan

Department Name and #: **Health Department – 0015**

Job code **22014**

Division and Fund #: **125 - 125**

Dept Program Name and #: **Prevention Services - 625**

Grant Title: **RW Grant Year Rebate**

Purpose of grant (Brief description of work to be performed): To provide infectious disease (HIV, STD and Adult Viral Hepatitis) prevention services.

Existing/ongoing program: ☒ Yes New Program: ☐ Yes

Source of grant funding: Federal ☒ State ☐ Local ☐ Other ☐

Grant Term: From 7/01/2025 to 6/30/2026

Grantor: Department of Health – Consolidated Contract

Grant Award **\$86,554.00**

Is match required: ☐ Yes ☒ No If yes, match amount required: _____

Match Source (General Fund, Patient Fees, In-Kind, etc.): _____

If County-funded match, enter Charge Code Title and # below.

Charge Code Title and # _____ Amount: \$ _____

Charge Code Title and # _____ Amount: \$ _____

Total Resources	\$86,554.00
------------------------	--------------------

EXPENDITURES

1. Internal Operations: (Admin., Operations, Direct Service, etc.) Estimated Cost: \$86,554.00

Who will complete the work?

Existing FTE(s) ☒ Existing project FTE(s) ☐ New FTE(s) ☐

If new FTEs are needed, complete the following. Attach additional sheet if needed.

# FTEs	Classification
_____	_____
_____	_____

Total FTEs: _____

2. Pass-Thru Estimated cost: \$ _____

Total Expenditures	\$86,554.00
---------------------------	--------------------

2026 Grant Work Plan

Department Name and #: **Health Department – 0015**

Job code **22015**

Division and Fund #: **125 - 125**

Dept Program Name and #: **Prevention Services - 625**

Grant Title: **State Disease Control & Prevention -FPH.**

Purpose of grant (Brief description of work to be performed): To provide infectious disease (HIV, STD and Adult Viral Hepatitis) prevention services.

Existing/ongoing program: ☒ Yes New Program: ☐ Yes

Source of grant funding: Federal ☒ State ☐ Local ☐ Other ☐

Grant Term: From 1/01/2026 to 12/31/2026

Grantor: Department of Health – Consolidated Contract

Grant Award **\$146,951.00**

Is match required: ☐ Yes ☒ No If yes, match amount required: _____

Match Source (General Fund, Patient Fees, In-Kind, etc.): _____

If County-funded match, enter Charge Code Title and # below.

Charge Code Title and # _____ Amount: \$ _____

Charge Code Title and # _____ Amount: \$ _____

Total Resources \$146,951.00

EXPENDITURES

1. Internal Operations: (Admin., Operations, Direct Service, etc.) Estimated Cost: \$146,951.00

Who will complete the work?

Existing FTE(s) ☒ Existing project FTE(s) ☐ New FTE(s) ☐

If new FTEs are needed, complete the following. Attach additional sheet if needed.

# FTEs	Classification
_____	_____
_____	_____

Total FTEs: _____

2. Pass-Thru Estimated cost: \$ _____

Total Expenditures \$146,951.00

2026 Grant Work Plan

Department Name and #: **Health Department – 0015**

Job code **22020**

Division and Fund #: **125 - 125**

Dept Program Name and #: **Prevention Services - 625**

Grant Title: **FFY24 STD Prevention PCHD – FPH.**

Purpose of grant (Brief description of work to be performed): To provide infectious disease (HIV, STD and Adult Viral Hepatitis) prevention services.

Existing/ongoing program: ☒ Yes New Program: ☐ Yes

Source of grant funding: Federal ☒ State ☐ Local ☐ Other ☐

Grant Term: 12/01/2025 to 12/31/2026

Grantor: Department of Health – Consolidated Contract

Grant Award **\$64,643.00**

Is match required: ☐ Yes ☒ No If yes, match amount required: _____

Match Source (General Fund, Patient Fees, In-Kind, etc.): _____

If County-funded match, enter Charge Code Title and # below.

Charge Code Title and # _____ Amount: \$ _____

Charge Code Title and # _____ Amount: \$ _____

Total Resources	\$64,643.00
------------------------	--------------------

EXPENDITURES

1. Internal Operations: (Admin., Operations, Direct Service, etc.) Estimated Cost: \$64,643.00

Who will complete the work?

Existing FTE(s) ☒ Existing project FTE(s) ☐ New FTE(s) ☐

If new FTEs are needed, complete the following. Attach additional sheet if needed.

# FTEs	Classification
_____	_____
_____	_____

Total FTEs: _____

2. Pass-Thru Estimated cost: \$ _____

Total Expenditures	\$64,643.00
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2026 Grant Work Plan

Department Name and #: **Health Department – 0015**

Job code **22024**

Division and Fund #: **125 - 125**

Dept Program Name and #: **Prevention Services - 625**

Grant Title: **FFY24 STD Prevention Supplemental (PCHD).**

Purpose of grant (Brief description of work to be performed): To provide infectious disease (HIV, STD and Adult Viral Hepatitis) prevention services.

Existing/ongoing program: ☒ Yes New Program: ☐ Yes

Source of grant funding: Federal ☒ State ☐ Local ☐ Other ☐

Grant Term: From 1/01/2026 to 12/31/2026

Grantor: Department of Health – Consolidated Contract

Grant Award **\$346,223.00**

Is match required: ☐ Yes ☒ No If yes, match amount required: _____

Match Source (General Fund, Patient Fees, In-Kind, etc.): _____

If County-funded match, enter Charge Code Title and # below.

Charge Code Title and # _____ Amount: \$ _____

Charge Code Title and # _____ Amount: \$ _____

Total Resources	\$346,223.00
------------------------	---------------------

EXPENDITURES

1. Internal Operations: (Admin., Operations, Direct Service, etc.) Estimated Cost: \$346,223.00

Who will complete the work?

Existing FTE(s) ☒ Existing project FTE(s) ☐ New FTE(s) ☐

If new FTEs are needed, complete the following. Attach additional sheet if needed.

# FTEs	Classification
_____	_____
_____	_____

Total FTEs: _____

2. Pass-Thru Estimated cost: \$ _____

Total Expenditures	\$346,223.00
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2026 Grant Work Plan

Department Name and #: **Health Department – 0015**

Job code **22025**

Division and Fund #: **125 - 125**

Dept Program Name and #: **Prevention Services - 625**

Grant Title: **SCHD Syndemic Community Based Integrated Testing/STD Prevention**

Purpose of grant (Brief description of work to be performed): To expand and develop new partnerships to provide community-based integrated infectious disease testing and linkage to service in high-impact settings to provide access to communities that are disproportionately impacted.

Existing/ongoing program: ☒ Yes New Program: ☐ Yes

Source of grant funding: Federal ☐ State ☒ Local ☐ Other ☐

Grant Term: From 7/01/2025 to 6/30/2026

Grantor: Department of Health – Consolidated Contract Grant Award **\$38,800.00**

Is match required: ☐ Yes ☒ No If yes, match amount required: _____

Match Source (General Fund, Patient Fees, In-Kind, etc.): _____

If County-funded match, enter Charge Code Title and # below.

Charge Code Title and # _____ Amount: \$ _____

Charge Code Title and # _____ Amount: \$ _____

Total Resources \$38,800.00

EXPENDITURES

1. Internal Operations: (Admin., Operations, Direct Service, etc.) Estimated Cost: \$38,800.00

Who will complete the work?

Existing FTE(s) ☒ Existing project FTE(s) ☐ New FTE(s) ☐

If new FTEs are needed, complete the following. Attach additional sheet if needed.

# FTEs	Classification
_____	_____
_____	_____

Total FTEs: _____

2. Pass-Thru Estimated cost: \$ _____

Total Expenditures \$38,800.00

2026 Grant Work Plan

Department Name and #: **Health Department – 0015**

Job code **22230**

Division and Fund #: **125 - 125**

Dept Program Name and #: **Prevention Services - 625**

Grant Title: **TB Elimination – FPH.**

Purpose of grant (Brief description of work to be performed): To provide funding for tuberculosis (TB) prevention and control activities.

Existing/ongoing program: ☒ Yes New Program: ☐ Yes

Source of grant funding: Federal ☒ State ☐ Local ☐ Other ☐

Grant Term: From 1/01/2026 to 12/31/2026

Grantor: Department of Health – Consolidated Contract

Grant Award **\$71,275.00**

Is match required: ☐ Yes ☒ No If yes, match amount required: _____

Match Source (General Fund, Patient Fees, In-Kind, etc.): _____

If County-funded match, enter Charge Code Title and # below.

Charge Code Title and # _____ Amount: \$ _____

Charge Code Title and # _____ Amount: \$ _____

Total Resources \$71,275.00

EXPENDITURES

1. Internal Operations: (Admin., Operations, Direct Service, etc.) Estimated Cost: \$71,275.00

Who will complete the work?

Existing FTE(s) ☒ Existing project FTE(s) ☐ New FTE(s) ☐

If new FTEs are needed, complete the following. Attach additional sheet if needed.

# FTEs	Classification
_____	_____
_____	_____

Total FTEs: _____

2. Pass-Thru Estimated cost: \$ _____

Total Expenditures \$71,275.00

2026 Grant Work Plan

Department Name and #: **Health Department – 0015**

Job code **22560**

Division and Fund #: **125 - 125**

Dept Program Name and #: **Prevention Services - 625**

Grant Title: **STD Pilot Project: STI - Sexually Transmitted Infections Program**

Purpose of grant (Brief description of work to be performed): To reduce STIs in the County by developing a two-year pilot project to develop and expand a comprehensive, STI model of care that will expand field-based services out in the community and establish an in-house clinic in the Health Department to provide equitable care to reduce the alarming rise of STI in the County.

Existing/ongoing program: ☒ Yes New Program: ☐ Yes

Source of grant funding: Federal ☐ State ☒ Local ☐ Other ☐

Grant Term: From 1/01/2026 to 6/30/2026

Grantor: Department of Health – Consolidated Contract

Grant Award **\$307,389.00**

Is match required: ☐ Yes ☒ No If yes, match amount required: _____

Match Source (General Fund, Patient Fees, In-Kind, etc.): _____

If County-funded match, enter Charge Code Title and # below.

Charge Code Title and # _____ Amount: \$ _____

Charge Code Title and # _____ Amount: \$ _____

Total Resources	\$307,389.00
------------------------	---------------------

EXPENDITURES

1. Internal Operations: (Admin., Operations, Direct Service, etc.) Estimated Cost: \$307,389.00

Who will complete the work?

Existing FTE(s) ☒ Existing project FTE(s) ☐ New FTE(s) ☐

If new FTEs are needed, complete the following. Attach additional sheet if needed.

# FTEs	Classification
_____	_____
_____	_____

Total FTEs: _____

2. Pass-Thru Estimated cost: \$ _____

Total Expenditures	\$307,389.00
---------------------------	---------------------

2026 Grant Work Plan

Department Name and #: **Health Department – 0015**

Job code **22577**

Division and Fund #: **125 - 125**

Dept Program Name and #: **Prevention Services - 625**

Grant Title: **FFY22 HIV Prevention Grant – FPH**

Purpose of grant (Brief description of work to be performed): To provide infectious disease (HIV, STD and Adult Viral Hepatitis) prevention services.

Existing/ongoing program: ☒ Yes New Program: ☐ Yes

Source of grant funding: Federal ☒ State ☐ Local ☐ Other ☐

Grant Term: From 7/01/2025 to 5/31/2026

Grantor: Department of Health – Consolidated Contract

Grant Award **\$183,995.00**

Is match required: ☐ Yes ☒ No If yes, match amount required: _____

Match Source (General Fund, Patient Fees, In-Kind, etc.): _____

If County-funded match, enter Charge Code Title and # below.

Charge Code Title and # _____ Amount: \$ _____

Charge Code Title and # _____ Amount: \$ _____

Total Resources	\$183,995.00
------------------------	---------------------

EXPENDITURES

1. Internal Operations: (Admin., Operations, Direct Service, etc.) Estimated Cost: \$183,995.00

Who will complete the work?

Existing FTE(s) ☒ Existing project FTE(s) ☐ New FTE(s) ☐

If new FTEs are needed, complete the following. Attach additional sheet if needed.

# FTEs	Classification
_____	_____
_____	_____

Total FTEs: _____

2. Pass-Thru Estimated cost: \$ _____

Total Expenditures	\$183,995.00
---------------------------	---------------------

2026 Grant Work Plan

Department Name and #: **Health Department – 0015**

Job code **23034**

Division and Fund #: **125 - 125**

Dept Program Name and #: **Prevention Services - 625**

Grant Title: **LHJ COVID-19 GFS.**

Purpose of grant (Brief description of work to be performed): To support LHJ COVID-19 work utilizing American Rescue Plan Act (ARPA) funding and General Fund Stat funding.

Existing/ongoing program: ☒ Yes New Program: ☐ Yes

Source of grant funding: Federal ☒ State ☐ Local ☐ Other ☐

Grant Term: From 1/01/2026 to 12/31/2026

Grantor: Department of Health – Consolidated Contract

Grant Award **\$376,924.00**

Is match required: ☐ Yes ☒ No If yes, match amount required: _____

Match Source (General Fund, Patient Fees, In-Kind, etc.): _____

If County-funded match, enter Charge Code Title and # below.

Charge Code Title and # _____ Amount: \$ _____

Charge Code Title and # _____ Amount: \$ _____

Total Resources	\$376,924.00
------------------------	---------------------

EXPENDITURES

1. Internal Operations: (Admin., Operations, Direct Service, etc.) Estimated Cost: \$376,924.00

Who will complete the work?

Existing FTE(s) ☒ Existing project FTE(s) ☐ New FTE(s) ☐

If new FTEs are needed, complete the following. Attach additional sheet if needed.

# FTEs	Classification
_____	_____
_____	_____

Total FTEs: _____

2. Pass-Thru Estimated cost: \$ _____

Total Expenditures	\$376,924.00
---------------------------	---------------------

2026 Grant Work Plan

Department Name and #: **Health Department – 0015**

Job code **23750**

Division and Fund #: **125 - 125**

Dept Program Name and #: **Prevention Services - 625**

Grant Title: **Community Violence Intervention & Prevention Initiative**

Purpose of grant (Brief description of work to be performed): To lead a Community Safety Council (CSC) to steer local community violence reduction efforts.

Existing/ongoing program: ☒ Yes New Program: ☐ Yes

Source of grant funding: Federal ☒ State ☐ Local ☐ Other ☐

Grant Term: From 2/01/2025 to 9/30/2026

Grantor: Public Health Seattle and King County/Dept of Commerce Grant Award **\$99,798.49**

Is match required: ☐ Yes ☒ No If yes, match amount required: _____

Match Source (General Fund, Patient Fees, In-Kind, etc.): _____

If County-funded match, enter Charge Code Title and # below.

Charge Code Title and # _____ Amount: \$ _____

Charge Code Title and # _____ Amount: \$ _____

Total Resources	\$99,798.49
------------------------	--------------------

EXPENDITURES

1. Internal Operations: (Admin., Operations, Direct Service, etc.) Estimated Cost: \$99,798.49

Who will complete the work?

Existing FTE(s) ☒ Existing project FTE(s) ☐ New FTE(s) ☐

If new FTEs are needed, complete the following. Attach additional sheet if needed.

# FTEs	Classification
_____	_____
_____	_____

Total FTEs: _____

2. Pass-Thru Estimated cost: \$ _____

Total Expenditures	\$99,798.49
---------------------------	--------------------

2026 Grant Work Plan

Department Name and #: **Health Department – 0015**

Job code **23751**

Division and Fund #: **125 - 125**

Dept Program Name and #: **Prevention Services - 625**

Grant Title: **Safe Storage Device Giveaway (AKA Lock it up program).**

Purpose of grant (Brief description of work to be performed): To provide safe gun storage devices in Snohomish County at no charge.

Existing/ongoing program: ☒ Yes New Program: ☐ Yes

Source of grant funding: Federal ☐ State ☐ Local ☒ Other ☐

Grant Term: From 1/01/2026 to 6/30/2026

Grantor: Public Health Seattle and King County

Grant Award **\$2,500.00**

Is match required: ☐ Yes ☒ No If yes, match amount required: _____

Match Source (General Fund, Patient Fees, In-Kind, etc.): _____

If County-funded match, enter Charge Code Title and # below.

Charge Code Title and # _____ Amount: \$ _____

Charge Code Title and # _____ Amount: \$ _____

Total Resources	\$2,500.00
------------------------	-------------------

EXPENDITURES

1. Internal Operations: (Admin., Operations, Direct Service, etc.) Estimated Cost: \$2,500.00

Who will complete the work?

Existing FTE(s) ☒ Existing project FTE(s) ☐ New FTE(s) ☐

If new FTEs are needed, complete the following. Attach additional sheet if needed.

# FTEs	Classification
_____	_____
_____	_____

Total FTEs: _____

2. Pass-Thru Estimated cost: \$ _____

Total Expenditures	\$2,500.00
---------------------------	-------------------

2026 Grant Work Plan

Department Name and #: **Health Department – 0015**

Job code **23754**

Division and Fund #: **125 - 125**

Dept Program Name and #: **Prevention Services - 625**

Grant Title: **Youth Marijuana Prevention**

Purpose of grant (Brief description of work to be performed): To reduce initiation and use of cannabis and tobacco by youth (ages 12-20) in the North Sound Region.

Existing/ongoing program: ☒ Yes New Program: ☐ Yes

Source of grant funding: Federal ☒ State ☐ Local ☐ Other ☐

Grant Term: From 1/01/2026 to 12/31/2026

Grantor: Whatcom County (DOH)

Grant Award **\$56,000.00**

Is match required: ☐ Yes ☒ No If yes, match amount required: _____

Match Source (General Fund, Patient Fees, In-Kind, etc.): _____

If County-funded match, enter Charge Code Title and # below.

Charge Code Title and # _____ Amount: \$ _____

Charge Code Title and # _____ Amount: \$ _____

Total Resources	\$56,000.00
------------------------	--------------------

EXPENDITURES

1. Internal Operations: (Admin., Operations, Direct Service, etc.) Estimated Cost: \$56,000.00

Who will complete the work?

Existing FTE(s) ☒ Existing project FTE(s) ☐ New FTE(s) ☐

If new FTEs are needed, complete the following. Attach additional sheet if needed.

# FTEs	Classification
_____	_____
_____	_____

Total FTEs: _____

2. Pass-Thru Estimated cost: \$ _____

Total Expenditures	\$56,000.00
---------------------------	--------------------

2026 Grant Work Plan

Department Name and #: **Health Department – 0015**

Job code **23755**

Division and Fund #: **125 - 125**

Dept Program Name and #: **Prevention Services - 625**

Grant Title: **LHJ Opioid Campaign Proviso.**

Purpose of grant (Brief description of work to be performed): Opioid abatement settlement account – state appropriation to administer grants to local health jurisdiction for opioid and fentanyl awareness, prevention and education campaigns.

Existing/ongoing program: ☒ Yes New Program: ☐ Yes

Source of grant funding: Federal ☐ State ☒ Local ☐ Other ☐

Grant Term: From 7/01/2025 to 6/30/2026

Grantor: Department of Health – Consolidated Contract Grant Award **\$56,000.00**

Is match required: ☐ Yes ☒ No If yes, match amount required: _____

Match Source (General Fund, Patient Fees, In-Kind, etc.): _____

If County-funded match, enter Charge Code Title and # below.

Charge Code Title and # _____ Amount: \$ _____

Charge Code Title and # _____ Amount: \$ _____

Total Resources	\$56,000.00
------------------------	--------------------

EXPENDITURES

1. Internal Operations: (Admin., Operations, Direct Service, etc.) Estimated Cost: \$56,000.00

Who will complete the work?

Existing FTE(s) ☒ Existing project FTE(s) ☐ New FTE(s) ☐

If new FTEs are needed, complete the following. Attach additional sheet if needed.

# FTEs	Classification
_____	_____
_____	_____

Total FTEs: _____

2. Pass-Thru Estimated cost: \$ _____

Total Expenditures	\$56,000.00
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2026 Grant Work Plan

Department Name and #: **Health Department – 0015**

Job code **23766**

Division and Fund #: **125 - 125**

Dept Program Name and #: **Prevention Services - 625**

Grant Title: **NACCHO Grant/IOPSL.**

Purpose of grant (Brief description of work to be performed): To build capacity for local health departments (LHDs) serving jurisdictions with an above average burden of drug overdose deaths in the following areas: Surveillance and Data Sharing, Linkages to Care, Providers and Health Systems Support, Partnerships with Public Safety and First Responders, Communication Campaigns, Stigma Reduction and Harm Reduction Activities.

Existing/ongoing program: ☒ Yes New Program: ☐ Yes

Source of grant funding: Federal ☒ State ☐ Local ☐ Other ☐

Grant Term: From 1/1/2026 to 12/31/2026

Grantor: NACCHO

Grant Award **\$257,053.39**

Is match required: ☐ Yes ☒ No If yes, match amount required: _____

Match Source (General Fund, Patient Fees, In-Kind, etc.): _____

If County-funded match, enter Charge Code Title and # below.

Charge Code Title and # _____ Amount: \$ _____

Charge Code Title and # _____ Amount: \$ _____

Total Resources \$257,053.39

EXPENDITURES

1. Internal Operations: (Admin., Operations, Direct Service, etc.) Estimated Cost: \$257,053.39

Who will complete the work?

Existing FTE(s) ☒ Existing project FTE(s) ☐ New FTE(s) ☐

If new FTEs are needed, complete the following. Attach additional sheet if needed.

# FTEs	Classification
_____	_____
_____	_____

Total FTEs: _____

2. Pass-Thru Estimated cost: \$ _____

Total Expenditures \$257,053.39

2026 Grant Work Plan

Department Name and #: **Health Department – 0015**

Job code **23767**

Division and Fund #: **125 - 125**

Dept Program Name and #: **Prevention Services - 625**

Grant Title: **Snohomish County OD2A Community Response Year 3**

Purpose of grant (Brief description of work to be performed): This CDC funding opportunity will allow the Snohomish County Health Department to enhance our data surveillance methods and to accomplish the proposed strategies in the proposal. This approach will create a more equitable, system-wide response to overdose prevention in Snohomish County.

Existing/ongoing program: ☒ Yes New Program: ☐ Yes

Source of grant funding: Federal ☒ State ☐ Local ☐ Other ☐

Grant Term: From 9/1/2025 to 8/31/2026

Grantor: CDC

Grant Award **\$889,476.00**

Is match required: ☐ Yes ☒ No If yes, match amount required: _____

Match Source (General Fund, Patient Fees, In-Kind, etc.): _____

If County-funded match, enter Charge Code Title and # below.

Charge Code Title and # _____ Amount: \$ _____

Charge Code Title and # _____ Amount: \$ _____

Total Resources	\$889,476.00
------------------------	---------------------

EXPENDITURES

1. Internal Operations: (Admin., Operations, Direct Service, etc.) Estimated Cost: \$889,476.00

Who will complete the work?

Existing FTE(s) ☒ Existing project FTE(s) ☐ New FTE(s) ☐

If new FTEs are needed, complete the following. Attach additional sheet if needed.

# FTEs	Classification
_____	_____
_____	_____

Total FTEs: _____

2. Pass-Thru Estimated cost: \$ _____

Total Expenditures	\$889,476.00
---------------------------	---------------------

2026 Grant Work Plan

Department Name and #: **Health Department – 0015**

Job code **23767**

Division and Fund #: **125 - 125**

Dept Program Name and #: **Prevention Services - 625**

Grant Title: **Snohomish County OD2A Community Response Year 4**

Purpose of grant (Brief description of work to be performed): This CDC funding opportunity will allow the Snohomish County Health Department to enhance our data surveillance methods and to accomplish the proposed strategies in the proposal. This approach will create a more equitable, system-wide response to overdose prevention in Snohomish County.

Existing/ongoing program: ☒ Yes New Program: ☐ Yes

Source of grant funding: Federal ☒ State ☐ Local ☐ Other ☐

Grant Term: From 9/1/2026 to 8/31/2027

Grantor: CDC

Grant Award **\$999,500.00**

Is match required: ☐ Yes ☒ No If yes, match amount required: _____

Match Source (General Fund, Patient Fees, In-Kind, etc.): _____

If County-funded match, enter Charge Code Title and # below.

Charge Code Title and # _____ Amount: \$ _____

Charge Code Title and # _____ Amount: \$ _____

Total Resources	\$999,500.00
------------------------	---------------------

EXPENDITURES

1. Internal Operations: (Admin., Operations, Direct Service, etc.) Estimated Cost: \$999,500.00

Who will complete the work?

Existing FTE(s) ☒ Existing project FTE(s) ☐ New FTE(s) ☐

If new FTEs are needed, complete the following. Attach additional sheet if needed.

# FTEs	Classification
_____	_____
_____	_____

Total FTEs: _____

2. Pass-Thru Estimated cost: \$ _____

Total Expenditures	\$999,500.00
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2026 Grant Work Plan

Department Name and #: **Health Department – 0015**

Job code **37101**

Division and Fund #: **125 - 125**

Dept Program Name and #: **Prevention Services - 625**

Grant Title: **COVID Response: ELC EDE LHJS CDC**

Purpose of grant (Brief description of work to be performed): To provide supplemental funding for the LHJ to ensure adequate culturally and linguistically responsive testing, investigation, and contract tracing resources to limit the spread of COVID-19.

Existing/ongoing program: ☒ Yes New Program: ☐ Yes

Source of grant funding: Federal ☒ State ☐ Local ☐ Other ☐

Grant Term: From 1/01/2026 to 12/31/2026

Grantor: Department of Health – Consolidated Contract Grant Award **\$1,122,598.00**

Is match required: ☐ Yes ☒ No If yes, match amount required: _____

Match Source (General Fund, Patient Fees, In-Kind, etc.): _____

If County-funded match, enter Charge Code Title and # below.

Charge Code Title and # _____ Amount: \$ _____

Charge Code Title and # _____ Amount: \$ _____

Total Resources	\$1,122,598.00
------------------------	-----------------------

EXPENDITURES

1. Internal Operations: (Admin., Operations, Direct Service, etc.) Estimated Cost: \$1,122,598.00

Who will complete the work?

Existing FTE(s) ☒ Existing project FTE(s) ☐ New FTE(s) ☐

If new FTEs are needed, complete the following. Attach additional sheet if needed.

# FTEs	Classification
_____	_____
_____	_____

Total FTEs: _____

2. Pass-Thru Estimated cost: \$ _____

Total Expenditures	\$1,122,598.00
---------------------------	-----------------------

2026 Grant Work Plan

Department Name and #: **Health Department – 0015**

Job code **xxxxx**

Division and Fund #: **125 - 125**

Dept Program Name and #: **Prevention Services - 625**

Grant Title: **Local Health Department Healthcare-associated Infections and Antimicrobial Resistance Project**

Purpose of grant (Brief description of work to be performed): To strengthen LHD capacity for healthcare-associated infections (HAIs) and antimicrobial resistant (AR) prevention and response for the Local Health Department Healthcare-Associated Infections and Antimicrobial Resistance (HAI/AR) project.

Existing/ongoing program: ☐ Yes New Program: ☒ Yes

Source of grant funding: Federal ☒ State ☐ Local ☐ Other ☐

Grant Term: From 8/01/2025 to 7/31/2026

Grantor: NACCHO

Grant Award **\$120,000.00**

Is match required: ☐ Yes ☒ No If yes, match amount required: _____

Match Source (General Fund, Patient Fees, In-Kind, etc.): _____

If County-funded match, enter Charge Code Title and # below.

Charge Code Title and # _____ Amount: \$ _____

Charge Code Title and # _____ Amount: \$ _____

Total Resources	\$120,000.00
------------------------	---------------------

EXPENDITURES

1. Internal Operations: (Admin., Operations, Direct Service, etc.) Estimated Cost: \$120,000.00

Who will complete the work?

Existing FTE(s) ☒ Existing project FTE(s) ☐ New FTE(s) ☐

If new FTEs are needed, complete the following. Attach additional sheet if needed.

# FTEs	Classification
_____	_____
_____	_____

Total FTEs: _____

2. Pass-Thru Estimated cost: \$ _____

Total Expenditures	\$120,000.00
---------------------------	---------------------

2026 Grant Work Plan

Department Name and #: **Health Department – 0015**

Job code **xxxxx**

Division and Fund #: **125 - 125**

Dept Program Name and #: **Prevention Services - 625**

Grant Title: **Equipping Local Health Departments to Address Vaccine Hesitancy**

Purpose of grant (Brief description of work to be performed): To provide capacity-building resources that support LHD leaders in developing and implementing public health policies and practices to ensure communities have access to the vital programs and services that protect them from disease and disaster.

Existing/ongoing program: ☐ Yes New Program: ☒ Yes

Source of grant funding: Federal ☒ State ☐ Local ☐ Other ☐

Grant Term: From 7/01/2025 to 6/30/2026

Grantor: NACCHO

Grant Award **\$100,000.00**

Is match required: ☐ Yes ☒ No If yes, match amount required: _____

Match Source (General Fund, Patient Fees, In-Kind, etc.): _____

If County-funded match, enter Charge Code Title and # below.

Charge Code Title and # _____ Amount: \$ _____

Charge Code Title and # _____ Amount: \$ _____

Total Resources	\$100,000.00
------------------------	---------------------

EXPENDITURES

1. Internal Operations: (Admin., Operations, Direct Service, etc.) Estimated Cost: \$100,000.00

Who will complete the work?

Existing FTE(s) ☒ Existing project FTE(s) ☐ New FTE(s) ☐

If new FTEs are needed, complete the following. Attach additional sheet if needed.

# FTEs	Classification
_____	_____
_____	_____

Total FTEs: _____

2. Pass-Thru Estimated cost: \$ _____

Total Expenditures	\$100,000.00
---------------------------	---------------------

2026 Grant Work Plan

Department Name and #: **Health Department – 0015**

Job code **206xx**

Division and Fund #: **125 - 125**

Dept Program Name and #: **Prevention Services - 625**

Grant Title: **FPHS Funding**

Purpose of grant (Brief description of work to be performed): To partially fund case management work or any of the upstream and downstream community education efforts targeting BIPOC and low-income areas with the goal of increasing testing rates.

Existing/ongoing program: ☒ Yes New Program: ☐ Yes

Source of grant funding: Federal ☐ State ☒ Local ☐ Other ☐

Grant Term: From 07/01/2025 to 6/30/2026

Grantor: Department of Health – Consolidated Contract Grant Award **\$20,000.00**

Is match required: ☐ Yes ☒ No If yes, match amount required: _____

Match Source (General Fund, Patient Fees, In-Kind, etc.): _____

If County-funded match, enter Charge Code Title and # below.

Charge Code Title and # _____ Amount: \$ _____

Charge Code Title and # _____ Amount: \$ _____

Total Resources	\$20,000.00
------------------------	--------------------

EXPENDITURES

1. Internal Operations: (Admin., Operations, Direct Service, etc.) Estimated Cost: \$20,000.00

Who will complete the work?

Existing FTE(s) ☒ Existing project FTE(s) ☐ New FTE(s) ☐

If new FTEs are needed, complete the following. Attach additional sheet if needed.

# FTEs	Classification
_____	_____
_____	_____

Total FTEs: _____

2. Pass-Thru Estimated cost: \$ _____

Total Expenditures	\$20,000.00
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2026 Grant Work Plan

Department Name and #: **Health Department – 0015**

Job code **206xx**

Division and Fund #: **125 - 125**

Dept Program Name and #: **Prevention Services - 625**

Grant Title: **Lead Decision Package.**

Purpose of grant (Brief description of work to be performed): To continue to conduct sustainable case management and WDRS documentation, as well as sustain the provider outreach and targeted community engagement (BIPOC and low-income) work and continue efforts around reducing childhood exposures to lead and increasing blood lead testing.

Existing/ongoing program: ☒ Yes New Program: ☐ Yes

Source of grant funding: Federal ☒ State ☐ Local ☐ Other ☐

Grant Term: From 07/01/2025 to 6/30/2026

Grantor: Department of Health – Consolidated Contract

Grant Award **\$189,097.46**

Is match required: ☐ Yes ☒ No If yes, match amount required: _____

Match Source (General Fund, Patient Fees, In-Kind, etc.): _____

If County-funded match, enter Charge Code Title and # below.

Charge Code Title and # _____ Amount: \$ _____

Charge Code Title and # _____ Amount: \$ _____

Total Resources	\$189,097.46
------------------------	---------------------

EXPENDITURES

1. Internal Operations: (Admin., Operations, Direct Service, etc.) Estimated Cost: \$189,097.46

Who will complete the work?

Existing FTE(s) ☒ Existing project FTE(s) ☐ New FTE(s) ☐

If new FTEs are needed, complete the following. Attach additional sheet if needed.

# FTEs	Classification
_____	_____
_____	_____

Total FTEs: _____

2. Pass-Thru Estimated cost: \$ _____

Total Expenditures	\$189,097.46
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2026 Grant Work Plan

Department Name and #: **Health Department – 0015**

Job code **xxxxx**

Division and Fund #: **125 - 125**

Dept Program Name and #: **Prevention Services - 625**

Grant Title: **HUD Lead Grant.**

Purpose of grant (Brief description of work to be performed): This grant program assists states, cities, counties/parishes in developing and implementing comprehensive programs to identify and control lead-based paint hazards in eligible low-income privately-owned rental and owner-occupied housing.

Existing/ongoing program: ☒ Yes New Program: ☐ Yes

Source of grant funding: Federal ☒ State ☐ Local ☐ Other ☐

Grant Term: From 7/01/2026 to 12/31/2027

Grantor: Housing and Urban Development (HUD) Grant Award **\$7,000,000.00**

Is match required: ☐ Yes ☒ No If yes, match amount required: _____

Match Source (General Fund, Patient Fees, In-Kind, etc.): _____

If County-funded match, enter Charge Code Title and # below.

Charge Code Title and # _____ Amount: \$ _____

Charge Code Title and # _____ Amount: \$ _____

Total Resources \$7,000,000.00

EXPENDITURES

1. Internal Operations: (Admin., Operations, Direct Service, etc.) Estimated Cost: \$7,000,000.00

Who will complete the work?

Existing FTE(s) ☒ Existing project FTE(s) ☐ New FTE(s) ☐

If new FTEs are needed, complete the following. Attach additional sheet if needed.

# FTEs	Classification
_____	_____
_____	_____

Total FTEs: _____

2. Pass-Thru Estimated cost: \$ _____

Total Expenditures \$7,000,000.00

2026 Grant Work Plan

Department Name and #: **Health Department – 0015**

Job code **xxxxxx**

Division and Fund #: **125 - 125**

Dept Program Name and #: **Prevention Services - 625**

Grant Title: **COVID-19 Health Outreach and Education for Immigrant Communities**

Purpose of grant (Brief description of work to be performed): Global to Local program. To build community-based health literacy by strengthening communication and relationships between community navigators to address key public health issues, including substance use prevention, chronic disease prevention and COVID-19, through tailored community outreach plans.

Existing/ongoing program: ☐ Yes New Program: ☒ Yes

Source of grant funding: Federal ☒ State ☐ Local ☐ Other ☐

Grant Term: From 7/01/2025 to 6/30/2026

Grantor: WA State Department of health

Grant Award **\$60,000.00**

Is match required: ☐ Yes ☒ No If yes, match amount required: _____

Match Source (General Fund, Patient Fees, In-Kind, etc.): _____

If County-funded match, enter Charge Code Title and # below.

Charge Code Title and # _____ Amount: \$ _____

Charge Code Title and # _____ Amount: \$ _____

Total Resources	\$60,000.00
------------------------	--------------------

EXPENDITURES

1. Internal Operations: (Admin., Operations, Direct Service, etc.) Estimated Cost: \$60,000.00

Who will complete the work?

Existing FTE(s) ☒ Existing project FTE(s) ☐ New FTE(s) ☐

If new FTEs are needed, complete the following. Attach additional sheet if needed.

# FTEs	Classification
_____	_____
_____	_____

Total FTEs: _____

2. Pass-Thru Estimated cost: \$ _____

Total Expenditures	\$60,000.00
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2026 Grant Work Plan

Department Name and #: **Health Department – 0015**

Job code **xxxxx**

Division and Fund #: **125 - 125**

Dept Program Name and #: **Prevention Services - 625**

Grant Title: **Collaborative Action Network Partner**

Purpose of grant (Brief description of work to be performed): To strengthen community-rooted public health in Snohomish County by sustaining the Community Navigator program, which fosters transcultural relationships and ensures historically underserved populations have equitable access to accurate health information, resources, and services through trusted, culturally responsive partnerships. (North Sound ACH_Community Navigators

Existing/ongoing program: ☐ Yes New Program: ☒ Yes

Source of grant funding: Federal ☐ State ☐ Local ☒ Other ☐

Grant Term: From 1/01/2026 to 12/31/2026

Grantor: North Sound ACH

Grant Award **\$200,000.00**

Is match required: ☐ Yes ☒ No If yes, match amount required: _____

Match Source (General Fund, Patient Fees, In-Kind, etc.): _____

If County-funded match, enter Charge Code Title and # below.

Charge Code Title and # _____ Amount: \$ _____

Charge Code Title and # _____ Amount: \$ _____

Total Resources \$200,000.00

EXPENDITURES

1. Internal Operations: (Admin., Operations, Direct Service, etc.) Estimated Cost: \$200,000.00

Who will complete the work?

Existing FTE(s) ☒ Existing project FTE(s) ☐ New FTE(s) ☐

If new FTEs are needed, complete the following. Attach additional sheet if needed.

# FTEs	Classification
_____	_____
_____	_____

Total FTEs: _____

2. Pass-Thru Estimated cost: \$ _____

Total Expenditures \$200,000.00

2026 Grant Work Plan

Department Name and #: **Health Department – 0015**

Job code **xxxxx**

Division and Fund #: **125 - 125**

Dept Program Name and #: **Prevention Services - 625**

Grant Title: **TB Elimination Alliance Mini-Grant**

Purpose of grant (Brief description of work to be performed): In partnership with Marshallese Association of North Puget Sound (MAONPS). To strengthen community-rooted public health in Snohomish County by sustaining the Community Navigator program, which fosters transcultural relationships and ensures historically underserved populations have equitable access to accurate health information, resources, and services through trusted, culturally responsive partnerships.

Existing/ongoing program: ☐ Yes New Program: ☒ Yes

Source of grant funding: Federal ☐ State ☐ Local ☒ Other ☐

Grant Term: From 9/01/2025 to 4/30/2026

Grantor: TB Elimination Alliance (TEA)

Grant Award **\$10,000.00**

Is match required: ☐ Yes ☒ No If yes, match amount required: _____

Match Source (General Fund, Patient Fees, In-Kind, etc.): _____

If County-funded match, enter Charge Code Title and # below.

Charge Code Title and # _____ Amount: \$ _____

Charge Code Title and # _____ Amount: \$ _____

Total Resources \$10,000.00

EXPENDITURES

1. Internal Operations: (Admin., Operations, Direct Service, etc.) Estimated Cost: \$10,000.00

Who will complete the work?

Existing FTE(s) ☒ Existing project FTE(s) ☐ New FTE(s) ☐

If new FTEs are needed, complete the following. Attach additional sheet if needed.

# FTEs	Classification
_____	_____
_____	_____

Total FTEs: _____

2. Pass-Thru Estimated cost: \$ _____

Total Expenditures \$10,000.00

2026 Grant Work Plan

Department Name and #: **Health Department – 0015**

Job code **xxxxx**

Division and Fund #: **125 - 125**

Dept Program Name and #: **Prevention Services - 625**

Grant Title: **SCHD & First Responders Coordinated Community Overdose Response Yr 1.**

Purpose of grant (Brief description of work to be performed): Reduce fatal overdoses in Snohomish County by increasing the availability of harm reduction education and resources among first responders and community members.

Existing/ongoing program: ☐ Yes New Program: ☒ Yes

Source of grant funding: Federal ☐ State ☐ Local ☒ Other ☐

Grant Term: From 9/30/2025 to 9/29/2026

Grantor: SAMHSA (Substance Abuse & Mental Health Serv Admin Grant Award **\$791,184.00**

Is match required: ☐ Yes ☒ No If yes, match amount required: _____

Match Source (General Fund, Patient Fees, In-Kind, etc.): _____

If County-funded match, enter Charge Code Title and # below.

Charge Code Title and # _____ Amount: \$ _____

Charge Code Title and # _____ Amount: \$ _____

Total Resources \$791,184.00

EXPENDITURES

1. Internal Operations: (Admin., Operations, Direct Service, etc.) Estimated Cost: \$791,184.00

Who will complete the work?

Existing FTE(s) ☒ Existing project FTE(s) ☐ New FTE(s) ☐

If new FTEs are needed, complete the following. Attach additional sheet if needed.

# FTEs	Classification
_____	_____
_____	_____

Total FTEs: _____

2. Pass-Thru Estimated cost: \$ _____

Total Expenditures \$791,184.00

2026 Grant Work Plan

Department Name and #: **Health Department – 0015**

Job code **xxxxx**

Division and Fund #: **125 - 125**

Dept Program Name and #: **Prevention Services - 625**

Grant Title: **ELC Funding**

Purpose of grant (Brief description of work to be performed): To conduct activities related to health education and promotion of COVID-19, long COVID and other vaccine preventable diseases for at-risk populations, including strengthening bi-directional relationships with health care providers and increasing access to care.

Existing/ongoing program: ☐ Yes New Program: ☒ Yes

Source of grant funding: Federal ☒ State ☐ Local ☐ Other ☐

Grant Term: From 7/01/2025 to 6/30/2026

Grantor: Department of Health – Consolidated Contract Grant Award **\$45,150.00**

Is match required: ☐ Yes ☒ No If yes, match amount required: _____

Match Source (General Fund, Patient Fees, In-Kind, etc.): _____

If County-funded match, enter Charge Code Title and # below.

Charge Code Title and # _____ Amount: \$ _____

Charge Code Title and # _____ Amount: \$ _____

Total Resources \$45,150.00

EXPENDITURES

1. Internal Operations: (Admin., Operations, Direct Service, etc.) Estimated Cost: \$45,150.00

Who will complete the work?

Existing FTE(s) ☒ Existing project FTE(s) ☐ New FTE(s) ☐

If new FTEs are needed, complete the following. Attach additional sheet if needed.

# FTEs	Classification
_____	_____
_____	_____

Total FTEs: _____

2. Pass-Thru Estimated cost: \$ _____

Total Expenditures \$45,150.00
