Funding Application

Organizational Information

Organization:_____
Contact & Title: _____
Address: _____ Phone: _____
City: _____ State: _____ Zip: _____
Email: _____

Project Information

Project Title:_____ Total Budget: _____
Requested Amount: _____ Portion of project that will be funded: (%)_____
Dates of Project: _____ Date Funds Needed: _____

Project Description:

_____
_____
_____
_____
_____
_____

How will this project Align with the LCHF mission?

Our mission is to enhance local health care services by providing scholarships, sponsor health education and awareness programs, upgrade technology and provide medical equipment, and assist in recruitment of medical professionals.

_____
_____
_____
_____
_____
_____

STATEMENT OF POLICIES

1. All funds granted must be used for the purpose provided in the application.
2. Grantors are encouraged to use local vendors if possible.
3. Application does not guarantee that the applicant will receive the exact amount requested.
4. Application must be received by the 3rd Monday of the month to be considered at the next Board of Directors Meeting.

_____ _____

Signature and Title of Applicant **Date**