



BAYCARE CLINIC[®]
Foundation
A not for profit organization to promote the health of Northeastern Wisconsin

Phone: (920) 405-5382

Fax: (920) 405-8004

COMMUNITY UNRESTRICTED GRANT REQUEST FORM

You have expressed interest in receiving financial support from the BayCare Clinic Foundation for your health and/ or wellness related community – based program, project or service. In order to receive consideration for this request by the Foundation Screening Committee, it is important you respond to all questions completely. You may wish to add attachments and supporting data. Thank You.

Mission: The mission of BayCare Clinic Foundation is to promote the health and well-being of Northeast Wisconsin residents.

Deadline for request: January 14, April 14, July 14, and October 13.

** (Request received beyond a date will be held and reviewed at the next committee meeting.)

1. Name of program/service/equipment:

Total dollars being requested:

2. Program/Service Lead Person:

Phone Number:

Email Address:

3. Where will the program/service/equipment be located?

4. When will the program/service begin?

5. What percent of funds stay local?

6. What is the percentage of overhead/administrative costs?

7. What is the purpose of the program/service/project/equipment? How does it relate to the BayCare Clinic Foundation's mission?

8. What will the program/service/project/equipment accomplish if/when implemented or purchased?

9. Who will benefit from this program/service/equipment? (Please be specific: age, gender, location, number in target population, etc.)

Number of individuals impacted: _____
Number of children (under 18): _____
Number of elderly (65+): _____
Number of adults (18 to 64): _____

10. How was the need for this program,/service/project/equipment determined? (Give results of surveys, needs analysis, feasibility study, etc.)

11. How will the program/service/project/equipment meet the stated needs and its success measured? (Methods, procedures, assessment tools, outcome measurements, etc.)

12. What are the qualifications of the provider (organization and staff) to offer this program/service/equipment?

13. (a) A detailed budget is required (attach additional sheets, if necessary):

Total dollars needed to fund program/service/equipment: _____

Total funds requested of BayCare Clinic Foundation: _____

Percent of total projected cost being requested: _____

(b) How will funds be used, (i.e. equipment, materials, etc.)? Please be specific.
(Salaries are not eligible.)

14. (a) How will program/service/project/equipment be funded if grant is not approved?

(b) After grant monies are depleted:

15. How will the BayCare Clinic Foundation be recognized if funds are approved?

16. Is your organization: Not-for-profit? _____ (include IRS Letter)
 For profit? _____

17. What other organizations, if any, are involved in this program/service/project?

18. (a) Have you applied for funds from any other source(s)? Yes _____ No _____
(b) If yes, please indicate from where and amount(s) applied for/received:

19. What will you do with monies if more than one grant is received?

20. Is there anything you wish to add?

21. Name(s) of any BayCare Clinic employees associated with this project/program/organization:

Signature of person submitting request Date

Name of person submitting request and organization represented (please print or type)

Address

City State Zip

Daytime Phone Number(s)