DAKOTA HOSPITAL FOUNDATION

PART A: REQUEST BEING MADE BY

_____

Name of Requesting Individual, Group, Organization

_____

Address City State Zip

_____ _____ _____

Contact Person/Title Contact phone E-mail

Is your organization a non-profit? Yes ____ No _

If yes, non-profit or federal ID#: _____

If no, name authorized organization to receive funds): _____

Is your organization run by a Board of Directors? Yes ____ No __(if yes, see attachments required*)

Program/Project Title _____

Amount of funds requested from the Dakota Hospital Foundation: $_____Total cost: $_____

PART B: PROJECT DESCRIPTION (Briefly summarize the purpose of your request, i.e., measurable outcomes, impact, sustainability, etc. as part of the purpose of your request. Also, how does your project identify with the path(s) eat well, move more, feel better and the 2024 community health needs assessment?)

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PART C: (Briefly describe the use of the funds and how you will measure the effectiveness of your activities.)

PART D: (Please list funding sources to date)

Funding sources to date	Amount	Date Received

Funding sources pending	Amount	Date Expected

PART E: (Please provide the timeline for project completion and include how DHF will be recognized.)

Attachments required:

- Current W-9.
- *Letter of support from your board chair giving you the authority to request funding on their behalf.

I acknowledge that all the information provided in this grant application is true and correct to the best of my knowledge. I also certify that I have the authority to request these funds and certify that the funds will be used solely for the purpose described herein. I agree to furnish additional information as requested by the Dakota Hospital Foundation.

Authorized Signature and Title

Date

SEND COMPLETED APPLICATION TO:
Dakota Hospital Foundation, 20 South Plum St, Vermillion, SD 57069