



# DAKOTA HOSPITAL FOUNDATION

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## 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 501(c)3? Yes \_\_\_\_ No \_\_\_\_

If NO: Please provide name of organization authorized for receipt of grant funds:

\_\_\_\_\_  
Non-profit or Federal ID # \_\_\_\_\_ (please attach W-9)

Is your organization run by a Board of Directors? Yes \_\_\_\_ No \_\_\_\_

If YES, please provide a copy of the Board resolution giving you the authority to request funding on their behalf.

Received: \_\_\_\_\_ Date: \_\_\_\_\_

What is the amount of grant funds requested from the Dakota Hospital Foundation? \$ \_\_\_\_\_

What is the TOTAL cost of the project? \$ \_\_\_\_\_

Program/Project Title \_\_\_\_\_

**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.)

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

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**PART D:** (Please list funding sources to date)

| <b>Funding sources to date</b> | <b>Amount</b> | <b>Date Received</b> |
|--------------------------------|---------------|----------------------|
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**PART E:** (Please list funding sources that are pending)

| <b>Funding sources pending</b> | <b>Amount</b> | <b>Date Expected</b> |
|--------------------------------|---------------|----------------------|
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**PART F:** (Please provide the timeline for project completion.)

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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 Street  
Vermillion, SD 57069**