



HUNTSVILLE HOSPITAL

Community Health Initiative

Date: _____

APPLICANT INFORMATION

Name of Agency or Agencies _____ Year Organized: _____
(If more than one agency involved in project, choose one primary agency)

Agency Federal I.D. No.: _____

Board President/Chairman

Agency Executive Director

Person Serving as Contact for Project

Name _____

Address _____

Phone/Fax _____

Email _____

Signature _____

Identify members of your Board of Directors, their length of term, and how often they meet: _____

How many full-time staff does your organization employ? _____ Part-time: _____ Volunteers: _____

List other agencies, if any, that offer the same or similar service(s) to Huntsville/Madison County: _____

List other organizations from which you have received funding in the past year: _____

Amount of funds requested from Community Health Initiative: _____

PROJECT INFORMATION

Project Purpose: _____

Project Goals and Objectives _____

Is this a new project or an increase or continuation of a current project? _____

If this is a new project, how will Community Health Initiative funds be used? _____

If this is a current project, how will Community Health Initiative funds be used to enhance the project? _____

Will this project require additional staff? _____ If so, how many? _____

What other source of funding is currently in use on this project? _____

Have you received Community Health Initiative funds for this project in the past? _____

How will the project be promoted? _____

COMMUNITY HEALTH INITIATIVE GRANT APPLICATION

Grant Year 2010-2011

Page Two

What other organizations/agencies will you collaborate or cooperate with on this project? _____

Explain in detail how the success of the project will be measured: _____

Community Health Initiative projects are funded for one year periods. What are your plans/needs/sources for future funding? _____

Please complete the following information on the project beneficiaries:

Who will this project serve? _____

How Many? _____

What Age? _____

How are clients selected or found? _____

What is the income level of those to be served? _____

What method of income verification will be used? _____

What method of documentation of eligibility will be used? _____

HISTORY OF AGENCY OR AGENCIES

Please attach a brief history, not to exceed one page, of the requesting agency or agencies in the area of the project proposed, along with the agency's latest annual report and any other information you might wish to add for the Committee's review.

FINANCIAL INFORMATION

Please attach copies of the following information with your grant application:

1. Completed budget for proposed project.
2. Latest balance sheet listing assets and liabilities.
3. Last fiscal year income statement detailing sources and uses of funds.
4. A determination letter from the Internal Revenue Service addressed to the organization applying for the grant indicating exemption from federal income tax as a 501 (c) (3) organization and including the following statement, or its equivalent: "Contributions to you are deductible by donors under section 107 (c) of the Internal Revenue Code."
5. Latest financial audit. If your agency has never had a financial audit performed, please explain.

CHECKLIST FOR COMPLETED GRANT PROPOSAL:

1. Completed application form
2. Brief history and annual report
3. The five documents requested under "Financial Information"

Return completed proposal package to:

Karen Kiss
Community Health Initiative
Huntsville Hospital
101 Sivley Road
Huntsville, Alabama 35801

ALL APPLICATIONS FOR 2010-2011 GRANTS MUST BE RECEIVED BY MARCH 12, 2010

PROJECT PERIOD - July 1, 2010 - June 30, 2011