



Osceola Community Health Foundation, Inc.

2600 65th Avenue – PO Box 218
Osceola, WI 54020

GRANT APPLICATION

Date of application: _____

Organization Information

Name of organization

Legal name, if different

Address

Employer Identification Number (EIN)

Phone#

Fax #

web site

Name of contact person regarding this application:

Title

Phone #

e-mail

Is your organization an IRS 501(c)(3) not-for-profit?

Yes

No

If no, is your organization a public agency/unit of government?

Yes

No

List name and address of fiscal agent:

Name

Address

Fiscal agent's EIN #

Proposal Information

Please attach a typewritten narrative (less than 5 pages in length) including:

Purpose of your organization

Project dates/timeline

Project description

Amount requested and project budget

Evidence of need

Project impact on community

Geographic area served

Project evaluation process

Population served

Other sources of funding

Project goals/objectives/outcomes

Sources of on-going support

Please enclose a list of Board Members or Officers and your 501(c)(3) determination letter if applicable.

Budget

Dollar amount requested: \$ _____

Authorization

Name and title of person authorized to sign for organization:

Name

Title