Osceola Community Health Foundation, Inc.

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

GRANT APPLICATION

OSCEOLA MEDICAL CENTER

This grant application is for Osceola Medical Center department requests only. It is required that all managers clear requests with their Director *prior* to completing the application. Please do not apply for funding for items that should be covered by your department budget. For programmatic support, please be sure to address sustainability in your request narrative.

Date of application:__________________________ Dollar amount requested:$_____________________

OMC Departmental Information

Name of OMC Department Director Signature Date

Name of contact person regarding this application:____

Title Phone # e-mail

Total Annual Department Budget:

Geographical Area Served:

Project Information

BRIEF PROJECT DESCRIPTION AND SUMMARY OF REQUEST:

Include how your request addresses health related needs of the community.

Request Narrative

Please attach a typewritten narrative (less than 5 pages in length, single spaced, size 12 font) including:

- ☐ Project description
- ☐ Evidence of need
- ☐ Geographic area served
- ☐ Population Served
- ☐ List past OCHF support & how funds were utilized
- ☐ Projects goals and objectives
- ☐ Project dates/timelines
- ☐ Project impact on community
- ☐ Project evaluation process
- ☐ Amount requested
- ☐ Other sources of funding
- ☐ Sources of on-going support
- ☐ Sustainability

Enclosures

Please enclose the following:

- ☐ Project budget