EDEN HEALTH DISTRICT
INVESTING IN THE HEALTH OF OUR COMMUNITY SINCE 1948

COMMUNITY HEALTH FUND
GRANT APPLICATION - SHORT FORM
(for grants up to $5,000)

Legal Name of Organization: _____

Organization Director: _____

Address: _____

Phone: _____ Fax: _____ E-Mail: _____

Proposed Program/Project Title: _____

Amount of Funds Requested: _____ (may not exceed $5,000)

IRS Number (located on 990 form): _____

IRS tax-exempt status (attach copy): _____

Are you receiving any other funds for this project? _____ Yes _____ No

If yes, please describe: _____

_____

Percentage of agency budget spent on:

0.00% Direct program services
0.00% Fund-raising and other
0.00% Management and general operating expenses
100% Total Budget

Is this the first time you are submitting a proposal to the Community Health Fund? __ Yes __ No

If yes, previous funding: Month _____ Year _____ Amount _____

Please attach any promotional materials, such as a brochure or annual report, that describe your organization or this program/project.

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I (we) certify that all the information included in or attached to this proposal is complete and accurate.

_____	_____	_____
Authorized Signature of Agency Representative	Printed Name and Title	Date

_____	_____	_____
Authorized Signature of Agency Representative	Printed Name and Title	Date

proceed to page 2

Please attach your responses to the following items, using the Frequently Asked Questions (FAQ) pages in the Grants section of our website at www.ethd.org as your guide. (Maximum 2 pages total)

1. Program/project description.
2. Program/project goals, objectives and intended outcomes.
3. Program/project target population.
4. Describe the need for the program/project in the Eden Township Healthcare District.
5. Describe your agency's ability to provide the proposed services.
6. How does this program match the Community Health Fund priorities?
7. Detailed project budget showing how Eden Health District funds would be used.
8. How will the effectiveness of the program be assessed?
9. How will this program or service sustain itself beyond this funding cycle?

Please submit two original copies of the proposal and all required documents to Eden Health District, 20400 Lake Chabot Road, Suite 303, Castro Valley, CA 94546-5367. In addition, send an electronic copy to Barbara Adranly at badranly@ethd.org. Facsimiles will not be accepted. For assistance, please call (510) 538-2031 ext. 201.