MARSHALL FOUNDATION FOR COMMUNITY HEALTH

# Request For Funding Proposal

AREA OF FOCUS FOR 2018: MENTAL HEALTH AND SUBSTANCE ABUSE EDUCATION

## Contact Information

Grant No. _____

**Full Legal Organization Name**

**Street Address**

**City** **State**

**Zip Code**

**Organization Website**

**Organization President / CEO/Executive Director**

Title

Phone Number E-Mail Address

**Grant Contact Person** (if different)

Title

Phone Number E-Mail Address

# Organization Information

**501(c)(3)?** ◯ Yes ◯ No

Year Established or Incorporated

EIN or TIN

Fiscal agent name (if applicable)

Fiscal agent address

**Total # of Paid Staff**

**Total # of Volunteers**

**Mission Statement**
(350 characters or less)

**Brief Description of Organization**
(500 characters or less)

**Attach or Provide URL for Annual Report** (if applicable)

**Population Served**
(200 characters or less, include age groups, race & ethnicity, income levels, etc.)

# Proposal Request

**Program / Project Name**

**Total Program Budget**

**Requested Amount**

**Percent of Total Budget**

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**Grant Period** **Grant Period To**

**From Multi-Year?**

- ◯ Yes
- ◯ No

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**Geographic Area Served**

What is the Focus?

Is this program /project:

- ◯ Existing
- ◯ Proposed

**Describe the need for this program/project**
(and provide additional information demonstrating the need that exists)

With what other organizations are you collaborating to address this need?

How is your organization suited to meet this need?

How will this project address the need?

What is the project timeline and major milestones?

What is the anticipated impact of the project?

How will measure the results of the projects?

Number of un-duplicated clients to be served with this program if funded?

If this is a clinical program, what is the standard recidivism rate?

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Do you have another funding source?If yes, list all other funding sources:

Yes No

Total of All Funding Sources:

Describe and provide amount of all Grant Program / Project Expenses. You may be asked to validate expenses.

**Application Instructions:**

Reporting - We would like a report to learn of the effectiveness of your program. Please include:

1. Number of people served;
2. Amount of unused funds.
3.

This report will be due the 12th month from the grant approval date.

Marketing/Publicity - We ask for any publications or marketing materials referencing this program include our name and/or logo. Please email your request for logo to mfnd@marshallmedical.org.

Limitations - We will not grant funding for operating expenses or capital improvements. Our service area is for programs administered in El Dorado County.

**Additional materials required:**

- History of Organization and Area Served (not needed for Marshall Medical Center programs)
- 501(c)(3) IRS Letter of Determination, if applicable (not needed for Marshall Medical Center programs)
- Letters of Support
- Other Sources of Financial or Collaborative Support
- List of Board and/or Advisory Committee Members (not needed for Marshall Medical Center programs)

**Signature of Person Submitting Request:** _____ **Date:** _____

**Foundation Approval:** _____ **Date:** _____

**Deadline is Friday, October 19, 2018 at 5 PM to: Marshall Foundation For Community Health PO Box 1996, Placerville CA 95667 or via email to mfnd@marshallmedical.org**