**Sunshine Health’s Community Connections Investment Grant**

Application Form

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| Please complete the enclosed application for grant consideration. Follow the application carefully.  Incomplete or inaccurate forms are not accepted. | |
| Organization Name \* | |
|  | |
| Please include requesting organization's legal name. | |
| Contact (First Name) \* | Contact (Last Name) \* |
| Click or tap here to enter text. | Click or tap here to enter text. |
| Contact Phone Number \* | Organization Phone Number \* |
| Click or tap here to enter text. | Click or tap here to enter text. |
| (###) ###-#### | (###) ###-#### |
| Contact's Email Address \* | Organization's Website Address |
| Click or tap here to enter text. | Click or tap here to enter text. |
| [contact]@[website].[org or com] | [http://www.](http://www/)[address].[org or com] |
| Organization's Mission \* | |
| Click or tap here to enter text. | |
| Organization's Physical Address \* |  |
| Street Address |  |
| Click or tap here to enter text. | |
| Apt, Suite, Bldg. (optional) | |
| Click or tap here to enter text. | |
| City | State/Province/Region |
| Click or tap here to enter text. | Click or tap here to enter text. |
| Postal/ZIP Code | Country |
| Click or tap here to enter text. | Click or tap here to enter text. |
| Title of Requested Grant \* | |
| Click or tap here to enter text. | |
| Years of Operation \* | |
| Click or tap here to enter text. | |
| Amount Requested \* | |
| Click or tap here to enter text. | |
| Please use numbers only (For example: (4000 NOT 4000.00 or 4000) Maximum amount is $4000. | |

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| Target Audience (Check all that apply) \*  Adults with Disabilities  Children with Disabilities  Children / Youth  Dads  Grand families  Grandparents  Low-income Families  Men  Moms  Moms-to-be  Seniors  Seniors with Disabilities  Women  Young Adults  Other | Designation (Check all that apply) \*  Non-profit (501c3 or other)  Minority-Owned Enterprise  Disability-Owned Enterprise  Women-Owned Enterprise  Veteran-Owned Enterprise  Other  Culture/Ethnicity (Check all that apply) \*  African American  Asian (Chinese, Korean, etc.)  Caucasian  Disability Community  Native Hawaiian/Pacific Islander  Hispanic  Native American (Native Alaskan, etc.)  Other |
| Please choose a service/program area:  (select only one)\*  Aging in Place  Autism  Caregiver Mental Health Support  Cultural Competency  Education  Foster Care Support  Free/Reduced Healthcare: Dental  Health & Wellness Program  Obesity (Adults or Children)  Smoke-Free Environments  Transportation  Veterans Services  Other | Asthma  **Behavioral Health / Mental Health**  Community Improvement  Eating Disorder  **Financial Assistance Rent and/or Utility**  Free Cellphone  **Food Program**  **Homeless/Housing Program**  Interpersonal/Domestic Violence  Pregnancy-related Support  Substance Use (including Opioid)  **Condition-Specific Support Service – social isolation, disability support**  Workforce Innovation |
| If other, please describe | |
| Click or tap here to enter text. | |
| If a Health & Wellness Program, please indicate if the program is: \* | |
| Evidence-based |  |
| Evidence-informed/Other |  |
| Description of Grant \* |  |
| Please provide **3-5 sentences** to describe your grant and the anticipated impact of the grant to your organization and/or to  the community | |
| Click or tap here to enter text. | |
| Objective #1 \* | |
| Click or tap here to enter text. | |
| Objective #2 (if applicable) \* | |
| Click or tap here to enter text. | |
| (Please include "N/A" if not applicable.) | |
| Objective #3 (if applicable) \* | |
| Click or tap here to enter text. | |
| (Please include "N/A" if not applicable.) | |