**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[ ]  OtherCulture/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 tothe 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.) |