Sunshine Health's Community Connections Investment Grant

Level 2 Application Form 2022

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) *

Contact Phone Number *	Organization Phone Number *

Contact's Email Address *	Organization's Website Address

Organization's Mission *

Organization's Physical Address *

Apt, Suite, Bldg. (optional)

City	State/Province/Region

Postal/ZIP Code	Country

Title of Requested Grant *

Years of Operation *

Amount Requested *

Please use numbers only (For example: 5000 NOT 5000.00 or 5,000) Maximum amount is $5000.

Target Audience (Check all that apply) *	Designation (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	☐ 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** ☐ **Health Equity and/or Health Education** ☐ **Homeless/Housing Program** ☐ Interpersonal/Domestic Violence ☐ Pregnancy-related Support ☐ Substance Use (including Opioid) ☐ **Condition-Specific Support Service – mental health, social isolation, disability support** ☐ Workforce Innovation
If other, please describe	
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	

Objective #1 *
Objective #2 (if applicable) *
(Please include "N/A" if not applicable.)
Objective #3 (if applicable) *
(Please include "N/A" if not applicable.)

sunshine health

Community Connections Investment L2 Grant Budget Report

Organization Name:	
Person Completing Report:	
Report Date:	
Project Title:	

Instructions: Please outline below the costs associated with the program you're seeking funds for.

Item	Description and Timeframe	Cost	Requested amount $_____& - each cost line for balance below
		$	$0.00
TOTAL			**$0.00**