**REQUEST FOR FOUNDATION FUNDING**

The Community Health Foundation (CHF) is a nonprofit organization that was founded in 1979 by Aspirus Langlade Hospital. Its Mission is to identify needs, raise funds and award grants to provide for the health care needs of the community through financial and educational support. The Community Health Foundation is incorporated as a 501(c)(3) not-for-profit corporation and is governed by a volunteer board of directors.

**Organization Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Contact:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Please address the following questions and submit to the Foundation office along with the Request for Funding.**

1. Requested expenditure amount $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.
2. Describe the problem/need this request will address.
3. Describe the proposed program.
4. What are the goals of the program (these should be measurable)?
5. Who will benefit from this project?
6. Describe your population to be served and how many and how individuals will benefit from this project?
7. Describe how this request aligns with top health priorities identified in the most recent Community Health Needs Assessment. Provide which area aligns with the goals of the project.
	* Substance Abuse & Mental Health
	* Chronic Disease Prevention & Management
	* Access & Affordability of Healthcare Services

Adverse Childhood Experiences has been identified as having a strong association between poor social, mental, and physical health outcomes in adulthood and is incorporated within each priority.

1. Have you applied to the CHF, Aspirus Langlade Hospital or the Langlade Health Coalition for funding in the last 12 months? If so, which entity and was your grant awarded? What was the grant request for and how much was received?
2. Please include:
	* Budget
	* Key Personnel (Key personnel are defined as, and should be limited to, individuals who contribute in a substantive way to the project or execution of the project).
	* Purchase documentation which total the amount of funds needed.

**Please submit information to:** **The Community Health Foundation**

 **112 East Fifth Avenue**

 **Antigo, WI 54409**

 **or** **Sherry.Bunten@aspirus.org**

**Requestor:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Print Name Telephone Date

**Organization**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Email**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Address**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**City**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State:\_\_\_\_\_\_\_\_\_ Zip:\_\_\_\_\_\_\_

(***If Aspirus Langlade Hospital grant, must get their respective executive leader’s approval, prior to submission).***

**Executive's Signature (VP or Clinic Director)**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***(If Aspirus Langlade Hospital grant, please tell us where to allocate funds).***

**Account #**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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***(For staff only)***

**[ ] CHF Restricted Fund**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ [ ] **Unrestricted Fund**