HUNTINGTON COUNTY HEALING PARTNERS

Huntington County Medical Society * Parkview Huntington Hospital * Parkview Huntington Foundation

APPLICATION FOR GRANT ASSISTANCE

Date of Application: _____

Applicant Organization Name: _____

_____

Applicant Organization Mailing Address: _____

_____

Primary Organization Contact Name: _____

Contact's Daytime Phone Number: _____

Contact's Email Address:

_____

Address of Applicant Organization's Website: _____

Applicant Organization's Description/Mission: _____

_____

_____

Applicant Organization's Service Area (county or counties):

_____

Applicant Organization's EIN: _____

Organization's Internal Revenue Code Section Designation: _____

Work Program Title or Description: _____

Purpose of grant: _____

_____

_____

_____

Number to serve: _____

Work Program Budget (total): _____

Grant Amount Requested: _____

Work Program Description, Goals, Sustainability:

_____

_____

_____

Work Program Service Area (county or counties): _____

_____

Work Program Start Date: _____

Target Work Program Population: _____

Other Work Program Funding Partners or Sources: _____

_____

Return to Healingpartners@parkview.com