DAKOTA HOSPITAL FOUNDATION

PART A: REQUEST BEING MADE BY

____
Name of Requesting Individual, Group, Organization

____
Address | City | State | Zip

____________________________________ ____________ ____________________
Contact Person/Title | Contact phone | E-mail

Is your organization a non-profit 501(c)3? Yes ____ No _____

If NO: Please provide name of organization authorized for receipt of grant funds:

____

Non-profit or Federal ID # ____________________________________ (please attach W-9)

Is your organization run by a Board of Directors? Yes ____ No ______

If YES, please provide a copy of the Board resolution giving you the authority to request funding on their behalf.
Received: ______ Date: ____________________

What is the amount of grant funds requested from the Dakota Hospital Foundation? $__________________

What is the TOTAL cost of the project? $ ________________

Program/Project Title ____

PART B: PROJECT DESCRIPTION (Briefly summarize the purpose of your request.)

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PART C: (Briefly describe the use of the funds and how you will measure the effectiveness of your activities.)

PART D: (Please list funding sources to date)

Funding sources to date	Amount	Date Received

PART E: (Please list funding sources that are pending)

Funding sources pending	Amount	Date Expected

PART F: (Please provide the timeline for project completion.)

I acknowledge that all the information provided in this grant application is true and correct to the best of my knowledge. I also certify that I have the authority to request these funds and certify that the funds will be used solely for the purpose described herein. I agree to furnish additional information as requested by the Dakota Hospital Foundation.

Authorized Signature and Title

Date

SEND COMPLETED APPLICATION TO:

Dakota Hospital Foundation
20 South Plum Street
Vermillion, SD 57069