POCONO HEALTH FOUNDATION

Grant Application

Dr. Alberta Finch Children's Health Endowment Fund

Due March 31 for grants awarded in June

Grants generally range from $500 to $1,000

Name of Requesting Organization: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Ext: _____ Fax: _____

Email: _____

Primary contact for this grant request:

Name/Title: _____

IRS Tax Status:

Organization's Legal Name: _____

Tax exempt under IRS Code: _____ 501(c)3 _____ 509(a)1 _____ 509(a)2 _____ 509(a)3

Registration date: _____ Federal EIN: _____

Have you applied in previous years? _____ Yes _____ No

Year	Amount Requested	Amount Received
_____	_____	_____
_____	_____	_____
_____	_____	_____

Briefly describe your organization's background and general scope of work:

Funding Subject of Grant Application (check only one):

_____1. AIDS/HIV
_____2. Child Welfare
_____3. Diseases (specify): _____
_____4. Family Planning
_____5. Health Services
_____6. Homelessness
_____13. Social Services
_____14. Substance Abuse
_____15. Hunger & Nutrition
_____ 16. Behavioral Health
_____17. Other (specify): _____

Please list other sources of support and indicate status (received or pending):

Total Budget for the Project:_____ **Request Amount:** _____

Summary of Grant Request (must conform to space provided here):

Geographical Area Served (check one)

____PA ____Pike County ____Monroe County ____NJ ____Other: _____

Total Number of Children Served: _____

Population Served: *Check one in each category*

Gender
____ Female
____ Male
____ Both

Age
____ Infants 0-2
____ Adolescents 13-18
_____ Children 3-12
_____ All children 0-18

Name of Applicant:_____ **Request Date:**_____

Signature:_____ **Title:**_____

Send completed application to: Pocono Health Foundation
206 East Brown Street
East Stroudsburg, PA 18301-3094
(570) 476-3530

Or fax to: (570) 476-3469

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