

**GRANT APPLICATION
 SHELBY COUNTY HEALTH FOUNDATION
 FOR HEALTH AND WELLNESS RELATED PROJECTS
 c/o MYRTUE MEDICAL CENTER
 1213 Garfield Avenue
 Harlan, IA 51537**

APPLICANT _____ FEDERAL ID # _____

ADDRESS _____

CONTACT PERSON _____

	Name	Title		Telephone
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Principal purpose and history of the organization requesting a grant: _____

IRS DESIGNATION (501(c)(3), 509a, etc.) _____

Proposed use of grant requested (be specific; use additional paper if necessary but limit to one page please) _____

Primary source of funding for organization/project/program (please submit audited financial statement if available)

FUNDS SUPPORTING PROJECT

	Amount	Percent
Funds available and/or pledges received		
Amount of this request for grant		
Balance required to totally fund project/program (for this fiscal year)		
Total funding required for project/program (per fiscal year)		
Anticipated source of balance required		
Number of persons served annually by applicant		
Number of persons to benefit directly from project/program		
Fiscal year of applicant		

Signature of Applicant, Title

Date

Printed Name