100 N. Ripley, Suite F ▪ P.O. Box 495 ▪ Alpena, MI 49707-0495 ▪ Phone: 989-354-6881
Toll Free: 877-354-6881 ▪ Fax: 989-356-3319 ▪ www.sacf.net

STRAITS AREA HEALTH CARE FUND
Application Information

The Straits Area Community Foundation welcomes your application for grants from the Straits Area Health Care Fund.

- Annual application deadline: June 1. Applications must be received in the Community Foundation office or postmarked by June 1 (or the first regular business day of June).
- Eligible applicants: non-profit medical facilities or other nonprofit organizations who are recognized under section 501 (c)(3) of the IRS code AND who are providing general health care services for the residents of Cheboygan County and/or Mackinaw City.
- Funding from the Straits Area Health Care Fund will be used specifically for programs providing general health care activities for the benefit of residents of Cheboygan County and/or Mackinaw City.
- Grants are not made to individuals
- Maximum award amount: $2,000 (to be used only for expenses incurred after Board approval, which will be in early August)
- Term of grant: one year (possible time extension of six months)

Please contact the SACF office if you have any questions.

A COMPLETE GRANT APPLICATION INCLUDES THE FOLLOWING:

- **Completed grant application**
- **If necessary, additional documentation may be requested.**

Application submission instructions

Applications must be submitted to the Community Foundation office by the first regular business day of June (or postmarked by June 1st).

Mail: SACF, P.O. Box 495, Alpena, MI 49707

E-mail: E-mailed applications (to chitch@cfnem.org) must either be scanned to include signatures, or the cover page of your application should be printed, signed and mailed separately.

STRAITS AREA COMMUNITY FOUNDATION
STRAITS AREA HEALTH CARE FUND
GRANT APPLICATION FORM

Date of Application: _____

Legal name of organization applying: _____
(Name on IRS non-profit determination letter and as stated on IRS Form 990.)

Year Founded: _____ Current Operating Budget: $_____

EIN/Federal ID Number (*required*): _____

Executive Director: _____ Phone: _____

Project contact person and title:
(if different from executive director): _____

Address for primary correspondence: _____

City/State/Zip: _____Day Phone: _____

Fax: _____ E-mail: _____

Project Name: _____

Purpose of Grant (one sentence):

Dates of the Project: _____ Amount Requested: $_____
($2,000 maximum)

Total Project Cost: $_____

Does this project specifically serve residents of Cheboygan County and/or Mackinaw City?
☐ Yes ☐ No

_____ _____
Signature, project contact person Date

_____
Printed name and title

_____ _____
Signature, president, executive director, or principal Date

_____
Printed name and title

PROJECT OVERVIEW

1. **Provide a brief description of your organization (i.e. years of operation, services provided).**

2. **Describe your project/program.**

3. **Specifically, for what general health care activities will this grant be used? What items will be purchased with this grant, and/or what services will be provided?**

4. **How will this project be funded? Please list all committed and projected sources of income that will be used to complete this project.**

**If you are awarded a grant, you will be asked to provide a brief final report of your project.*