**Community Collaboration for Health Equity Grant**

**Cover Form**

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| **Requestor Information** | |
| Organization Name: |  |
| Street Address: |  |
| City, State & Zip: |  |
| Tax Identification Number (TIN or EIN): |  |
| Website (if available): |  |
| Organization have current IRS 501(c)(3) status? |  |
| **Grant Request Details** | |
| Amount Requested: | $ |
| Organization General Operating Budget: | $ |
| Project Name: |  |
| Project Site(s) Address: |  |
| Which significant health need(s) in the CHNA are you addressing? |  |
| **Organization Contact Information** | |
| Name: |  |
| Position Title: |  |
| Telephone: |  |
| Email: |  |
| Signature: | Date: |
| **Project Contact Information (*if different from organization contact*)** | |
| Name: |  |
| Position Title: |  |
| Telephone: |  |
| Email: |  |