Grant Application
Community Health Investment Program (CHIP)

Applicant: _____ Date: _____

Address: _____ City: _____

State: _____ Zip: _____ Email: _____

Contact Person: _____ Telephone: _____

Project Title: _____

Funding Priorities

CHIP grants may be awarded to healthcare programs/projects proposed by eligible organizations that address the following priorities. Please select whether your request falls into one or more of these categories:

Children's Health (prenatal to 18 years)	Yes
Depression/Mental Health	Yes
Aging Population	Yes
Child Obesity	Yes
Drug Overdose and Substance Abuse	Yes
Heart Disease Related Indicators	Yes
Stroke	Yes

If you did **not** answer "yes" to any of the above priorities, your request does not fall under the CHIP funding requirements. If you have any questions, please contact Marla McElderry, Executive Director, at mmcelder@srhc.com.

If you answered "yes" to any of the above priorities, please explain how your request falls into the category in the field below:

[text field]

Policies

Applicants are limited to one CHIP application per 12-month period (excluding Good Neighbor Fund grants), from the date their organization's previous application was considered by the CHIP Committee.

Applications for multi-year funding will not be accepted.

Request for Funds

- All applications must use the completed application forms as the cover page.
- On a separate page, please list your board members or principals.
- Complete the Foundation's application budget page and attach to your application.
- Please do not include any supplemental materials (brochures, letters of support, etc.)
- Using no more than two 8 ½ x 11 single-sided sheets of paper, please tell us about your proposal. Be sure to include the following, and label the information by letter in your narrative:

    a) The mission or purpose of your organization or group

    b) A definition of the need, including how the need has been determined

    c) The targeted population

    d) A description of the project

    e) Your expected results

    f) Your timetable and process for achieving results

    g) How you will evaluate the process of your proposal

Financial Information

Time period of your project: From _____ to _____   Date when funds will be needed: _____

Total Project cost $_____   CHIP grant requested $_____

Other Funding sources _____

Submit

Submit 14 copies of the completed application, including additional narrative, budget and board list to:

Salina Regional Health Foundation
400 S. Santa Fe Ave.
Salina, KS 67401

In addition, please include one copy of the most recently completed financial audit for the applicant organization.

Questions? Contact the Salina Regional Health Foundation at (785) 452-6088,
or email Marla McElderry, Executive Director, at mmcelder@srhc.com.