



Masonic Family Health Foundation, Inc.

Grant Application Form

Grant Request:

Amount requested: \$ _____

_____ Operating Support

This request is for Program/project title: _____

_____ Capital Support

Time frame in which the funds will be used: From _____ To _____

Organizational Information:

Organization Name _____

Address/City/State/Zip _____

Telephone _____ Fax _____ Email _____

Executive Director _____ Telephone _____

Name/title of Contact Person _____ Telephone _____

Date of Incorporation _____ FEIN (or equivalent) _____

Is your organization Tax Exempt under Section 501(c)(3)? Yes ___ No ___ Section 509(a)? Yes ___ No ___

If not, do you have a fiscal agent? (Please identify organization, contact person, and telephone number):

Service Category of Organization (check all that apply):

_____ Healthcare

_____ Masonic Related Services

_____ Services for Children

_____ Human Services

_____ Education

_____ Other: _____

Summarize the Organization's Mission: _____

Geographic Service Area(s):

_____ City of Chicago

_____ Suburbs (specify) _____

_____ Chicago neighborhood(s) (specify) _____

_____ Other (specify) _____



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Staff Composition in Numbers:

	<u>Professional</u>	<u>Support</u>
Paid Full-Time: _____	_____	_____
Paid Part-Time: _____	_____	_____
Volunteers: _____	_____	_____
Interns: _____	_____	_____
Other: _____	_____	_____
Totals: _____	_____	_____

Summarize the purpose of your request: _____

List other private and public funding sources related to this particular request:

<u>Funding sources—to date</u>	<u>Amount (\$)</u>	<u>Date received</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

<u>Funding sources—pending</u>	<u>Amount (\$)</u>	<u>Date received</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

Total Organizational Budget (last fiscal year): Revenues \$ _____ Expenses \$ _____

Total/project Budget (if applicable): Operating Expenses \$ _____ Capital _____

Additional Information:

1. Provide a copy of your last audited financial statements or Form 990. If not available, provide unaudited financial statements for the last fiscal year.
2. Provide a copy of your last Annual Report, if available, or a list of the current board members with related employment affiliation.

Signature of authorized official: _____ Date: _____

Name: _____ Title: _____

Submit Grant Application to: Email GrantApplication@MasonicFamilyHealthFoundation.org

Then Mail the application and all supporting documents to:

Robert A. Rylowicz, Executive Director
Masonic Family Health Foundation
836 West Wellington Avenue, CFE, Room 191
Chicago, Illinois 60657-5193