

FOUNDATION

for Seacoast Health

100 Campus Drive, Suite 1

Portsmouth, NH 03801

Tel. (603) 422-8200 • Fax (603) 422-8207

E-mail: fsh@communitycampus.org

PROPOSAL COVER SHEET

Please type your response or duplicate this form on your computer

Date: _____ **Name of Applicant Organization:** _____

Telephone #: _____ **Address:** _____

E-mail Address: _____

CEO/Executive Director: _____

Contact for this proposal: (if different) _____ **Telephone #:** _____

Contact Address: if different from above) _____

E-mail Address: _____

Fiscal Agent: (if applicant is not a 501(c)3 organization) _____

Application for (please specify amount): \$ _____ **Total Project Cost: \$** _____

Total Operating Budget: \$ _____

Please respond briefly in the spaces provided. A more detailed description should be included in your full proposal.

PLEASE PROVIDE BRIEF DESCRIPTION OF PROPOSED PROJECT:

PLEASE SUMMARIZE PROJECT OBJECTIVES: (What will be accomplished with the funding requested?)

FOUNDATION for Seacoast Health

ORGANIZATION PROFILE

Describe current services provided by the applicant organization:

Geographical area served:

Year founded:

Number of Paid Staff: (specify # full and # part-time)

Number of Directors/Trustees:

Number of Volunteers:

Other: (describe)

FINANCIAL SUMMARY

Provide information from most recent audit or annual financial statement:

Last Fiscal Year (FY) ended date \$ _____

Last FY total expenditures * \$ _____

Last FY total income \$ _____

*If operating surplus or loss is more than 5% of total income, please comment:

Total Net Assets \$ _____

Current (Projected) FY

Operating budget \$ _____

Sources of Support	LAST FISCAL YEAR	
	Amount	%
Government grants & contracts	\$ _____	_____
Program fees/sales/ 3 rd party payments	\$ _____	_____
Endowment/interest income	\$ _____	_____
Other earned income	\$ _____	_____
United Way	\$ _____	_____
Contributions:		
• Business	\$ _____	_____
• Individuals	\$ _____	_____
• Foundations	\$ _____	_____
• Other	\$ _____	_____
TOTAL	\$ _____	_____

FOUNDATION for Seacoast Health

PROJECT REVENUE AND EXPENSE BUDGET

Dates: _____ to _____

Revenue *	FSH Request	Other Foundations	Public Sources	Fundraising	Your Agency Contribution	Other Revenue	Total
FSH funding request							
Other Foundations **							
Public Sources							
Fundraising							
Your Agency Contribution							
Other Revenue (Please list sources)							
Total Income							

* Note: Please indicate which funds are committed (c) or pending (p).

** Please provide total here with details in narrative.

Total Project Expenses							
Personnel: Project Coordinator Other Staff (Itemize Staff in budget narrative)							
Program materials/supplies							
Outreach and marketing							
Phone/Fax							
Office Supplies							
Equipment							
Overhead (please list)							
Other Expenses (please list)							
Total Expenses							

Please attach a budget narrative to clarify all Revenue and Expense line items.

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TO CONTINUE EXISTING OPERATION GRANTS PROPOSAL COMPONENTS

Please present information in the format outlined below. Use this outline as a checklist in preparing your proposal and number your responses to correspond to the listing of information requirements. Proposal pages should be stapled (not bound) and pages numbered. Incomplete proposals shall not be considered. **Submit one original and one copy.**

1. Briefly describe your organization, its mission, and its current programs and services.
2. Document the continued need for what you are proposing to do. Include current in-house data, and appropriate information from other service providers with whom you collaborate.
3. Do other organizations address these needs in the community and, if so, how will your proposal supplement or augment these services?
4. If you are already collaborating with other community or statewide partners, what do each of you bring to the table? How do you and the other providers coordinate activities and avoid duplication of services? (You may wish to include letters of support from collaborators.)
5. Describe the project you propose to continue through Foundation for Seacoast Health grant funds. Provide the ages, number, and geographic area of people expected to be served. (Has this changed since your last proposal?)
6. Describe planned activities specifically including goals for services, events, participants, etc.
7. Provide a timeline with action plan and those responsible for implementation of services, events, and activities.
8. Describe the cost/benefit of your program.
9. Evaluate the success of the program, if possible, in both quantitative and qualitative terms. What specific, measurable outcomes, and what quality indicators do you use to evaluate and report on the program on a quarterly and annual basis? How will your staff use this data? What impact do you expect your

program to have on your community?

10. How will you keep the public informed about the services you offer?
11. What additional sources of financial support are being developed to ensure continuation beyond the period of Foundation for Seacoast Health funding?
12. What is the vision of where your program will be in the next three years?

ATTACHMENTS

With all proposals, please attach in the following order:

- Board resolution or transmittal letter authorizing grant request;
- Agency organizational chart;
- Curriculum Vitae of person responsible for proposed program;
- One paragraph abstracts of staff involved with program implementation;
- Current list of Board of Trustees with addresses;
- Current operating budget;
- Current audit/financial statement;
- Copy of current 990 federal tax return;
- Letters of support from clients and/or collaborating partners (optional);
- Current program brochures or marketing materials (optional).