INQUIRY FORM

Date:

Project Director/Principal Investigator

Prefix: **Name:** **Suffix:**

Title:

Organization:

Email: **Secondary Email:**

Phone:

Address (Line 1):

Address (Line 2):

City: **County:** **State:** **Zip Code:**

Website:

Secondary Contact

Name: **Email:**

Title of Program/Project:

Select Grant Program for submission: Community Research (CHM ONLY)

Focus area of the Children's Foundation the program/project addresses (select all that apply):

Physical Health Mental Health Substance Use Disorder Health Equity Access

CHM Legacy Initiatives (CHM ONLY) CHM Research (CHM ONLY)

Target Population (Number and age range):

Purpose of Project (Include target population; character limit: 1000)

Description of Project (Include rationale and target population; character limit: 2000)

Expected Impact/Outcomes (Include measurable outcomes and what impacts and outcomes you expect the target population to experience because of the project; character limit: 1500)

How will expected Impact/Outcomes be measured? (character limit: 1500)

How will your project address Health Equity, Access, or the Social Determinants of Health? (char limit: 1200)

How will the proposed project be sustained by the end of the grant period? (char limit: 1200)

Total Project Budget:

Grant Request Amount:

Estimated Start Date:

Please email the completed form to: Grants@yourchildrensfoundation.org