

INQUIRY FORM

Date:

Project Director/Principal Investigator

Prefix:	Name:		Suffix:	
Title:				
Organization:				
Email:			Secondary Email:	
Phone:				
Address (Line 1):				
City:	County:		State:	Zip Code:
Website:				
Secondary Contact	:			
Name:		Email:		

Title of Program/Project:

Please select the Children's Foundation focus area(s) relevant to your organization type and program/project:

COMMUNITY ORGANIZATIONS	Physical Health	Mental Health	SUD	Health Equity	Research
CHM INITIATIVES *Please read below	Programs	Research			

*CHM Initiatives include programs and research led by Children's Hospital of Michigan (CHM), University Pediatricians, CMU, and programs led by community organizations or universities serving patients at CHM. All new CHM program funding inquiries must have prior approval from CHM administration before submitting this form. Research funding inquiries from CHM, CMU, and University Pediatricians must be approved by Dr. Karin Przyklenk, Scientific Director, Clinical Research Institute, before submitting this form. Please reach out to Dr. Przyklenk at przyk1k@cmich.edu

Target Population:NumberAge Range

Purpose of Project (Character limit: 750)

Description of Project (Include rationale. Character limit: 2000) For research proposals, please attach a one-page abstract that includes in text citations. Click here for a sample: Sample Abstract

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 Social Determinants of Health? (Character limit: 1200)

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

Total Project Budget:

Grant Request Amount:

Estimated Start Date:

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