INQUIRY FORM

Date:

Project Director/Principal Investigator Name:

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 of Michigan focus area(s) relevant to your organization type and project:

COMMUNITY ORGANIZATIONS	Physical Health ☐	Mental Health ☐	SUD ☐	Health Equity ☐ Youth Arts Education ☐ Early Childhood Ages 0-5 ☐	Research ☐
CHILDREN'S HOSPITAL OF MICHIGAN (CHM) INITIATIVES*	Programs ☐	Research ☐			

*CHM Initiatives include grants made to Children's Hospital of Michigan (CHM), University Pediatricians, CMU, and community organizations or universities with programs directly impacting patients at CHM. Research conducted by CHM, University Pediatricians, or CMU investigators must be vetted by Dr. Karin Przyklenk, Scientific Director, Clinical Research Institute, prior to submission of this Inquiry Form. Please reach out to Dr. Przyklenk at przyk1k@cmich.edu

Target Population: **Number** **Age 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