BayCare Clinic Foundation Grant Request

BayCare Clinic Foundation Mission Statement: The mission of BayCare Clinic Foundation is to promote the health and well-being of northeastern Wisconsin residents.

Thank you for your interest in receiving financial support from the BayCare Clinic Foundation for your health- and/or wellness-related community program, project or service.

For the BayCare Clinic Foundation Board of Directors to consider your request, you must respond to all questions completely. You may wish to add attachments and supporting documentation, this can be done at the end of the form.

All fields marked with a red asterisk * are required.

Please review the following information and email grants@baycareclinic.com with questions.

Eligibility:

- Applicants must be 501(c)(3) nonprofit organizations in good standing.
- Organizations must operate within the counties served by BayCare Clinic.
- Programs proposed for funding must improve health and wellness in our community.

Non-funded Activities:

- Endowments or debt reductions.
- Political campaigns or lobbying efforts.

- Activities that have already occurred or expenses already incurred.
- Hiring new staff or operational activity that would otherwise require ongoing revenue for program sustainability
- Unrestricted gifts to foundations

Funding Period

BCCF accepts grant applications through the year. We fund approved requests quarterly. Grant requests submitted to BCCF are reviewed quarterly. The time it takes to review and make decisions on grant requests varies based on when your application was submitted. Please note that all grant requests submitted after October 1 may not be considered for funding during the calendar year.

1. Name of program, service or project *

2. Organization

3. Total dollars being requested *

4. Proof of 501(c)(3) Status *

Please upload your determination letter from the IRS, articles of incorporation or similar document. Only PDF files accepted.

5. W-9 Tax Information *

Please upload a completed, current W-9 form with an appropriate date. Only PDF files are accepted.

6. Where will the program or service begin? *

7. What percentage of funds stay local? *

8. What is the purpose of the program or service? *

9. How does the program or service relate to BayCare Clinic Foundation's mission? *

10. What will the program or service accomplish if/when implemented or purchased? *

11. Who will benefit from this program or service? Please be specific: age, gender, location, number in target population, etc. *

12. How was the need for this program or service determined? Provide results of surveys, needs analysis, feasibility study, etc. *

Attach supporting documentation at the end of this form.

13. How will the program or service meet the stated needs and measure its success? Include methods, procedures, assessment tools, outcome measurements, etc. *

14. What are the qualifications of the provider (organization and staff) to offer this program or service? *

15. Please provide a detailed budget to include total dollars needed to fund the program or service, total funds requested, percent of total projected costs being requested, and how the funds will be used (Please be specific. Salaries are not eligible.) *

Attach supporting documentation at the end of this form.

16. How will the program or service be funded if the grant is not approved? *

17. How will the program or service be funded after grant monies are depleted? *

18. How will the BayCare Clinic Foundation be recognized if funds are approved? *

19. What other organizations, if any, are involved in this program? *

20. Please indicate if you have applied for funds from any other sources. Include where you applied and the amounts applied for/received. *

21. What will you do with monies if more than one grant is received? *

22. Is there anything you would like to add? *

23. Include names of any BayCare Clinic providers/employees associated with this program or service. *

24. Name of contact person *

First Name Last Name

25. Address *

Street Address

Street Address Line 2

City State / Province

Postal / Zip Code

26. Email *

example@example.com

27. Supporting documentation

Only PDF files accepted.

28. Signature of applicant *

By signing this application, I certify that all information provided is true and complete to the best of my knowledge. I understand my application will not be sent to any other organization and is reviewed only by the Selection Committee. If a grant is awarded, BayCare Clinic may use my name and information received as part of the application, in communications, marketing materials, media releases and/or social media posts.