



MINI-GRANT APPLICATION

The Kent County Medical Society Alliance Foundation promotes the social welfare of West Michigan and supports organizations that promote the science and art of medicine and/or the betterment of public health and hygiene in our community.

GUIDELINES

Thank you for your interest in our Mini-Grant Program. The goal of the KCMSA Foundation is to promote the health and well being of the Grand Rapids community and surrounding areas. We do this by making funding assistance available to non-profit organizations. Consideration is given to requests that meet the following criteria:

- ★ *Provide health education, medical services, or medical supplies.*
- ★ *Promote social welfare.*
- ★ *Demonstrate a relationship between the project/proposal & our mission.*
- ★ *Located in West Michigan.*
- ★ *Up to \$3,000.*
- ★ *A 501(c)3 non-profit organization.*

NOTE: *We do NOT grant funds for paid staff positions, office supplies or office equipment.*

QUESTIONS

Attach typewritten answers on letterhead with this application cover sheet, also include any additional information that would aid our decision.

1. Describe the project/proposal. Include the purpose, need, target population & geographic area your organization will address with funds from this grant.
2. How does your project/proposal meet the goals of the Foundation?
3. Give a brief description of your organization.
4. Attach your organization's 501(c)3 IRS tax identification letter.
5. List the names and qualifications of the individuals who will implement this project/proposal.
6. Attach your organization's budget for the current year.
7. Attach project budget.

PROCESS

The KCMSA Foundation Board of Directors consider grant requests four times a year. Applicants will be notified of decisions approximately three weeks after each deadline.

Grant Application Deadlines— August 15, October 15, February 15, & April 15.

Mail to: KCMSA Foundation, 233 East Fulton, Suite 222, Grand Rapids, MI 49503 or

info@kcmsalliance.org

PROJECT/PROPOSAL TITLE

APPLICANT/ORGANIZATION

CONTACT *name, phone, address*

DATE ____/____/____

NEW REQUEST

RENEWAL

AMOUNT \$ _____

OFFICE USE ONLY: Tax ID #:

Check payable to:

Foundation Board Action Date: ____/____/____

Disapproved Approved

Date Paid: ____/____/____

Reason for denial: