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# GRANT APPLICATION

Please fill out this grant application, keeping the total application length to no more than 4 pages. Additional information or clarification will be requested if needed. The most important consideration in your application is to ensure that it is interpretable to a general audience without medical training.

**OUR MISSION:** To support children’s health initiatives that provide impact within 1-3 years throughout southeastern Wisconsin.

## APPLICANT INFORMATION

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Full Name: |  |  |  | Date: |  |
|  | Last | First | M.I. |  |  |

|  |  |  |
| --- | --- | --- |
| Address: |  |  |
|  | Street Address |  |

|  |  |  |  |
| --- | --- | --- | --- |
|  |  |  |  |
|  | City | State | ZIP Code |

|  |  |  |  |
| --- | --- | --- | --- |
| Phone: |  | Email |  |
|  |  |  |  |
|  | Please include a resume or curriculum vitae with your application. | | |

## BACKGROUND

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| *Please provide a background of the state of the art, medical necessity, or other relevant information that explains the need for the grant.* |

## PURPOSE

*Explain what problem, health initiative, or need this grant will address, solve, or advance.*

## NEED

|  |  |  |
| --- | --- | --- |
| *Provide a description around the level of need and/or why this has not been addressed in your field or institution to date. This may include financial reasons, visibility, practicality, or other considerations.* |  |  |

## TOTAL GRANT AMOUNT REQUESTED

*Total funds being requested and a breakdown of what the funds will do. For example: $1,000 in supplies, $1,000 in administrative costs, $1,000 for study execution time. Historically, grants have ranged up to $30,000 per need.* ***Funds may not be used to cover institutional indirect costs or overhead.***

## IMPACT

*How many patients each year, or how large of a total care pool will this grant impact?*

## TIMELINE

*Please describe when (how many months, years) the first medical or social impacts would be realized in the target audience or patients.*

## THE UNDERSERVED

*Is there a medically, social-economic, or otherwise unrecognized population that this helps support, serve, or improve the care of?*

I certify that my answers are true and complete to the best of my knowledge.

If this application leads to employment, I understand that false or misleading information in my application or interview may result in my release.

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| --- | --- | --- | --- |
| Signature: |  | Date: |  |