



Salina  
Regional  
Health  
Foundation

## Grant Application

Community Health Investment Program (CHIP)

Applicant: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_

State: \_\_\_\_\_ Zip: \_\_\_\_\_ Email: \_\_\_\_\_

Contact Person: \_\_\_\_\_ Telephone: \_\_\_\_\_

Project Title: \_\_\_\_\_

### Funding Priorities

CHIP grants may be awarded to healthcare programs/projects proposed by eligible organizations that address the following priorities. Please select whether your request falls into one or more of these categories:

Children's Health (prenatal to 18 years)	<input type="checkbox"/> Yes
Depression/Mental Health	<input type="checkbox"/> Yes
Aging Population	<input type="checkbox"/> Yes
Child Obesity	<input type="checkbox"/> Yes
Drug Overdose and Substance Abuse	<input type="checkbox"/> Yes
Heart Disease Related Indicators	<input type="checkbox"/> Yes
Stroke	<input type="checkbox"/> Yes

If you did **not** answer "yes" to any of the above priorities, your request does not fall under the CHIP funding requirements. If you have any questions, please contact Marla McElderry, Executive Director, at [mmcelder@srhc.com](mailto:mmcelder@srhc.com).

If you answered "yes" to any of the above priorities, please explain how your request falls into the category in the field below:

**Policies**

Applicants are limited to one CHIP application per 12-month period (excluding Good Neighbor Fund grants), from the date their organization's previous application was considered by the CHIP Committee.

Applications for multi-year funding will not be accepted.

**Request for Funds**

- All applications must use the completed application forms as the cover page.
- On a separate page, please list your board members or principals.
- Complete the Foundation's application budget page and attach to your application.
- Please do not include any supplemental materials (brochures, letters of support, etc.)
- Using no more than two 8 ½ x 11 single-sided sheets of paper, please tell us about your proposal. Be sure to include the following, and label the information by letter in your narrative:
  - a) The mission or purpose of your organization or group
  - b) A definition of the need, including how the need has been determined
  - c) The targeted population
  - d) A description of the project
  - e) Your expected results
  - f) Your timetable and process for achieving results
  - g) How you will evaluate the process of your proposal

**Financial Information**

Time period of your project: From \_\_\_\_\_ to \_\_\_\_\_ Date when funds will be needed: \_\_\_\_\_

Total Project cost \$ \_\_\_\_\_ CHIP grant requested \$ \_\_\_\_\_

Other Funding sources \_\_\_\_\_

**Submit**

Submit 14 copies of the completed application, including additional narrative, budget and board list to:

**Salina Regional Health Foundation**

**400 S. Santa Fe Ave.**

**Salina, KS 67401**

In addition, please include one copy of the most recently completed financial audit for the applicant organization.

Questions? Contact the Salina Regional Health Foundation at (785) 452-6088,  
or email Marla McElderry, Executive Director, at [mmcelder@srhc.com](mailto:mmcelder@srhc.com).