

Pediatric Foundation of Georgia

1330 W. Peachtree St., NW, Ste. 500

Atlanta, GA 30309-2904

404-881-5091

Grant Application Form

Date: _____

Organization: _____

Address: _____

Phone: _____ Fax: _____

Contact Person: _____

Email: _____

Board President/Chair: _____

Organization's Tax Status: _____

Amount of Request: _____ Total Project Budget: _____

Organization's Total Annual Operating Budget: _____

Mission Statement of applying organization:

Description of the project for which funds are being requested in one or two paragraphs:

Does the project have medical director or is a physician otherwise involved? If so, please name them below:

Describe the target population that you plan to serve with the project:

List the partners and briefly describe their responsibilities and contributions to the project:

What are the three outcomes you expect to occur during the grant period as a result of the services of your program? Briefly describe the method you will use to measure each outcome:

Outcome 1:

Measurement tool 1:

Outcome 2:

Measurement tool 2:

Outcome 3:

Measurement tool 3: