Medical Center Neighborhood Fund

Phone: 212-305-8060 **Fax: 212-342-3914** **E-mail**: *gca@cumc.columbia.edu*

2020 REQUEST FOR APPLICATIONS

Application Deadline: Friday, January 24, 2020

Name of organization:

_____

Address:

_____

_____

Program director:

Name: _____

Title: _____

Phone: _____

Email: _____

Title of program:

_____

Total program budget: $_____

Amount requested in this proposal: $_____

Tax ID #: _____

Fiscal conduit (if applicable):

Organization Name: _____

Address: _____

_____

Phone: _____ Email: _____

Geographic area(s) served by this program:

_____

Collaborative partners (if applicable):

_____

Has your organization ever applied to the Medical Center Neighborhood Fund? Yes _____ No _____

If yes, please indicate the amount and the most recent fiscal year: $_____ YR_____

Signature of program director:

_____ Date: _____

Signature of fiscal conduit:

_____ Date: _____

Year organization formed: _____ Annual operating budget: $_____
Approximate population within service area_____
Number of employed staff _____ Number of volunteers _____

I. CURRENT MAJOR SOURCES OF ORGANIZATION FUNDING

Source	Annual Amount

II. Please describe the overall purposes and general activities of your organization. Please attach organizational brochures or other supportive material such as flyers and website addresses.

Title of proposed program for funding: _____

Is the program new? or existing? Start date: _____ End date: _____

I. Executive Summary

Please provide a summary of the proposed program/ project.

II. Please provide the following information for your proposed program: (purpose of the program, importance to the community, community involvement, if any in the program, number of people who will directly benefit, staff and their responsibilities to the program)

BUDGET SHEET

I. PROPOSED PROGRAM BUDGET

A. EXPENSES	TOTAL PROGRAM BUDGET $		TOTAL FUNDING REQUEST $
1. Program Supplies	1.		1.
2. Equipment Rental	2.		2.
3. Transportation	3.		3.
4. Space Rental	4.		4.
5. Advertising & Publicity	5.		5.
6. Other/ Consulting Services/ Stipend (specify)	6.		6.
TOTAL EXPENSES			
B. PERSONNEL EXPENSES			
1. 2. 3. 4. 5. 6.	1. 2. 3. 4. 5. 6.		***MCNF grants cannot be used to cover or support personnel expenses**
TOTAL BUDGET (A+B)			**MCNF Funding Request $**

II. OTHER SOURCES OF INCOME FOR PROPOSED PROGRAM

SOURCES	
1. Corporate/Business 2. Foundation 3. Govt. (specify) 4. Other private/individual 5. Other	1. 2. 3. 4. 5.

Organization Name: _____

Funded Program Summary Report

(If your organization has received a Medical Center Neighborhood Fund Award in the past, kindly provide a brief summary report on the outcomes of the funded program.)

Funded Program _____ Year Awarded: _____ Amount: $ _____

Describe the impact the program or project had in the community, did the program meet the goals and objectives, how did the intended audiences benefit as well as any setbacks, successes and lessons learned.