FLOW
HEALTH CARE FOUNDATION, INC.

EXECUTIVE SUMMARY

Date Submitted:

Amount of Request:

Name of Organization:

Grant Supervisor Name/Title:

Complete Mailing Address:
Grant Payments are mailed to this address.

Contact Phone:

E-mail:

FID#:

Years in Operation:

Purpose of Organization: 150 word limit

Describe the specific purpose for which Flow Health Care Foundation, Inc. funds will be used. Estimate the number of individuals reached or service provided by your program. 500 word limit

EXECUTIVE SUMMARY - continued

Estimate the reach of the proposed program.

Item/Service	Total $$	Flow $$$
Item/Service	Total $$	Flow $$$
Item/Service	Total $$	Flow $$$

Number of Individuals or Service That Will be Provided

# of Individuals/Service	Agency Total #	Flow Total #
# of Individuals/Service	Agency Total #	Flow Total #
# of Individuals/Service	Agency Total #	Flow Total #

Will the total amount of the Flow Grant be used by Dec. 31, 2023?

If NO, why not?

If your grant is funded by Flow Health Care Foundation we will place this information on our website. Please submit a digital copy of your logo and very short video link for use on our website www.flowhcf.org. This will be published along with a brief description of the grant purpose and link to your website. We will enclose your basic contact information only.

Organizational Website:

Video link:

Logo Link:

Grant Supervisor Signature: **Title:**