FLOW
HEALTH CARE FOUNDATION, INC.

2026 FHCF GRANT EVALUATION REPORT

This form is required if Flow Grant Funds were received in the prior year. No further request for funding will be granted unless this form has been submitted by September 30, 2025.

Organization: _____

Agency 2026 Total Budget:_____ **Flow Grant 2026**: _____

Primary Purpose of the Grant:

_____

How was the FHCF Grant used? ***Be specific but please summarize.***

Item/Service_____ **Total $$**_____ **Flow $$$**_____

Item/Service_____ **Total $$**_____ **Flow $$$**_____

Item/Service_____ **Total $$**_____ **Flow $$$**_____

Number of Individuals or Service Provided

# of Individuals/Service_____ **Agency Total #**_____ **Flow Total #**_____

# of Individuals/Service_____ **Agency Total #**_____ **Flow Total #**_____

# of Individuals/Service_____ **Agency Total #**_____ **Flow Total #**_____

Was the total amount of the Flow Grant be used by Dec. 31, 2026? _____Yes _____No

If not, why?

_____

Comments:

_____

_____

_____

_____

_____

Grant Supervisor Signature:_____ **Title:** _____