



Application for Visiting Nurses Foundation Grant

Return completed form to Foundation office at

222 S. Pearl St. Centralia, WA 98531

Phone (360)623-1560 Fax to: (360) 623-1563

MISSION STATEMENT

The Mission of the Visiting Nurses Foundation is to create funding for education and assistance of Home Health and Hospice patients and their families.

To be completed by the Organization or Individual: **DATE:** _____

Select one:

Home Health & Hospice Agency Fax No: () - _____

Organization Name: _____ Fax No. () - _____

Individual: _____

Contact Name: _____ Title: _____

Contact Phone: - - E-Mail: _____

Address: _____

City: _____ State: _____ Zip: _____

Contact Signature _____ Patient Name _____

Amount Requested: \$ _____ Needed by: _____ Pay to: _____

Pick up Mail _____

Address City/State Zip

What County will this grant be benefiting?

CIRCLE THE COUNTY

Adams Clallum Grant Jefferson Lewis Lincoln Mason Thurston

What service does your organization provide to the local community? _____

Specifically, What is the reason you are requesting these funds? Attach additional page if necessary.

If grant is approved, how will this grant be utilized to further our mission statement? _____

Organization Representative or Individual: By signing below I acknowledge that this form represents a request for funding and is not a guarantee of funding. Final approval is subject to the review from the Visiting Nurses Foundation. This request will not be processed unless completed and signed

Sign: _____ Print: _____ Date: _____

Foundation Use Only:

Approved: Yes No Amount Approved: \$ _____

Executive Director Approval: _____ Print: _____

Notified: _____ Date: _____ Via: _____

Report on impact by: (2 months from check date) _____